SHELTER FOR GOOD?:
EXAMINING THE ETHICAL ISSUES OF HOUSING FIRST FOR HOMELESS SUBSTANCE ABUSERS

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TYLER DANE BARRETT

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Dedication

This project is dedicated to the professionals who have devoted their livelihoods to serving the needs of individuals affected by addiction, homelessness, and mental illness, and dedicated to my parents, Lynn Sandeman and Mark Barrett for their enduring enthusiasm and encouragement.

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Introduction

Homelessness and substance abuse have long coexisted as chronic social problems and co-occurred within individuals as compound afflictions. According to Fichter (1999), alcoholism is the most enduring challenge in homeless males, with over 53-73 percent of chronic homeless also being chronic alcoholics. Despite the long-documented correlation between persistent and reoccurring homelessness and chronic substance abuse, up until the last decade, the two have generally been addressed separately and sequentially in a linear fashion.

The term "housing first" refers to offshoots of a program and corresponding philosophy pioneered by several homelessness service providers throughout the United States separately and simultaneously in the late 1980s and early 1990s. According to this philosophy, substance-using individuals who are homeless are allowed permanent shelter and support immediately, without having to first attend treatment and proceed through the sequential and compartmentalized system known as the continuum of care. Though a relatively nascent practice, housing first has rapidly proliferated as empirical research has demonstrated significant cost-savings and public policy has embraced the application of its principles.

Despite the swift spread and supporting research pushing the adoption of housing first policies forward, there remain a number of significant ethical considerations that have not yet been addressed. In this paper, I review the growth

and acceptance of housing first from researchers and policymakers and explore the ethical questions that accompany the practice and philosophy.

Using the principles of biomedical ethics established by Beauchamp and Childress (1979), I evaluate the moral issues of housing first considering the principles of autonomy, justice, beneficence, and nonmaleficence. I will also employ theories of feminist ethics to examine notions of relational autonomy as affected by the roles assumed in housing first settings and the ethics of care.

While many proponents of housing first policies have cited outcomes-based research as support for its acceptance (Larimer, et al., 2009), others have promoted the movement as an extension of the basic human right to housing (van Wormer & van Wormer, 2009). Relatedly, I will discuss the merit of outcomes-based support for a philosophy that some have argued should theoretically not concern itself with such validation (Stanhope & Dunn, 2009).

Though only recently employed in practice, housing first is simply another strategy in a long line of harm reduction approaches that has included needle exchanges, safe injection sites, and methadone maintenance. Alcohol-specific housing first facilities, known as wet houses, have proliferated in recent years with lively debates regarding the ethics of their philosophy (Petroskas & Moyers, 2012). I compare housing first with analogous harm reduction strategies, drawing distinctions and parallels and analyzing the ethical considerations and ongoing deliberations in the public forum.

A central question in the debate regarding housing first and wet houses specifically is if service providers have a moral obligation to encourage participants to seek treatment, despite that it is not required for residence. Questions have been raised if participants are presented with enough motivation for change or if their sobriety and chance at recovery is conceded (Collins, Malone & Larimer, 2012).

This paper explores the dilemma presented when service providers are asked to respect the autonomy and decisions of program participants and if they should quietly nudge them toward considering treatment and behavioral changes. Additionally, I examine the availability of counseling and treatment for participants and evaluate its role within the housing first philosophy.

Since housing first initiatives are seen as permanent housing for chronically homeless individuals (often with terminal substance abuse), when they are enrolled in the program it is expected they will live out the rest of their lives in the facility. This raises important questions regarding end-of-life issues, palliative care, long-term care, and hospice. Though there is relatively little research exploring these issues (Kushel & Miaskowski, 2006), I review the current literature and highlight the questions and considerations deserving further discussion.

Finally, I conclude by summarizing the current research, ethical considerations, and lingering questions. I provide recommendations for the direction of future research and policy decisions.

Part 1:
History of the problem of alcoholism and homelessness

I. Social conceptions of alcoholism and homelessness

Alcoholism and homelessness have long been connected public health and social problems in the United States, identified by academic researchers as far back as the early 1900s. Rice's (1918) article "The Homeless" (as well as Marsh, 1904; Cook, 1910; and Laubach, 1916) each confirmed that "excessive drinking" was a consistent trait of the homeless population. Early research by Solenberger (1911) and Sutherland & Locke (1936) calculated chronic alcoholism at around 10 percent, a number that would only grow with subsequent studies (as cited in McCarty, et al., 1991). Straus (1946) determined through interviews of homeless men in New Haven, Connecticut that nearly 60 percent could be classified as "steady excessive" drinkers, while another 20 percent were identified as "irregular excessive" or "spree" drinkers.

Garrett (1989) iterates the significance of these studies in not simply demonstrating prevalence but also in asserting causality. Straus (1946) reported that heavy drinking appeared to be a significant and notable factor contributing to homelessness in as many as two-thirds of the sample. Additionally, Straus expressly emphasized that the rehabilitation needs of homeless alcoholics should be differentiated from those of nonalcoholic members of the homeless population.

For many years prior to the start of the Temperance Movement in the 19th century and again before the founding of Alcoholics Anonymous in the early 20th century, alcoholism was seen as primarily a moral failing and result of weak

willpower while alcohol itself remained highly regarded (Levine, 1984). However, this concept shifted with the Temperance Movement spawned in part from Dr. Benjamin Rush's *An Inquiry into the Effects of Ardent Spirits* (1823), which reported that "drunkenness resembles certain hereditary, family, and contagious diseases."

The idea of alcoholism as primarily a question of moral integrity eventually gave way to the disease model, bolstered by the proliferation first of the Temperance Movement and later by Alcoholics Anonymous and the American Medical Association's classification as such in the middle of the 20th century. In this model, it is argued that "drug dependencies, including alcoholism, are diseases and their treatment is a legitimate part of medical practice" (American Medical Association).

Though occasionally challenged (Peele, 1985; Fingarette, 1998), the disease model has remained the dominant view of addiction as substantiated by the World Health Organization[1], American College of Physicians[2], National Institutes of Health[3], American Medical Association[4], American Public Health

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[1] World Health Organization. World Health Organization, (2004). *Neuroscience of psychoactive substance use and dependence*. Retrieved from website: http://www.who.int/substance_abuse/publications/en/Neuroscience.pdf

[2] American College of Physicians. (2007, April). Special focus: Alcohol abuse and related disorders. *ACP Observer*, Retrieved from website: http://www.acpinternist.org/archives/2007/04/special.htm

[3] National Institute on Alcohol Abuse and Alcoholism. (n.d.). *History of the NIAA*. Retrieved from http://www.niaaa.nih.gov/about-niaaa/our-work/history-niaaa

[4] American Medical Association. (n.d.). *Definitions*. Retrieved from http://www.ama-assn.org/resources/doc/alcohol/alcoholism_treatable.pdf

Association[5], Centers for Disease Control and Prevention[6], and American Psychiatric Association[7].

The conception of alcoholism as a disease is at the root of the reasoning behind the traditional orders of treatment-before-sobriety known as the "linear model" or "continuum of care." This so-called "medical model" characterizes alcohol dependence as a "chronic relapsing brain disease" that should be addressed using formal treatments that are designed to help people achieve and maintain abstinence. This model continues to be the most widely used means of housing and service provision to chronically homeless alcoholics (Collins, et al., 2012).

There are many additional reasons linear approaches have remained the standard when it comes to addressing addiction and homelessness. While some reasons are clearly due to preferences in practice, others seem based solely on principle. Rupert van Wormer and Katherine van Wormer (2009) argue that one of the primary rationales for the predominance of the linear approach is that it has been dictated by tradition. They contest that substance-abuse issues in the United States have been and remain based on the principles of Alcoholics Anonymous,

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[5] American Public Health Association. (n.d.). *Policy statement database - alcoholism*. Retrieved from http://www.apha.org/advocacy/policy/policysearch/default.htm?id=791

[6] Alcohol and public health: Frequently asked questions. Centers for Disease Control and Prevention. http://www.cdc.gov/alcohol/faqs.htm. Accessed March 29, 2010.

[7] Substance-related disorders. (2000). American Psychiatric Association (Ed.), *Diagnostic and Statistical Manual of Mental Disorders DSM-IV-TR* (4 ed.). Retrieved from http://www.psychiatryonline.com

which promotes that alcoholics are powerless over alcohol and complete abstinence is the only means to achieving freedom from its destructive nature (van Wormer & Davis, 2008).

This treatment-centered approach, which expels individuals from their treatment program if they fail to maintain their sobriety, generally follows the 12-step goals of Alcoholics Anonymous but is even more rigid. Naturally, the shelter and housing programs connected in the continuum-of-care have also followed a treatment philosophy that is abstinence based. According to Srebnik, Connor, & Sylla (2013), individuals who are homeless and disabled by mental illness, chemical dependency, and medical illnesses often cycle among hospitals, jails, emergency care, and institutional settings. Those who are homeless are far more likely than the general population to have chronic medical diseases because of lack of regular treatment.

Additionally, van Warmer and van Warmer (2009) suggest preference for the linear approach among service providers may be based on service providers' experience in practice, as well. They contend that homeless individuals who are substance using and mentally ill (or both) are among the most problematic clients, placing "unique demands on the system." Aside from what they deem "prejudice" against a "troublesome group" by service providers, they recognize that organizations may lack the resources and skills required to effectively accommodate such clients. Housing homeless individuals with co-occurring disorders (simultaneous substance addiction and mental illness) requires

specialists from multiple disciplines to provide the range of services necessitated by this population, including medical professionals, social workers, and often in-house substance abuse and mental health clinicians.

II. The birth of the housing first approach

According to Waegemakers Schiff & Rook (2012), what came to be known as housing first developed separately and nearly simultaneously in three cities without inter-coordination but all embracing some parallel philosophies and principles. Pathways to Housing in New York City, Houselink in Toronto, Ontario, and Beyond Shelter in Los Angeles, California all promoted the idea of immediate, permanent supportive housing but provided such services in different ways.

Los Angeles' Beyond Shelter introduced a program called "Housing First for Homeless Families" in 1988, though this program was aimed primarily at families with dependent children and did require at least six months of sobriety among adult family members (Tull, 2004). Despite being the first to adopt the term "housing first," I will not focus on Beyond Shelter's program due to differences in the organization's goals and scope compared to what has become known as the "housing first" philosophy.

New York's Pathways to Housing is generally considered the pioneer within literature reflecting the history of housing first (Tsemberis & Elfbein, 1999; McNaughton Nicholls & Atherton, 2011). Founded in 1992, Pathways to Housing has been touted as a highly successful model for housing and

maintaining housing for individuals dually diagnosed with substance abuse and mental health issues as well as a history of homelessness (Collins, Malone, & Larimer, 2012). Much of the reason Pathways to Housing is considered a pioneer for housing first is due to the diligent research and policy reports it has produced throughout its history. Dr. Sam Tsemberis both founded and developed the housing first model for Pathways to Housing, and has conducted and authored much of the empirical research evaluating its effectiveness.

According to an interview with Tsemberis (Evans, 2012), Housing First grew out of working directly with people diagnosed with mental illness who were living on the streets of New York, where Tsemberis determined that services beyond hospitalization were needed. He also noticed a pattern that stifled possibilities for both sobriety and stable housing: Discharging individuals back into homelessness after repeated hospitalizations made them worse and they soon became disenchanted and suspicious of treatment, eventually refusing treatment altogether. This refusal of treatment had many adverse consequences such as disqualifying people from the possibility of admission to housing programs, which would not accept referrals from people who were not medicated and sober.

This frustration led to the creation of Pathways to Housing, funded by a grant from the New York State Office of Mental Health. From the beginning, Pathways' client-centered services helped steer the development of the program as well as dictate what services were needed on an ongoing basis. Tsemberis recounts:

"Pathways was the only agency that would provide housing for people who were still using [substances] and had active psychiatric symptoms. We developed the program in collaboration with clients who, to the casual observer, may have seemed disorganized, but when communicating with us, clearly and unanimously declared that what they wanted first and foremost was a place to live (housing first!). We quickly discovered it was much easier to engage people in the program when we began to follow their lead and honor their priorities (Evans, 2012)*."*

Pathways to Housing then developed a scattered-site program renting apartments from private landlords, providing participants with ordinary residence coupled with a variety of services tailored to their needs. An Assertive Community Treatment (ACT) care team staffed with a nurse, a psychiatrist, and employment, peer, and addiction specialists provided these services in the initial model, and ACT teams are often (though not always) employed when housing first is replicated by other cities. Team members make weekly house calls, working with the individual and using a person-centered approach.

After its first year, Pathways to Housing boasted an 84 percent housing retention rate (Evans, 2012). Pathways' model has become the focus of much empirical research, including a randomized controlled trial funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) of 225 participants. The outcome of this study favored the housing first approach and led to the replication of its model to eleven cities across the United States and the

support of the US Interagency Council on the Homeless (USICH) and Mental Health Commission of Canada.

Long before Pathways to Housing became the standard model of housing first practices, in 1977 Toronto, Ontario's Houselink program began providing immediate, permanent shelter to individuals without treatment requirements (Adair, et al., 2007; Houselink 2011b). Initially providing housing for those discharged from local psychiatric facilities, Houselink has provided a variety of housing options for individuals with a history of mental illness with or without substance use issues.

Unlike Pathways to Housing, which only operates in private, rented apartments, Houselink provides access to agency-owned buildings, scattered-site apartments, and congregate care in varying levels of intensity (Waegemakers Schiff & Rook, 2012). Additionally, there is no Assertive Community Treatment (ACT) team to provide around-the-clock service, though Houselink does offer an array of support, social and rehabilitation services to all tenants (Carpinello, Rosenberg, Stone, Schwager, & Felton, 2002).

III. Shared principles and definitions

One of the challenges in assessing housing first as a policy is the variation that has occurred when diverse cities, shelters, and organizations adopt the idea of putting housing before treatment. Waegemaker Schiff & Rook (2012) identify several overarching principles that help define housing first as a philosophy

(which they title “program fidelity standards”) to provide a unified framework with which to consider housing first as an approach in research.

The guiding principle of all housing first programs is that they do not require demonstration of housing readiness, though participants cannot be incapacitated by psychiatric symptoms so as to prevent them from independent living. Support services are generally available on an ongoing basis but are not required by all programs. Services are also client-based insofar as residents are allowed to choose type, frequency, and sequence of services except when regular check-ins are required. In all housing first programs, a harm reduction model is employed, wherein tenants will not lose their housing due to substance use.

Despite these common principles, Waegemakers Schiff & Rook (2012) note that within the context of evidence-based practice, shared program fidelity standards to housing first principles have not been explicitly articulated, which impacts the generalizability of results. They argue the proliferation of these programs is affected by the leadership styles within the organizations and the political climate in which they operate.

Pleace and Bretherton (2012) see this lack of explicit fidelity as an eminent threat to the effectiveness of housing first as a policy. They argue that as cities have raced to incorporate an alternative to the traditional treatment-first model, there has been a growing diversity in “housing first” services and many have “drifted” significantly from the design established by Tsemberis and Pathways to Housing. Furthermore, they suggest that housing first as a movement

is at risk of losing focus, with discussion and implementation of programs that are only nominally based in the housing first model encompassing a variety of ideas and service models.

For the purpose of this paper, I focus on the programs within the framework established by Pathways to Housing and shared with Houselink as outlined by Waegemakers Schiff & Rook (2012). While many of the issues with loosely-based housing first implementations raised by Pleace and Bretherton (2012) have been in the European Union, programs modeled after and guided by Tsemberis and Pathways to Housing have been transplanted in Seattle, Minneapolis, Phoenix, Boston, and many other large urban centers in the United States.

Part 2:
Empirical evidence and research on housing first

I. Current state of research on housing first

Following the initial success of Pathways to Housing in housing retention, housing first has been the subject of many research studies of various types (quantitative and qualitative, evaluative, and cost-benefit). Waegemakers Schiff & Rook (2012) identify some 66 contributions to academic journals on the topic, over 100 unduplicated references of government and program publications, and thousands of articles in newspapers and magazines between 2000 and 2011.

However, despite the fact that the initial goals of the housing first approach represent a deontological-based duty to provide housing as a human right, the majority of the academic literature focus on what would be considered

treatment outcomes: decreased mental health symptoms, hospitalization rates, decreased substance abuse, and measures of harm reduction. Waegemakers Schiff & Rook (2012) assert this calls into question whether housing first programs do indeed represent housing separate from treatment, or if the audience for this research expects to see improvements in mental health and substance abuse outcomes in all housing programs. Whatever the case, there is a clear proclivity for including cost-savings analysis among any empirical research studies attempting to gauge the effectiveness of housing first.

Arguably among the most reliable empirical research is that by Larimer et al., (2009) and published in the Journal of the American Medical Association. This controlled study compared housing first participants with severe alcohol problems in Seattle with wait-list control participants over a 16-month span. Because the researchers deemed it unethical not to offer housing when available, random assignment to control groups was not used. Rather, a "first found, first assigned" basis was employed by housing program staff to determine the control group.

Results from the study showed a substantial cost savings in housing first compared to non-housing first participants. In the control group, use of services such as jail bookings and incarceration, shelter and sobering center use, hospital-based medical services, publicly funded detoxification and treatment, and emergency medical services accounted for the majority of costs. This resulted in a total overall cost rate reduction of 53 percent for housed participants relative to

wait-list controls after six months, with benefits increasing to the extent that participants were retained in housing longer (Larimer, et al., 2009). Additional research summarized by Kuehn (2012) deemed the cost savings of the Seattle supportive housing first program “impressive” when compared to linear, continuum-of-care models.

Srebnik, Connor, and Sylla (2013) found that housing first participants showed notable reductions in acute-care use relative to their comparison group, demonstrating that housing first can be a successful model for people with complex medical conditions and high prior acute-care use. Additionally, they note the cost-savings revealed as a result of these reductions in usage of high-cost services such as emergency and inpatient care, jail, and sobering services.

Gulcur, Stefancic, Shinn, Tsemberis, & Fischer (2003) conducted a truly randomized controlled study of 225 participants in New York assigned to either a traditional linear or “continuum of care” that required treatment as a prerequisite to housing or the experimental Pathways to Housing group. The results demonstrated significant success for the housing first group in reducing both the rate of homelessness and psychiatric hospitalization for the study participants.

Though not a requirement for participation in the research, the authors note that “most” of the participants also had substance abuse problems. Kertesz, Crouch, Milby, Cusimano, & Schumacher (2009) explain that because addiction alone does not qualify individuals for disability-related Social Security support,

housing first programs draw heavily on a homeless population with both medical and nonaddictive mental conditions.

This raises the question of whether there ought to be a distinction in research between housing first programs that address homeless populations with only alcoholism or substance abuse (known colloquially as wet houses), programs that focus on psychiatric and mental illness, or those that address individuals with co-occurring disorders of both chemical dependence and mental illness. Though psychotherapeutic treatment is among the standard prescriptions for both addiction and mental illness in the linear, continuum-of-care models, there is distinct variation in the rigidity of requirements, with substance abuse programs more clearly defining parameters such as recovery and relapse (Motz, 2010). Additionally, when comparing savings in financial resources, differences in cost between both housing first programs that address or specialize in substance abuse management and those that may not, as well as linear models that require treatment in addiction or psychiatric illness may prevent the collection of accurate and generalizable results.

Moreover, housing first programs designed specifically for alcoholics have different resource and specialization needs. Podymow, et al., (2006) explored the effect of shelter-based managed alcohol administration to chronically homeless people addicted to alcohol as part of the Managed Alcohol Project (MAP). In the Ottawa, Ontario study, participant-residents who had failed or refused abstinence-based services were given up to a maximum of 5 ounces of

wine or 3 ounces of sherry hourly, on demand, 7 days a week. Results showed participants significantly decreased their emergency room visits, increased their compliance with medication or attendance at medical appointments, improved overall hygiene and even decreased total alcohol consumption despite the fact that alcohol was continuously available.

This study raises the question of which, if any, outcomes should be considered a legitimate basis to support evidence-based practices and policies. Though the bulk of empirical research and policy advocacy has shown success in cost savings, studies such as that by Podymow, Turnbull, Coyle, Tetisir, & Wells, (2006) that show increased compliance with medical care or a reduction in alcohol consumption may be of greater ethical significance to a harm reduction model and the principle of beneficence (discussed in greater depth later).

Furthermore, there is widespread agreement among housing first providers that housing should be viewed as a human right, including by its pioneers in Pathways to Housing (Evans, 2012; van Wormer & van Wormer, 2009). This deontological view sees a duty to provide housing independent of other outcomes, in contrast to the consequentialist framework focusing on outcomes that has made the program attractive to policymakers.

This raises yet another question that if housing first is deontological in nature and exists to realize the duty to provide housing as a matter of principle, is even adherence-to-housing data relevant to its mission? What if housing first programs only nominally decreased rates of homelessness without significant cost

savings while substance abusing participants continued or increased rates of use and did not improve hygiene or medical care attendance? Housing first would be fulfilling its moral duty to provide housing, but if participants increased their rates of substance abuse, would this be considered enabling self-harm?

Fortunately for housing first advocates, the hypothetical question of enabling has thus far not been supported by empirical research. Collins, et al., (2012) tracked within-subject drinking of housing first participants over a two year period in Seattle, Washington, with results showing significant decreases across alcohol use outcomes. Months spent in housing consistently predicted additional decreases in alcohol use outcomes. The empirical research published by Podymow, Turnbull, Coyle, Yetisir & Wells (2006) as well as Collins, Malone & Larimer (2012) reaffirms that individual alcohol consumption tends to decline in housing first settings despite no such demands placed upon participants.

Thus, even if housing first programs were to view their mission as providing access to housing solely as a deontological imperative, research shows housing first is a successful platform for increases in housing retention rates, decreases in substance abuse rates, and—perhaps most significant from a public policy perspective—decrease in cost to the public. It is likely these persuasive measurements have been instrumental in the spread of housing first programs and its adoption as a policy by cities across the United States and internationally.

II. The significance of positivism in housing first

Still, some authors (Stanhope & Dunn, 2011; Culhane, 2008) contend the push for housing first has come with a dependence on empirical scientific standards (positivism) and is void of moral issues. Culhane (2008) asserts that moral dimensions of homelessness include dehumanization, diminished capacity to actualize basic societal rights and privileges, and susceptibility to victimization, including violence.

This bias in favor of outcomes and evidence has political implications, as well. Stanhope and Dunn (2011) argue that the proliferation of housing first has been based on an over-reliance of positivist methods and technical approach to policy making. They contend that evidence-based policy fails to integrate evidence and values into policy deliberation. Instead, social problems are adapted to the scientific method and the process of applying research to these problems can provide viable solutions. Research findings are void of ethical considerations but presented as reliable and objective due to their reliance on positivist methods measuring outcomes and producing generalizable data. Fischer (2003) explains the methods rely on abstracting and reducing aspects of the human condition to manageable measurable constructs so that alternative explanations or solutions can be compared objectively using statistical analysis.

Stanhope and Dunn (2011) argue that in regards to housing first, policy debates should not be restricted to values only since empirical knowledge is critical to the democratic process, but it must be understood that research informs but does not answer value questions.

Culhane (2008) presents a position that considers both the ethical measures and empirical costs. He argues that though less easily monetized, moral dimensions reflect 'costs' to the individuals affected, and also to society. Service utilization research is limited in that it is based on a 'cost accounting' approach to cost analysis. A more comprehensive approach would monetize other aspects of homelessness, including the value to persons and to society of having stable housing and improved health, employment prospects and relations with family members.

In defending the cost accounting approach, he argues its goal is that government agencies and the public can be shown that existing resources be allocated to most effectively assist people who are homeless with ending their homelessness. The efficient and effective use of public resources is the responsibility of policymakers and once it is identified, the moral argument regarding the use of current expenditures is given more validity (and potentially more resources), than the less tangible costs in a purely economic study of less accountable benefits to society. He concludes that researchers and advocates should be careful not to over-promise or over-generalize the results found for particular interventions for very specific populations.

III. Need for further research

Kertesz, Crouch, Milby, Cusimano & Schumacher (2009) argue that more robust research is needed in regards to housing first, and the current wave of acceptance and promotion should be tempered by more cautious investigation.

They contend that the recent proliferation may overreach the current research, wherein outcomes may not correlate with projected benefits and the public could become disenchanted with the results. The extraordinary adoption of plans to end chronic homelessness, paired with the excitement surrounding housing first as a possible solution, makes it all the more important to review the data supporting it as well as research regarding more traditional rehabilitative approaches.

Part 3:
Ethical considerations

I. Housing first as harm reduction

Housing first program architect Sam Tsemberis identifies housing first as a harm reduction approach for homeless individuals with substance abuse and psychiatric illness diagnoses (Tsemberis, Gulcur & Nakae, 2004). Leslie (2008) defines harm reduction as

> *"a strategy directed toward individuals or groups that aims to reduce the harms associated with certain behaviours* [sic]. *When applied to substance abuse, harm reduction accepts that a continuing level of drug use (both licit and illicit) in society is inevitable and defines objectives as reducing adverse consequences. It emphasizes the measurement of health, social and economic outcomes, as opposed to the measurement of drug consumption."*

This approach is applied to housing first simply in the form of substance use not precluding individuals from admittance to housing programs and sobriety never being a requirement for access to housing. Specific to serving homeless

alcoholics, wet houses seek to reduce the harm associated with homelessness while respecting the autonomy of individuals and their choice to continue drinking. Harm resulting from homelessness includes frostbite, hypothermia, heat stroke, and dehydration among other medical needs (Levy, 2011), as well as threats of violence, robbery, and other consequences of living on the street (Petroskas, 2012).

In other words, there is a concession that allowing some self-harm in the form of continued substance use while preventing harm that occurs as a byproduct of homelessness is preferable to allowing both to occur. Parallel harm reduction approaches are employed in needle exchange programs that allow intravenous drug users to continue using without the risk of contracting bloodborne diseases, oral methadone maintenance for opioid addicts, and safe alcohol consumption education for college students.

In his discussion regarding the ethics of harm reduction, Kleinig (2008) describes the place of values in harm reduction in that there is a judgment about the relative weight that different harms are accorded, and that the manifest harms prevented by harm reduction policies make them preferable to whatever the status quo without such policies may be. Though he argues that by and large, the public tacitly supports harm reduction as the lesser of two evils, opposition to a broad range (and occasionally a blanket concept) of harm reduction methods has been pervasive and vocal in equating measures intended to reduce harm with sanctioning abuse.

International support for harm reduction models has been widespread from myriad authorities including the World Health Organization (WHO), Joint United Nations Programme on HIV/AIDS (UNAIDS), Human Rights Watch, U.S. Institute of Medicine, and even the UN General Assembly (International Harm Reduction Association & Human Rights Watch, 2009). Housing first specifically has even gained the support of the department of Housing and Urban Development (HUD) in the United States.

Opposition to harm reduction in the U.S. has generally come from conservatives in the media and political spotlight. Former President George W. Bush argued that harm reduction programs weaken drug laws and "signal nothing but abdication" (Kleinig, 2008). Housing first in particular has been the target of hostile rhetoric by radio pundits who termed the approach "bunks for drunks" and has garnished antagonism from right-wing talk show hosts such as Glenn Beck and Bill O'Reilly (van Wormer & van Wormer, 2009). Much of the criticism has centered on the use of public resources to pay for services provided to chronic inebriates.

In an article titled "Bunks for Drunks Threatens to Spread," the conservative website Right Wing News asserts, "Hardcore drunks get free government-funded apartments, catered meals and complimentary beer runs from staff. […] In Seattle, they dine on three catered meals a day at a new apartment building that cost taxpayers more than $11 million (Blount, 2011). It is unclear if critics of publicly funded program components are unaware of the actual cost

savings that has been demonstrated, skeptical of the veracity of the research, or choosing to ignore it on ideological grounds.

In some ways, the opposition to housing first and harm reduction involving drug use may reflect the tension of an obligation to fighting the ongoing "War on Drugs." Though in the United States the term has been decommissioned, the policies of what was called the War on Drugs have not been abandoned (Fields, 2009). The zero tolerance policies initiated as part of the War on Drugs in the Ronald Reagan and George H.W. Bush presidencies are somewhat parallel to the abstinence-based requirements set forth by traditional linear treatment models. Both perspectives see the presence of drugs negatively in absolute terms and with a rigidity that could not be mistaken for tolerance of an individual's choice to use drugs.

Marlatt (1996) states that harm reduction offers a non-judgmental, pragmatic yet compassionate approach to working with individuals who use and abuse substances. This clearly aligns with the objective of housing first, based on the idea of consumer choice and allowing participants to define their own needs and goals and levels of service utilization. (Tsemberis, Gulcur & Nakae, 2004).

II. Respect for autonomy and the benefit of treatment

Housing first, like all harm reduction models, values the respect for autonomy of individuals in their ability to make decisions regarding their substance use or other potentially harmful activity. Identified by Beauchamp and Childress (2001) as one of four pillars in their landmark *Principles of Biomedical*

Ethics, respect for autonomy emphasizes the right of individuals to exercise self-determination in regards to decision-making and the mode and level of care they receive.

As it relates to housing first programs, respect for autonomy is reflected in policies that don't mandate sobriety, abstinence, or treatment adherence as a requisite to be considered for participation. Embracing this principle means that even if individuals choose not to attend treatment or to continue drinking or using drugs, housing is not leveraged as an incentive for them to choose differently. While the opportunity for housing first participants to seek treatment is always available, the decision to do so is theoretically placed entirely in the hands of the individual, and never as a result of coercion from the institution.

This respect for autonomy and the availability of treatment brings up an important question, for which answers thus far have varied. The question is, do housing first service providers have a moral obligation to encourage participants to seek treatment? To answer this question, there are a few basic assumptions that must be clarified. First, I assume that to be free of addiction is an ideal outcome. I also assume it is good to have access to permanent shelter. In the traditional linear, continuum-of-care model, the good of access to shelter is dependent on the good of sobriety and an individual's ability to stay sober. Therefore, the linear model puts the good of shelter at risk if factors such as chemical dependence, environmental or peer influence, or other challenges create barriers to sobriety. Additionally, this perspective assumes it is preferable to an individual to be sober,

when in fact circumstances may make substance use more desirable than housing in certain situations.

The linear approach also promotes the idea that either sobriety is a means to an end or housing is an end in itself. From this perspective, it could be argued that respect for autonomy is not being honored in the linear model, since homeless individuals seeking housing are forced to abide by what the continuum-of-care program has deemed the only way to address substance use.

As a result, homeless persons with addiction are funneled into treatment programs whether they want to be sober or not, simply in order to have access to housing. The effect is that by and large, treatment is ineffective for this population and most end up homeless and using again (Bechtel, 2010). Studies by Johnson & Chamberlain (2009) show housing is more often a precursor to sobriety, not the other way around. Their study found that approximately one-third of homeless addicts had substance abuse problems prior to becoming homeless, while two-thirds developed these problems after becoming homeless.

Research by Orwin, Garrison-Mogren, Jacobs, & Sonnefeld (1999) shows that few homeless people start treatment, and of those who do, relatively few complete it (2.5% - 30%). Perhaps of even greater relevance to this discussion, they identify that treatment engagement in this population tended to decrease as treatment demands increase.

Research by Collins, et al. (2012) on motivation for change shows that mandating treatment as a requirement for shelter-seeking homeless is also

ineffective as a means to achieving sobriety. Data from the two-year study shows a participant's own motivation to change outweighs treatment attendance in supporting alcohol behavior changes in chronically homeless individuals. This supports the philosophy set forth by Tsemberis, et al. (2004) that behavior change is most lasting if it is client-driven and thereby reflects clients' own motivation to change.

Nevertheless, if we acknowledge individuals should have unconditional access to shelter but still believe it would be better for them to be free of addiction, the question persists if it would be beneficial for service providers to apply any sort of suggestion for housing first participants to seek treatment or consider changing substance use behavior. Waegemakers Schiff & Rook (2012) report that in part, Assertive Community Treatment (ACT) teams are intended to provide "quiet encouragement" to those who wish to enter or maintain mental health and/or substance abuse treatment.

However, there is no clear indication of to what degree or for how long such intentional encouragement should be applied, especially if housing first participants are uncertain whether they want to seek treatment or decide against it after showing initial interest. Collins, et al. (2012) reports that many chronically homeless individuals do not find abstinence-based goals or treatment to be acceptable or desirable. Further, data suggests that repeated failed treatment attempts may erode self-efficacy and self-control for future behavioral change. However, many of the same individuals who were not interested in abstinence-

based treatment did express an interest in changing their drinking behavior to reduce alcohol-related problems (Collins, et al., 2012). Thus, by respecting the autonomy of the individuals, service providers were able to draw out a preference for behavior change without directly calling for it.

On the other hand, as Polcin, Korcha, Greenfield, Bond, & Kerr (2012) point out, even when problem drinkers know they need help and recognize drinking-related problems, they often do not seek assistance. Korcha, Polcin, Greenfield, Kerr, and Bond (2011) reported that those who received pressure from formal or informal sources were more likely to seek help than those not receiving pressure (as cited in Polcin, et al., 2012). Individuals who received pressure about their drinking were 5.4 times more likely than those who did not receive pressure to seek help. However, these studies do not focus specifically on homeless or dually diagnosed individuals with mental illness. Homeless persons or housing first participants are less likely to have the presence of family and friends in their lives to apply the pressure that Polcin, et al., (2012) sees as a crucial catalyst for treatment seeking and behavior changing.

II. A. Relational autonomy

While traditional notions of autonomy help provide principle to a hypothetical model individual, they do not take into account other factors that affect an individual's decision making. Taking a feminist approach to ethics, Sherwin (1998) outlines what she calls "relational autonomy" that considers the myriad dynamics at play affecting an individual's sense of autonomy. Situational

and circumstantial factors such as setting, socioeconomic and political status, gender, race and ethnicity, language, health or illness, relationships, access to certain resources and power differentials make autonomy a more relative concept than an absolutely defined principle as identified by Beauchamp and Childress (2001).

Within such a disparate dichotomy as housing first where participants often have very few resources and education while service providers are generally well-educated and accredited professionals, a thorough look at the relational autonomy of participants and service providers affords a deeper insight into the true faculty of power and change. First, one must recognize that homeless populations are among the most marginalized and disenfranchised classes of society (Buchman & Russell, 2009). This alone greatly affects the power differential between provider and participant and gives these individuals less power to act freely and without coercion.

On top of this, Sherwin (1998) points out that in situations between a patient (or in this case a resident/participant) and health care professionals, the patients generally have less social power. Since physicians and other health care professionals tend to have more education and relative affluence than even patients from the general population, there is an even greater disparity for those who work with homeless populations. When such dichotomies supporting dominance in race, gender, class, and ability exist, the patient is likely to be on the side that is marginalized.

Sherwin (1998) also emphasizes that illness tends to undermine a patient's autonomy, which is especially threatening when patients face other dominant barriers to exercise their autonomy, as members of groups that are systematically shown prejudice such as the chronically homeless alcoholics housing first serves often experience. Sherwin's use of the term illness is especially important given that the primary illness affecting housing first participants is addiction, a chronic, relapsing disease of the brain (Leshner, 1997).

The affect of substance addiction on individual autonomy has been the subject of considerable debate. The National Bioethics Advisory Commission (1998) has suggested that drug users may be impaired in decisional capacity even "outside the circumstances of intoxication and certain forms of withdrawal." However, they also concede "the diagnosis of substance abuse disorders does not imply that decision-making capacity is necessarily impaired." Beauchamp and Childress (2001) define this decisional capacity as including the ability to understand information, deliberate options, communicate a choice and appreciate the impact of that choice on one's life history and values.

Buchman & Russell (2009) argue it is imperative to consider that addicted people are what they describe as often "multiply disadvantaged: unemployed, poor, inadequately housed, medically untreated, isolated and stigmatized" (page 1053). Certainly this describes, at least in some ways, the general population of housing first participants. This vulnerability raises concerns regarding the ability to exercise autonomy due to pressures stemming from diminished relational

autonomy.

So if housing first participants can potentially have a constrained capacity for individual autonomy due to the factors described by Sherwin (1998) in her description of relational autonomy, what is at stake in the housing first context? After all, the demonstrated respect for autonomy based on the principles set forth by Beauchamp & Childress (2001) affords participants the decision *not* to attend treatment or discontinue substance use as its primary function. But if participants were actually at risk for coercion, into what would they be coerced?

Since housing is the only stated outcome desired of the program's mission, there is the possibility that homeless individuals may be unable to exercise their autonomy and are coerced when being recruited as participants for housing first programs. In some programs homeless individuals are approached on the street and recruited while in other cases individuals are filtered into housing first from medical or penal institutions (Waegemakers Schiff & Rook, 2012). Concern may be raised that these individuals are not given an equal say in their housing situation. However, this concern seems to be somewhat alleviated by the fact that participants are free to leave and return to the streets whenever they want, thus again demonstrating a respect for autonomy. That said, if individuals do have a reduced capacity for self-determination, do they in fact know what is best for them in returning to homelessness?

II. B. Addiction, mental illness, and self-determination

In some ways, the same dilemmas regarding autonomy that have always

surrounded substance abuse and psychiatric illness interventions are present in the housing first and wet house context, but in a contrasting manner. In a setting where a mentally ill or substance abusing individual is surrounded by family members or coworkers, they may stage an intervention to challenge the individual's autonomy and decisions he or she is making. The mentally ill or substance abusing individuals are confronted with the group's consensus that they are not in control of their own lives and behavioral change is required. In such situations, the individual is often persuaded to go to treatment, and may or may not have the support required of recovery to stay sober. Though posing important questions, the ethics of such staged interventions is not the focus of this paper.

In housing first, no such staged group interventions exist. First, many homeless individuals do not have the support network of family, coworkers, and friends to intervene and coerce behavior change or compel treatment attendance. Secondly, they would have to apply for public funding to pay for treatment, which would indicate an exercise of autonomy in itself. Therefore, participants who seek out treatment on their own despite the lack of demands required by housing first programs likely do not do so as a result of coercion.

II. C. Exceptions to the principle of autonomy

Of course, most significant to this discussion is whether or not housing first service providers should in any form intervene in participants' substance use or psychiatric illness. Beauchamp and Childress (2001) suggest that a tension between respect for autonomy and protection exists where the *de facto* inclination

should be to respect autonomy, but protection can trump respect for autonomy if there is significant risk for harm or questions of decisional capacity. Though it is clear that even with housing first's loose definition and treatment or sobriety not required for participants to receive housing, there is no consensus on whether service providers should "quietly encourage" treatment as is recounted by Waegemakers Schiff & Rook (2012).

Minneapolis housing first coordinator John Petroskas argues that the primary mission of housing first operations is to provide housing and the only measured outcome of significance is housing adherence data. Whether participants decide to attend treatment is entirely up to them, and they will have support regardless (J. Petroskas, personal communication, March 27, 2013).

According to Tiderington, Stanhope, & Henwood (2013), substance abuse may reach a threshold wherein providers must confront participants when their wellbeing is in jeopardy. This is often preceded by much forethought and lengthy discussions in team meetings in which providers expressed a conscious concern of the impact of the confrontation on the relationship. The authors describe a heuristic model for intervention in crisis situations, focused around the quality of the relationship between participant and provider and the paths of communication that could lead to different outcomes in terms of substance use and self-determination.

As an alternative to demanding or even suggesting housing first participants seek treatment or consider changes in substance use patterns,

Petroskas suggests a loose interpretation of motivational interviewing may be beneficial in getting residents to decide what is in their best interest. Motivational interviewing is a technique used primarily in psychotherapeutic interventions to help clients consider if they are ready for change (Rosengren, 2009).

This approach seems to be an appropriate compromise between respecting the individual autonomy of participants as a matter of principle as well as considering the relational autonomy factors that could influence individuals to be coerced into treatment due to power differentials or kept out of treatment due to a lack of familial and social support.

After all, empirical research has already shown that drinking may be reduced in housing first settings simply as a byproduct of residents having stable access to housing (Podymow, Turnbull, Coyle Yetisir & Wells, 2006; Collins, et al., 2012). To further push participants into treatment, however delicately, may jeopardize the care relationship that exists between service provider and participant. As this relationship is important to the participant's continued adherence to housing and therefore opportunity to make associated strides in health and substance use behavior, such encouragement could actually constitute a threat to the participant's possible substance use reduction.

III. Beneficence, nonmaleficence, and self-harm

Among the principles of bioethics set forth by Beauchamp and Childress (2001) are beneficence and nonmaleficence. There are two components to beneficence: positive beneficence and utility. Positive beneficence requires the

acting individual to provide benefits, while utility requires that individuals balance benefits and drawbacks to produce the best overall results.

In the context of housing first, positive beneficence is realized as the assortment of services, including shelter, provided to participants in an ongoing basis by the assertive community treatment (ACT) team and other professionals. Utility is somewhat more complex in the housing first context, as it negotiates a compromise that allows participants to continue using substances and potentially causing themselves harm while providing the benefit of continuous access to housing.

The concept of beneficence is tied closely to the principle of nonmaleficence, which Frankena (1973) defines as the duty not to inflict evil or harm, to prevent evil, and promote good, and Beauchamp and Childress (2001) shorten to simply the duty not to inflict harm or evil (as cited in Beauchamp & Childress, 2001). A potential conflict in the housing first context arises when participants are provided or administered alcohol as a part of the program. It could be argued that the principle of nonmaleficence is at risk since alcohol supplied to chronic inebriates is likely to have continued deleterious effects on the participant's health.

However, this allegation of harm is countered by the study from Podymow, Turnbull, Coyle, Yetisir & Wells (2006) that showed housing first participants administered alcohol by shelter staff actually reduced their drinking. Though providing alcohol to residents may still inflict harm, the net harm when

drinking is reduced as overall alcohol consumptions decreases, and the practice takes on more of a semblance of beneficence in that it prevents or removes evil or harm in the form of heavy drinking (Beauchamp and Childress, 2001).

There is also the question of whether it is unethical not to treat when behavior such as chronic alcohol abuse create terminal health conditions. Beauchamp and Childress (2001) identify several conditions that may override the moral obligation to treat.

One reason for abstaining from treatment is that theoretically if it were carried out it would be considered *futile* or pointless. They define the condition of futility not necessarily only in terminal instances, but anytime a situation offers only improbable outcomes, improbable success, and unacceptable benefit-burden ratios. Given the extremely high rate of treatment failure[8] and relapse into either substance abuse, homelessness, or both, the housing first philosophy of not requiring treatment seems to satisfy the conditions that override an obligation to treat.

Beauchamp and Childress (2001) also remark that it may be unjustified to begin or continue therapy knowing that it will upset a balance of pain and suffering. For chronic inebriates who face the pains associated with withdrawal or chronic pain in sobriety, this may be a justifiable reason for care providers to not compel treatment attendance.

Another facet of nonmaleficence highlighted by Beauchamp and Childress

[8] Collins, Malone & Larimer (2012)

(2001) is the distinction between killing and letting die. The question should be raised whether housing first's acceptance of continued substance use for addicts constitutes either of these acts.

It would be difficult to argue that the absence of demanding treatment in a housing first context could be considered killing. If anything, housing first's philosophy of allowing continued substance use could perhaps be construed by critics as letting die since a) no interventions are generally made to thwart the agent causing death (in this case alcohol or other drugs deleterious to health) and b) housing first functions as a long-term shelter and expects that participants will die while being housed as a result of their ongoing addictions and related complications.

However, ambulatory and extended medical care is still available to housing first participants in the event of health problems, whether they are substance-induced or not. While the ACT care teams serving housing first participants address basic health and hygiene upkeep, it is unclear if they would be responsible for making decisions in situations regarding treatment that would sustain life. The fact that questions regarding who makes decisions when a participant is not able is not clearly established is an indication that further development of an explicit protocol for housing first programs is needed.

However, according to Petroskas, most participants of housing first do not reach the end of their life in a shelter. Should participants become unable to live independently in their housing unit, they are transferred to publicly funded

nursing homes or hospice care. However, as Song, et al. (2007) and Rosseau (1998) stress, access to hospice care for homeless or transient individuals is often not available and in some cases not desired.

If housing first does not serve the role of hospice care, could it instead be considered palliative care? Palliative care is defined by the World Health Organization as “an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.”

It seems reasonable that chronic alcoholism, or at least the related illnesses it directly causes such as liver cirrhosis, pancreatitis, and polyneuropathy, would meet the conditions to be considered in the above definition. Thus housing first functions as relief by providing stable, supportive housing and care resources for individuals who suffer from the life-threatening combination of chronic alcoholism and substance abuse with recurring homelessness.

The ethical implications of this analogue are that the role of housing first acting simply as a shelter and providing basic services can help relieve the suffering of having to live on the street if addiction is unmanageable and substance abuse treatment has not been effective for individuals. By not forcing homeless addicts to attempt substance abuse treatment, housing first is able to provide care while respecting the autonomy of individuals and honoring their

decisions regarding their use.

IV. Justice

The concept of justice, one of Beauchamp and Childress' (2001) four central principles of biomedical ethics, is the "fair, equitable and appropriate treatment in light of what is due or owed to persons." Conversely, an injustice involves a wrongful act or omission that denies people benefits to which they have a right or distributes burdens unfairly."

Discourse and debates in the mainstream media[9] and even within medical ethics committees[10] have frequently pondered the question of whether alcoholics should be recipients of scarce resources (including organs) that could go to non-addicted individuals. The idea that alcoholics have chosen to abuse their body and are thus less deserving of medical interventions, care and resources than someone who is not addicted to alcohol has been propagated widely in the mainstream media, especially in regards to liver transplants.[11]

It is obvious that concerns over justice are also underlying in the aforementioned conservative rhetoric that has ideologically opposed housing first programs. Blount (2011) makes clear note of the fact that it is, in fact, alcoholics who are receiving public resources with the negative portrayal that "*Hardcore*

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[9] Newton, P. (2009, February 15). [Web log message]. Retrieved from http://www.psychologytoday.com/blog/mouse-man/200902/do-alcoholics-deserve-liver-transplants

[10] Cohen, C. & Benjamin, M. (1991). Alcoholics and liver transplantation. *Journal of the American Medical Association, 265*,1299-1301.

[11] Donors' organs should be treated with more respect. (2009, February 18). *The Week*, Retrieved from http://www.theweek.co.uk/politics/24459/donors'-organs-should-be-treated-more-respect

drunks get free government-funded apartments, catered meals and complimentary beer runs from staff."

This argument hinges on the notion that alcoholics have relinquished their just deserts for equal consideration of resources by continuing to drink even when it is deleterious to their health and livelihood. The fallacy in this line of reasoning is the assumption that alcoholics have chosen to be addicted to alcohol, and that they are somehow to blame for their disease despite that the majority of the American public consume alcoholic beverages on a regular basis.[12] Research showing that alcoholism is a chronic, relapsing brain disease[13] and not simply a choice to continue drinking challenges these arguments of alcoholism as a lack of personal responsibility or a moral failing.

There also exist questions of justice that arise when examining the selection of housing first participants. When participation as a housing recipient has been included as a part of research studies, there have been inconsistent criteria used for selection and inclusion.

In a study by Larimer, et al., (2009), participants were included on a "first found, first served" basis, with the first being enrolled as experimental group and those on the waitlist serving as the control. Conversely, Gulcur, Stefancic, Shinn,

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[12] Saad, L. (2012, August 17). Majority in U.S. drink alcohol, averaging four drinks a week. *Gallup News*. Retrieved from http://www.gallup.com/poll/156770/majority-drink-alcohol-averaging-four-drinks-week.aspx

[13] Leshner, A.I. (1997). Addiction is a brain disease, and it matters. *Science, 278*(5335), 45-47.

Tsemberis, & Fischer (2003) randomly assigned participants to either an experimental or control group, meaning some were assigned to housing first while the others were referred to the linear, continuum-of-care treatment model.

Larimer, et al., (2009) argued it is unethical to assign people to a control group when housing options are available. However, participants were drawn from a ranked list of chronically homeless inebriates who incurred the highest cost for use of alcohol-related hospital emergency, sobering, and law enforcement services.

This method of targeting for participation only the homeless individuals who cost the public the most raises the question of whether individuals who were "better behaved" but still in need of housing were overlooked for a study and project that could have potentially benefited them. Beauchamp & Childress (2001) refer to a "fairness opportunity rule" that institutions ought to counteract lack of opportunity caused by unpredictable bad luck and misfortune over which the person has no meaningful control. This rule argues that those who demonstrate the most need should be the first to receive scarce resources. In this case, the fairness opportunity rule may support recruiting the most problematic individuals for participation because the cycle of hospitalization, arrest, and treatment has already been shown not to work for them.

V. End-of-life issues

End of life issues for homeless people (including those in shelters and in this case, housing first programs) present a number of challenges. Song, et al.

(2007) argue that homeless individuals have the greatest risk of death, encounter barriers to care, and lack the resources and relationships assumed necessary for appropriate end of life care.

Many of these barriers remain even after homeless individuals are housed in programs such as housing first, where resources are still rather limited and participants may still be isolated from their families and society. Thus the findings by Song, et al. (2007) can be extrapolated to include housing first participants who often face the same challenges regarding end-of-life issues.

Specifically, Song, et al. (2007) identify six themes relating to end-of-life issues commonly expressed by homeless individuals in their research with focus groups in Minneapolis and Saint Paul, Minnesota: past experiences with end-of-life care, fears and uncertainties, advance care planning, preferences/wishes/hopes, spirituality/religion, and veteran status.

Discussions regarding end-of-life care revealed that many study participants had been exposed to poor and upsetting experiences with care. Some expressed a lack of control and opinions that interventions are intrusive and unwanted, as well as limiting of personal freedoms. This concern regarding restriction of personal freedoms lends credence to the housing first model, which may help build a culture of respect for autonomy and participant-led decision-making.

Song, et al. (2007) report that dying anonymously is a fear that may be unique to the homeless and indigent population. Likely as a result of their own

lack of resources, many participants expressed concern that their life and death would go without notice or memorialization. Common misconceptions were frequently cited, such as the idea that doctors would go to great lengths to obtain surrogate approval to end treatment or that bodies would be cremated or unceremoniously disposed of without the consent of the individual.

With regard to preferences, wishes, and hopes, participants expressed a desire for the presence of a compassionate person at the time of their death, in some instances a family member, homeless friend, or even anonymous care provider. In a housing first context, members of the Assertive Community Treatment (ACT) care team who initiate frequent contact with participants might fill this role. Additionally, participants frequently noted they would want pain to be medically managed, and that the disposal of their body be consistent with their cultural traditions. With early and diligent planning, housing first staff and ACT team members can aid in ensuring these wishes are carried out to the best of their abilities. However, it is critical that care providers are responsive primarily to participant needs and not their own agendas or those of the institution.

Advance care planning was conveyed as a means to retain some form of control given the belief that end-of-life care is paternalistic and often mismanaged by professionals. However, it is interesting to note that when surrogate decision-makers were appointed, they were rarely family members and were more frequently care providers, friends, or romantic partners.

For many participants, the idea that a higher being is present makes the

physical reality of being alone easier to cope with. Spirituality and religion helps facilitate the beliefs that regardless of family or relational status in society, one need not die alone and without the presence of God.

Another common theme was veteran status. Whether they viewed this as a point of solidarity with other veterans or as a distrust of the VA and U.S. government to carry out their wishes, experience in the armed services precipitated a significant theme of veterans' issues among participants in the study.

Relational themes also deeply permeated discussions of end-of-life issues in the study by Song, et al., (2007). Participants were commonly apprehensive about authority figures, including police, medical professionals, and even social service agency staff, feeling disrespected and disappointed in what they perceived as a low quality of care. However, others were greatly appreciative of the care providers and their ability to tend to participant needs. The same is true of family members, where many participants did not wish for their family to be involved, some did not wish to be a financial or emotional burden on their family members.

Kushel & Miaskowski (2006) state that homeless individuals rarely have access to hospice services because they lack the financial resources for inpatient hospice and have neither the home nor the social support required for home hospice. Furthermore, homeless individuals are less likely to have a surrogate decision maker. They assert that employing a care team for homeless patients helps address their needs and improve care related to end-of-life issues. For

patients who continue to use while receiving end-of-life care, they recommend scheduling frequent medical visits, using long-acting pain medications, dispensing small quantities of medications at a time, and using a written pain agreement. They contend that new paradigms such as housing first are necessary to improve care at the end-of-life for chronically homeless individuals.

Song, et al., (2007) report that homeless individuals frequently requested participant-directed interventions as a means to addressing their own end-of-life issues. This method aligns with the original goal of housing first set forth by Tsemberis and Pathways to Housing to give participants a voice in setting their own priorities in regards to care (Evans, 2012). ACT care teams who regularly engage with participants can help amplify this voice and act as intermediaries to communicate preferences and concerns with the program's case managers.

VI. Care ethics

The emphasis and functional reliance of housing first on assertive community treatment (ACT) care teams represents an example of the ethics of care, itself an offshoot of feminist ethics. Expanding on the concept of relational autonomy put forward by Sherwin (1998), care ethics regards context as fundamentally implicated in all relationships, stressing interdependence and responsibilities to concrete others (Koggel & Orme, 2010). Noddings' (1984) definition of care includes the three requirements of engrossment (gaining the perspective of another individual), motivational displacement (acting on behalf of the needs of others), and a response from he or she for whom care is being given.

Tronto (2005) identifies the four principle elements of care as attentiveness, responsibility, competence, and responsiveness. These four elements of care ethics have direct application to the philosophies of housing first and the manner in which its philosophies are carried out.

Attentiveness recognizes that the needs of others must be identified in order to care for them. This is expressed in the delivery of housing first services by the ACT teams on an around-the-clock basis and by the practice of initially and then frequently and regularly thereafter inquiring regarding participant needs and attending to them on an as-needed basis.

Responsibility is described as a personal sense of duty, separate from the sense of obligation imposed on individuals from society. In the context of housing first, service providers have a desire to offer care for participants with unconditional support and attentiveness.

Competence is also a critical component of providing care. In order to be effective in offering care, one must have the appropriate skills and knowledge base to provide support. Members of ACT care teams must possess a balanced skill set of medical, social and psychological expertise to handle the diverse challenges that arise in housing first situations and be able to respond in a way that respects and maintains the relationship between service provider and resident.

Responsiveness is stated as an acute recognition and commitment to provide care in instances of vulnerability and inequality. Responsiveness is similar to empathy with an action component, wherein caregivers are able to

identify with the care receiver and duly respond. In a housing first context, ACT members should consider the social, mental, medical and relational standing of participants when providing care and understand how it influences participants' respective viewpoints. By taking these points into consideration, care providers are able to make better judgment and provide levels of care that are both effective and do not intrude on participants' autonomy.

On a collective level, society also communicates the importance of care for vulnerable individuals by supporting public programs that address their needs such as housing first. While controversy does inevitably arise[14][15], communities have continued to adopt the housing first model, developing policies and devoting public resources in order to provide care in this manner. The public actively supports these endeavors by electing officials who allocate taxpayer funds to housing first as opposed to demanding a treatment-first approach.

Housing first embodies the spirit of care ethics and the moral responsibilities to provide support for those who are vulnerable or disadvantaged economically, socially, and medically. The ACT teams responsible for the delivery of this support exhibit the care ethics principles of attentiveness, responsibility, competence, and responsiveness in their service provision, which

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[14] Sankin, A. (2012, February 15). Wet houses, homeless shelters that give booze to alcoholics, may save San Francisco millions. *Huffington Post*. Retrieved from http://www.huffingtonpost.com/2012/02/15/wet-houses-san-francisco_n_1279755.html

[15] Welch, C., & Escobedo, T. (2011, May 11). A safe place to drink, or just giving up?. *CNN Health*. Retrieved from http://www.cnn.com/2011/HEALTH/05/11/minneapolis.wethouse.alcoholics/index.html

in turn offers a more informed and complete care delivery for housing first participants. Additionally, this care may be of practical necessity for housing first. Newman & Goldman (2008) state that for the population housing first serves to remain housed once housing is established, supportive services must be available for those who need them, as the manifestations of severe and persistent mental illness do not disappear when a mentally ill person becomes housed. To promote housing stability, individuals need services offering continuity of care, as is offered in housing first by ACT teams.

The work of ACT care teams on behalf of clients has not been without its share of criticism. Gomory (1999) asserts that a PACT (Program of Assertive Community Treatment) team's level of involvement and transfer of decision-making responsibilities from client/participant to care provider could be considered coercive and the prime mechanism for PACT is coercion backed by the biomedical model.

Gomory cites passages from PACT pioneers Stein & Test (1980) that "the program was "assertive"; if a patient did not show up for work, a staff member immediately went to the patient's home to help with any problem that was interfering."

Additionally, Stein & Diamond (1985) acknowledge, "Congruent with our conceptual model, we tell our patients that indeed we believe they are ill, otherwise we would not be prescribing medication for them."

This approach raises questions of the line between providing complete

care and infringing on autonomy. The problem lies in determining participants' capacity and their ability to make decisions in their best interest. This question becomes even more entangled when considering the fundamental principle of housing first that allows addicted participants to continue using substances deleterious to their physical and mental health.

Gomory (1999) argues the complete care that meets clients' every need offered by ACT is empirically impossible and "utopian." Rather, he contends the ACT effort to meet all clients' needs appears to be based more on the providers' definition of needs than what the clients desire. Gomory insists that professionally defined expectations of client change can lead to coercion and patronization, and are ultimately harmful. Additionally, he begs the question, "Who should be authorized to define appropriate change of client environment and behavior?"

In answering this question, it must be noted that the PACT (Programs of Assertive Community Treatment) developed in the 1970s was not carbon copied into the ACT (Assertive Community Treatment) teams that provide participant care in housing first settings. Furthermore, as Tsemberis iterates regarding the direction of care: *We quickly discovered it was much easier to engage people in the program when we began to follow their lead and honor their priorities* (Evans, 2012).

However, Waegemakers Schiff & Rook (2012) point out that according to their research, Pathways to Housing places two conditions on participants: 1) the agency assumes representative payee status for the tenant so that rent and utilities

are paid, and 2) participants accept contact from a member of the ACT team on a regularly scheduled basis in order to ensure that participants do not become isolated or decompensate. This evidence lends credence to the argument by Gomory (1999) that assertive care may overtake autonomy from participants.

However, not all housing first programs utilize ACT teams. Petroskas (2013) notes that even loose associations in which programs adopt the principle of housing before sobriety may be considered "housing first" without necessarily adopting the entire model set forth by Tsemberis and Pathways to Housing. This is echoed by Pleace & Bretherton (2012), in their argument that housing first lacks fidelity in its definition and proliferation. However, this lack of specificity does clearly provide flexibility for services to define their own specific approaches centered on the principle of housing before treatment. Thus, some programs that are considered housing first might not employ ACT care teams.

In regards to the question of whether service providers have an obligation to encourage participants to seek treatment as viewed through the ethics of care, an initial response may be affirmative based on the aforementioned responsibility to the wellbeing of others. However, at the root of care ethics is the importance of relationships and interdependence. Encouraging treatment, no matter how delicately, for which participants may not be ready, is liable to put the relationship in jeopardy if the participant perceives any degree of coercion or anything less than unconditional acceptance.

Psychologist and therapist Carl Rogers (1961) identifies *unconditional*

positive regard as critically important in developing healthy and functional relationships between individuals. Nonjudgmental approaches to providing care that avoid expectations for behavioral change help build these relationships and foster the trust that is needed by many shelter residents. Tiderington, Stanhope, & Henwood (2013) report that participants themselves identify the relationship as one of the most important aspects of their service experience.

Homeless shelters often serve individuals who have, due either to previous experience or mental illness, developed an aversion to authority figures and are resistant to cooperating with any kind of demands (Kleinig, 2003; Priebe, Watts, Chase & Matanov, 2005). For this reason, relationships between care providers and participants in a housing first context can be jeopardized if conditions or expectations are perceived as being imposed upon the participant. Thus, encouraging treatment or behavioral change can actually be counterproductive in achieving client's motivation to change.

Part 4:
Conclusion

I. Summary

The housing first approach has transformed the way society addresses the combinations of addiction, mental illness and homelessness. While the practices of putting housing first have succeeded in reducing costs to the public and in some cases lowering rates of drinking and other substance use, serious questions persist that must be addressed in order to ensure the ethical integrity of its implementation and proliferation. Should cost-savings and empirical evidence

influence the political support and spread of housing first? Are there moral obligations for service providers to encourage treatment attendance or behavior change? Are housing first or its oft-employed assertive community treatment teams coercive? How can end-of-life issues be addressed in a way that respects the wishes of participants given the lack of resources? Recommendations based on these critical issues are subsequently provided.

II. Recommendations

Empirical evidence, including cost analysis should be taken into account when assessing the success of housing first as an instrument of social policy. Local and state governments have a limited amount of resources with which to devote to addressing such issues, and determining the best use of these resources through empirical research and cost-benefit analysis is an appropriate and necessary step in establishing effective and sustainable policies. However, positivist methods must be accompanied by a holistic examination of a policy that includes ethical and values-based assessment in addition to empirical methods.

In relation to housing first, research should also specify the relevant demographic and delineate if participants required resources for alcoholism, illicit drug use, mental illness, or a combination of disorders. Steps should be taken to ensure that qualitative research is generalizable and transferable for policymakers or entities responsible for implementing programs.

An ethical assessment of housing first includes analysis using the framework of bioethical principles (respect for autonomy, justice, beneficence,

and nonmaleficence) put forth by Beauchamp & Childress (2001), as well as evaluating the impact of relational autonomy and coercion in care ethics. Given the socioeconomic and professional disparity between provider and participant, particular attention must be paid to ensure that relationships include two-way communication instead of top-down instruction from the service provider. Service providers must give care for the benefit of participants, not as part of an agenda set by service providers or the housing first institution.

Since empirical research has shown that substance use is more likely to decrease when individuals are housed and supported in housing first settings, service providers should not feel obligated to explicitly encourage treatment attendance or behavior change since it may put the participant-provider relationship in jeopardy. There is also the risk that participants would feel coerced and the autonomy of participants would not be respected if providers expected behavior change as a condition of having access to safe housing. Furthermore, as research by Collins, Malone, & Larimer (2012) has shown, a participant's personal motivation to change is a greater indicator of reduction in substance use than is treatment attendance.

In emergency situations when a participant's behavior threatens immediate injury or death, service providers should not hesitate to put the participant's wellbeing ahead of respect for autonomy. In situations where it is not an emergency but in which it is clear the behavior is deleterious to the participant or the environment, service providers can use motivational interviewing techniques

to help spur thoughtful assessments of the situation by the participant. Motivational interviewing can potentially lead to behavior or attitude change, though it is certainly not guaranteed.

There is still much progress to be made in developing a systematic approach to handling end-of-life issues in housing first settings. Many chronically homeless individuals lack the financial and social resources needed for hospice and long-term care, and formal discussions regarding withdrawal of treatment or advance directives are uncommon. Assertive community treatment (ACT) care team members can help facilitate these discussions and aid in ensuring the needs of participants are met regarding end-of-life issues of medication, planning, and preferences.

Though flexibility may exist within the frameworks of individual housing first programs, the lack of fidelity connecting them means there are no guarantees or consistency across housing first platforms. Housing first institutions should devise and implement procedures for dealing with end-of-life issues in order to ensure that the needs of participants are met in the most efficient ways possible.

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