J Primary Prevent (2007) 28:281–293
DOI 10.1007/s10935-007-0096-6

ORIGINAL PAPER

Sober Housing and Motivational Interviewing: The Treatment Access Project

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Published online: 6 June 2007

Abstract This paper describes an innovative program that provides rental subsidies for sober housing and supportive services to persons in early recovery who are homeless and have substance use disorders. Preliminary data point to the success of this program in enhancing recovery and exiting from homelessness. In supporting sober house placements, the Treatment Access Project creates a bridge that supports these individuals in their transition from clinical treatment services to the community. Integration with natural community supports can help to build self-efficacy, which can enhance the likelihood that this population will obtain and maintain abstinence, gainful employment, and permanent housing.

Keywords Homelessness · Substance abuse · Sober housing · Housing supports

Introduction

The most recent reports of homelessness in America estimated that in 1996 approximately 637,000 adults were homeless in a given week and an estimated 2.1 million adults were homeless over the course of a year (Burt 2001). Approximately 200,000 people are chronically homeless (Metraux et al. 2001),

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defined by having been homeless for a year or more, or having had at least four episodes of homelessness in the last three years (U.S. Department of Health and Human Services 2003). Individuals who are chronically homeless use proportionately more homeless assistance and social services, and are more likely to have disabling health, psychiatric, or substance use disorders (U.S. Department of Health and Human Services 2003). Substantial local and federal attention has been given over the last two decades to reducing the numbers of people who are homeless and preventing chronic homelessness.

In this paper, we report on an innovative program—The Treatment Access Project (TAP)—that provides sober housing rental subsidies and support services for homeless people with substance use disorders in the early stages of their recovery. We describe how the TAP project holds promise as a strategy for preventing chronic homelessness for persons with substance abuse disorders by (1) removing them from shelters where substance use may be widespread and into a sober setting that can serve as a buffer to relapse, (2) helping them to build a network of social supports for promoting recovery, and (3) facilitating their access to employment opportunities that will enable them to pay for continued residence in sober or independent housing. Given the absence of programs that provide housing supports for homeless persons with addiction disorders, models designed to prevent chronic homelessness among this population are critically important.

Background

Untreated substance use disorders represent a major risk factor for homelessness (Braucht et al. 1995; Hartwell 2003). An estimated 30–40% of persons who are homeless have alcohol disorders (Burt 2001); more than 15% have other substance use disorders (McCarty et al. 1991); and two-thirds have either a substance use and/or a mental health problem (Burt 1999). The economic and social costs associated with untreated substance use disorders in the population at large are staggering, reaching an estimated $245.7 billion nationally in 1992 (Cartwright 1998), a 50% increase over the 1985 estimate. Health and medical services, criminal justice costs, job losses and premature death, tax revenue losses, family impoverishment, and reliance on public assistance and other social services present a significant financial burden to society. In addition to the social and economic impacts of untreated substance abuse problems, systemic and interpersonal barriers further complicate the treatment for homeless persons with substance use disorders. Traditional substance abuse treatment programs report a high rate of relapse from substance use disorders (Hunt et al. 1971), and there are specific treatment engagement concerns regarding homeless persons with substance use disorders. An Urban Institute study, for example, found that homeless persons with substance use disorders rated their need for treatment as low (9%) compared to their need for getting a job (42%), finding affordable housing (38%), or securing other financial assistance in order to maintain permanent housing (30%). In addition, they rated insufficient income (30%), the lack of a job (24%), and the lack of affordable housing (11%) as causes of their homelessness more frequently than addiction to drugs and alcohol (9%)

(Burt 1999). These assessments are also highlighted by research demonstrating that service providers often rank their homeless clients' need for substance abuse treatment higher than do the clients themselves (Calsyn et al. 1997; Rosenheck and Lam 1997).

These findings support the rationale for assertive treatment engagement programs to increase treatment motivation among homeless persons with substance use disorders. Street outreach (Tommasello et al. 1999) and outreach using a mobile medical van (Rosenblum et al. 2002) have been effective in linking these persons to treatment. Other promising approaches include hospital-based alcoholism treatment programs (Miescher and Galanter 1996), intensive case management services (Braucht et al. 1995; Stahler et al. 1995), and on-site substance abuse treatment and relapse prevention programs in emergency shelters (Braucht et al. 1995). In the past decade, housing and employment supports have also been found to help this population achieve and maintain abstinence (Milby et al. 1996, 2000, 2003, 2004, 2005; Schumacher et al. 2000, 2002)

Despite the clear need, however, outreach-based services to homeless persons with substance use disorders are only beginning to garner recognition (Rowe et al. 2002), and such programs are rare when compared to those for persons with psychiatric disorders (Cohen et al. 1991; Dennis et al. 1991; Hopper et al. 1997; Kuhlman 1994; Martin 1990). In this paper, we report on an innovative program—The Treatment Access Project (TAP)—that provides sober housing rental subsidies and support services for homeless people with substance use disorders in the early stages of their recovery. The TAP project integrates a harm reduction philosophy that has been used successfully in Housing First, a model developed by Pathways to Housing in New York to meet the housing and treatment needs of chronically homeless persons with psychiatric or co-occurring disorders (Tsemberis et al. 2004). Housing First, which operates on the premise that housing is a basic human right, provides apartments to eligible persons without mandating their involvement in psychiatric or substance abuse treatment or imposing sobriety requirements. Service interventions are matched to participants' stage of recovery and are aimed at helping them recognize the adverse consequences of their choices and enhancing their motivation for treatment and sobriety. Initial research has shown a higher rate of retention in housing for Housing First clients over matched clients residing in traditional continuum of care programs (Tsemberis et al. 2003, 2004). To date, however, this model has been largely used for persons with primary psychiatric disorders.

The Treatment Access Program (TAP)

The TAP was funded in 2000 by the city of New Haven to provide subsidies for sober house placements for homeless persons with substance use disorders. The original design of the project used partnerships with a local substance abuse outpatient and partial hospital clinic, a detoxification program, New Haven city-funded shelters case managers, and the Outreach and Engagement (O&E) Project operated by the Connecticut Mental Health Center (CMHC). An O&E Project clinical supervisor provides ongoing oversight for project operations, supervision, and consultation to participating case managers. The South Central Behavioral

Health Network provides ongoing administrative and accounting oversight for the project.

New Haven has been committed to providing innovative services to homeless persons for the last two decades. Building on the PATH (Projects for Assistance in Transition from Homelessness) project at Columbus House, Inc., the CMHC secured funding in 1993 as part of the federal ACCESS (Access to Care and Effective Services and Supports) demonstration project to provide assertive outreach, mental health treatment, and rehabilitative services to homeless persons with mental health and co-occurring disorders (Randolph et al. 2002). When the federal funding for the ACCESS project ended in 1999, the Connecticut Department of Mental Health and Addiction Services (DMHAS) provided funding for its continuation as the O&E Project. The project's target population was expanded to include homeless persons with addiction disorders, marking it as the first project in the state to provide street outreach to addicted and homeless individuals.

As in other urban cities, New Haven is challenged with persistent homelessness. The New Haven Homeless Count 2003 (TCC 2003), using the HUD definition of homelessness, found that 1035 people in New Haven were homeless during the third week of February 2003. An estimated 3,938 people experience homelessness in New Haven at some point during the year. African Americans (43%) and Latinos (31%) are significantly over-represented among the homeless population in New Haven (TCC 2003).

Project Model

The TAP project set out to accomplish two interrelated goals: (1) to integrate motivational interviewing into case management work with homeless persons with substance use disorders, and (2) to transition individuals into sober housing who are in the contemplation phase or higher on the motivational continuum. Motivational interviewing is a counseling style that helps individuals change problematic behavior by exploring and resolving their ambivalence about change. The five key principles of motivational interviewing are: express empathy; note discrepancies between current and desired behavior; avoid argumentation; refrain from directly confronting resistance; and encourage the individual's belief that he or she has the ability to change. Empirical research has found that the use of motivational interviewing techniques leads to increased participation in substance abuse treatment and positive treatment outcomes, including a reduction in alcohol consumption, increased abstinence rates, better social adjustment, and successful referrals to treatment (Gold and Miller 1993), especially when matched to the person's stage of treatment readiness (Diclemente et al. 1991). There are six stages of treatment readiness, which are: pre-contemplation, contemplation, preparation, action, maintenance, and relapse (Diclemente et al. 1991). In the pre-contemplation stage, individuals are not interested in changing their behavior even if they have identified that it is problematic. In the contemplation stage, they may think they have a problem but are not sure if they want to change. In the preparation stage, individuals recognize they have a problem and are making or beginning to make changes to address the problem. In the action stage, they are actively doing things to

help change the problem behavior, and in the maintenance stage actively supporting their recovery. The final stage in the model is relapse, which for many individuals is part of the recovery process (Diclemente et al. 1991).

TAP project case managers participated in intensive training in the use of motivational interviewing provided by a local consultant. Once trained, they were assisted by a clinical supervisor in identifying homeless individuals who met the following criteria: resided in one of the three local city-funded homeless shelters, had a primary addiction disorder, were in the pre-contemplation phase of treatment readiness or higher, and were willing to maintain an ongoing relationship with a case manager. Clients who meet these criteria are reviewed in weekly rounds facilitated by a clinical supervisor. The supervisor also helps case managers design and implement motivational interviewing techniques specific to individual clients. Motivational interventions with clients in the pre-contemplation phase of treatment readiness include: educating clients about the rental subsidies offered by the project, ongoing engagement, small informal group sessions, and imposed limits of stay at emergency shelters. Ongoing discussion of individuals in weekly rounds affords the opportunity to monitor their progress toward the next stage of treatment readiness, contemplation.

Clients who move into the contemplation phase of treatment readiness become eligible to receive housing subsidies to reside in one of several local sober houses. Clients are considered in the contemplation stage when they are successfully involved in residential or outpatient substance abuse treatment. Residential treatment is the recommended treatment option for clients, as it affords them the opportunity to be placed in a sober house after treatment without returning to the shelter. For individuals who opt to participate in outpatient substance abuse treatment, four weeks of continued abstinence is an established requirement to receive housing subsidies.

Subsidies are provided that pay three months of full rent for sober housing, and partial rent for an additional three months. Once clients enter a sober house, case managers develop self-sufficiency plans with them detailing how they plan to pay at least half of their rent in the fourth month at the sober house and full rent after six months. The self-sufficiency plan also includes an individualized recovery plan that details the development of recovery supports. Some clients need extended intensive services (partial hospital), others need outpatient treatment services (individual and group treatment), others need medications (antabuse, methadone, buprenorphine), others need to attend 12 step recovery group meetings, and others need a combination of these recovery supports. Clients are also referred to vocational programs and offered assistance in seeking part-time or full-time employment. The project also extends funds for clients to purchase certain items deemed essential such as clothes for job interviews and for work, bus passes, and meal vouchers. After clients move into sober houses, their cases are reviewed in weekly TAP rounds and in individual supervision. Emphasis in rounds and supervision remains on motivational interviewing strategies that can be employed by case managers to assist clients move to the next stage higher on the motivational continuum.

The TAP project builds upon the success of sober housing in the United States. Oxford House bears the distinction of being the first sober house founded in 1975 in

Silver Spring, Maryland (Jason et al. 2001). The Oxford House and the sober houses that followed were designed to be supportive and democratic environments that provided an opportunity for persons with substance use disorders to support each other to sustain recovery (Jason et al. 2001; Majer et al. 2002). One of the benefits of sober housing is that it associates people with others in recovery and provides an environment that both promotes and supports recovery. For homeless people, this may serve as a better alternative than to be among people in shelters who may be actively using drugs and alcohol. For some, this may also be a better alternative than the isolation they may experience when they directly move to their own apartment after an episode of homelessness.

The sober house environment also allows people to begin to build natural supports in the community. Although TAP case managers continue to provide case management services to clients who move into sober housing, clients are encouraged to develop natural supports by attending twelve step meetings and local social groups, and becoming involved with faith-based organizations. As clients build their support networks and maintain sobriety, case managers provide less intensive services. As they move away from the clinical treatment community to support networks in the community, they may participate in more mainstream day-to-day experiences that lead to increased self-efficacy. The transition to housing and the building of social networks also serve to help homeless people move from a status of non-citizen to full citizenship by building necessary social capital.

In cases in which an individual relapses, housing subsidies are continued, provided that the person is able to remain in the sober house. Relapse necessitates a review of the supports presently available for the individual; in some cases supports need to be intensified. Individuals may need a course of residential treatment after a relapse, which does not disqualify them from continuing to receive rental subsidies.

Discharges from the project are individualized to meet the unique needs of project clients. There are two types of discharge, positive and negative. A positive discharge occurs when (1) a client is no longer receiving rental subsidies from the project; (2) the client has maintained at least six months of continuous sobriety and housing; and (3) the case manager and clinical supervisor agree that the client no longer requires assertive case management services from TAP. If clients are in need of continued case management, they either remain TAP project clients or are transferred to one of the several assertive case management programs that are managed by the O&E Project. A negative discharge occurs when clients relapse, are expelled from the sober house where they are residing, and express no current motivation for recovery. These individuals are transferred to the outreach roster of the O&E Project, where identified workers assertively use motivational interviewing techniques with them to foster their motivation for recovery.

Consistent with Housing First, the TAP project integrates the philosophy of harm reduction in service provision. The TAP program differs from Housing First in three respects. First, the project is exclusively geared toward homeless persons with primary addiction disorders. Second, the housing subsidies offered by the project are time-limited. Third, motivation for treatment is required to receive housing subsidies. These differences are driven, not by a difference in philosophy, but rather by the limited entitlement and supported housing opportunities for persons who

have primary substance use disorders. People with primary substance use disorders do not qualify for federal disability benefits. Unless these individuals are consistently employed, they cannot pay the specified portion of their rent in program-based subsidized housing. The time limits on housing vouchers and the motivational requirement for treatment are strategies to move program participants back into the workforce so that they can afford the costs associated with housing over time.

Evaluation

The purpose of this study was to evaluate data gathered on all clients who were discharged from the TAP project in the calendar year 2005 in order to (1) examine the rate of positive and negative discharges from the project, (2) review demographic information collected on clients, (3) and investigate any existing associations between variables. We hypothesized that there would be a relationship between discharge status and stage of treatment readiness at referral. This would support our notion that providing subsidies for sober housing for people in higher stages of the motivational continuum helps facilitate recovery and transition to permanent housing.

Sample

The sample consisted of 74 individuals who were discharged from the TAP project for the calendar year 2005. The 74 individuals consisted of all discharges in that time period. Of the individuals discharged, 59 were admitted to the project between July 1, 2004 and December 31, 2005. An additional 15 of the discharged individuals were admitted to the project prior to July 1, 2004. At the time of this analysis, 44 individuals who were admitted between July 1, 2004 and December 31, 2005 continued to receive active services from the project and as such were not included in the sample.

Data Collection

A semi-structured data form was designed by the authors to collect information on TAP clients when (1) they are referred for housing subsidies, and (2) they are discharged from the project. When clients are referred for housing subsidies, the case manager gathers demographic data including age, gender, and race. Additional information collected includes the number of days that individuals are homeless at the point of referral, their drug of choice, if they are abstinent and for how long, what type of treatment they are involved in, the case managers' assessment of their motivational stage, and a narrative plan for the development of recovery supports. At discharge, the case manager provides information about whether or not clients are abstinent and housed. The discharge is coded as positive when clients are abstinent and housed at discharge and negative when clients are discharged due to relapse.

Data Analysis

Frequencies, Pearson Chi square, and ANOVA analyses were used to evaluate the data collected. Analyses were tested for significance at the $p = .05$ level.

Results

Table 1 describes the demographic characteristics of the clients in the sample. Of the clients who were discharged, the majority were men less than 50 years old, with an average of 44 years and a range of 23–63 years. The average length of time these individuals were homeless at the time they were referred for housing subsidies was 448 days (range 1 day–16 years). Of these clients, nine were in the maintenance phase of treatment readiness, 35 were in the action phase, six were in preparation, 19 were in contemplation, and five were in pre-contemplation. No clients were referred in the stage of relapse.

A total of 44 of the clients were discharged with a positive status, in which they had maintained sobriety for a 6-month period of time and were stably housed at the point of discharge. A total of 30 of the clients were discharged with a negative status and were actively using substances.

A Pearson Chi square analysis found a trend toward significance between stage of treatment readiness at the point of referral and discharge status, $\chi^2(4,$

Table 1 Demographic characteristics of TAP clients who were discharged ($N = 74$)

Variable	Total	
	%	N
Age (years)		
<40	28.4	21
40–49	44.6	33
50 and older	27.0	20
Gender		
Male	85.1	63
Female	14.9	11
Race/ethnicity		
Black	54.0	40
White	28.4	21
Hispanic	16.2	12
Other	1.4	1
Days homeless		
1–90	66.2	49
91–365	13.5	10
366–1,825 (5 years)	12.2	9
1,826–5,840 (16 years)	8.1	6

$N = 74) = 9.346$, $p = .053$. A gamma analysis demonstrated a statistically significant relationship between the two variables γ(ase = .168, $N = 74$) = .411, $p = .022$. Clients who were in higher stages of treatment readiness when they were referred were more likely to be discharged with a positive status.

A one-way ANOVA with stage of treatment readiness as a between groups factor demonstrated a statistically significant relationship between stage of treatment readiness and length of time homeless, $F(4, 74) = 2.530$, $p = .048$. Post-hoc comparisons using the LSD procedure with an alpha value of .05 found that clients who were in the maintenance stage of treatment at the point they were referred for rental subsidies ($M = 1277.20$, SD = 1787.70) were homeless for significantly more days than clients who were in the contemplation stage ($M = 177.83$, SD = 495.46), $p = .025$, or the pre-contemplation stage ($M = 122.22$, SD = 145.78), $p = .043$. Additionally, clients who were in the action stage of treatment at referral were significantly homeless for more days ($M = 862.05$, SD = 1617.95) than clients who were in the contemplation stage ($M = 177.83$, SD = 495.47), $p = .020$. These associations suggest that the availability of sober housing subsidies and support services may enhance the motivation for recovery for individuals who are chronically homeless, thus providing support for the importance of assertive engagement programs with contingencies for persons who are homeless and have substance use disorders.

Discussion

The major goal of the TAP project is to prevent chronic homelessness among people who have primary addiction disorders. The high prevalence of homelessness among persons with alcohol and drug problems necessitates the development of creative and innovative strategies that reduce and prevent homelessness for this subgroup. Persons with primary addiction disorders are not qualified for local or federal entitlements that can help them transition to independent housing without employment or social supports. Programs that offer rental subsidies for sober housing as well as supports for persons with primary addiction disorders offer several advantages. First, programs can provide incentives to treatment for certain homeless addicted individuals. Second, they afford individuals the opportunity to move from residential treatment to a sober environment without returning to homeless shelters. Third, they affiliate individuals with others who are in recovery. Finally, they provide a respite in which they can attend to their recovery and begin to transition back into the workforce and rebuild social networks. Once connected to other sober individuals and employed, these individuals have a greater likelihood of retaining permanent housing. This service model, as well as other creative initiatives, not only has the potential to enhance recovery but also to prevent chronic homelessness for people with substance use disorders.

There are several limitations in the presentation of this model and the associated data. First, the sample size is small. Second, this investigation evaluated only a subgroup of people who were served by the project. A more rigorous research

design would be necessary for more precise analysis of project data. Finally, the project solicits candidates who are motivated for treatment, thus increasing the likelihood that individuals will be discharged with a positive status. As such, the ability to generalize this model to other settings is limited.

Despite the growing body of literature that points to the success of assertive and innovative programs that serve persons with substance use disorders, such programs are scarce when compared to programs that serve homeless persons with psychiatric disorders. There are two possible explanations. First, a division exists between the articulated philosophy of practice in substance abuse treatment programs and actual practice. Researchers in addictions services are learning more about the genetic causes of substance abuse, the role of the environment in the development of substance-related disorders, medications that can facilitate abstinence from addictive substances, and effective treatment models. In addition, motivational interviewing and the stages of change model promote harm reduction, or decreased substance use, and are helpful in the recovery process. This model, however, is in contrast to the abstinence model that has long dominated the substance abuse field, known as the Minnesota or Hazelton model (Anderson et al. 1999).

These opposing practice perspectives often collide in the substance abuse treatment field. Some clinicians and counselors have adopted and use the harm reduction model, while others have continued to embrace the abstinence model. As emerging evidence continues to support the harm reduction model, those who support the abstinence model may become further fixed in their position that persons with substance abuse disorders must ''hit bottom'' for treatment to be effective. Further, as a sizeable percentage of substance abuse counselors are in personal recovery from various substance-related disorders, they may be prone to counsel clients based on their own individual experiences (Forman et al. 2001), thus drawing more from their personal experience than evidence from their practice. As the contours of addiction disorders are highly individualized, no ''one size fits all'' treatment approach exists (Miller and Hester 1986).

The second issue may be related to attitudes toward substance use disorders as a disease. Although genetic studies have found a strong biological disposition to substance use disorders, current research has not found biology to be the only cause (Lessov et al. 2004). Thus, persons with substance use disorders may be viewed less favorably than people with other diseases, such as diabetes or cancer. Also, many people who have substance use disorders are fully capable of making rational decisions when they are not actively under the influence of addictive substances. Therefore, there are those who argue that people with addictions are fully responsible for their choice to consume substances, though they may be unable to stop their use once they are under the influence of addictive substances. People who support this viewpoint suggest that addiction disorders involve ''willful misconduct'' on the part of the addicted person. In this view, responsibility for the treatment, medical, and support services for addicted persons should not be assumed by public sector mental health or addiction services.

Conclusion

The TAP project offers housing incentives for treatment and assists people in early recovery to build social supports. This innovative service model has the potential to enhance recovery from substance use disorders, reduce the growing numbers of people who are homeless, and prevent chronic homelessness. Preliminary data from the TAP project suggest that alternative models of substance abuse service delivery can be effective in enhancing recovery and reducing homelessness for persons with addiction disorders. The data presented from the project, however, must be viewed with caution due to the small sample size and the short timeframe used to gather outcome data. Despite these limitations, this project has significant potential for promoting recovery among these clients. This is critical since traditional substance abuse treatment models have been largely ineffective in serving persons with substance use disorders as evidenced by (1) the high rate of recidivism from these programs; (2) the mounting social and economic costs associated with untreated substance use disorders; and (3) the high prevalence of alcohol and drug use disorders among the homeless population. The project also offers promise in reducing homelessness among persons with addiction disorders and preventing chronic homelessness.

Acknowledgments This project is funded by the City of New Haven in New Haven, Connecticut. The authors would like to thank Edward Mattison, Debra Bloom, Gail Tilley, and Barbara Reynolds for their ongoing assistance in managing various aspects of the project, and Deborah Baer for her assistance in collecting project data.

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