

# Harm Reduction Outreach Services and Engagement of Chemically Dependent Homeless People Living with HIV/AIDS: An Analysis of Service Utilization Data to Evaluate Program Theory

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## ABSTRACT

This study examines service utilization patterns among a socially vulnerable population of homeless people living with HIV/AIDS and who have a history of chemical dependence, as they are engaged through outreach services. CitiWide Harm Reduction collaborates with Montefiore Medical Center to connect homeless people with health care through harm reduction outreach and low threshold medical services. Analysis of two cohorts – individuals engaged through harm reduction outreach and individuals who “walk-in” to engage in services at CitiWide Harm Reduction’s drop-in center – assesses the program’s theory that outreach engagement is a mediating variable increasing service utilization. These results demonstrate that low-threshold harm reduction outreach, a brand of outreach designed to reduce barriers to services, does increase access to health care and related services for a socially vulnerable, traditionally “hard-to-reach,” population. Harm reduction outreach is a valuable intervention for increasing service utilization among this highly marginalized group.

## LITERATURE REVIEW

### Harm Reduction

The harm reduction approach can be defined as a set of interventions which seek to “reduce the negative consequences of drug use, incorporating a spectrum of strategies from safer use, to managed use to abstinence” (HRC, 2004). Rooted in pragmatism, harm reduction acknowledges the risks which accompany drug use, but recognizes the reality that drug use is a part of life. “Harm reduction is not making drug use solely acceptable, but its accepting that people use,” notes Allan Clear, the executive director the NY based Harm Reduction Coalition (Richardson, 2004). Thus, rather than condemn or condone, harm reduction practitioners seek to work collaboratively with the client. Rather than view addiction as simply a disease, drug use is viewed as a complex social phenomenon worthy of investigation (Heller et al., 2004). The client is viewed as an expert on his or her life and its relation to drug use. Like a good detective or anthropologist, harm reduction practitioners seek to

make sense of the individual’s drug use within the context of the user’s own life story and culture (Coher, 1993; Germain and Gitterman, 1980; Steeley, 2004).

Harm reduction aims to build on the ability of individuals to make decisions about their own lives. Unfortunately, countless social and economic barriers reduce the possibilities for client self-determination and diminish the individual capacity to limit drug-related harm (HRC 2004). Social and economic inequalities present countless barriers to care for low-income people, including those with HIV/AIDS (Adler et al., 1993; Cunningham et al., 2005, Moore et al., 1994; Smedley et al., 2002; Williams, 2000). Keefe suggests that “understanding the economic factors that affect people’s lives and seeing them reflected in the problems clients experience demand empathic skill of the highest order.” Rather than locate social problems within personal weaknesses and failure to function according to social norms, harm reduction practitioners consider the structural factors which interfere with the initiation of healthier behaviors practices (Parsons, 1991; Shepard, 1997; Woods, 1998). The aim is to reduce barriers to health care and other services, including housing, rather than to fixate on the moral dimensions of client lives (Murray and Paine, 1988).

Harm reduction recognizes that admonishments about failure to “adhere” or “comply” often function as thinly veiled narratives of social control (Keefe, 1978). Thus, rather than aim to control, harm reduction practitioners work to cultivate the capacities and strengths of drug users as creative partners in addressing their health needs (Marlatt, 1998). Harm reduction based interventions focus on minimizing harmful effects of drug use, rather than insisting on abstinence as the only viable treatment goal. Drug use is thus viewed along a spectrum, ranging from heavy use to abstinence. The aim is to create choice. Emmitt Velten, of the Bay Area Addiction Research Center, notes: “When clients are given the choice of treatment, they do better than if they are assigned treatment by someone else,” (Marratt, 1998). To the extent that harm reduction honors self-determination and individual dignity, it can be viewed as an ideologically progressive approach (Mullaly, 1993). By emphasizing choice rather than coercion, harm reduction functions as a deeply humanistic, democratic mode

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of practice. Rather than advance approaches which serve the interests of the dominant culture over client needs, harm reduction practitioners promote an egalitarian spirit of partnership between provider and client (Keefe, 1978).

By emphasizing client self determination, harm reduction functions as an alternative to medical models of treatment which reinforce a hierarchical doctor-patient relationship. Rather than call for clients to passively adhere to provider treatment plans, harm reduction practitioners work to avoid being viewed as authority figures (Marlatt, 1998). Clients are viewed as "the primary agents of reducing the harms of their drug use" (HRC, 2004). Four basic steps are involved in this approach: 1) engaging participants 'where they are at' by discussing and learning about their life, their drug use, and asking questions like 'tell me about your dreams and goals?'; 2) reducing barriers to health care for participants; 3) emphasizing participant rather than provider goals; and 4) helping clients reach these goals (Springer, Undated Interview). Along the road, participants are allowed the space to actually consider the pros, cons, and contradicting feelings about their drug use (Marlatt, 1998). In this respect, harm reduction borrows from the assumptions of motivational interviewing approaches to addressing addictive behaviors (Miller and Rollnick, 1991). Yet, harm reduction emphasizes incremental change in manageable steps for the client (Tobias, 2003).

Harm reduction practitioners recognize the multiple competing social, economic, and cultural pressures affecting client bio-psycho-social functioning. The goal is to create solutions which actually serve client needs. By seeking to elicit client participation and engagement in problem solutions, harm reduction is not inconsistent with a number of empirically tested best practice approaches to working with socially vulnerable populations (Epstein, 1992; Woods and Hollis, 1999).

### Outreach

The harm reduction literature specifically addresses the need for effective outreach to populations at risk of HIV infection, including young people and gay men, and those with issues of chemical dependence (Springer, 1991). Yet, this literature fails to adequately account for dynamics of mental illness or homelessness. At the same time, the literature on outreach to homelessness (Kuhlman, 1994; Levy, 2000; Morse, 1996; Susser et al, 1990; Whittaker and MacLeod, 1998) fails to account for the "wildcard" of interconnection between substance use and psychiatric problems among people with HIV/AIDS (Cunningham, 2005; Zwebem and Denning, 1998). Levy (2000) delineates five principles of outreach to homeless people: 1) promote safety; 2) relationship formation; 3) develop common language; 4) promote and support change; 5) cultural and ecological effects. While Levy offers a useful general framework, there is

still no literature which addresses engaging homeless people with HIV/AIDS dealing with substance use as well as mental health issues.

Literature reviews reveal few studies of the impact of outreach on access to and utilization of medical, social support services, or health outcomes among people living with AIDS (PLWAs) (Tobias, 2003). Elwood notes that "historically, outreach has been used to designate the process of locating, contacting, and recruiting groups that are invisible, hidden or otherwise difficult to engage in a program..."

Definitions of outreach are also important on methodological, programmatic, and policy levels. While some studies define outreach as a brief encounter, others outline a more complex, dynamic encounter. Brief contact includes an exchange of information and supplies which establish the context for creating basic trust between participant and provider. The outreach encounter, on the other hand, includes more intensive interaction. Components include: addressing problems, crisis intervention, skills building, education, risk reduction education, and discussion. All these aspects are conducive to developing the kind of relationship between provider and participant necessary to address and reduce the barriers impeding entry into care (Tobias et al., 2003). Outreach interventions to PLWA's are based on three core theoretical frameworks: 1) individual behavior change, 2) community and social networks, and 3) relationship building between the outreach worker and the individual client.

### Context

The outreach interventions relevant to the current study involve conditions in single room occupancy (SRO) hotels in NYC. The evidence of poor conditions in SRO hotels in NY is well documented (Housing Works, 1999; Kiplonger et al, 2003 ). Ethnographic research on these conditions in SRO hotels has provided the basis for expanding outreach and engagement of SRO residents into a continuum of care (Feldman, 1998). This evidence suggests the most practical form of service provision available to address the needs of people living with AIDS (PLWAs) in commercial SROs is harm reduction outreach. The majority of harm reduction outreach programs are operated by the non-profit organizations such as Citiwide Harm Reduction.

Based on the literature, outcomes for these interventions can be broken down into three major categories: 1) behavior change with an emphasis on risk reduction, 2) entry into testing and counseling, and 3) engagement into health and social services (Tobias, 2003). The current study aims to offer a framework for assessing the service utilization patterns of participants of a harm reduction outreach program. A description of the specific program model follows.

### Program Model and Theory

CitiWide Harm Reduction collaborates with Montefiore Medical Center to connect homeless people with health care through harm reduction outreach. This outreach model integrates low threshold harm reduction outreach with home delivered social and medical services.

The model's key features include: integrated staffing (medical providers and peer workers), evening outreach hours, useful tools (e.g. syringe exchange, self care kits), tailored service options, consistent services, and a supported transportation provision. Program theory is grounded in the belief that this model increases access to and engagement in, care for this marginalized population. Once trust is established, participants are provided access to health care services in their rooms or at Montefiore Hospital and/or social services at CitiWide's drop-in center.

The aim is to create a comfort level with participants who may be wary, distrusting, or uncomfortable with service providers after negative experiences or interactions in the past. Given the social isolation, stigma, and shame experienced by individuals residing in the SRO hotels targeted by outreach, and the frequently chaotic and unsafe environment of the SRO hotel setting, it is essential that the team set out to build trust with this community of PLWAs to support and promote use of the services offered (CitiWide, 2002).

PLWAs living in SRO hotels suffer from multiple medical complications, including Hepatitis C and diabetes, as well as substance dependence and mental health problems. Through its needle exchange and home delivery model, CitiWide Harm Reduction engages this hard to reach population of people through harm reduction outreach services. Over the years, the program has been expanding its home delivery model to address the widest range of health care services possible. Today, a nurse practitioner, a doctor, and a team of outreach workers deliver services, which range from food pantry delivery to service referrals, all on-site in SRO hotel rooms. Medical staff deliver medical and mental health services, from blood tests to gynecological exams to medication prescriptions and counseling, while setting up appointments and travel arrangements to and from Montefiore's Comprehensive Health Care Center and CitiWide's drop in center program participants receive an additional array of case management, mental health services, groups, and holistic health services. Rides to and from can be arranged with CitiWide's full time van driver.

Just reaching homeless people at risk can be a difficult first step. To build a trusting relationship is even more difficult, yet it is an essential step with which to create a context that promotes behavior change (DeCarlo et al., 1996). The low threshold harm reduction outreach model attempts to establish such a context for change.

### METHODS

To assess the efficacy of this intervention approach, the following study evaluates the CitiWide Harm Reduction harm reduction medical outreach model using service utilization data (Weiss, 1998). Client-level utilization of outreach and center-based services have been collected since 1998. Using this data, the study investigates whether hard-to-reach participants engaged through harm reduction outreach at SROs access the same level of services as those engaged through the agency's drop-in center.

This study tracks service utilization patterns among agency participants engaged through harm reduction outreach, and compares them to those engaged at the drop-in center. The study borrows from data mining, a practice-based research approach involving a secondary analysis of an existing data set (Epstein, 2001). Emphasis is placed on the use of data already immediately available in agency records and collected for purposes other than research. The study involves a-priori testing of a hypothesis that harm reduction outreach and services allow a hard-to-reach, socially-vulnerable population to access health care and other services, comparing the effects of mode of entry into the program. A stratified random sample of 100 cases was drawn from CitiWide Harm Reduction's client-level management and information database. All individuals who had enrolled in the program between April 2002 and July 2003 were eligible for sampling inclusion. Half of the sample cases were initially engaged through program outreach efforts at SROs and the remainder through walk-ins at the agency's drop-in center. This sampling technique used is powerful in a statistical sense.

### RESULTS

The following tables summarize service utilization patterns among CitiWide participants, and a typology of those engaged through outreach and those who received referrals to medical and housing placement services. Table 1 presents a brief picture of the patterns of services utilized by CitiWide participants, regardless of mode of entry. Services range from harm reduction outreach, where participants are initially engaged, to case management, housing placement, legal and holistic services training and education, and medical referrals.

It is instructive to consider that some 50 percent of participants utilized clusters of eight to 12 vital categories of services available at CitiWide Harm Reduction. These include a range from low-threshold outreach offerings, such as Syringe Exchange and Program Supplies (e.g. toiletries), to entitlements and more intensive services including Mental Health Counseling and Medical Referrals. Fifty percent of the sample got seven or more services. The mean number of services utilized was approximately seven, while the median was eight.

Number of Services	Frequency	Cumulative Percent
0	5	5
1	8	13
2	5	18
3	4	22
4	7	29
5	7	36
6	7	43
7	6	49
8	13	62
9	12	74
10	15	89
11	8	97
12	3	100
Total	100	

Table 1 traces the average number of services utilized by CitiWide participants. Frequencies range from zero to twelve services.

Preliminary findings confirm that those contacted through harm reduction outreach access referrals to medical services at basically the same rates as those who walk in for services on their own at the drop-in center. Table 2 examines utilization of medical care by enrollment mode.

		Enrollment Mode	
		Outreach	Center
<b>Medical Care</b>	YES	32 (64%)	35 (70%)
	NO	18 (36%)	15 (30%)

Chi-square=.407, df=1, p=.523

In Table 2, 64 percent (n=32) of the clients who enrolled in CitiWide through outreach services utilized medical care, nearly the same proportion as those engaged through the drop-in center (70 percent; n=35). Because the association between medical services utilization and mode of

engagement was not significant (Chi-square=.407, df=1, and p=.523), this data suggests there is no difference between mode of entry and access to medical care. Those hardest to reach, who are engaged while living in SRO hotels, access basically the same levels of medical services as those enrolled through the drop-in center.

While there was little relationship between mode of entry and medical services, clear patterns emerge when considering the relationship of housing placement services and mode of entry. Table 3 assesses housing placement services by mode of enrollment.

		Enrollment Mode	
		Outreach	Center
<b>Housing Placement</b>	YES	39 (78%)	29 (58%)
	NO	11 (22%)	21 (42%)

Chi-square=4.596, df=1, p=.032

In Table 3, enrollment mode is the independent variable, with referrals to housing placement services as the dependent variable. CitiWide participants are by definition homeless. Of those contacted through outreach, seventy eight percent (n=39) were referred for housing placement, while only 58 percent (n=29) of those engaged through walk-in at the drop-in center requested housing placement. Thus, data (Chi-square=4.596, df=1, p=.032) indicates a statistically significant relationship between harm reduction outreach and referral to housing placement. Certainly, those living in the SROs request housing placement at a higher rate than those walking in for services who may already be permanently housed. Participants who enroll through outreach are significantly more likely to engage in housing in placement services than participants who engage through the drop-in center alone.

		Housing Placement	
		NO	YES
<b>Medical Care</b>	YES	11 (34.4%)	56 (82.4%)
	NO	21 (65.6%)	12 (17.6%)

Chi-square=22.654, df = 1, p=.000

In Table 4, housing placement is the independent variable and referrals for medical care serve is the dependent variable. Of the 68 cases that used housing placement services, 82 percent (n=56) were also referred for medical care which eighteen percent (n=12) were not. Of the 32

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cases that did not use housing placement services, 34 percent (n=11) also used medical care services and sixty-six percent (n=21) did not. Thus, these Chi-square=22.654, df=1, p=.000) suggest there is a statistically significant relationship between housing placement and medical care referrals. This data is important because it confirms a core finding of the Columbia CHAIN Study (Aidala and Lee 2000), which suggests that housing equals healthcare for homeless people with HIV/AIDS.

Further significant relationships are found between a number of other services and medical care referrals. Table 5 assesses the relationship between medical care referrals and harm reduction services.

		Harm Reduction Services	
		NO	YES
Medical Care	YES	11 (33.3%)	56 (83.6%)
	NO	22 (66.7%)	11 (16.4%)

Chi-square=24.5, df=1, p=.000

In Table 5, harm reduction services are the independent variable and medical care referrals the dependent variable. Of those who used harm reduction services, 84 percent (n=56) utilized medical care referrals, compared with 16 percent (n=11) who did not. This data (Chi square 24.5, df=1, and p=.000) indicates a strong statistical relationship between harm reduction services, including syringe exchange and counseling, and medical care. Through syringe exchange and other harm reduction services, socially-vulnerable populations are engaged in a respectful egalitarian manner, barriers to services – including social stigma related to drug use – are reduced, and participants are given tools to care for themselves and their communities. Thus, participants are engaged for their health care needs and connected to services on their own terms. As a result of connection to syringe exchange services the transmission of HIV infection in communities is reduced (Des Jarlais et al, 1996). Table five suggests that with increased access to referrals for medical services, health outcomes for homeless drug users are improved.

### Limitations and Benefits

We understand that data mining does not include the stories of those waiting for care. It does not include narrative perspectives from the participants included. However, it does offer a route toward the development of practical knowledge outside of “gold standard” placebo controlled studies. Unlike certain research based prac-

tices in which clients are turned into research subjects, one is denied care with the application of this method of secondary analysis of research data. Clients continue to receive services without contact with research researchers. This approach is inherently ethical and consistent with a primary commitment to respectful, high-quality service provision.

### Implications

The above data finds significant relationships between variables, including harm reduction services, medical care, housing placement, and access to healthcare. Findings suggest CitiWide Harm Reduction program theory is accurate in assuming that low-threshold harm reduction outreach – a brand of outreach that reduces barriers to services while offering useful tools for improved health – does increase access to medical care. Harm reduction outreach contributes to stability for homeless drug users with HIV/AIDS by allowing them to access housing placement and medical care services. By identifying ways to consider the relationship between service utilization and mode of engagement in a fashion which does not impede service delivery, this study has aimed to provide a framework for future research endeavors.

Still, a great deal of attention remains paramount to connect socially vulnerable populations, including those managing the competing pressures of HIV/AIDS, Hepatitis C, homelessness, drug use, and mental health complications, with respectful, responsive care. Low-threshold services designed to reduce barriers and truly meet participants “where they are at,” e.g. with drug use, source of income, gender, and sexual preference, are urgently needed to prevent this population from encountering systemic and often deadly roadblocks to care. If providers are truly going to provide services to people in a non-judgemental fashion, they will need to recognize the complex reasons why people use drugs (DesJarlais, 1998) and seek to work collaboratively with drug users. Within this context, the emphasis is on addressing the multiple elements of a person’s life, from housing, to healthcare, to education, to mental illness, as well as drug use management, according to the participant’s stated priorities (Denning, 2000). Future studies still need to assess connections between referrals for care and health outcomes.

CitiWide program theory presumes a harm reduction approach based in a democratic framework of participant-provider collaboration. It offers a useful strategy for reducing the barriers inherent within medical models that are based on patient subservience and provider expertise (Heller et al, 2004). At this point, the walls between the harm reduction model and the medical model remain. Impediments to effective patient care for this population persist.

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### NOTE

An early version of this research was presented as a poster presentation at the Second International Conference on Urban Health in New York City, October 15-18, 2003.

The author would like to thank Michael Bosko for his assistance with analysis of the data for this project and Michael Carden, Daliah Heller, and Kate McCoy for their careful readings of an early draft of this paper. Heller, in particular, helped create this model of service and care.

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