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Addiction Disorders and Homelessness

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The relationship between homelessness and alcohol and drug addiction is quite controversial. While addictive disorders appear disproportionately among the homeless population, such disorders cannot, by themselves, explain the increase in homelessness. Most drug and alcohol addicts never become homeless. However, people who are poor and addicted are clearly at increased risk. In the last two decades, competition for increasingly scarce low income housing grew so intense that those with disabilities such as addictive and mental disorders were more likely to lose out and find themselves on the streets.

PREVALENCE

The 2007 United States Conference of Mayors "Hunger and Homelessness Survey" reports that approximately 9.6% of the homeless population in a family with children is dealing with issues of substance abuse while 37.1% of homeless individuals are dealing with these issues. Studies that report substantially higher numbers often over-represent long-term shelter users and single men, and use lifetime rather than current measures of addiction. Another important aspect to consider is that many addiction issues arise while people are experiencing homelessness, rather than causing them to become homeless.

RELATIONSHIP TO HOMELESSNESS

In the past, single-room-occupancy (SRO) housing housed many poor individuals, in particular those persons suffering from addictive disorders and/or mental illness. From 1970 to the mid-1980s, an estimated one million SRO units were eliminated as a result of abandonment, gentrification, demolition, and conversion (Wright and Rubin, 1997). The demolition of SRO housing was most notable in large cities: between 1970 and 1982, New York City lost 87 percent of its $200-per-month-or-less SRO stock; Chicago experienced the total elimination of cubicle hotels; and by 1985, Los Angeles had lost more than half of its downtown SRO housing (Koegel et al, 1996). From 1975 to 1988, San Francisco lost 43 percent of its stock of low-cost residential hotels; from 1970 to 1986, Portland, Oregon lost 59 percent of its residential hotels; and from 1971 to 1981, Denver lost 64 percent of its SRO hotels. With such a great decline in SRO housing, many people dealing with addictions were forced into homelessness.

Untreated addictive disorders do contribute to homelessness. For those with below-living wage incomes and just one-step away from homelessness, the onset or exacerbation of an addictive disorder may provide just the catalyst to plunge them into residential instability. And for people who are addicted and homeless, the health condition may be prolonged by the very life circumstance in which s/he finds her/himself. Alcohol and drugs are often used in an attempt to relieve stressful and sometimes even violent conditions, distracting from activities oriented

toward stability. For people with untreated co-occurring serious mental illness, the use of alcohol and other drugs may serve as an inappropriate form of self-medication. For still others, a sense of hopelessness about the future allows them to discount their addictive disorder. These explanations for addiction's sway over some homeless people should not obscure the reality that many homeless persons with addictive disorders desire to overcome their disease. However, the combination of the homeless condition itself and a service system ill-equipped to respond to these diseases essentially bars their access to treatment services and recovery supports. Therefore, many homeless people view a turn to alcohol or drugs as their only outlet.

POLICY ISSUES

There are numerous barriers to treatment and recovery opportunities. Homeless people typically do not have health insurance, including Medicaid. This means that few homeless people with addictive disorder are able to find the resources necessary to pay for their own treatment or health care. In addition, there are extensive waiting lists for addiction treatment in most states. The National Association of State Alcohol and Drug Abuse Directors estimated that in 2005, over 19.3 million people needed, but did not receive, addiction treatment services. The number one reason for which people did not receive treatment was the high cost and insurance barriers (NASADAD, 2007). Moreover, people who are not easy to contact, such as homeless people, are often dropped from the lists.

A study done in 2001, found that of the 326 homeless people with substance abuse disorders sampled only 27.5% had received treatment (Wenzel et.al. 2001). The barriers to treatment include lack of transportation, lack of documentation, lack of supportive services, and abstinence-only programming. The bulk of addictive disorder treatment and recovery public policies and programs focus on abstinence as the single goal for individuals participating in programs and for the programs themselves, and in some cases forbid the alternative programs. Absolute lifetime abstinence is not a reality for the majority of people with addictive disorders; relapse is an expected occurrence in the course of treatment of the disease.
Thus, this singular focus has served as a barrier to the establishment programs willing to deal with people who have relapsed, which may be more appropriate in some cases. The abstinence-only orientation also fails to recognize the other important outcomes from individual participation in addictive disorder treatment, including improved overall physical health.

SSI policy changes appear to have increased homelessness among impoverished people suffering from addictive disorders. In March 1996, President Clinton signed into law legislation (P.L. 104-121) that denies Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) disability benefits and, by extension, access to Medicaid, to people whose addictions are considered to be a "contributing factor material to" the determination of their disability status. Thus far, an estimated 103,000 disabled individuals have lost their SSI or SSDI as a result of this legislation. SSI and SSDI benefits are often the only income that stands between an individual and homelessness. The benefits also provide access to health care through Medicaid. As such, the loss of SSI or SSDI would be detrimental so someone dealing with an addiction. This lack of insurance in the homeless population was confirmed in a 2001 study in which 2974 homeless individuals were surveyed. Of this sample, 55.6% reported that they were uninsured (Kushel, Vittinghoff, & Haas, 2001).

In a national study conducted to document the effects of SSI eligibility changes for persons served by Health Care for the Homeless, results confirmed the suspicion that loss of SSI and SSDI income is resulting in increased homelessness. Of those who had lost their SSI or SSDI because of an alcohol or drug-related disability, and of those persons who had been paying for their own housing prior to losing SSI/SSDI benefits, two-thirds lost their housing because they could no longer pay for it (National Health Care for the Homeless Council, 1997).

The dominant ideas concerning addiction that have shaped public policy stand in sharp contrast to the policies recommended by many researchers and medical practitioners. While the dominant public policy approach to addictive disorders has been punitive, the most widely recommended policies developed from medical and public health perspectives focus on prevention and treatment. This is true for housed as well as homeless populations. There has been a great deal of research based on federally funded demonstration grants on how to respond to the needs of homeless persons suffering from addiction (Oakely and Dennis, 1996). This research makes clear that housing stability is essential for successful treatment and/or recovery. Drop out rates for homeless people in addiction treatment are significantly higher in non-residential programs than in their residential counterparts (Zerger, 2002) When combined with supportive services, meaningful daily activity in the community (including work), and access to therapy, appropriate housing can provide the framework necessary to end homelessness for many individuals. Without a stable place to live, recovery often remains out of reach. Thus, for those dealing with an addiction, housing first is the ideal model for recovery.

Regrettably, the discoveries of the demonstrations have not translated into wide implementation. Research has been fairly extensive in the area of homelessness and addiction. However, very little of this research has been put into action (Zerger, 2002). Additionally, despite the severity of the problem, there are currently very few federal programs that target funds to services for homeless people who have addiction disorders. The Substance Abuse Prevention and Treatment Block Grant, the main source of federal substance abuse treatment funds, does not currently target funds to homeless people. Furthermore, current programs mandated to meet the health care needs of homeless people do not have the resources necessary to adequately address addictive disorders (Cousineau, 1995).

Congress has established two programs, the Treatment for Homeless Persons (THP) and the Projects for Assistance in Transition from Homelessness (PATH), to provide addiction and mental health services for people experiencing homelessness. However, PATH focuses mainly on mental health issues, and both lack funding; PATH was funded in FY2006 at only $54 million and THP at only $44 million, greatly impeding their effectiveness at reaching and assisting homeless (National Health Care for the Homeless Council, 2007). A budget of $100 million for each program would render them much more effective. A targeted funding stream devoted to providing services to homeless people with addiction disorders would help this population overcome homelessness.

In addition to targeted services, homeless people with addiction disorders need affordable housing, jobs that pay livable wages, and health care if they are to live and remain off the streets.

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