



Regular article

A qualitative analysis of case managers' use of harm reduction in practice

Emmy Tiderington M.S.W.^{*}, Victoria Stanhope Ph.D., Benjamin F. Henwood Ph.D.

New York University, Silver School of Social Work, 1 Washington Square N New York, NY 10003-6654, USA

ARTICLE INFO

Article history:

Received 17 August 2011
 Received in revised form 19 March 2012
 Accepted 20 March 2012
 Available online xxxx

Keywords:

Co-occurring disorders
 Homelessness
 Case management
 Harm reduction
 Service engagement

ABSTRACT

The harm reduction approach has become a viable framework within the field of addictions, yet there is limited understanding about how this approach is implemented in practice. For people who are homeless and have co-occurring psychiatric and substance use disorders, the Housing First model has shown promising results in employing such an approach. This qualitative study utilizes ethnographic methods to explore case managers' use of harm reduction within Housing First with a specific focus on the consumer–provider relationship. Analysis of observational data and in-depth interviews with providers and consumers revealed how communication between the two regarding the consumer's substance use interacted with the consumer–provider relationship. From these findings emerged a heuristic model of harm reduction practice that highlighted the profound influence of relationship quality on the paths of communication regarding substance use. This study provides valuable insight into how harm reduction is implemented in clinical practice that ultimately has public health implications in terms of more effectively addressing high rates of addiction that contribute to homelessness and health disparities.

© 2012 Elsevier Inc. All rights reserved.

1. Introduction

Harm reduction offers a non-judgmental, pragmatic approach to working with individuals who use and abuse substances (Marlatt, 1996). The goal of harm reduction is to limit or prevent negative consequences associated with drug use rather than focusing on preventing drug use itself. Although harm reduction began as a grassroots effort to limit the spread of HIV and hepatitis B infections in the 1980s (Stimson & O'Hare, 2010), it is now considered a legitimate alternative to an abstinence-based approach to addressing drug use in a broad array of health and mental health services (Koutroulis, 2000).

Harm reduction is often characterized as a framework or approach, which is then implemented by a specific set of *practices* such as needle-exchange programs for intravenous opiate users, methadone for heroin users or nicotine patches for cigarette smokers (Perreault et al., 2007). One theory that has informed harm reduction is the trans-theoretical model of behavior change, which recognizes the need to calibrate treatment to an individual's stage of change (Prochaska, DiClemente, Velicer, & Rossi, 1992). When someone is not willing or able to be abstinent from drugs, it may, therefore, be more effective to engage that person in strategies to make their drug use safer and more responsible (Miller & Rollnick, 1991). Persistent drug abuse can be attributed to various causes including: unresolved ego conflicts that manifest in self destructive behaviors (Spotts & Shontz, 1982); the

inevitable course of a chronic medical disease (McLellan, Lewis, O'Brien, & Kleber, 2000); or self medication due to mental illnesses and adverse circumstances (Henwood & Padgett, 2007). Whatever the reasons for persistent drug use, there has been growing acceptance that, from a public health perspective, there is a need to decrease some of the negative impacts associated with drug use that can be prevented while the person continues to use (Drucker & Hantman, 1995).

Interventions designed to serve those who use drugs have often been shaped by notions of moral worthiness and a perceived need for change at an individual level that pervades much of U.S. social policy. As a result, for people who are homeless and have co-occurring disorders, access to housing has traditionally been reserved for those who “earn” it through sobriety and compliance with treatment (Dordick, 2002). This approach has not always been effective, however, as evidenced by the failure of supportive housing programs to engage or maintain people who experience long-term homelessness either residing in shelters or on the streets (Tsemberis & Eisenberg, 2000). Sobriety is a particular barrier for many people, with providers most commonly attributing service disengagement to substance abuse relapse (Stanhope, Henwood, & Padgett, 2009). Harm reduction, therefore, can be understood as a pragmatic response to the challenge of ending chronic homelessness. More recently, the notion of self-determination has been a competing moral concern that has emerged from the mental health recovery movement and given additional impetus to the harm reduction approach. Self-determination is now deemed to be an ethical imperative within behavioral health and has resulted in a greater adoption of consumer centered models of care that tailor services to consumer preferences (Drake & Deegan, 2009).

^{*} Corresponding author. New York University, Silver School of Social Work, 1 Washington Square N New York, NY 10003-6654, USA. Tel.: +1 347 423 6629; fax: +1 212 995 4836.

E-mail address: emmy.tiderington@nyu.edu (E. Tiderington).

Housing First, a supported housing program, adopted a harm reduction approach in order to engage people who are homeless with co-occurring psychiatric and substance use disorders (Tsemberis and Eisenberg, 2000). By providing people with immediate access to independent housing that is not contingent on treatment adherence or sobriety, consumers make choices about their drug use that do not necessarily threaten their housing status or the availability of helping professionals. The program has dramatically improved rates of housing stability for people experiencing long-term homelessness, with up to 85% maintaining their housing versus 55% in traditional programs (Tsemberis, Gulcur, & Nakae, 2004). Moreover, this “consumer choice” approach has resulted in substance use outcomes that are no worse (Padgett, Gulcur, & Tsemberis, 2006) and potentially better than abstinence based programs (Padgett, Stanhope, Henwood, & Stefancic, 2011). Although, there is some evidence that without augmented addiction supports there are some who may fare worse (Kertesz, Crouch, Milby, Cusimano, & Schumacher, 2009).

Housing First has been the subject of considerable empirical research and is now designated an evidence based practice (Substance Abuse Mental Health Services Administration, 2007), but there has been little research on how Housing First providers implement a harm reduction approach. The service platform for Housing First is assertive community treatment (ACT), an intensive wrap around service model with a multidisciplinary team of providers. With a staff-to-consumer ratio of approximately 1:10, providers deliver a broad range of supports primarily in the community, often seeing consumers several times a week depending on their level of need. Providers offer support and treatment based on consumer preferences, but avoid the dual role of providers in traditional housing programs where they must also act as gatekeepers to housing by monitoring consumer sobriety and compliance with treatment (Henwood, Stanhope, & Padgett, 2011). Housing First providers do play an active role in promoting housing stability for consumers, which includes facilitating relationships between consumers and landlords and intervening when problems arise, particularly around substance use (Tsemberis, 2010).

The success of ACT often depends on a strong working alliance between providers and consumers, particularly with people who have a history of service disengagement and distrust of the system (Priebe, Watts, Chase, & Matanov, 2005). Providers can permeate every aspect of their client's lives, spending time with them in a broad array of settings including their homes. Research has underscored the importance of the working alliance demonstrating that strong alliances improve retention in treatment, symptomology, quality of life, and goal attainment (Howgego, Yellowlees, Owen, Meldrum, & Dark, 2003). Moreover, consumers themselves view the relationship as one of the most important aspects of their service experience. Ware, Tugenberg, and Dickey (2004) found that, in addition to seeking treatment and material benefits, consumers were “looking for common ground,” “feeling known,” “the importance of talk” and “feeling like somebody.” Within harm reduction-based substance use treatment, consumers have described success in treatment as related to internal processes such as demarginalization and the motivation to engage in treatment programs which often occur through interactions with staff (Lee & Zerai, 2010). In addition, “hard to reach” populations such as homeless users have described harm reduction-based treatment as destigmatizing, normalizing, humanizing and non-judgmental in contrast to high-threshold abstinence-based programs in which consumers feel a loss of voice when they are unwilling or unable to abstain from substances (Lee & Petersen, 2009).

This study seeks to explore how harm reduction is both understood and shaped by the relationships and communication between providers and consumers. Qualitative research is uniquely suited to capture both the context and process of service implementation (Hopper, 2008) by providing a multifaceted and in-depth analysis of social interaction. Utilizing ethnographic methods, the study addressed the following

question: How do Housing First case managers understand and implement harm reduction support services?

2. Materials and methods

The study setting was a Housing First program in a mid-size city on the East Coast. The program consisted of two ACT teams serving approximately 125 residents, supported by housing staff and administrators. The study focused on the period immediately after a resident had been housed. Ten residents were enrolled in the study; nine had been in the program for less than 2 months and one had been in the program for more than a year but had recently been re-housed (see Table 1). Fourteen providers from the two ACT teams agreed to participate in the study (see Table 1). The teams included social workers, nurses, a substance abuse counselor, and a peer specialist. The study was approved by university and agency institutional review boards and all participants completed a consent process.

Data were collected through participant observation and by conducting semi-structured interviews. Two researchers spent approximately 280 hours in the field observing over the course of a year from 2009 to 2010. Researchers observed by accompanying case managers on visits with residents participating in the study, sitting in on daily team meetings and observing social interactions in the office. Researchers asked participants for permission to observe on each occasion. Observations were chosen in order to capture the spectrum of case manager and client interactions. They were made in various settings (home, community and office) and during a range of activities, including move-ins, shopping, and attending medical appointments. Researchers utilized “the go-along method” (Kusenbach, 2003), which involved accompanying case managers and collecting data primarily by observing and listening, but at times, they asked questions to gain insight into what was taking place in real time. The researchers had previous case management experience, which they used to “blend in” with the environment. Field notes were not taken until after the visit was completed and researchers participated in activities such as helping with a move-in and joining in the conversation when appropriate.

In-depth qualitative interviews were conducted after the participant observation had concluded. The 23 interviews ranged between 20 and 80 minutes, with the large majority taking an hour. One participant declined to be interviewed. The interviews were conducted with case managers and clients separately in order to ensure

Table 1
Sample demographics.

Characteristics	Mean	n
Resident characteristics (n = 10)		
Gender		
Male		7
Female		3
Race		
African American		5
White		5
Age	51.6	
Case manager characteristics (n = 14)		
Gender		
Male		5
Female		9
Race		
African American		2
Asian American		1
White		11
Age	29.4	
Education		
12th Grade	1	
Undergraduate	8	
Graduate	5	
Employment		
Years in Behavioral Health	4.6	

confidentially and focused on areas pertaining to engagement between consumers and providers. Areas covered by the interview were the role of housing, the harm reduction approach, and the quality of relationships between case managers and residents. The interviews were guided by a set of pre-determined, open-ended questions but the semi-structured nature of the interviews allowed for clarification or probing to pursue a certain topic in greater detail. Questions were also used to clarify observations in the field and participants were given opportunity to discuss whatever they believed to be relevant to engagement in the program. Interviews were digitally recorded and transcribed.

Transcriptions and field notes were reviewed and independently open-coded by the authors. The participant observation data (which included the “go-along” interview data) and interview data were analyzed as one unit in order to meld the intersubjective and observational data in the findings. Open codes and short descriptive statements or “memos” were used to note initial impressions of the data. Coders then met to discuss these memos and using the independently derived open codes and memos, collaboratively developed a code list (or codebook). Axial codes were also utilized (e.g. codes related to statements made by case managers regarding positive relationships and negative relationships with consumers were combined into a general “relationships” code). Transcripts were then re-coded independently using this code list and collaboratively co-coded. Researchers then used related codes to examine the concepts, conditions, and paths between them (Strauss & Corbin, 1990, p. 96). For instance, the code “negative honesty”—when consumers were not honest with providers about use was analyzed in relation to the “relationship code”—related to statements about the provider's perceived relationship with that consumer. Families of codes were extracted and analyzed. From this iterative process, themes were identified building on the code families. According to the grounded theory approach, the relationships among the themes were analyzed to provide a conceptual diagram of harm reduction practice based on the findings.

3. Results

The findings revealed the complexity of decision making that occurs when providers are implementing harm reduction. Provider participants spoke about the challenges they faced in deciding how to engage consumers' around their substance use: When to broach the subject, and what, if any considerations should be made regarding the impact that these conversations may have on the existing relationship with the consumer. The practice of harm reduction involved walking the fine line of knowing when to step in and when to stand back. Provider participants in this study described instances in which they spoke directly to consumers about their use, instances in which consumers were the first to acknowledge their use, and instances in which neither the consumer nor provider chose to directly address the use. An overarching theme found within each of these three distinct communication paths was the influence of the relationship between consumer and provider on the readiness for either party to be open and direct about the consumers' use. In turn, the degree of openness and honesty about substance use also influenced the quality of the relationship.

3.1. The relationship as the catalyst

Within an emergent model of harm reduction in Housing First practice, the quality of the relationship between consumer and provider often dictated the communication between the two parties regarding consumers' drug use. When consumer and provider experienced a positive alliance based on interpersonal dynamics and often facilitated by the program's ability to deliver on a promise of housing, communication regarding a consumer's use often took place freely. Similarly, the openness of communication between consumer

and provider served to reinforce a positive relationship. This open communication then presented greater possibilities for harm reduction conversations and practices to take place. When consumers were open about their use, providers experienced this as a willingness to at least discuss the possibility of reducing use. “I can think of people again, like, actively use and, like, it's not great but, like, for the most part they're open to at least talking about maybe using less or recognizing that it's not the best thing. You know, might keep wanting to do it but at least talk to us about it and then (inaudible) decide like, 'I want to stop.' Like, we're able to respond to that.”

Even without expressing a commitment to reducing use, open communication provided a starting point, “So once they bring it up or they talk about using then I'll go in and I'll be like, okay, you know, you're talking about—maybe they'll say, you know, 'I want to stop.' Okay, well since you want to stop I can help you with that. But I don't come out and say, 'You need to stop.' I don't want them to feel as though I'm trying to control them in any way. I don't want them to shut down on me.” This recognition of the delicate nature of these conversations and the impact they could have on the relationship reflected providers' sensitivity to the interaction between the two. Within these conversations, providers navigated a fine line of responding in a way that preserves the relationship while encouraging the consumer to address their drug use.

When the consumer and provider did directly discuss a consumer's use, these discussions were often preceded by time spent building the relationship rather than an immediate focus on a consumer's substance use. Information regarding possible consumer use may come to the attention of providers through previous case records, anecdotal evidence from others, or other third-party sources. However, according to the harm reduction approach, providers would allow the consumer to broach the subject of their use first and drive the conversation. Provider participants described using the relationship to facilitate consumer-initiated discussions, “And so typically when discussions about like using drugs comes up it's usually, you know, after so much time, after getting to know them, and we kind of begin to establish kind of a, you know, a trusting relationship and they feel comfortable talking about their drug and alcohol use. It's kind of like they just—you know, it's them bringing it up to me.” Therefore, when a consumer did broach the subject with a provider, providers often attributed this to the positive relationship they had built with the individual.

In some instances, the ability for the case manager to be flexible and creative in engaging consumers, a key component of the ACT model (Allness & Knoedler, 2003), provided the impetus for a consumer's openness about use. One provider described taking a consumer to play basketball; an activity the case manager knew that the consumer enjoyed: “And then on the way back, I mean we talked a little bit about like his drug use and his getting activity. And, you know, I felt, you know, maybe by playing basketball he felt a little more open with me and a little more comfortable talking to me about that.” This suspension of the professional–client hierarchy and the sense of familiarity established by the sharing of a common interest created an atmosphere conducive to a consumer-prompted discussion about use.

However, open discussions about drug use was not always a function of the quality of the relationship. At times, from the very beginning consumers were completely open with providers about their use, whether they were open to change. This openness that may have been reflective of habituation to treatment settings where drug use is the focus of discussion or of a natural inclination toward transparency provided opportunities for providers to engage consumers in harm reduction discussions. One consumer, who was very open with his team about his use, expressed no intention to stop using or cut down his use: “Yeah, but, you know, I mean like we all have talents, you know, but I never had ambition. You know, I never had ambitions. I encountered drugs, and the drugs I did, when I did it—first time I did narcotics, the first time it struck such a chord with me that I

knew—I knew I'd never do anything else.” With this consumer, case managers focused on minimizing the harmful side effects caused by his intravenous drug use, which they could address directly because of his honesty. However, case managers still took the long view and held out hope though that improvements in their lives because of a harm reduction approach may eventually lead to them not using. “I mean—I mean I think it—I think it definitely works. Because I think the people—I think regardless people—the people that were going to do drugs are going to do drugs anyways. And maybe there's the chance that once they get stabilized and once they see like they have their own apartment, they have this money now and their life isn't all that bad now, perhaps then they'll stop using drugs.”

3.2. The open secret

Where consumers were not open about drug use, this often became a barrier to good communication between the providers and consumers, although providers understood this to be influenced in part by consumers' previous experience with abstinence based programs. One provider described a particular consumer's use as an “open secret”: something obvious to all, but a topic that the team felt little ability to engage the individual around after he had resolutely refused to acknowledge his use despite reports of it from neighbors and other providers. Sometimes, they would figure out creative ways to get their point across while not actually addressing it directly. One provider describes talking with a consumer about medication when she was sure he was drinking, “Because, I mean he's initiated it with me quite the opposite. Like, [case manager's name], do you know there's a liquor store on every corner? But I haven't had a drink in 20 years.’ And I'm like, ‘Oh, really, [consumer name]? Well, that's really...’ So I'll go the opposite. I'll say, ‘Man, that's really important with the medications you're doing. That's wonderful.’ I mean I'll just go the opposite.” But most of the time the lack of directness had a negative impact on the consumer-provider relationship. As one provider describes, “I think that whole [harm reduction] model... everything about that falls apart if they are actively concealing something from us like using. Like, if there's walls there, then there's something that we can do to get through that. But there's this sense of being on edge and anxiety of... that I think compromises relationship...” When consumers are actively hiding use, engaging in a direct conversation about reducing harm becomes difficult to navigate without seeming accusatory. In addition, broaching the subject without the consumer *on board* for a discussion was understood as potentially endangering to the relationship, which providers felt they must maintain to have any hope of convincing consumers to address their substance use.

3.3. A holding environment

When neither provider nor consumer chose to directly discuss the consumer's substance use, provider participants described this as a point in time during which the relationship could be used to develop the trust needed to eventually explore reducing harmful use. One case manager describes this as, “More so—at first you don't bring it up. Like I know I—I don't bring it up, and I try to build a relationship with them. Once you build a relationship with someone then they're more open to talking to you about certain stuff.” In these instances, the relationship functioned more as a “holding environment” (Winnicott, 1965), which was a safe space for consumers to take their time in deciding whether to acknowledge their use. Providing a safe space for ambivalence and room for the consumer to initiate the conversation demonstrated the provider's commitment to the consumer's right to self-determination. Self-determination and a non-judgmental stance are integral parts of the harm reduction approach, which with the act of “waiting” can strengthen the therapeutic relationship and foster more direct communication. Waiting, therefore, became a harm

reduction strategy as outlined by one case manager, “We give second, third, fourth, fifth, sixth chances. You have to wait for them to come around. You have to wait for them—the only thing you can do is encourage and support. But, yeah, besides encouraging and supporting, I mean I can't say, ‘You need to stop using.’ Because that's not the model we're using. We put you in apartment and we're providing support, and if you want to stop using—I can encourage you every day, and when you're ready I—I have the resources that you need to stop using. I can make those resources available to you. The only thing we can do is encourage and support.”

Some providers described the impact a positive alliance could have on consumers' willingness to engage with substance abuse services and how providing a non-confrontational, supportive environment could facilitate communication, “But not saying she couldn't use, but just kind of helping her through that. I think in some ways that, you know, contributes to, ‘Well, I have a support system. So, and having a support system at some point and when I am ready I know that I can.’ Because she came right to us and we got her connected to a methadone clinic.” Focusing on the relationship rather than directly confronting the individual resulted in progress towards change.

3.4. Reaching a threshold

The times that providers did choose to be direct with consumers about their use, without waiting for the consumer to broach the subject, only occurred after much forethought and lengthy discussions in team meetings. In most instances the providers felt it was necessary to confront the consumers because their safety or well-being was in jeopardy. Providers expressed being conscious of the impact this confrontation could have on the relationship. “It's a little bit challenging to—like, you know, if you suspect someone's using, we don't necessarily jump to that conversation. Because we don't—because people have had negative experiences with people like accusing them and judging them. Even on like the suspicion of use, say we're wrong. What would that do to the relationship, that they would kind of go—even if it's done in a sensitive way, their memory, their muscle memory would go back to how they felt when their family member kicked them out of the apartment for using drugs, or how a program discharged them because they were using. So we are very like I think sensitive to that.” Despite these concerns, there were times when providers encountered external forces or situations in which they felt it was necessary to discuss a consumer's use whether the consumer was “ready.”

Sometimes providers directly encountered a consumer using in the community and so were able to open up a discussion about reducing harm. At these times a strong relationship could act as a buffer and facilitate a productive discussion. However, if the relationship was less solid, providers were still hesitant about initiating the discussion, “Yeah, I still wouldn't feel comfortable, like, coming out and saying like, ‘Listen, like, this all feels a little strange and outlandish.’ Like, ‘Are you using?’ I don't know. And I could have been... Maybe that would have been a good thing actually but I guess at the time it felt more like, ‘Hmm. There's enough of a chance that he's telling the truth. That, like, if I accuse him of that or even, like, suggest that I'm thinking about that, that could just do a lot of damage.”

Communication about a consumer's substance use was often precipitated by a crisis situation. Providers spoke about a “threshold” that was reached when a consumer's health, safety, or resources (such as housing) were in jeopardy and the provider then made a decision to directly confront the consumer without waiting for the consumer to open up to them or for the team to directly witness the use. One case manager described such a situation, “I think if it's something that's affecting somebody's housing, like the landlord's reporting like they're smelling marijuana smoke and if they continue to do that they're going to evict them, then we bring it up right away as a

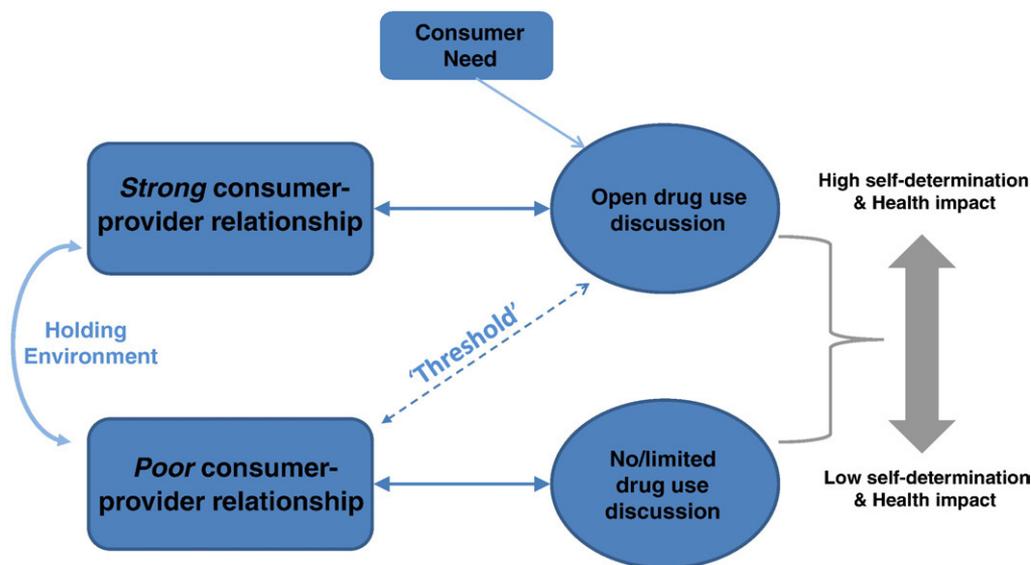


Fig. 1. Housing First harm reduction emergent conceptual model.

housing—like, you know, ‘This is going to affect your housing. You could potentially be kicked out of your apartment, and we don’t want that, so we want to know what we can do to help support you. Is there a way that we can help you,’ and try to, in that situation try to be their, like, ally. Like, ‘We’re here to help. What can we do?’ And sometimes that will open up an opportunity. Sometimes not. I don’t know.” Even in these instances, providers attempted to initiate communication regarding consumer use employing supportive and non-judgmental language that focused on the negative consequences of their use.

3.5. Emergent model of harm reduction practice

From these findings emerged a heuristic model of harm reduction practice that highlighted the profound influence of the consumer–provider relationship on the paths of communication between consumer and provider regarding substance use (Fig. 1). The themes identified different paths of communication around substance abuse according to the quality of the relationship between consumers and providers and the consumers own individual need. The quality of the relationship depended on multiple factors including interpersonal dynamics and individual histories that also took place in the context of a significant life event of transitioning from homelessness to an apartment of one’s own (Stanhope in press). These subsequent paths of communication could lead to different outcomes in terms of the course of the consumer’s substance use, impact on their health and well-being, and the extent to which they were self-determined.

4. Discussion

The study findings demonstrated how the implementation of harm reduction within intense service models such as ACT is shaped by the relationship between consumers and providers. The paths of communication that represented “when to broach the subject” about substance abuse were heavily influenced by the stage and quality of the consumer–provider alliance, which is, itself, a complex phenomenon. The emergent model identified a path where strong alliances led to an openness about substance abuse, which could then lead to interventions that would improve outcomes for clients and also potentially lead to reduced substance use or even sobriety. The extent of the openness was also influenced by the length of the relationship. There were examples of “waiting out” communication regarding consumers’ use demonstrating that harm reduction does

not always involve an active approach and sometimes requires a long term view. In addition, this path was bi-directional in that openness about substance abuse reinforced the relationship presumably leading to improved outcomes unrelated to substance use. The alternate path was when alliances were poor between providers and consumers, which often resulted in either none or limited discussion about substance use. The outcome of this lack of communication was less opportunities for case managers to discuss harm reduction strategies or encourage them to reduce their substance use.

An exception to the predominant communication paths was when consumers were direct about their drug use irrespective of their relationships with case managers. This directness may in part be due to their trust of the program as whole (based on an understanding that there would not be negative consequences) or this may have been due to the individual’s approach to drug use. Whatever the reasons, this honesty did allow case managers to discuss and implement harm reduction strategies even when consumers were not open to reducing their use. The other times where the alliance played less of a role was when concerns about safety and well-being overrode the need to let the consumer initiate a discussion and worries about harming the relationship. However, still in these cases, despite facing potential crises, case managers weighed the consequences carefully before intervening.

The communication paths could lead to varying outcomes from no progress on substance use, minimizing the harmful effects of drug use, or being able to work with consumers to treat their substance abuse. These paths also had implications for the self-determination of the consumer in terms of how substance abuse and its consequences were addressed. Overall, the approach of harm reduction respects an individual’s self-determination by not withholding services because of their choice of using substances. Instead, interventions are calibrated to and dictated by “where the client is.” In the case of strong alliances, the directness and the openness of discussion about substance use gave the most opportunity for consumers to fully participate in decision making around substance abuse and explore their individual preferences. Whereas, where there was not a good alliance, even though they were able to continue to choose using, often this impeded them having other needs met by the program, because of the barriers created by hiding their substance use. In addition, on the occasions where the substance use reached a crisis stage, then case managers would prioritize intervention over self-determination for the sake of the consumer’s overall welfare. These findings illustrate the extent to which self-determination, which

includes being informed about your options, is dependent on the quality of the helping relationship.

Harm reduction in the Housing First context, therefore, is similar to other behavioral interventions in that its success is often dependent on the social interactions between the provider and the consumer rather than the intervention, itself (Luborsky et al., 2002). The debate over therapist effects and their role in bringing about positive outcomes has persuaded some to demand “evidence based process” rather than evidence based practice (Anthony, 2003). In other contexts, such as a needle exchange program, the harm reduction approach may be far more explicit and therefore, apparent to the consumer on entry into the program. In Housing First, harm reduction is one aspect of the program and how it manifests is often mediated through the particular case manager–consumer relationship. Although, consumers are informed of the harm reduction approach, Housing First is particularly targeted at consumers who are hard-to-reach and have a distrust of the mental health system. Many have had negative experiences with abstinence only programs and they carry this experience into Housing First—whereas one consumer who was open about his substance abuse upon entering the program demonstrated a familiarity with the harm reduction approach which may have been based on prior experience of such programs.

One central mechanism in engaging people in Housing First is the “shared narrative,” the opportunity for consumers and case managers to experience together the significant and mundane events in the consumer's life on a daily basis (Stanhope in press). This, combined with social interactions that make the consumer “feel like somebody” forms the basis of a trusting relationship (Ware et al., 2004). The shared narrative helps consumers talking more openly about their substance use with case managers and conversely, when they hide their drug use, this limits the shared narrative and undermines the engagement process. On these occasions, when substance abuse escalates out of control, the harm reduction approach breaks down and case managers find themselves overriding consumer self-determination. While hard-to-reach populations have found the harm reduction approach humanizing (Lee & Petersen, 2009), within Housing First, the approach needs a positive social environment to fully realize its humanizing potential.

5. Conclusion

The demonstrated effectiveness of Housing First in engaging people who have traditionally been hard to reach has led to the widespread implementation of the program. The model has now been used in over 40 cities throughout the United States and the U. S. Veterans Administration has recently adopted a Housing First approach in all its housing programs (Tsemberis & Henwood, 2011). As the program becomes replicated in more diverse settings, concrete knowledge about how to implement harm reduction within this model becomes increasingly important. These study findings revealed that providers must show considerable discretion and clinical judgment in how they approach discussions about substance use and that these discussions occur within the context of their ongoing therapeutic relationships with consumers. Although harm reduction is embedded within the structure of Housing First, its success lies very much in the “process” of the program, i.e., the everyday decisions providers make about how they communicate with consumers. The practice skills of the case managers, therefore, mediate the public health impact of Housing First, which is keeping consumers safely housed and addressing their health needs even when they are actively using. These findings, however, were from one program and may also be shaped by the program's own organizational climate, culture and setting. More research is needed to understand this complex implementation process in diverse settings in order that Housing First continues to be effective in meeting the needs of people with co-occurring disorders.

Acknowledgments

This study was funded by the New York University Research Challenge Fund.

References

- Allness, D. J., & Knoedler, W. H. (2003). A manual for ACT start-up: Based on the PACT model of community treatment for persons with severe and persistent mental illnesses. Arlington, VA: National Alliance on Mental Illness.
- Anthony, W. A. (2003). Letter: Process, not practice. *Psychiatric Services*, 54, 402.
- Dordick, G. (2002). Recovering from homelessness: Determining the “quality of sobriety” in a transitional housing program. *Qualitative Sociology*, 25 7–5.
- Drake, R. E., & Deegan, P. (2009). Shared decision making is an ethical imperative. *Psychiatric Services*, 60, 1007.
- Drucker, E., & Hantman, J. A. (1995). Harm reduction drug policies and practice: International developments and domestic initiatives. Overview of a symposium. March 22, 1995. *Bulletin of the New York Academy of Medicine*, 72, 335–338.
- Henwood, B., & Padgett, D. K. (2007). Reevaluating the self-medication hypothesis among the dually diagnosed. *American Journal on Addictions*, 16, 160–165.
- Henwood, B. F., Stanhope, V., & Padgett, D. K. (2011). The role of housing: A comparison of front-line provider views in Housing First and traditional programs. *Administration and Policy in Mental Health and Mental Health Services Research*, 38, 77–85.
- Hopper, K. (2008). Qualitative and quantitative research: Two cultures. *Psychiatric Services*, 59, 711.
- Howgego, I. M., Yellowlees, P., Owen, C., Meldrum, L., & Dark, F. (2003). The therapeutic alliance: The key to effective patient outcome? A descriptive review of the evidence in community mental health case management. *Australian and New Zealand Journal of Psychiatry*, 37, 169–183.
- Kertesz, S. G., Crouch, K., Milby, J. B., Cusimano, R. E., & Schumacher, J. E. (2009). Housing First for homeless persons with active addiction: Are we overreaching? *Milbank Quarterly*, 87, 495–534.
- Koutoulis, G. (2000). “That original tension”—Negotiating abstinence in clinicians' accounts of harm reduction in nonresidential treatment of heroin withdrawal. *Journal of Substance Abuse Treatment*, 19, 89–98.
- Kusenbach, M. (2003). Street phenomenology: The go-along as ethnographic research tool. *Ethnography*, 4, 455–485.
- Lee, H. S., & Petersen, S. R. (2009). Demarginalizing the marginalized in substance abuse treatment: Stores of homeless, active substance users in an motion harm reduction based drop in center. *Addiction Research and Theory*, 17, 622–636.
- Lee, H. S., & Zerai, A. (2010). “Everyone deserves services no matter what”: Defining success in harm-reduction-based substance user treatment. *Substance Use & Misuse*, 45, 2411–2427, doi:10.3109/10826081003712060.
- Luborsky, L., Rosenthal, R., Diguier, L., Andrusyna, T. P., Berman, J. S., Levitt, J. T., et al. (2002). The dodo bird verdict is alive and well—Mostly. *Clinical Psychology: Science and Practice*, 9, 2–12.
- Marlatt, G. A. (1996). Harm reduction: Come as you are. *Addictive Behaviors*, 21, 779–788.
- McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association*, 284, 1719–1720.
- Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people for change*. New York, NY: Guilford Press.
- Padgett, D. K., Gulcur, L., & Tsemberis, S. (2006). Housing first services for people who are homeless with co-occurring serious mental illness and substance abuse. *Research on Social Work Practice*, 16, 74–83.
- Padgett, D. K., Stanhope, V., Henwood, B. F., & Stefancic, A. (2011). Substance use outcomes among homeless clients with serious mental illness: Comparing housing first with treatment first programs. *Community Mental Health Journal*, 47, 227–232.
- Perreault, M., Heroux, M. C., White, N. D., Lauzon, P., Mercier, C., & Rousseau, M. (2007). Treatment retention and evolution of clientele in a low threshold methadone substitution treatment program in Montreal. *Canadian Journal of Public Health*, 98, 33–36.
- Priebe, S., Watts, J., Chase, M., & Matanov, A. (2005). Processes of disengagement and engagement in assertive outreach patients: Qualitative study. *British Journal of Psychiatry*, 187, 438–443.
- Prochaska, J. O., DiClemente, C. C., Velicer, W. F., & Rossi, J. S. (1992). Criticisms and concerns of the transtheoretical model in light of recent research. *British Journal of Addiction*, 87, 825–828 [discussion 833–825].
- Spotts, J. V., & Shontz, F. C. (1982). Ego development, dragon fights, and chronic drug abusers. *International Journal of the Addictions*, 17, 945–976.
- Stanhope V. (in press). The ties that bind: Using ethnographic methods to understand service engagement. *Qualitative Social Work*.
- Stanhope, V., Henwood, B., & Padgett, D. (2009). Understanding service disengagement from the perspective of case managers. *Psychiatric Services*, 60, 459.
- Stimson, G. V., & O'Hare, P. (2010). Harm reduction: Moving through the third decade. *International Journal on Drug Policy*, 21, 91–93.
- Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage Publications.
- Substance Abuse Mental Health Services Administration (SAMHSA). (2007). National Registry of Evidence-based Programs and Practices (NREPP): Pathways' Housing First program. Retrieved from <http://www.nrepp.samhsa.gov/>.
- Tsemberis, S. (2010). *Housing first: The Pathways model to end homelessness for people with mental illness and addiction manual*. Center City, MN: Hazelden.

- Tsemberis, S., & Eisenberg, R. F. (2000). Pathways to housing: Support housing for street-dwelling homeless with psychiatric disabilities. *Psychiatric Services, 51*, 487–493.
- Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing First, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health, 94*, 651–656.
- Tsemberis, S., & Henwood, B. (2011). Pathways' Housing First: A consumer-driven approach to ending homelessness and promoting recovery. In S. A. Estrine, R. T. Hettenbach, H. Arthur, & M. Messina (Eds.), *Service delivery for vulnerable populations: New directions in behavioral health* (pp. 183–203). New York, NY: Springer Publishing Company.
- Ware, N. C., Tugenberg, T., & Dickey, B. (2004). Practitioner relationships and quality of care for low-income persons with serious mental illness. *Psychiatric Services, 55*, 555–559.
- Winnicott, D. W. (1965). *The family and individual development*. London: Tavistock Publications.

UNCORRECTED PROOF