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Why substance use services are needed in shelters to address client addictions before the crisis of overdose occurs: *examining HELP USA shelter client histories & addiction patterns, their experiences with recovery programs, and the challenges to and potential solutions for an effective shelter-based substance use program*

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Abstract

Overdose remains the leading cause of death among people experiencing homelessness in New York City (DHMH, 2022). The Department of Homeless Services' (DHS) substance use policy has ensured the distribution of 60,000 naloxone kits and 30,000 trainings in naloxone administration to agencies that manage the city's shelters (DHS, 2022). These interventions may have prevented even more overdose deaths from occurring. Yet, the high overdose death toll may indicate that other components of the policy that promote recovery or managed substance use, such as the provision of harm reduction education, may be underutilized. This study posits that a lack of understanding of clients' needs may undermine the ability of policymakers and service providers to design and implement such programs.

It is crucial to unravel the complex relationship between addiction and homelessness among people afflicted by both maladies. Early life traumas and high exposure to drugs and alcohol amid poverty induce substance use problems in this population before homelessness, while the dire experience of homelessness itself exacerbates their risks to overdose and death (Padgett et al 2006; Padgett & Henwood 2012:189Yamomoto 2019 et al). It is also important to identify the socio-economic drivers of addiction among New York City shelter clients because most are native New Yorkers from Black and Latinx communities from the city's poorest districts (DHS, 2021, 2022). Mid-20th century practices of housing segregation and discrimination explain both the concentration of poverty in the city's majority Black and Latinx neighborhoods and the exclusion of these communities from local, legal sources of employment in the latter 20th century (Dunlap & Johnson, 1992; Taylor, 2019). Scholars have attributed these structural factors to intergenerational poverty that, consequently, led to the trade and use of illicit drugs in their areas (Bourgois 1995; Dunlap & Johnson, 1992; Farber, 2019; Reinarman and Levine, 1997). Lastly, it is essential to identify substance use service models that can address challenges of homelessness and addiction in cognizance of the structural causes of poverty that inform them.

In this context, this study is based on life history interviews of 19 clients in two HELP USA single adult male shelters. It examines shelter client histories and addiction patterns, their experiences with recovery programs, and the challenges to and potential solutions for an effective substance use program in shelters that may target addictions before overdoses occur.

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Introduction

Nearly 108,000 Americans died of drugs overdoses in 2021 (CDC, 2022). Substance – and especially opioid - addiction is indeed a national crisis. But this crisis is even more severe among people experiencing homelessness, particularly in New York City. Overdose has been the leading cause of death among homeless New Yorkers since 2014 - 37% of the 640 deaths among people in this population in 2021 were by overdose (NYCDHMH, 2022). People experiencing homeless comprise 1% of New York City's population, more than 10% of the city's total overdose deaths, and are 12 times more likely to die from an overdose than the general population (Bronxworks, 2022).[1]

It would seem logical that higher rates of overdose deaths and substance use disorders among the homeless - including problematic drinking (Carver et al 2021) – would require a program of services that target addictions during critical periods of homelessness before overdoses occur. Yet, implementing substance use services in New York City shelters is a challenge. Under the city's 'right to shelter' legal framework, the primary mandate of shelter managing agencies is to provide safe and secure shelter and housing for residents. The city evaluates these agencies based on monthly 'housing' targets, such as the number of clients that social workers 'place' in housing, the extent of chronic homelessness in shelters ('length of stay'), and shelter recidivism (the number of people who return to shelter one year after being placed in housing).

A shelter-based substance use policy does exist. In 2006, New York City's Department of Homeless Services (DHS) designed a shelter harm reduction protocol after overdose was first identified as the leading cause of death (32%) in the single adult shelter client population (Gambatese et al 2013). The protocol's naloxone trainings for shelter staff and DHS police were intended to prevent these deaths. The city implementated the program in 2009 in shelter and street homeless programs[2], which 'ostensibly reduced overdose deaths'

[1] A recent study also found that the homeless in Boston were 12 times more likely to die by an overdose than the Massachusetts population (Fine et al, 2022). In Los Angeles, drug overdoses accounted for nearly 25% of deaths of people experiencing homelessness but overdose deaths had also doubled between 2015 and 2019 (Nicholas et al, 2022).

[2] 200 street outreach, drop-in centers, and Safe Haven staff (Gambatese et al 2013)

between July 2009 and June 2011 (to 13 and 12 deaths) from the previous years (20 and 23 deaths) (Gambatese et al 2013).

In 2018, DHS implemented an official Substance Use and Overdose Response Policy (DHS, 2019). The policy incorporated the protocol's naloxone trainings and administration. It also included other provisions rooted in the harm reduction approach.[3] The policy designated a staff 'Overdose Prevention Champion' to (i) administer naloxone to overdosing clients (ii) admit non-fatal overdosing clients to local hospitals (iii) link clients to medication assisted treatment (MAT) (i.e., methadone) or other outpatient care and (iv) provide clients harm reduction education on drug use.[4]

DHS has trained over 30,000 persons to administer naloxone and distributed approximately 60,000 naloxone kits to social service providers (DHS, 2022). In 2021, naloxone trained shelter personnel reversed 93% of reported overdose incidents (Brand, 2022).

Overdose remains a leading cause of death in this population despite the government's provision of naloxone trainings and supplies. This study posits that other aspects of the policy that promote recovery or managed substance use may be underutilized. It is possible that frontline social workers may not have an adequate understanding of clients' needs and addiction histories, or the resources to address these proactively. In this context, social workers are potentially compelled to only respond to the crisis of overdose. This study therefore aims to thoroughly understand the socio-economic dynamics of substance use problems among shelter clients. The goal of is to recommend a comprehensive course of action to prevent overdose from occurring.

This study employs the qualitative research methodology of grounded theory (Charmaz, 2006; Urquhart, 2013), that is based on in-depth life history interviews of 19 substance using clients in two HELP USA single adult male shelters. The interviews focused on (i) the social and economic circumstances that informed clients' addictions, (ii) their current addiction patterns and experiences with services in shelters, and (iii) their perceived successes with and challenges to managing or reducing their addictions. The analysis of these parameters yielded (iv) recommendations to improve substance use services in shelters, which are detailed in the final section.

Analytical Framework: Understanding the co-occurrence of multiple burdens & socio-economic drivers associated with substance use and homelessness and the corresponding challenges and outcomes of implementing abstinence and harm reduction recovery models for this population

The multiple burdens & socio-economic drivers associated with substance use and homelessness

The experience of homelessness is an independent risk factor for overdose , visiting an emergency department and being hospitalized (Yamomoto 2019 et al). Yet, these crises are often informed

[3] mandated by the 2017 Local Law 225 (DHS, 2019)

[4] on avoiding drug 'mixing', keeping naloxone kits on hand for self-administering (ibid)

by mental health burdens[5] that simultaneously afflict people experiencing homelessness(Henwood, Padgett, Smith & Tiderington, 2012:238). Substance use and mental health disorders are, further, associated with traumas that homeless people have experienced during childhood, including abuse, maltreatment , and untimely – often violent - deaths of their family members (Padgett et al 2006; Padgett & Henwood 2012:189; Ibabe et al 2014:374).

How do we understand the complex relationships between trauma, homelessness, addiction, and mental health burdens? Researchers have noted that homelessness among single adults is a product of multiple early life traumas (Padgett & Henwood 2011:189). These traumas occur amid 'constant exposure…' (ibid) to drugs and alcohol, which 'exacerbate… mental illness', early drug and alcohol use, and 'substance abuse…symptoms' (Henwood, Padgett, Smith & Tiderington, 2012:238). In this context, researchers have recently suggested that we understand the relationship between addiction and homelessness as 'bidirectional' (Doran, 2022 et al: 1), rather than framing either affliction as the irreparable cause, or pathway into, the other. In this framework, 'root structural contributors to homelessness' (i.e., trauma[6]) induce substance use problems *as* 'homelessness itself plays a role in drug use and overdose risk' (Doran 2022 et al:1). New York City shelter clients also often live in and circulate between jails, prisons, hospitals, and shelters[7] at multiple times before and during homelessness(Culhane, Metraux and Hadley, 2002; Metraux, Byrne and Culhane, 2010). Shelters represent 'one institution among a continuum of institutions' that homeless men intermittently inhabit (Metraux, Byrne and Culhane, 2010:29).

In New York City, incarceration predicts chronic homelessness[8] (Caton et al, 2005) and higher health risks among the temporarily homeless (Lim et al, 2015). Men who shuttle between prisons and shelters[9] are more prone to die from 'all', including 'drug-related', 'causes' within a two-year period than those who remain 'continually' homeless during that time (Lim et al 2015). Clients in New York City shelters therefore need a 'complex recovery model' (Padgett, Smith, Henwood, and Tiderington, 2012) that can treat substance use disorders *in context* of the 'multiple challenges' (ibid) that homelessness itself presents: the 'cumulative'[10] but varying effects of childhood traumas, early life exposure to substances, and institutionalization.

Who, then, are the homeless of New York City? The majority of New York City shelter clients are native New Yorkers (93%) from Black and Latinx communities (DHS, 2021). Black and Latinx people comprise 53.3% and 40.6% of family shelter and 59.2% and 26.8% of single adult shelter

[5] 'Substance abuse is the most common and clinically significant comorbidity among people with serious mental illness' (Drake et al., 2001; Henwood et al, 2012:238)

[6] Traumas, due to early abuse, and substance use 'are important risk factors and concomitant of homelessness' (Ibabe et al, 2014:374; Wu, Schairer, Dellor and Grella, 2010) and are associated with having a substance use disorder during adulthood (Ferguson, 2009; Gwadz, Nish, Leonard, & Strauss, 2007; Hamburger, Leeb, & Swahn, 2008).

[7] Circulating within this 'institutional circuit'(Hopper et al., 1997) is also a 'structural contributor' to homelessness in New York City (Culhane, Metraux and Hadley, 2002; Metraux, Byrne and Culhane, 2010)

[8] Caton et al (2005) define 'chronic homelessness' based on individuals that remained homeless for the 18 month follow up period of the study.

[9] 'revolving door pattern' (Lim et al, 2015)

[10] Padgett and Henwood note that respondents were not 'struck down' by mental illness and a subsequent descent into poverty, joblessness, and isolation…abusing drugs and alcohol was not a simple matter of 'self-medication' of psychotic symptoms but began earlier in life as a response to living amidst near constant exposure to substances from a young age (Padgett & Henwood, 2012: 189)

populations, respectively (DHS, 2022). Each group comprises 20.2% and 28.3% of the city's total population and is, therefore, overrepresented in the shelter system (U.S. Census, 2020) (DHS, 2022).

This trend was discovered in the 1990s. Researchers found that 61% of 71,0354 family shelter clients between 1987 and 1994 hailed from three of the city's most impoverished districts (Culhane et al., 1996). These locations were majority Black areas where households with children were headed by women and below the poverty line (Culhane et al., 1996). Nearly three decades later, this link between the geographic and demographic concentration of poverty in New York City *and* the characteristics of the city's homeless population remains. An analysis of 38,239 prior address histories of DHS homeless residents across the city's community districts reveals that 60.4% of these residents are from the poorest districts[11] (DHS,2021). Over one-third (36%) hail from one cluster of 9 impoverished Latino and Black majority community districts in the Bronx (Black and Latino population shares exceed the city's[12].

Historical segregation and housing discrimination explain the concentration of poverty in these New York City neighborhoods. In the mid to late 20th century, policymakers, the real estate market, and banks excluded Black and Latinx communities from formal housing opportunities by denying them access to federally backed housing mortgages and interest rates (Taylor, 2019). These communities were relegated to 'deteriorating urban core communities', where housing access was determined by speculators who demanded higher costs, relative to formal market conditions, to finance lower quality, less valued and ever-limited supplies of housing (Taylor, 2019:31).[13] Exploitation of segregated inner cities extended beyond the housing and into the consumer market, in which goods in Black neighborhoods were sold at higher prices (ibid). Beginning in the 1960s, the shift in the economy from public investment in manufacturing jobs, once located in working class urban areas, into the service industry, located in city and suburban business districts, excluded urban African Americans from local and legal sources of employment (Dunlap & Johnson, 1992)[14]. The legacy of 20th century residential and economic segregation of

[11] poverty rates that exceed NYC's 19.7% (DHS,2021)

[12] There are two exceptions: Bronx 7 – 16.7% Black; Bronx 12 – 27% Latinx (DHS, 2021)

[13] Taylor notes two factors that have had a lasting impact on racialized housing inequality in urban America. First, under urban renewal projects in the post-World War II era, private land developers demolished 'slum neighborhoods that occupied valuable land' in cities. Instead of 'redevelop[ing] the heavily subsidized land with affordable housing for [the] displaced,' they 'built condominiums and apartments and refurbished shopping districts for a middle-class clientele'. The federal government then built public rental housing that 'had become the relocation housing of last resort…for …displaced…Black renters. Secondly, federal home ownership programs, in response to urban renewal catastrophe, were either too small and still restricted within the paradigm of segregation to greatly increase black home ownership (Section 221(d)(2) of the 1954) or not implemented for them at all (Voluntary Home Mortgage Credit). Speculators profited from Black exclusion by 'blockbusting': 'beating down prices' paid to 'white owners' -- who were incentivized to buy affordable homes in the suburbs -- then selling to Black families at 'inflated places 'at 'very high rate[s] of interest' (Taylor 2019:48).

[14] New York City lost 100,000 manufacturing jobs between 1967 and 1987; gained 250,000 service sector jobs that required higher-education and added 250,000 such service jobs in the suburbs during this period (Dunlap and Johnson, 1992). Unemployment of out of school 16- to 24-year-old inner city males increased from 19% in 1968-70 to 44% in Boston, Newark, New York, Philadelphia, and Pittsburgh. In Midwest and northeast cities, high school drop-out rates in inner city neighborhoods reached 50% or higher while, Dunlap & Johnson note, 'a high-school diploma from such schools was undervalued by employers (Dunlap & Johnson, 1992:7).

African Americans endures in the form of continued shortages of affordable housing units in the historically disinvested areas in which they disproportionately live.

Scholars attribute *urban segregation*, *housing exclusion*, *economic extraction*, and *economic transformation* to the intergenerational dispossession of many Black and Latinx households that enabled the entry and rise of the illicit drug trade in their areas (Bourgois 1995; Dunlap & Johnson, 1992; Farber, 2019; Reinarman and Levine, 1997). The incursion of heroin in the 1970s and crack in the 1980s into New York City's Black and Latinx communities destroyed family systems and increased the number of households headed by single mothers, incarceration rates and homelessness (Dunlap & Johnson, 1992; Farber, 2019). Scholars identify this phenomenon as a 'consequence of U.S. social and economic policies' in 'shap[ing] the social settings of [substance] use' among 'African American and Puerto Rican…victims of extreme forms of structural violence' (Farber, 2019:84-85).

In the 1980s, federal policies under the 'War on Drugs' created another paradigm of racial dispossession. These laws[15] (i) enforced stricter mandatory minimum sentences for possessions of smaller amounts of drugs that were disproportionately used and sold in Black and Latinx communities (i.e., crack); (ii) increased local police authorities to 'stop-and-frisk' persons they deemed suspicious of criminal activities; (iii) provided federal funds to state and local authorities to build prisons specifically for drug offenders; and (iv) cancelled eligibility for public benefits, including public housing, for first time drug-related offenders (Alexander, 2010; Farber, 2019). War on Drugs laws rapidly increased national incarceration rates over the next three decades (Alexander, 2010). Drug-related charges accounted for more than 31 million people being arrested between1980 to 2010 while drug-related Latinx and Black incarceration rates increased 22 and 25 times, respectively, between 1983 and 2000 (Alexander, 2010).

The challenges and outcomes of implementing abstinence and harm reduction recovery models for this population

In the 1990s and 2000s researchers found that abstinence-based models in homeless service systems did not often work for people in shelters or on the streets because the prospect of housing was made contingent on achieving sobriety (Padgett, Henwood, Abrams, & Davis, 2008; Tsemberis & Eisenber, 2000). Later studies confirmed that most 'abstinence' clients abscond from treatment (Ball, Caroll, Caning-Ball, & Rounsaville, 2006; Palmer, Murphy, Piselli & Ball, 2009; Polcin, 2016). However, some studies noted that a critical barrier of this model was the occasional inability to provide housing for participants who 'achieve[d] abstinence' at the conclusion of the program (Kertesz, 2009; Polcin, 2016)

In recent years, social workers and policymakers have advocated the harm reduction approach, which permits clients to continue using substances under supervised conditions without prohibiting access to essential services. In some contexts, programs that provide housing to clients *before* initiating substance use and other social services (i.e., Housing First) have cost-effectively reduced mentally ill homeless persons' drug and alcohol consumption at higher rates in comparison to abstinence-based models (Padgett, Stanhope, Henwood, & Stefanic, 2011; Rog et

[15] i.e., Anti-Drug Abuse Act of 1986; Anti-Drug Abuse Act of 1988 (Farber, 2019)

al 2014 in Polcin,2016). However, 'independent effects of housing alone on substance abuse are inconsistent' (Hwang et al, 2005; Polcin, 2016; Tsai, 2020). Housing First (HF) critiques note that 'case management' is essential to client successes in, both, harm reduction and abstinence programs (Hwang et al, 2005; Polcin, 2016). Researchers have also noted that client recoveries in harm reduction programs have been due to 'non-program 'factors such as 'closer family relations' and the 'spiritual awakening' and 'maturation' of clients (Henwood, Padgett, Smith, &Tidderington, 2012:240). Clients placed in permanent supportive housing units in communities that are afflicted by 'concentrated disadvantages' may continue to struggle with substance use and health problems ((Henwood et al 2018:1,2; Henwood, Cabassa, Craig, & Padgett 2013; Sampson, Raudenbush, & Earls, 1997; Sundquist et al, 2006Yanos, 2007). Successful outcomes of both models therefore occur when programs ensure a supportive environment for clients ('case management 'and 'closer family relations') that instill trust and reciprocity (i.e., the assurance of housing after the completion of an abstinence program).

A recovery model in New York City shelter must incorporate methods that address multiple challenges of homelessness and substance use disorders, which are rooted in structural causes of intergenerational poverty and dispossession. Motivations and abilities of shelter clients to abstain, reduce or manage their use of drugs and alcohol could be a function of their isolation or connectivity to local communities from which they hail.

Implementing this model in New York City shelters is a challenging endeavor. Recent shelter-based trials of harm reduction programs for drug and problematic alcohol drinkers in Canada provide examples of how it may work. A program in British Columbia that relied on trained client 'peers' to distribute and 'witness' injections in 'shared-using rooms'[16] reversed users' 'overdose risk and 'drug-related harms' because peers involvement increased the capacity of the organization beyond 'part-time staff and volunteers' to implement harm reduction practices consistently (Bardwell et al, 2017:1-2). Conversely, another program that distributed needles and crackpipes in shelters, as part of a local harm reduction policy, was unsuccessful because these provisions conflicted with shelter rules that prohibited drug use on the premise (Wallace, Barber and Pauly, 2018:2) . This study noted that 'shelter residents … [felt] unable to access the needed clean supplies from staff for fear of repercussions' (Wallace, Barber and Pauly, 2018:85)

Managed alcohol programs (MAP) in Canadian shelters that provide regular and measured daily doses of alcohol alongside access to health care, housing and healthcare services to shelter clients have proved more uniformly successful in (i) reducing client withdrawal symptoms, (ii) mending their broken relationships (iii) improving their 'quality of life, wellbeing and safety 'and (iv) decreasing their consumption of harder alcohol over time (Carver et al, 2021:221; Collins et al, 2019; Larimer er al, 2009; Pauly, Gray and Perkin, 2018; Pauly, Vallance, Wettlaufer, 2018; Podymow, Turnbull, Coyle, Yetisir, & Wells, 2006; Stockwell et al., 2017; Vallance et al., 2016)

Case selection and methodology

This study focuses on drug and alcohol abusing men in two single adult male shelters. These shelters had a higher proportion of overdose and problematic drinking clients, respectively, than

[16] equipped with a table, chairs and sterile water, syringes, and cookers (SCS) (Bardwell et al, 2017:1-2)

all other single and family HELP USA shelters throughout the year before this study began (October 1, 2020, to September 30, 2021). Shelter 1 recorded 37 overdose cases (64% of all overdoses in 16 HELP single and family shelters) and 46 alcohol incidents (30% of all HELP shelter alcohol incidents), while Shelter 2 recorded 56 alcohol incidents (36% of HELP shelter alcohol incidents).

I interviewed 19 drug and alcohol abusing clients in both shelters. Staff had identified these clients in official incident reports (*only alcohol cases*), provided them harm reduction or abstinence-based services (*serious drug and alcohol cases*) and/or had discussed their substance use problems with them in separate conversations before the study began (*serious drug cases*). I employed a grounded theory method of analysis (Charmaz, 2006; Urquhart, 2013) to in-depth interviews of these clients. Open-ended questions focused on their histories of substance abuse (in context of social and economic conditions before homelessness), current addiction patterns and experiences with services in shelters, and perceived successes with and challenges to managing or reducing their addictions in context of the substance use services they had availed. This approach was based on the study's research questions:

- What are client histories of substance use, and the social and economic circumstances that informed these patterns?
- What are current addiction patterns in shelters and how these patterns are informed by substance use histories and causes of homelessness?
- How have substance use programs that men avail enable them to manage, abstain or reduce their addictions? What are the barriers to quality or effective treatment?
- How do we improve substance use services in shelters?

I recorded these 45-minute interviews on an audio recorder, then transcribed them into written documents (using Otter and manually) and analyzed the resulting cases by themes (using NVivo Plus). Line by line coding of all transcribed interviews yielded themes, which were harnessed into a thematic framework that is discussed in the findings section. This thematic framework also foregrounded this study's theoretical framework presented in the preceding section. All interviews have been anonymized. In the next section, each case is sited by the case numbers I assigned to them – S.A. (an abbreviation for substance abuse) and a number. For example, the first interviewee is referred to as SA1.

Findings

Respondent demographics (n=19)	
Age	
average	51.9
median	52.5
Race	
Black	10

Latinx	6
White	3
Place of Origin	
New York City	15
Puerto Rico (and NYC)	1
Russia	1
Ohio	1
Jersey City	1
Adverse childhood experiences amid poverty (self-reported)	
exposure to illicit drug trade and use (i.e., heroin, crack)	15
death or absence of parent	10
abuse	7
Adverse adulthood experiences	
Incarceration	14
mental health diagnosis	10

Table 1: Demographics of the 19 interviewed clients at Meyer and SEC shelters

(1) Heavy exposure to hard drugs during youths of poverty and trauma in, primarily, New York City neighborhoods influenced substance use before homelessness

Most men in the study were born and raised in the poorest NYC neighborhoods from the 1960s to 1990s **(table 1**) throughout Manhattan (i.e., Harlem), the Bronx (i.e., South Bronx) and Brooklyn (i.e., East New York)[17]. From childhood, they were exposed to frequent alcohol consumption and the use and trade of marijuana, heroin, PCP ('dust') and crack cocaine[18] by other youths and adults in their locales. The high level of substance *exposure* escalated to use, then addiction, during youth, in most cases, as follows: *progressively* ('I started when I was like twelve… smoking weed, skin popping, sniffing coke, doing acid'-SA8), *dramatically* ('my life [with crack cocaine] started back in '85 after Richard Pryor windup setting himself on fire -- I found out that he was freebasing.'-SA1) or *cyclically/episodically* ('Marijuana, and then cocaine, and then dust, and then drank a little bit, and then nothing, and then went back to marijuana and drinking.'-SA7). These patterns of early addiction amid intense and constant exposure to illicit substances occurred amid childhood traumas (i.e., the death of a parent and/or abuse, or violence) and the associated difficulties under the already enduring strain of poverty (SA6)

I went through some trauma when I was twelve years old – I got shot in my face in 1992. I still got the bullet in my head. So, after that incident I felt like a victim and I kind of like turned into The Joker. I grew up in Harlem with my mother present. My father died on my birthday. [That] was kind of traumatizing. After that I started being very disobedient. I started using marijuana at thirteen, maybe, and started playing with firearms. And I got locked up. – SA6

[17] Some men shuffled between such localities.

[18] Men were exposed to varying but intense degrees of use of these drugs.

(2) Respondents attributed early and heavy substance use to (a) their participation in criminal activities, to support their habit, and/or (b) being expelled - then ostracized for varying periods - from their families.

The engagement with criminal activities most often led to incarceration before the experience of homelessness. Family expulsion most often expedited immediate homelessness. Eight of fourteen men that had a history of incarceration went to jail or prison before their first experience in a shelter. Amid poverty and the constant exposure to drugs and alcohol, the experience of abuse and/or the death or absence of one parent during youth (**table 1),** often compelled men to seek protection – including shelter - from the 'wrong crowd' (SA10), which ranged from small-grouped, neighborhood 'hoodlums'(SA7) to territorialized 'gangs'(SA8) to syndicates under powerful drug lords (i.e., 'Nicky Barnes') (SA1). Within this alternative support system, men used drugs and alcohol, sold drugs, and engaged in theft to secure drugs. One 75-year client (SA3) who went to jail multiple times for drug offences explained, 'We used to go into cars and steal…take the money and … split [it up]. That's how I used to live, using heroin, cocaine and weed.'

'People that I hung out with…was like…family to me. I didn't see no difference in the street life 'cause I was in the streets – going from place to place. It bothers me a lot, you know, losing my parents at a young age…but I try to work around it. I been through a lot in my life, man, before the shelter thing. Living in trap houses…backward and forward. Breaking into one and staying [for] 30 days so if the cops come they can't arrest me because I do live there and have mail coming to me. That's how I would survive. Selling drugs, using drugs, back and forth.' – SA10

In other cases, the process by which families expelled men from the home began as estrangement -- from their mothers (female-headed households) during youth; or their spouses, in adulthood. Under pressure to support their families, women distanced these men from other household members (SA12) or removed them from the home, as their substance use problems became intractable (SA9). These forms of estrangement and expulsion led to homelessness. Resultant broken relationships were, often, never mended (SA10).

'I grew up poor in Brooklyn [with] a lot of responsibilities at a young age because I was the oldest. I had a single mother, a father I never met, and it sort of groomed me into saying, hey, I really don't want to adjust to this. I didn't want responsibility because I was caught up in something that no one educated me on…and that was drugs. Speaking [of] my mother…there's a word for it…when you discontinue a relationship…it gets estranged. The drugs bec[a]me an important part of my life, [like] 'hey, you know what I got a friend here.' – SA12

'I kept on hurting everybody. I was hurting my mother (*starts crying*). I started selling everything out the house [and] stealing from my mother's purse. That's when I knew I had a big addiction. You know my mother just passed away. It's like (*crying*)…what… what I'm going to do now? Where I go from here? Where I go? The family don't want me 'cause the way I am. But they don't understand [inaudible] went away, I'm older now. You understand? But they think you the same man when you not. So that's what hurts the most. Your only family don't give a fuck about you. – SA9

(3) Formerly incarcerated men attributed prison violence and the personal tragedies they experienced during their sentences to mental health problems, such as depression. Some coped with these adverse experiences by continuing to use substances during incarceration.

The following description of prison life is based on a summary of respondents' experiences of incarceration:

Prison is a 'crazy', 'stressful' and 'rough' place where one must 'face' one's 'manhood' by 'battl[ing]' 'gangs', 'officers', and 'hate' to, both, secure daily needs like 'phone time' and one's inner and physical 'strength' to survive.

Men were, both, routine victims of violence ('There's a whole lot of stuff that happened to me in prison. Mostly, I got beat up by police (officers).' – *SA19*) and perpetrators of it ('Stand up, you know. You had to get aggressive. I didn't let nobody fuck with me. Big or tall, I threw down.'-SA4). They attributed these harsh prison conditions and the turmoil in their personal lives, such as broken family ties ('While you got to deal with the Bloods, Crips, the Latin kings – the gangs in jail – your girl ain't answering the phone, so that's more stress.' - SA6) and tragic deaths of loved ones (SA8), to stress, depression and suicidal ideation, which in the worst case resulted in an attempt (SA3).

'When I went to prison, they murdered my daughter. She was a newborn. She wasn't even three weeks. And they murdered my girl for [a] $50,000 drug deal. They killed my daughter. They went to my house. My girlfriend…she tell my sister to watch my daughter – right ? - with two guys, so two guys was using the drugs [at] my sister['s] house. When she went to the store, they ransacked her house, they threw the clothes in my daughter's crib, [looking for] money, they suffocate my daughter. She was only three weeks. Because [of that] I don't fear death. I'm not scared to die. I want to die. I want to die. I['ve] want[ed] to die every day [since] they murder[ed] my daughter.' – SA8

When I had 109 days left this White guy was telling me that he was going to go out with his friends and they're going to gang bang my sister. So I told the guard, 'Yo, let me sweep and mop the gallery'. Since it was dirty, you know, he let me out. So I went to the hot water -- up state, the hot water is *very* hot, steaming hot -- so I let the water get, like, boiling hot, got a bucket of water and put it next to his door. I call him out: 'Yo, come over here!' He came out to the gate with no t-shirt and put his arms up against the gate. I threw a bucket of hot water on him. He screamed so loud that the warden, who lived about a quarter of a mile away, called the prison and wanted to know, 'Who was the person that made that scream?' That night, a sergeant that used to get along with the Puerto Ricans told me, 'Look they're gonna take you to the court inside the prison.' They had like a court system. I knew that when you went to that court they grab you by the back of your pants and hold you with one hand and a night stick in the other. Because I knew what was gonna happen, I cut myself, like I tried to commit suicide. I started bleeding and spread the whole cell with blood. – SA3

In this context, men often used drugs and alcohol in prison ' to 'escape' or 'adapt' to (i) its violent conditions, which they endured over a period of decades, and/or (ii) their personal turmoil and losses. Feeding addictions amid violence and increasing personal alienation during incarceration negatively impacted these men ('And even in [prison], they had drugs in there. Getting high on cocaine and being locked up is no good.' -SA4)

(4) Formerly incarcerated men and men who became homeless due to family estrangement or expulsion attributed their current substance use problems in shelters to responses to negative emotions they associate with living in a homeless shelter, such as the distrust of other clients and frustration over the perceived lack of prospects of exiting the shelter.

Men reported they did not trust other shelter clients. They also reported feeling isolated. Their sense of isolation was, often, tied to losses of or estrangement from family members. As noted, estrangement occurred, at least in part, because of their substance use problems and/or periods of incarceration ('God, get me out of here please. [The other clients] steal...I don't like when they take stuff

from me. I just got too much on my mind, losing my mother…All they do is get you stressed out, depressed.' – SA9). Their past experiences and distrust of their peers foreground the turmoil that they currently suffer and assuage with drugs and alcohol. These substances are readily available in – or near - the shelter ('I use [heroin] when I just feel lonely -- a couple times a week - with other people from the shelter.'- SA14). Drug and alcohol consumption is intended to 'numb the pain' (SA5) But that pain, caused by alienation, is heightened by harmful levels of substance use. A 43-year-old man (SA5) describes this process:

'Being separated from my family, it hurt so much. Being in shelter increased my use, because I had to...I didn't like the shelter. It was dangerous. It was dirty. You know, you had to lock your shit up all the time [and] take a book bag out with you [during the] day with all your personal stuff. Because, lockers would get broken into, so I had to get high - and people were getting high regularly in there. Like, people are shooting heroin, right there, like sitting in their bed. So...drugs were right there, you know what I mean, so it was even easier to use. And then just to deal with the fact that I'm living like this, I had to numb the pain by using. – SA5

It is possible that formerly incarcerated men experience a heightened sense of alienation, particularly those who enter shelters (i) after living with family members post-release ('I was living with my brother. But eventually he succumbed, you know, he died. And I came to the shelter. To this day, that's where I am. I just couldn't function.'-SA 3) and (ii) directly from prison, when they have no family and rely on institutions to re-enter society ('When you have gotten out of jail society doesn't help you along. Your record is damaged and there is no help at all.' -SA13) These men perceive their loss of or discord with family members as a challenge that they must endure alone.

(5) Men reported having intermittently succeeded in abstaining, reducing, or managing their level of substance use in harm reduction programs that ensured environments of trust and communication. They believed that staff members in these programs cared about them. Men perceived abstinence-based programs to be ineffective due to violation of their trust or motivations to attend being driven by externally driven to secure a bed in a shelter facility or housing placement.

Staff connected most drug and alcohol abusing clients to a mix of harm reduction programs (mandated by parole x=5 and on self-disclosed voluntary basis=3) and abstinence services (self-disclosed voluntary basis; x=4). Registered sex offenders, for example, are required to attend out-patient facilities that provide medical-assisted treatment (MAT) and individual and group counseling sessions. Other clients that voluntarily disclose a substance use problem either choose to attend harm reduction facilities or in-patient detox and recovery programs for one-to-six-month periods. Two men each – a total of four clients – connected themselves to harm reduction and abstinence program services without help from staff. Three clients did not participate in any substance use services.

Staff members reported that clients often prefer out-patient harm reduction clinics. Their main desire, according to staff members, is to reunite with their communities and families. 'Clients consider their reintegration into society or with family a bigger problem or challenge than their substance problems,' one staff member said. 'They'll say, "What's more important to me is to get back to my family."'

This sentiment to reconnect with the family 'support system' (SA19) was expressed by more than half (x=10) of this study's respondents (SA2).

'I still talk to my sister from time to time. She's like my support system. That's my baby, bro. I could sit here and talk to her like I'm talking to you about anything. Anything. Girls, anything. She give me the best advice she possibly can.' -SA19

'I'm losing my family 'cause I never used to be around them. I'm just trying to go back around my kids now. Two boys, two girls, and [I am] a grandfather six times. My kids love to see me because they be like you be missing, we worried about you. Them worrying about me, I'm making them nervous.' – SA2

Clients that attended harm reduction programs attributed their intermittent ability to manage and desire to reduce the level of their substance use (SA1 and SA8) to the quality of care they received at these facilities (SA1). Men continue to struggle with their addictions. But their programs have also enabled them to help others in need (SA8).

I'm not using like I used to use -- I'm not as heavy on it - [and] things are starting to change. You know, I got that $1,900 voucher. I'm about to get my SRO. With the health, mental health and everything in there. I'm going to a program. I'm working towards [being] positive. I started the program under parole, being mandated. [Now], I see myself coming out the shelter into my own place, where there's gonna be a lot of trials and tribulations, a lot of temptation because I've had... I *have* friends that use. My counselor is my strong base. The RAs are my strong base. They the ones that pushed me. They say things that really penetrates in a good way. Makes me know they care, you know? – SA1

I've been going to my program for the last seven years. They talk to you about the drug, how the drug affect you and your family, your job… I already know that. But they also try to help you to stop doing drugs. You know what I mean - they want you to stop. They say I know it's hard. They say if you do it today one time and you want to do it again, do something, go and do something else, take your mind off it, because even though when you try to stop, you don 't want to, your body go through a pain, through a withdrawal. So, they give me 100 milligrams, I think, of methadone. It's a mental thing. If I do methadone, I can go three days without using. And …gaining momentum for three days, if I don't get my methadone, I might even go into a reaction…diarrhea, backpain. [But] I have saved five people's lives (referring to the use of Narcan). Out in the streets. In Manhattan on [location redacted].'-SA8

With exception to one case, men reported that abstinence-based services were ineffective. Counseling sessions did not ensure a trusted environment (SA2).

I went to NA meetings and AA meetings. And I shared. I never used to share. They heard my conversation. By the time I got home somebody run their mouth and I never went back to NA or AA again. What stays in group should stay in group, but it went out the door. It made me feel really upset. I shared. I finally opened up. I never used to talk. I used to just sit there and be quiet. Something told me to just open up. I opened up. I felt good about myself. But when I heard someone talking about what I shared in group, I just shut down completely. I mean you don't know me from Adam and Eve and here you are telling my business. That made me feel uncomfortable. I will never share again. How you going to walk around with my information in your head and you now get you a bag of heroin? -SA2

Motivations of these men to attend these programs were also externally motivated by receiving a bed in a shelter facility (SA16) or tied to the prospect of a housing placement ('They told me that if I go to a rehab, clean [up] my act, stop drinking, that they'll give me an apartment. I took 'em at their offer. I'm still waiting.' – SA15)

I been to a lot of detoxes in order to get my bed back in the shelter. Cause like if you're in the hospital, and you get discharged, you automatically shoot to the top of the list as far as getting a bed. Same thing they consider [in] detox. Rehab, the same thing. So that's a lot of the reason … that was a quick way to get my bed back. I'd go to a detox. Come back, [inaudible], and get a bed. [Then] I would lose it because I was late for coming back...and they put up with a lot of my stuff …'-SA16

Discussion

Most men in this study hail from areas of New York City that had been affected by housing and employment segregation in the latter 20th century. Their histories of substance use are rooted in social and economic inequalities that disproportionately affected New York City's Black and Latinx majority locales. These structural inequalities may have also frayed social bonds and support systems (Dunlap & Johnson, 1992; Farber, 2019) that made such neighborhoods vulnerable to the illicit drug trade. Indeed, these men were intensely exposed to other people using, buying, and selling substances from childhood, before they became homeless. However, the shift from these men's intense and early exposure to drugs and alcohol to, then, using and, eventually, becoming addicted to these substances, escalated in the context of traumas that they had endured amid poverty, such as the loss of family members and violence. These traumas were both the outcomes of intergenerational poverty and, potentially, destroyers of local family systems. Men often engaged in crime, to subsidize their substance use, *after* the death or absence of a parent. Expulsion from one's home, after being addicted, occurred in female-headed households.

The findings reveal the following pattern of substance use exhibited by this study's respondents. Early exposure, then addictions, to substances, occurred amid poverty and trauma before experiencing homelessness; addictions then deepened amid violence and alienation, from families and communities, in contexts of incarceration, homelessness, and the onset of mental health burdens before entering shelter. The effects of such traumas and feelings of alienation, which are factors associated with becoming homeless (Padgett et al 2006; Padgett & Henwood 2012:189; Ibabe et al 2014:374), were exacerbated once *in* the shelter when men were confronted with the aggression, distrust, and occasional violence of their peers. Men continued using substances to cope with adverse experiences that had occurred throughout their lives across numerous environments in the city. Each environment evoked – in their words - reminiscent 'people, places, and things.'

Knowledge of clients' traumas and their role in substance use disorders should be utilized to design program services that aim to help men both manage, or reduce, their addictions and mend fraught relations between them and their communities. One staff member recommended the type of specialist required in such a program:

'You need a person of integrity. Not just a peer specialist but a person who has experienced what they are going through and understands clients' interests. For example, we just had a client on the brink of an overdose who was just connected to a program. Staff designated a client 'peer' to assist and speak to this person. The peer helped him get his lost documents and benefits, which built trust. He arranged for someone to do his paperwork and connect him to the program. Sincerity, dialogue, and effective communication enable such clients to access and connect to resources and services.'

Two barriers currently prevent the implementation of these harm reduction services in HELP USA shelters. First, the absence of a *dedicated* Overdose Champion necessitates multiple front-line staff to respond to substance use crises – overdoses. Staff duties are currently pegged to housing placement mandates. They have limited bandwidth to identify patterns of and reasons for addictions. Assessing mental health burdens, childhood traumas and incarceration requires concerted effort. As one staff member said, 'We follow up with DHS [after overdosing clients are provided Narcan and admitted to hospitals] but don't have the personnel to address all responsibilities of the policy. Much of what DHS mandates are on the shoulders of case managers and clinical social workers while another staff member serves as a Narcan trainer, and all new employees are trained in how to administer Narcan.'

The second barrier is the inability to ensure a supervised and managed space of drug and alcohol use in shelters because the use of substances on the premises is officially prohibited. Clients who do attend harm reduction programs are presented with a conflict. They are connected by the shelter – or by themselves - to medical assisted treatment (MAT) regimens in facilities *outside* the shelter but face penalties for using substances, even at reduced rates, *in* or *near* the shelter. This inconsistency could undermine client trust in and efficacy of harm reduction services over time.

Recommendations

This study recommends the following reforms to overcome the current service barriers discussed in the preceding section. These reforms are envisioned as a two-stage process.

Stage 1: institute and resource a harm reduction team to address existing gaps in the DHS substance use policy, under the current prohibition of the use of substances in shelters (**immediate service reforms**)

HELP USA should hire at least one full-time harm reduction specialist (HRS) in each single adult shelter. The HRS should be assisted by a peer worker or peer group. A peer would be a current or former shelter client that has successfully undergone a harm reduction treatment program. This team would assume the responsibilities of the Overdose Champion, stipulated by the DHS policy, including to:

- administer Narcan to overdosing clients and admit them to hospitals (*currently implemented* by multiple staff members in response to crises)

- provide harm reduction education to clients and front-line staff in the shelters (*not implemented* due to the present lack of capacity to commit staff and resources to an additional program); and

- proactively link clients to outpatient medical assisted treatment (*partially implemented* due to limited capacity to identify client histories of substance use and associated traumas.

Harm reduction education, client identification and linkages to outpatient medical assisted treatment should include both drug and alcohol users.

This program would require DHS and a harm reduction provider to train this team and other frontline workers. This training would entail instruction on the following components of a harm reduction program, including assessing client needs, under the current prohibition of substance use in shelters (barrier 2):

- Design a module for harm reduction education for drug and alcohol users, respectively. This will entail instruction on how best to coordinate efforts between DHS and shelter staff and between shelter staff and clients, as well as resources needed to implement the program consistently.

- Design a module of assessing client needs and destigmatizing substance use. These components are necessary to mitigate barriers to clients' access to harm reduction programs or the cancellation of other services they need. This training module would focus on:

    - identifying client histories of substance use, trauma, status of family relationships and connections to communities (in acknowledgement that most clients are from New York City)

    - conducting the simultaneous tasks of (a) connecting clients to harm reduction services outside the shelter (with preference to programs that offer concomitant mental health services), (b) earmarking safe spaces *outside* shelter premises to use substances, and – in coordination with case management and housing teams – (c) ensuring clients can access other services without fears that using substances will initiate penalties or cancellations of benefits. These services include documents, public welfare provisions and, most importantly, housing placements.

This represents a harm reduction-based 'recovery model' (Padgett, Smith, Henwood, and Tiderington, 2012) that treats substance use disorders *in context* childhood traumas, early life exposure to substances, and institutionalization, which are the 'multiple' and 'cumulative' challenges' (Henwood and Padgett, 2007; ibid) that HELP USA shelter clients experience.

Stage 2: advocate that policymakers permit shelters to designate a supervised area in to manage the safe consumption of alcohol and drugs for clients that are connected to harm reduction programs (long-term policy advocacy)

This is a long-term strategy. It will require dialogue between service providers, DHS, and the mayor's administration. As noted, evidence of these shelter programs in Canada to reduce drug and alcohol use and increase health-seeking behaviors hinged on the establishment of trust and reciprocity. In those programs, medication assisted treatment was provided to clients who were

permitted to use substances in a managed environment. We must therefore acknowledge that the long-term effectiveness of a harm reduction program would depend on making all components of this service model available in one location.

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