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UNDER THE BRIDGE: A QUALITATIVE INVESTIGATION OF HOMELESS PERSONS'
PERSPECTIVES ON SUBSTANCE ABUSE AND ITS TREATMENT

By

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Thesis

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Under the Bridge: A Qualitative Investigation of Homeless Persons' Perspectives on Substance Abuse and Its Treatment

Chairperson: Dr. Daisy Rooks

Although homelessness is generally thought of as an urban problem, it is also a growing problem in rural areas, such as Missoula, Montana (Jacobson 2010). Studies of urban homelessness indicate that substance abuse is a part of life for many homeless individuals, and the barriers to substance abuse treatment are exacerbated by being homeless (Snow and Anderson 1993; Morrell 2007). "Prevalence studies estimate that the percentage of homeless people with alcohol use disorders to be at 30%-40% and drug abuse at 10%-15%" (Fisk, Raakfeldt, and McCormack 2006: 480). Substance abuse is also common among homeless individuals in rural areas, including Missoula, where this research takes place (Jacobson 2010). This research takes place in the only 'wet' day center for homeless persons in Missoula. Unlike traditional homeless shelters, harm reduction facilities or 'wet' facilities provide services to those under the influence of drugs and/or alcohol. Clients of 'wet' facilities offer an important perspective on substance abuse and treatment, as they are most likely to have experiences with both. To better understand this population, this project uses participant observation and in-depth interviews with clients and staff of a 'wet' facility to explain their perceived and experienced barriers to substance abuse treatment.

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CHAPTER ONE: INTRODUCTION

Substance abuse among the chronically homeless, as well as a lack of treatment for substance abuse among the chronically homeless, is a problem across America. Chronically homeless people often experience substance abuse and/or mental illness compounded with a lack of treatment options for substance abuse and mental illness. “Among the hardest to reach and retain in services are adults experiencing homelessness and mental illness with co-occurring substance abuse” (Stanhop et al. 2009: 459). In many cases, chronically homeless individuals will use substances as a method of dealing with untreated mental illness or pain. Regardless of the reason for the use, substance abuse is a problem that is left untreated for many homeless individuals (Stanhop et al. 2009).

Twelve step programs like Alcoholics Anonymous and Narcotics Anonymous claim the first step towards recovery from addiction is to admit both that one is powerless over a substance, and that his or her life is unmanageable because of it (Hanson, Venturelli, and Fleckenstein 2009). This is a logical step for those who sincerely believe they have a substance abuse problem, but what about the people who do not see substance abuse as a problem? People who do not see substance abuse as a problem are often the last to seek treatment options. People with this perspective exist across classes, genders, and races throughout America.

Barriers to Treatment for the General Population

Structural Barriers. Once an individual has decided that he or she wants to stop using substances, a person faces specific structural barriers in receiving intensive treatment. Structural barriers to substance abuse treatment include obstacles that are out of the individual’s immediate control like funding, availability of treatment, and accessibility of treatment. The largest most important structural issue for most individuals is funding. Substance abuse treatment is very

expensive in most cases. Members of the general population are likely to pay for treatment with health insurance or personal funds. Insurance companies can pick and choose which treatment facilities they will provide payment to as well as the length of stay they will pay for (Hanson et al. 2009).

Aside from the funding issue, one must actually be accepted into a treatment program in order to get treatment. Getting into a treatment program also requires large amounts of paperwork and appointments with staff to assess one's need for treatment. A person must also have the time to attend such meetings as well as a mode of transportation to physically be at the meetings (Hanson et al. 2009). Funding, time, and transportation all play a role in getting a person into a treatment program.

For many members of the general population, there are ways to overcome these barriers. There is another group of people, homeless people, who are in many ways excluded from the general population and experience these same barriers. All of these barriers are exacerbated for those experiencing homelessness, making the barriers much harder to overcome.

Broad View of Homelessness

Home is something that most Americans hold dear. However, for a significant number of people in America, home is a sidewalk, a shelter, a park, an alley, or a car. In 2005 approximately 150,000 to 200,000 people were chronically homeless (Lincoln, Espejo and Plachta-Elliott 2009). "The federal government defines those who are chronically homeless as individuals with a disabling condition (e.g., substance use disorder, serious mental illness, developmental disability, or chronic physical illness) who have been homeless either (a) continuously for one whole year or (b) four or more times in the past 3 years" (Lincoln et al. 2009: 236). While homelessness is generally thought of as an urban problem, it is a growing

problem in rural areas (Jacobson 2010). Homelessness exists in rural states like Montana, even though it is not a densely populated state. In both rural and urban homeless populations, substance abuse is a reoccurring issue due to the various barriers to substance abuse treatment that exist for the homeless (Belcher, DeForge, and Zanis 2005; Shlay and Rossi 1992).

Substance abuse exists in nearly all homeless populations, rural or urban. “Prevalence studies estimate that the percentage of homeless people with alcohol use disorders to be at 30%-40% and drug abuse at 10%-15%” (Fisk, Raakfeldt, and McCormack 2006: 480). Addictive behaviors occur more often in the homeless population than in the housed population (Lincoln et al. 2009; Morrell 2007). It is often extremely difficult to tell whether a person’s using habits put them on the street or whether living on the street caused them to use. “Untreated substance abuse represents a major risk factor for homelessness, with alcohol as the most frequently used substance” (Fisk, et al. 2006: 480). People who live with an untreated substance addiction are more likely to end up on the street than someone who gets substance abuse treatment (Fisk, et al. 2006).

Structural barriers to substance abuse treatment for homeless people. For a person who lives on the street and is dealing with addiction, receiving treatment is not simple. For some, cost is the major barrier to treatment, as traditional treatment is often very expensive. Those living on the streets do not normally have access to health insurance or personal funds. Those with lower education levels may not be able to complete the large amounts of paperwork, which creates an additional barrier to treatment. Homeless persons may have trouble getting to the actual treatment facility as well, depending on its location and the availability of public transportation in the area where they live (Padgett, Gulcur, and Tsembris 2006; Fisk et al. 2006).

Perspective as a barrier to substance abuse treatment. Apart from the structural barriers to treatment, an individual's perspective of addiction may also be an enormous barrier. Chronically homeless people often hold the perspective that substance abuse is not a problem, but is simply a lifestyle. Some members of the homeless population are shelter-resistant, meaning he/she will not stay in a shelter by their own choice, as well as treatment-resistant meaning he/she will not voluntarily enroll in substance abuse treatment, for their own personal reasons (Morrell 2007). These members of the population are simply not interested in rehabilitation. This viewpoint is an enormous barrier to seeking treatment for substance abuse. Even if a homeless person can overcome all of the structural barriers, if he/she doesn't see their substance abuse as a problem, it is unlikely that he/she will seek out treatment. This study explores whether the barriers to substance abuse treatment that have been identified during research on urban homelessness, are applicable to smaller cities and/or rural areas. To achieve this goal, this study examines homelessness in Missoula, Montana.

Background

In Montana, the city of Missoula contains the state's largest proportion of homeless people in 2007 (Christensen 2007). According to a recent estimate, Missoula contains approximately 26% of the 2,114 homeless people in Montana (Christensen 2007).¹ The homeless population in Missoula is counted every two years with a point-in-time survey. One day a year, surveyors canvass the town counting the number of homeless people. It was found that most of Missoula's homeless were fleeing from domestic violence, suffering from substance abuse, or struggling with mental illness (Christensen 2007).

In 2010, a point-in-time survey reported a total of 631 homeless people; nearly one-third of those being families with children, and the remaining being chronically homeless (Jacobson

¹ These numbers are from the most recent survey, 2010, compiled by the Continuum for Care Group.

2011). Missoula's chronically homeless exhibit similar traits in being resistant to treatment for substance abuse (Christensen 2007).

Many organizations exist to help homeless people in the Missoula community. The Poverello Center is a popular resource for this population, and has a branch called the Salcido Center, which is a day center for those under the influence of drugs and alcohol (Christensen 2007). The Salcido Center is the one facility for the homeless in Missoula that adheres to the "harm reduction model" of social service, a somewhat controversial approach that will be discussed in detail later on. Missoula, MT and specifically, the Salcido Center are the setting for this research. I seek to understand the barriers to substance abuse treatment for clients of the Sal.

CHAPTER TWO: LITERATURE REVIEW

Explaining the Issue

To better understand Salcido Center clients' perception of addiction, I will explore three social theories facilitate further understanding: stigma, social construction of reality, and rational choice theory. Like pieces of a puzzle, these theories fit together and create an understanding of why Salcido Center clients make the lifestyle decisions I observed during my research.

Together, these theories explain both how an individual will make decisions within the social network they reside, and how the individual's setting impacts the choices available to them.

Stigma

Erving Goffman, an instrumental theorist in developing the theory of stigma, applied stigma to various issues in the social world. Goffman defines stigma as an "attribute that is deeply discrediting" and that reduces the bearer "from a whole and usual person to a tainted discounted one" (Goffman 1963: 3). Stigmatization creates a wall between the person who stigmatizes and the one given the stigma. "In the extreme, the stigmatized person is thought to be so different from 'us' as to not be really human" (Link and Phelan 2001: 367). In one way or another, the stigmatized experience social exclusion.

There is an ongoing debate between researcher over whether a stigma creates a label or vice versa. According to Goffman, the application of a label to a person such as criminal or deviant results in stigmatization. A stigma is different from a label in that a label is often a result of a stigma. Once a stigma is connected to a person or group of people, the following are likely results: labeling, stereotyping, separation, status loss, and discrimination..." (Link and Phelan 2001: 367). Whether or not the label following the stigma is a correct representation of a person, it will most likely stick to the stigmatized individual (Goffman 1963; Lister 2004).

Social Construction of Reality

Influential phenomenologists Berger and Luckmann popularized the social construction of reality theory. Their ideas are based on the principle that people develop their own sense of reality based on their interactions with others. One cannot get a full picture of him/herself without the reactions of others; “Better knowledge of myself requires reflection (from others)” (Berger and Luckmann 1966: 29). Thus, people learn about themselves through the reactions they receive from those around them.

It is a two way street of acting and reacting; “To be in society is to participate in its dialectic” (Berger and Luckmann 1966:129). Through actions and reactions, humans create meaning and definitions of themselves. The knowledge a person receives from interactions with others may be interpreted as reality, regardless of its actual validity (Goffman 1963). Consequently, “the individual becomes what he is addressed as by his significant others” (Berger and Luckmann 1966:132). In these ways, interactions with significant and insignificant others create an individual’s reality (Berger and Luckmann 1966).

Rational Choice

Paternoster, an early rational choice theorist, built a foundation for rational choice theory. Although he used rational choice theory to explain delinquency, scholars have used Paternoster’s to explain how a wide range of people make decisions. In Paternoster’s words, ‘delinquents’ are active decision makers who evaluate their choices based on the information available to him or her. Therefore, their choices are always informed choices. This was important during Paternoster’s time because he was starting from the position that this population is acting thoughtfully rather than impulsively, as most theorists claimed. More recently, Pescosolido and Coleman expanded Paternoster’s ideas from delinquents to the general population. They applied the idea of rational choice to general decision making for individuals.

Stated simply, rational choice theory "...represents the theory of action used implicitly by most social theorists and by most people in the common sense psychology they use to understand what they and others do" (Pescosolido 1992:1100). Individuals act in a way that seems to be the most beneficial to them. Today, rational choice theory has moved further than the idea that humans simply weigh their gains and losses and make their decisions accordingly. Instead, decisions are situationally induced, and the information available about the gains and losses of the decisions depends on the specific situation. Decision options are limited or expanded depending on the context of the decision (Paternoster 1989; Pescosolido 1992).

Rational choice theory is a somewhat individualistic theory, thus, Coleman does not value social theories without an individualistic base. Those theories, Coleman argues, tend to be fatalistic, putting individuals "at the mercy of these uncontrollable external or internal forces" and making them "unable to purposely shape their destiny" (Coleman 1990:17). Instead, Coleman's idea of purposive action gives the actors freedom to act within their own social world (Coleman 1990). Paternoster also recognizes that the individual and social structure play a role in decision making (Paternoster 1989).

All three theorists, Paternoster, Coleman, and Pescosolido, agree that the factors that affect one's decision making vary by situation. Paternoster provides the following list of individual and structural factors that may impact decision making; demographics, family characteristics, psychological traits, gender, affective ties, material considerations, opportunities, informal and formal sanctions and moral considerations. There is no way to know which factors are the most influential, as they vary depending on the situation (Paternoster 1989).

A modified rational choice theorist, Pescosolido accepted the premises of rational choice theory, but added another component, social organization strategy. This strategy moved beyond

rational choice and considered the impacts of external social forces. “Building the social organization strategy does not require rejecting or denying the utility of a rational-action-based synthesis. The latter remains a particular and useful way of slicing through a problem” (Pescosolido 1992:1099). Pescosolido valued Paternoster and Coleman’s perspective to a degree, but insisted on adding a more overtly social perspective by claiming that social structure is more powerful than the individual (Pescosolido 1992).

Rational choice theory seeks to explain how humans make decisions. Pescosolido acknowledged the power of an individual to make choices but also placed importance on the social networks and events that constrain a person’s choices. On the other hand, Coleman began his analysis of decision making on an individual level, placing the most importance on the purposive actions of the individual. Because this is important, my research attempts to balance the two, giving credit to the individual as well as the structure they live in.

Coleman does recognize the role of social structure in individual decision-making, yet he begins on an individual level to explain the choices people make. “The assumption that actors hold rights of control over their actions and rights of transfer is never true for all actions of a person in a social system” (Coleman 1990: 70). There is some degree of freedom within a social structure; one is never completely free from the effects of their structural setting. As Paternoster states, actors will make informed decisions based on the information available to them (1989). One of the most significant ideas conveyed by all three theorists is that no matter how irrational a decision may seem from the outside; from the individual’s perspective the decision seems rational (Paternoster 1989, Pescosolido 1992, Coleman 1990).

Limitations of rational choice theory. While Goffman’s ideas about stigma and Berger and Luckmann’s ideas about the social construction of reality are generally well accepted, rational

choice theory has faced much criticism. One of the main arguments against rational choice theory is that people tend to act impulsively (Hechter and Kanazawa 1997). Coleman's counterargument is based in his idea that all actions are in fact rational, even if only to the actor. "Much of what is ordinarily described as nonrational or irrational is merely so because the observers have not discovered the point of view of the actor, from which the action is rational" (Coleman 1990:18). Understanding individual decisions requires understanding the perspective of the actor. The observer is not the one doing the action, thus the observer cannot fully explain another's actions. That is precisely why the observer must understand as fully as possible the perspective of the actor (Hechter and Kanazawa 1997).

Theory Application: Understanding the Perspective of a Salcido Center Client

Why are homeless people stigmatized? The stigma attached to homelessness affects homeless people in many ways. In America, it is a common belief that people should just pull themselves up by their bootstraps when they find themselves in hard times (Lister 2004; Morrell 2007). When people are not able to do this, whether the reason is legitimate or not, they are often labeled as lazy and worthless by many members of society (Phelan, Link, Moore and Stueve 1997). This label is a result of the stigma attached to poverty and/or homelessness, which is an extreme form of poverty (Goffman 1963).

How are homeless people stigmatized? The prevailing public conception of the average homeless person is "a disheveled man nursing a bottle of cheap wine" (Snow and Anderson 1993:42). The increased visibility of homeless persons adds to the perpetuation of stigma, as drinking under a bridge is more stigmatized than drinking at a bar. Those living in poverty experience this stigmatization and internalize the negative labels (Morrell 2007). "The impacts of stigma are profound...where the stigma of poverty is internalized; shame is a likely

consequence (Lister 2004: 118). The shame and humiliation that comes along with street life in particular may make it difficult for a person to believe that they integrate into 'normal' society (Morrell 2007; Snow and Anderson 1993).

Other members of society may not outwardly label the homeless negatively; instead they may choose to completely ignore them. Every day, homeless persons are ignored by those passing by on sidewalks that often refuse to even look at them. People literally walk by homeless people and pretend that they don't see them. This sends a strong negative message to the homeless person (Phelan et al. 1997; Morrell 2007).

If Berger and Luckmann are correct that one's perception of self is derived from peoples' reactions to them, then this could also explain stigmatization of the homeless. Negative reactions may negate a person's self esteem, and "...public image may become self image" (Lister 2004: 119). The way people view an individual adds to the individual's definition of him/herself. Although this can be positive for individuals who are viewed positively by society, for individuals who are viewed negatively by society, their "sense of humanity is hostage to categorizing judgments of others" (Lister 2004: 119). Living with despair and shame may have detrimental effects on an individual's interactions with other members of society, thus negatively impacting the individual's interpretation of the world around him/her. Living with a stigma of any sort affects the way one's reality is constructed.

The impact of stigmatization on homeless persons. A person's life experiences determine how they see the world they live in. Unfortunately, for many homeless people, their reality is constructed through their negative interactions with the general population or social institutions. As stated previously, the stigmatization of homeless people limits the number and types of interactions they have with others (Phelan et al. 1997).

One of the most influential forces on each individual's reality is their interactions with others. "The reality of everyday life is ongoingly reaffirmed in the individual's interactions with others" (Berger and Luckmann 1966:149). The structure in which those interactions take place will determine the types and patterns of interactions. Stigma plays a significant role in the structure homeless people live in, impacting the choices and resources they have available to them (Phelan et al. 1997).

Choices Available to Homeless Persons: What is a person to do? The life choices available to homeless people are often quite limited. Remaining homeless is not simply a matter of choice, but rather a lack of options to choose from. From Pescosolido's perspective, decisions are made by the individual within the structure they live in. If a person feels there is no way out, they will choose to remain where they are, because there is no other choice available to them. "The informed decision maker of the rational choice perspective repeatedly evaluates information and makes behavioral decisions on the basis of such information" (Paternoster 1989:37). If a homeless individual believes there are no options for him/her, they will most likely continue on the path they are, whatever that might be. From an outsider's perspective, "The person's activities regardless of his goals perpetuate his or her homelessness as if it were itself a goal" (Grunberg 1998: 241); however, from a homeless person's perspective, it may seem as though there are no other options but to keep doing what they are doing (Grunberg 1998).

Theory Applied: Understanding Decisions of Salcido Center Clients

The reasons for peoples' actions and beliefs are not black and white, based on either social structure or the individual. It is in the gray area that people make their decisions. As observers, we cannot say whether an action or belief was due solely to social structure or solely to the individual. People are not completely free agents making decisions, rather they are agents

acting with the resources they have available to them (Ritzer2007). “The constructed social environment, consisting of purposive actors and their agents, constitutes a large part of the social environment of most persons in modern societies” (Coleman 1990: 615). One constructs their environment with the resources they have and act accordingly.

To understand why clients of the Salcido Center do not believe addiction is a disease, we must understand the roles of stigma, social construction of reality, and rational choice theory in relation to decision making. The stigmatization of homeless people is a result of the social structure surrounding them. This stigma becomes part of the reality a homeless person creates for him/herself. “Stigma has affected the structure around the person, leading the person to be exposed to a host of untoward circumstances” (Link and Phelan: 373). Stigma is built into the structure of a homeless person’s everyday life. It is from their circumstances and their own social reality that they choose their actions and beliefs. This does not go as far as to say each homeless person’s reality is the same; no two realities are identical (Berger and Luckmann 1966). This leads one to ask what role stigmatization plays in substance abuse among homeless people and how might that prevent people from seeking treatment.

Most clients of the Salcido Center have been stigmatized and stereotyped by society in general. Stigmas exist in practically all areas of society; however, the stigma that inevitably follows a homeless person is arguably more severe than other stigmas in society (Goffman 1963). Homeless people may be more severely stigmatized than other poor persons because they are more visible to the general public than other groups of stigmatized people. Personal hygiene is more difficult to maintain for those living on the street, which may make homeless people seem aesthetically unappealing to the general public (Morrell 2007). A common assumption about homelessness is that it is associated with other stigmatizing conditions like substance

abuse and mental illness (Phelan et al. 1997). Regardless of whether or not these generalizations are true; they are often attached to homeless individuals.

As stated previously, individuals use other people's reactions to them to define themselves (Berger and Luckmann 1966). For a person labeled "homeless," the general population's reaction to them is often not a positive one. The stigma that they live with constrains their interactions and social networks, impacts the way that they interpret their world and shapes their choices about how to act and think in their own world. For example, compare the daily interactions of a single, middle-aged, homeless person and a young college student. For the most part, the individuals receive different reactions from others, and they will live in strikingly different realities because of it. This is why it is vital to understand an actor's perspective and experiences, when seeking to understand why they do what they do.

Sociological Research about Homelessness

To gain more insight to the perspectives and actions of clients at the Salcido Center, we must first look at homelessness in general. As soldiers returned home after World War II, America saw a decrease in the demand for transient labor (Gowan 2010). Also at this time, rates of homelessness had decreased justifying urban renewal projects in cities across the U.S.; which in turn, led to the demolition of many low income housing facilities and projects. As housing projects decreased, the visibility of the homeless increased. In the 1970's, the decriminalization of vagrancy laws made homelessness even more visible (Gowan 2010). Public awareness about homelessness grew throughout the 1980's; and as a result, the need for research about this issue began to rise (Shlay and Rossi 1992).

The socio-economic system in the United States produces continual and increasing income inequality. This increasing income disparity often locks people into poverty and

increases the risk of homelessness. Nationwide, America has a shortage of affordable housing and many attempts at improving this problem have been met with little success (Shlay and Rossi 1992). The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) were passed in 1996 and clearly reflected the government's lack of concern for the poor. For the most part, this act removed the social safety net and forced welfare recipients to compete for low-wage, dead-end jobs (Ehrenreich 2001; Belcher, DeForge, and Zanis 2005). "These new policies and programs focused on the individual responsibility, and mainly ignored the life events and circumstances of the majority of the poor" (Belcher et al. 2005: 8). While the term poverty encompasses much more than just the homeless, those living on the street are at the bottom of the social ladder, even among those in poverty.

Substance Abuse among Homeless Populations

The Age Old Question: Does homelessness cause substance abuse or vice versa? In 2003, the National Institutes of Health reported that 20 million Americans abuse drugs and alcohol, thus substance abuse will not always land a person on the street (Hartwell 2003). As stated previously, it is often hard to tell whether substance abuse causes a person to end up on the street, or if a person uses drug and alcohol because he/she lives on the street. It has also been found that chronic health problems, untreated or mistreated mental illness, or addiction to drugs and/or alcohol were important causes of homelessness (Morrell 2007).

Profiling the Homeless Substance Abuser

"It is estimated that there are 20 homeless persons for every 10,000 Americans, and of those 20 persons, approximately 15 individuals report a lifetime history of drug and/or alcohol use-related problems" (Hartwell 2003: 476). In 1998, Kuhn and Culhane conducted a longitudinal study of people accessing homeless services in New York City and Philadelphia.

They found that 31% of those surveyed in NY reported having a substance abuse problem and 38.2% of those in Philadelphia reported having a substance abuse problem. They used a service database in New York and Philadelphia, in order to survey as many homeless people as possible. They ended up with a sample size of about 27,000 people (Kuhn and Culhane 1998).

“Substance abuse among the homeless occurs across ages, ethnicities, and gender” (Cohen and Krating 1993: 194). Substance abusers are not a heterogeneous group of people (Cohen and Krating 1993; Hartwell 2003).

What substances are most commonly used?

From the fall of 1984 through the summer of 1986, Snow and Anderson studied the homeless population in Austin, Texas. Their study includes many interesting findings regarding substance abuse. They found the most commonly used drug to be alcohol, although there was a great deal of variation of the amount of use in the population that they studied (Snow and Anderson 1993).

Using Substances as a Strategy to Subsist

Using substances was found to be a common way of dealing with life on the street. Snow and Anderson’s research focused on “life on the streets as experienced by the homeless” as well as “their strategies and struggles to subsist from one moment to the next materially, socially, and psychologically” (Snow and Anderson 1993: xi). When asked why they used alcohol, the homeless individuals in their study explained that it was most commonly used as an ‘avenue of escape’ from the rigors of homelessness (Snow and Anderson 1993).

Another influential study of homelessness was conducted in 2007 by an organization called Sisters of the Road in Portland, Oregon. Sisters of the Road is an organization that seeks to help individuals find ways to exit homelessness. Over the span of several years, researchers

collected 600 interviews with people living on the streets. These interviews examined the circumstances leading to homelessness, as well as the experience of living on the street. They found that most people were homeless because of tragic events like divorce or loss of a family member, unexpected physical injury or job loss (Morrell 2007).

Substance abuse was a very common theme in the Sisters of the Road study. Similar to Snow and Anderson (1993), the Sisters of the Road study found that homeless individuals use substances in order to ease the stress of being homeless. “Many homeless people develop an addiction after losing their housing. Following the harsh and daily grind of homelessness, they turn to alcohol or drugs for solace, or to medicate untreated physical and mental pain” (Morrell 2007:140). For some, drug and alcohol use may be the only medication they can turn to, while others find alternative ways to deal with their situation.

Hartwell also provided some explanations as to why homeless people abuse substances. After interviewing thirty-three homeless men in New Haven, Connecticut, Hartwell found that most of the interviewees had alcoholic parents or parents addicted to substances. Most of the participants had also experienced violence as children, had at least five siblings and many of their siblings also had some type of substance abuse issue. Transience, violence and substance abuse were often the coping mechanisms the participants learned growing up (Hartwell 2003).

Obstacles to Providing Treatment for Substance Abuse among Homeless Populations

Many researchers agree that there is a lack of ‘program fit’ for homeless individuals. Researchers define ‘program fit’ as a program designed to deal with the issues of substance abuse as well as other issues unique to homeless people, specifically housing. This lack of program fit likely causes them to disengage from treatment programs (Stanhope et al. 2009; Snow and Anderson 1993; Morrell 2007; Culhane et al. 1998; Cohen and Krating 1993; Hartwell

2003). “Many homeless people have substance abuse problems, but few receive treatment in usual facilities...changes in how services are structured may help get them to accept treatment, especially if agencies address their characteristics” (Cohen and Krating 1993: 195).

Snow and Anderson found two facilities that offered substance abuse treatment for the homeless in Austin, Texas. Both programs were heavily influenced by Alcoholics Anonymous. They also found that neither program had much success among the homeless due to the fact that “they restore clients’ health so that they can function physically, but they seldom provide the resources or training their clients need in order to ‘get back into society’. Consequently, clients often end up back on the streets after being discharged,” and once on the streets they often reverted back to their substance abuse habits (Snow and Anderson 1993: 93).

The face of the homeless substance user. Snow and Anderson identified groups of homeless people who tended to have more substance abuse issues than other groups of homeless people like mothers with children. Their typologies consisted of transitional, episodic, and chronically homeless people. Those who were on waiting lists for housing programs or in between separate housing programs were considered transitionally homeless. Episodically homeless people were those who moved in and out of homelessness several times in their lives. People were considered chronically homeless when they were homeless for a majority of their adult life. Among those groups, Snow and Anderson found that those who were episodically homeless were more likely to receive treatment for substance abuse, with 44.5% receiving treatment compared to the 33% of the chronically homeless who received treatment. The authors recommended that services, including substance abuse treatment, be tailored to each of three groups of homeless individuals, in order to be most effective (Snow and Anderson 1993).

A different study conducted by the Sisters of the Road in Portland, Oregon uncovered a variety of different strategies used by homeless individuals to recover from substance abuse. For example, "...one man camped in the Rocky mountains as a kind of spiritual retreat to kick drugs" (Morrell 2007:143). Many individuals in the sample "belonged to twelve step programs, or had gone through programs offered by social service agencies" (Morrell 2007: 142). Others tried to keep busy to avoid substance abuse. For example, "One veteran who had been sober for seventeen years spends much of his time volunteering, because he believes in keeping busy as a key to sobriety" (Morrell 2007: 142). Their study shows that there are many roads to recovery as well as many barriers to recovery.

The Sisters of the Road study also found that not having a place to go and not having anything to do were huge barriers to recovery. One man said it quite clearly, "Recovery and sleeping under a bridge does not work; it does not work at all....There are a lot of places you can go as far as shelters and stuff, but it is just for the night. During the day what can you do? You wander around and that is all" (Morrell 2007: 144). In order to successfully deal with addiction, a person needs a safe place to live and an environment conducive to their recovery. Living on the street is a harsh and sometimes dangerous way to live. Remaining sober and on the streets is extremely difficult and often impossible (Morrell 2007). Hartwell also reported on the difficulty of remaining sober, "...relapse is inevitable in their environs and they simply slip back into old patterns" (Hartwell 2003: 494). In these ways, it becomes clear that environment plays an important role in sobriety (Morrell 2007; Hartwell 2003).

Most research regarding the treatment of substance abuse for homeless people reveals that there are inadequate treatment options available to homeless people. "The emergence of large numbers of individuals suffering from mental illness and drug abuse requires a new

perspective on the homeless” (Cohen and Krating 1993: 193). In order to begin to overcome the obstacles to substance abuse treatment for homeless people, a different approach to treatment is required.

A RESPONSE TO THE OBSTACLES: THE ABSTINENCE MODEL OF SOCIAL SERVICE VS. THE HARM REDUCTION MODEL OF SOCIAL SERVICE

Background

Beginning in the early 90’s, America has taken the ‘get tough’ approach to drug and alcohol use (Hanson et al. 2009). Drug policy is strongly influenced by law enforcement. Strict drug policies and increasing punishment for the possession of illegal drugs in America have been put in place over the years in hopes to deter the amount of illegal substance use (Hanson et al. 2009). However, there is little evidence to prove that these strict policies and punishments have significantly decreased drug use (Hanson et al. 2009). “After nearly three decades of a war-on-drugs strategy, certain realities remain: an upward trend in drug use among virtually every age group; a steady supply, decreased cost, and increased purity of street drugs; mounting emergency room visits and deaths from overdose and drug use-related diseases such as HIV/AIDS and hepatitis; and continued drug-related crime” (Bigler 2005:72). Although expenditures for drug control enforcement have only increased, illicit drug use continues to make the argument for stricter policies and punishments unconvincing (Hanson et al. 2009).

The initial enthusiasm for the War on Drugs is decreasing as substance abuse remains a nationwide problem (Brocato and Wagner 2003). Treatment for addiction was not a large part of the War on Drugs, and it remains as one of the ways to reduce drug use in America. Due to America’s initial ‘get tough’ approach to drug use, most substance abuse treatment facilities adhere to an abstinence model of treatment. This means that the facility will only serve those

who are abstaining from the use of drugs and alcohol. As a direct result of this, many of those in need of treatment are not receiving it. Treatment programs employing the abstinence model view those not immediately interested in quitting use as un-servable (Brocata and Wagner 2003; MacMaster 2004). For example, the Poverello Center, a homeless shelter in Montana, does not allow people under the influence of drugs or alcohol to use the facility. In order to stay at the Poverello Center, a person is required to maintain sobriety. In these ways, the abstinence model of social service excludes many people who are often in desperate need of help.

Criticisms of the Abstinence Approach

Among social workers and service providing organizations like the Poverello Center, many criticisms of the abstinence-only approach have emerged: it is moralizing, it is unreasonable to expect complete sobriety from this population and it is very difficult for some people to access the necessary treatment. “Models of this abstinence-only approach have been generically applied, dogmatically interpreted, and presented with moral overtones, which arguably have led to many people with substance abuse problems to avoid or reject traditional treatment” (Brocato and Wagner 2003: 118). As a result of the abstinence-only approach, homeless individuals who use substances are unable to access many programs that provide shelter. For many, using substances may go against a moral belief; using drugs is often seen as ‘wrong’ in American society. Aside from the moral argument against the abstinence approach, this assumption that everyone believes drug use is ‘wrong’ is a large generalization about an entire population; one that is not true for many people (Brocato and Wagner 2003).

Abstinence models make demands on people who have little means to meet those demands. If a person decides to get sober, they often need to change their surroundings in order to be free of drugs or alcohol. They also need to be in an environment that is conducive to their

recovery. Unfortunately, a life on the street is rarely a safe environment conducive to recovery (Morrell 2007).

Recovery is different for everyone, and some people may require more intense rehabilitation like inpatient treatment. There are many kinds of inpatient programs in the country; however, most are expensive. For the homeless, options like inpatient treatment are often unavailable. Many consider it unrealistic to expect sobriety of someone who does not live in a safe environment and does not have access to all types of treatment. To add to the unrealistic nature of the abstinence model, it is also unreasonable to expect sobriety from those experiencing addiction (Hanson et al. 2009). A person struggling with addiction cannot just abstain at any given moment. Relapse is often a part of recovery, so again to expect sobriety is improbable (Brocoato and Wagner 2003).

The abstinence model excludes the addict or alcoholic who is left, untreated, with little chance for rehabilitation. In response to these criticisms of the abstinence approach, social workers developed a more tolerant model of service, the harm reduction model (HRM).

Values of the Harm Reduction Model

The HRM was first used in the Netherlands in the 1970's and later made its way into Switzerland, Germany, and eventually to the United States (MacMaster 2004). This model projects the most fundamental values of social work, which is to help those in need. By treating drug users with respect and dignity, service providers hope that the participants will decide to make steps towards reducing use on their own accord rather than being pushed into abstinence treatment prematurely. Premature treatment is often ineffective. The Sisters of the Road organization sum up the key to this approach with their mantra, "Don't bring in your drugs, don't be looking for it, don't do it in the doorway. But you as human beings are welcome" (Morrell

2007: 139). The HRM addresses the negative consequences of drug use rather than criticizing the drug user.

Implementation of the Harm Reduction Model

Harm reduction programs often attempt to interest clients in treatment in innovative ways, rather than refusing services to people who are not sober (Caulkins et al. 2009; Fisk et al. 2006). This approach seeks to reduce the risk to the user as well as to society's health and safety (MacMaster 2004; Brocato and Wagner 2003). The HRM tries to reduce the harm caused by drug use without requiring abstinence from the user (Brocato and Wagner 2003; Caulkins, Tragler, and Wallner 2009; Morrell 2007). Examples of harm reduction strategies are changing the route of administration of a substance and provide a safer substance to replace the harmful one, or reducing the frequency of use (Brocato and Wagner 2003).

Resistance to the Harm Reduction Model

The harm reduction model has been met with much resistance in the U.S among service providers, social workers, policy makers, law enforcement and politicians. Many social workers and politicians believe that reducing harm for users will only increase the amount of use. Drug users are already labeled as risk takers and some believe that reducing risks would only encourage them to use more. For example, some believe that if a person is provided with clean needles they will increase their drug use because once an activity is not as risky; it takes more to feel the same rush from participation (Brocato and Wagner 2003).

Many believe that this model may send the message that using dangerous drugs is socially acceptable. Many law enforcement agencies work very hard at promoting abstinence from drugs. For them the HRM, when applied to substance abuse, threatens to undermine their efforts to reduce substance use (Brocato and Wagner 2003).

There is also fear among service providers that harm reduction will entice new users. If the risks of use are taken away, people who normally abstain from using for safety reasons may reconsider and begin to use. Service providers also fear that if the risks of using are reduced, it will discourage others from achieving abstinence. For example, a person who uses a clean needle program may be less inclined to quit if he/she know that he/she can always get clean needles. If they are addicted, they will most likely be more concerned about having a clean needle than the damage of the actual drug (Brocato and Wagner 2003).

The Harm Reduction Model in Practice

Methadone maintenance treatment. The most well-known harm reduction strategy in the United States is Methadone Maintenance Treatment. This program allows opiate users allotted amounts of Methadone in order to avoid severe withdrawals and stabilize the user. A constant dose of methadone will also prevent a user from feeling the regular high he/she may achieve from opiate use. Amounts of methadone are decided on a case-by-case basis and doses are given by medical staff. There is, however, a stigma that comes with this program because users are not actually drug free. (Brocato and Wagner 2003; Roche, Evans, and Stanton 1997).

Needle exchange programs. Needle exchange programs developed in Europe in the early 1980's as a response to the spread of HIV/AIDS. Today, there are about 167 registered needle exchange programs in the U.S. (Riley 2005). Some are legal and some are underground operations. "In addition to providing clean needles, some programs provide information and referral to treatment programs; others, social services including healthcare; HIV and hepatitis testing, and referral; overdose prevention training; abscess care information kits; kits to treat abscesses caused by injecting drugs; and street level therapy" (Brocato and Wagner 2003: 120). Opposition to needle exchange programs often comes from community members who believe

that needle exchanges are a threat to public order and safety in their community (Riley 2005). Another criticism of this particular HRM strategy is that needle exchanges may undermine treatment efforts (Brocato and Wagner 2003). Negative reactions towards programs like needle exchanges are often connected to the negative stigma people may attach to certain classes of people like the homeless or drug users (Riley 2005).

A Local Response to the Obstacles: Missoula, MT

The barriers to substance abuse treatment faced by homeless substance users in Missoula, MT are similar to barriers that many homeless people across nation face. The reality in Missoula is that there are very few treatment options for homeless people with substance abuse issues. There are no detox facilities or affordable accessible rehabilitation facilities in the area. According to staff members at a local homeless shelter, for a person without any money, lacking health insurance and dealing with addiction their one real option is to attend an Alcoholics Anonymous meeting or a Narcotics Anonymous meeting. Receiving intensive treatment for substance abuse is much more difficult for a homeless person than it is for most members of the general population. In talking with clients I found that, for many going to an actual inpatient treatment center, was not even considered an option.

It is important to understand the setting for a client of the Salcido Center in Missoula, MT in order to understand the perspective from which they act and believe. “Social actors should be considered as rational in the sense that they have reasons for believing what they believe, of doing what they do, and so forth” (Boudon 1998: 825). Most of the clients I had contact with were chronically homeless, single males. Of course there were other types of people, but a majority of the clients were males who had been homeless for most of their adult lives. Many of the clients also struggled with substance abuse, mental illness, or both.

The social environment for Salcido clients (outside the physical facility) leaves clients very much on their own and responsible for dealing with their own issues. “Stigmatized persons are disadvantaged when it comes to a general profile of life chances like income, education, psychological well being, housing-status, medical treatment, and health” (Link and Phelan 2001:371). Structure creates stigma, thus impacting the choices people are able to make and their general life chances. Research shows that there are “...many ways in which stigmatized persons can be encouraged to believe that they should not enjoy full and equal participation in social economic life” (Link and Phelan 2001:380). Here, it is not specifically social economic life that homeless people have been excluded from. Due to the structure they live in, many clients are socialized by the general public and their peers to believe that intensive inpatient treatment is not for them. Unfortunately in Missoula, that option does not exist at this time.

The Salcido Center

The Salcido Center (The Sal), a harm reduction facility was established to serve members of the homeless population in Missoula who cannot, or will not, maintain sobriety. The main homeless shelter in Missoula, The Poverello Center, does not provide services to those who are under the influence of any substance, and is an example of the abstinence approach. The Sal is not a treatment center. It is day center for anyone who needs a place to go. The Sal reduces harm for individuals by providing people with shelter during cold winter days and severely hot summer days.

While staff members at the Salcido Center do not push abstinence on clients, they are available to help as much as possible when a client does ask for help with sobriety. Staff members strive treat clients as human beings whether they are sober, drunk, or under the

influence of any substance (Scott 2008b). By embracing the harm reduction model, the Sal provides safety, support, and references to other services for those who have nowhere else to go.

CHAPTER THREE: METHODOLOGY

Local Context

Missoula, MT is a bustling city in comparison to most other towns in Montana. It is known around the state for its concentration of democrats and liberals, and is considered a progressive city by most Montanans. Missoula, Montana is referred to, by some, as the ‘San Francisco’ of Montana.

Missoula has a good deal of financial support for nonprofit organizations. In December of 2009, ten different grants were given by the U.S. Department of Housing and Urban Development to Missoula County, to fund various programs for the homeless, while all other counties in Montana received one or two grants (Johnson 2009). There are multiple organizations that provide services to the homeless in Missoula, such as the Poverello Center, Missoula 3:16 and the Salvation Army offer a variety of services to the homeless (Spzaller 2008).

Site Selection

The Salcido Center (also referred to as the Sal) is located in Missoula, Montana. The facility that I describe in this thesis was the first Salcido Center. The facility was temporarily closed in September 2010 until January 2011 and reopened in a different location. The first Sal was located in the basement of a church in downtown Missoula, MT. I conducted all of my research at the first Sal. In the entirety of this thesis, each time I mention the Sal, I am speaking only of the first Sal. After nearly 3 years of existing at that location, the church did not renew the Sal’s lease. This was mostly due to the increase of traffic in and out of the church building. The church’s plumbing system was beginning to have problems because of the increase in traffic, and an entire system replacement was required in order to sustain the high volume of clients. After an extensive, fruitless search for a new location, administration decided to do some remodeling in the Poverello Center basement and relocate the Sal there.

The Sal was a branch of the Poverello Center (also called the Pov), a shelter that provides emergency housing for people who find themselves on the street. The Pov has provided services to homeless people in Montana for 35 years and continues to do so today (Spzaller 2008). If a person comes to the Pov under the influence of drugs or alcohol, they are not allowed to stay there. Pov staff will still give them food, but they are not given shelter if they are using substances (for this reason the Pov is considered a ‘dry’ facility). The Pov building is a very old facility that is often overcrowded and understaffed (Spzaller 2008). Given the close quarters and insufficient staffing, the organization believes that it is too great of a liability to allow people under the influence of drugs or alcohol into the facility (www.thepoverellocenter.org).

Those denied access to the Pov often spent time at the Sal because it was a ‘wet’ facility. Many clients of the Sal were serial inebriates, meaning they were continuously under the influence of alcohol or drugs. Some of the clients at the Sal have been drinking for years. For one reason or another, treatment never worked for them, was never available to them, or simply did not appeal to them. In Montana, there is one state operated treatment center called, Montana Chemical Dependency Center (MCDC). It is located in Butte, Montana, approximately one hundred and ten miles from Missoula (<http://mcdc.mt.gov/>).

This is precisely why the Sal offers a unique perspective of the issues surrounding substance abuse treatment for the homeless. Since more substance abuse problems are found among clients at a wet facility, the Sal is an ideal location to complete an in- depth study on substance abuse, the availability of its treatment, and homeless individuals’ attitudes towards substance abuse treatment.

History of the Sal

The Salcido Center was created and named after Forrest Clayton Salcido, a man who chose to reject mainstream society and live on the streets for a majority of his life. Forrest was loved dearly by those in his small circle of friends. He was also a navy veteran who struggled with chemical dependency. He was often denied services from the Pov due to his alcohol use. He was beaten to death in December of 2007 by 18-year-old Anthony St. Dennis. Another high school student was with St. Dennis when the murder occurred, but was not charged with homicide. Salcido was found the next day by another homeless man. He died of head trauma. Two years later, St. Dennis was found guilty of homicide and sentenced to 100 years in prison (Scott 2008a; Scott 2008b).

After Forrest's death, the Poverello Center saw a dramatic increase of formerly service-resistant clients, most likely due to fear of being on the street. News of Forrest's unjust death spread nationwide and caused an enormous amount of local and national support. The Poverello Center also experienced an enormous increase in donations. In the month following Forrest's death, the Pov received \$15,000 in donations, all of which went to the creation of the Sal (Scott 2008a; Scott 2008b).

Why the Sal Existed

The Sal was created after Salcido's death, to provide a safe place for those under the influence of substances. It existed mainly to provide somewhere to go for those who cannot access the Pov due to their substance use. The Sal was the only wet facility in town, so it was the only place for people using substances to go.

The creation of the Sal eased concerns of many downtown business owners, because it dealt with the problem of loitering in front of stores and on street corners (Spzaller 2008). There is often conflict between business owners and homeless individuals who spend time downtown

because business owners usually frown upon a homeless person loitering in front of their store. Community members often complain about the visibility of homeless people in the community. The Sal helped mitigate that complaint.

How the Sal differs from the Poverello Center

The Sal was not a shelter where people could sleep for the night like the Pov, but it provided a warm safe place for people to stay from the hours of 7:30 a.m. till 6 p.m. There were also less rules at the Sal then at the Pov. At the Sal, a person could just come in with no questions asked. When accessing the Pov's shelter (not the food line), people have to fill out paperwork and must abide by several policies such as sobriety and doing daily chores.

As discussed previously, the largest difference between the two facilities was the tolerance for those using drugs and alcohol. The Sal served active drug and alcohol users on a day to-day basis, and because of this, provided a better cross-section of the homeless population dealing with substance abuse and their reasons for not receiving substance abuse treatment.

Services Offered at the Sal

On an average day, the Sal served approximately 30-40 people, a combination of regulars and those just passing through. The Sal did not serve meals, but one could always count on a hot cup of coffee. Computer use was offered at the Sal free of charge, and clients could access word processing programs and the internet. Apart from computer services, the Sal offered GED preparation classes, help with applications, and help preparing for interviews to help clients get back on their feet (<http://thepoverellocenter.org/programs/index.html#3>).

Funding for the Sal

The longevity of the Sal is unpredictable, because funding is not guaranteed (Spzaller 2008). The Sal was initially funded by the wave of donations after Forrest Salcido's death (Scott 2008a). After those donations and a two-year grant from the Montana Department of Public Health and Human Services were received, the Poverello agreed to a two-year lease for the Sal. However that grant was not renewed, and the Sal received no money from the city of Missoula. Thus, funding was a constant issue of concern for clients and employees while this research was being conducted.

Physical Organization of the Sal

In the heart of downtown Missoula, the Sal was located in the basement of a church with approximately 2,100 square feet of space. There was a computer area, a lounge area with shelves of donated books, a TV area, and a coffee area with shelves and a refrigerator to store food. Most of the Sal was an open space with the TV towards the back of the room and the computers near the entrance. There was one separate room with a few couches where clients could catch up on sleep, since sleeping outside does not normally make for a good night's rest. Behind the staff desk, there was a closet referred to as the "locker." Staff members were the only people with access to locker keys and clients are allowed to keep their belongings in the locker for two weeks (<http://www.thepoverellocenter.org/programs/index.html#3>).

Research Strategy

Before I began this process, I had to gain approval through the Institutional Review Board (IRB). The purpose of the IRB is to make sure the research is safe and ethical, and the committee is made up of various community members. Gaining IRB approval proved to be a lengthy and difficult process. The IRB had many concerns about this research, because the

homeless are deemed a vulnerable population. After my proposal appeared before the full IRB committee twice, approval was granted for the research.

I collected data through field observations and interviews with clients and staff. My fieldnotes described my time at the Sal and the interactions with clients that I observed and participated in. My second source of data, transcribed interviews, were full of clients' personal accounts and life stories. "As a rough rule of thumb, if you are interested in behavior and interaction, use the ethnographic model; if you are interested in biography and accounts, use the interview method; if you are interested in both, use both methods" (Warren and Karner 2010, 129). My goal was to understand clients' actions as well as the motivations behind them, so I used both methods for data collection.

I spent time at the Sal from February 2010 till August 2010. I volunteered and collected field notes about my experiences, and I interviewed clients and staff members beginning in April 2010 until the completion of my data collection in August 2010.

My research was not covert in any way. I was open about my study and the fact that I wanted to interview clients. Lofland, Snow, and Anderson sum it up well by advising to "...inform interested parties of your research...help others to know who you are through connections, provide them with a reasonable account of what you want to do, and demonstrate enough knowledge to suggest your competence to do it" (Lofland and Lofland 2006:47). I adopted this idea while I was at the Sal. Clients and staff asked me numerous times why I spent time there. I told them that I was from the University and I was researching the Sal and the issue of substance abuse among people who used the Sal.

I started my research in a class called Inequality and Social Justice Service Learning; Hunger and Homelessness. In the class, I was technically a teaching assistant. However, I went

into the class with the same knowledge about homelessness in Missoula and similar goals as the nine undergraduate students in the class. For the class, students volunteered at the Poverello Center or at one of its branches: the Salcido Center, the Joseph Residence, or the Valor House. Before we collected data at our chosen sites, the staff and clients were informed that students from the university would be visiting for a while to do research.

Throughout the semester, I and the rest of the students volunteered weekly at one of the Pov sites, took copious fieldnotes about those experiences, and conducted two in-depth interviews. Two students (besides me) spent time collecting data at the Salcido Center. Their research concluded at the end of the semester (May 2010). They agreed to let me add their four interviews to my pool of interviews.² I also used two transcripts from two students who interviewed clients at the Poverello Center. Their interviewees were also Salcido Center clients, and the interviewers used the same client interview guideline that I used.³ In total, I used twelve client interviews.

Sampling

An overview of the Sal. A large variety of people used the Sal. A majority of clients at the Sal were male and the ages of clients were all over the spectrum from eighteen and above. Young people and elderly people used the Sal, but on most days ages ranged from twenty-five to fifty-five. Staff members at the time of my research were male except for one female. It became obvious to me, after a few visits to the Sal, that there were two distinct groups of people who accessed services there; substance users and substance non-users. I learned what group a client belonged to through regular interactions, staff members or during the interview. Veterans utilized the center as well as those struggling with mental illness. Mental illness was difficult to

² I would like to acknowledge those who shared their interview transcripts with me: Sarah Seltzer and Dylan McShane (Salcido Center volunteers)

³ William Crabtree and Allyson Foster (Poverello Center volunteers)

identify; most clients did not usually verbally profess their mental illnesses. At the same time, according to staffers there is a lot of mental illness among clients went undiagnosed

(<http://thepoverellocenter.org/programs/index.html#3>).

Data sources. After I noted the different types of people at the Sal, I designed a sample that would accurately represent the population of individuals who frequented the Sal. I recruited interview subjects in two ways. First, I asked clients whom I had established relationships with if they would participate in an interview. I also asked clients and staff members for suggestions about participants to interview, and pursued interviews with these clients. It was relatively easy to find participants. I ended up with twelve client interviews, and I treated sets fieldnotes from specific interactions with five clients as interview transcripts. In my volunteer time, I found that people often wanted to talk about their lives. While I was observing at the Sal people sat with me and often shared very personal information with me, basically the same information that I would gather in interviews. In addition to the client interviews, I interviewed three staff members.

The figures in Appendix A show the spectrum of people that I spoke with. In summary, a majority of clients were male. Of the seventeen total participants, thirteen were male and four were female. Among the females in the sample, two used alcohol and two were non-users. Two females were chronically homeless, and the other two were temporarily homeless. The two who were temporarily homeless were on a waiting list for a low-income housing program. None of the females were veterans or had a diagnosed mental illness (See Appendix A Fig. 1). Among the males in the sample, nine were substance users and four were non-users, three were veterans, two had a diagnosed mental illness, seven were chronically homeless, three were temporarily homeless, and three were just passing through town (See Appendix A Fig. 2)

Interview Strategy

A majority of the interviewees were clients that I had talked to at least once before asking them to do an interview. On a few occasions, I asked clients whom I did not know if they would be interested in participating in an interview. This was a successful strategy on two occasions. Reggie was sitting alone at a table and seemed to be bored. I sat down by him, made small talk, and asked him if he would like to do an interview. Another client, Dallas, sat down and started telling me all about his life. I asked him if he minded doing an interview where I could record what he was already telling me. He also said yes right away, and the interview began immediately. This “ask at random” approach worked in a few cases. I tried it with a few other clients, and they politely declined. Overall, clients who knew me were more likely to say yes to an interview.

At the beginning of the interviews, clients were required to give a verbal agreement to be recorded. All of the clients I talked to agreed to be recorded. I informed clients not to use their own names during the interview or the names of other clients. To record the interviews, I used a digital voice recorder. Shortly after the interview, I moved the recordings to my personal computer.

I used two different interview guidelines for client and staff interviews (Appendix B: Client Interview Guideline and Appendix C: Staff Interview Guideline). For the most part, I followed the guidelines. When clients and staff members talked about issues that were not listed in guideline, I let them talk until they finished what they wanted to say.

Data Analysis Strategy

Upon completion of the data collection, I entered all of my interview transcripts and fieldnotes into a computer program called NVIVO. First, I identified broad themes like:

background information, feelings about the Sal, feelings about Staff members, substance use, and reasons for being homeless. In NVIVO, these broad themes are referred to as Tree Nodes.

Under the Tree Nodes, I created branches where I separated the data into more specific groups like; alcohol use, mental illness, positive feedback about the Sal, negative feedback about the Sal, dislike of substance users, tolerance of substance users, and experiences with substance abuse treatment. Throughout the coding process, I identified the most themes in my data, and from those I created the different sections seen in the Findings chapter.

Ethical issues

In order to complete the research in an ethical manner, my position as a researcher was not hidden from participants. I did not interview anyone under the age of 18. Staff members were present and aware when the interviews were happening, although the interviews took place in a semi-private room to protect interviewees' confidentiality. I asked clients' permission to digitally record each interview, and I used the same procedure to ask for consent in each interview. I developed interview guidelines that were examined by my advisors and the IRB. I kept all fieldnotes, interviews and interview transcriptions in a secure data storage area at the University of Montana.

I volunteered at the Sal once or twice a week for one to two hours at a time beginning in February 2010. Right away, staff members told me that building trust with clients might be difficult for me. However, building relationships with clients was easier than I anticipated. I spent most of my time at the Sal sitting by the staff desk or at a table that I began calling the "talking table" in my notes. When I sat by the staff table, staff members would introduce me to clients as clients came into the facility. When I sat at the talking table, a client or two usually joined me. I made conversation with whoever happened to sit down. When other clients saw

that someone talked to me, a few more clients would come and sit at the talking table. Of course a few people were simply not interested in speaking with me. After a few visits to the Sal, clients recognized me; and shortly after, many clients sat with me and shared their lives with me.

Building Relationships with Clients

I found Snow and Anderson and the Sisters of the Road's approach to homelessness research particularly helpful in deciding how to conduct my research. Prior to this project, my experience with homeless people was limited to occasional volunteering in soup kitchens or occasionally giving a homeless person on the street some food. Needless to say, I needed guidance for this research, and Snow and Anderson and the Sisters of the Road were a great resource.

My study examined a sensitive issue; substance abuse. I expected difficulty in getting people to share about their substance abuse experiences. I approached this project similarly to Snow and Anderson. I took the researcher-friend role that they did during their study of homelessness. They spent time at the shelter and building relationships, observing interactions, and conducting in depth interviews (Snow and Anderson 1993).

Like the population in Snow and Anderson's study, most of the clients at the Sal were male. However, this did not present a problem for me. In fact, I believe that being female made me more approachable to clients than a male researcher. I was often surprised at the amount of personal sharing clients did with me; as many clients would share their life stories with me shortly after meeting me. I have experience working at an inpatient addiction treatment center. An enormous part of my job there was to talk with clients and make them feel comfortable. I came into the Sal with experience in listening to and building relationships with people who struggled with addiction. I had practice in being an open, approachable person.

Dealing with Transience

Another issue that arose during my research was transience. Many people using the Sal were ‘just passing through’ especially in the summertime. Snow and Anderson (1993) also dealt with this issue during their research. They combated this issue by spending more time at the facility where they conducted research. As stated previously, I spent time at the Sal until the fall of 2010. In order to deal with transience, I went to the Sal on different days of the week and at different times. I was as random as possible in hopes of coming into contact with as many different clients as possible.

Interview Participation

Clients responded in a few different ways when I asked them to participate in an interview. Some were excited and immediately responded with a yes, some made up an excuse and told me they would do it another day, and a few clients gave me a direct no. In order to entice clients to participate in interviews, I offered individuals \$15 to participate in an interview. Interestingly, after the interviews, most clients said that they would have done it for free. As far as interview participation, I only had one client not show up for the interview. He rescheduled with me a few weeks later. After the no-show, I began doing interviews on the spot. Each time I went to the Sal, I brought my interview equipment, so I was ready at all times to do an interview.

At the onset of my research I was concerned that clients might show up for interviews heavily under the influence. The Sisters of the Road had some problems with clients being inebriated when they showed up for interviews. Interviewers from the Sisters of the Road used their own judgment as to whether a person was in a state of mind to consent and if they were, the interview commenced. If clients could not make sense of consent explanation, the interview was

rescheduled (Chambliss, Manuel, and Nelson 2007; Morrell 2007). I decided to take that approach if I was confronted with an interviewee who was under the influence. When I started conducting interviews on the spot, I did not confront this problem, since I only approached people who were coherent and able to have a conversation.

Some Sisters of the Road Interviewers also had problems with participants making inappropriate comments during the interview, so I was nervous that I would end up in similar situations (Morrell 2007). The interviews took place in the Sal with staff nearby, so if a situation became uncomfortable, staffers were immediately available to intervene. During my interviews, I was never uncomfortable or threatened in any way. Although in my initial IRB application, the IRB was quite concerned about my safety, clients treated me with respect during interviews and were incredibly grateful for a chance to tell their stories. Whether I was conducting interviews or hanging out in the facility, I was completely safe.

Limitations of the Research

Identifying mental illness. From my research, the only claim I am able to make about mental illness at the Sal is that much of it was undiagnosed or untreated. My evidence for that came from conversations with staff members. In some cases, clients provided me with evidence to suggest that they had a mental illness, but there was not a way for me to double check. In my interviews, two male clients disclosed that they had a diagnosed mental illness. I was not comfortable simply asking clients if they had a mental illness. In the interviews I asked clients if they used the local mental health clinic in hopes of gaining information about their mental health, but only two clients disclosed information about their own mental health. However, clients were quick to point out other clients whom they said to be “crazy” to me. Once again, I did not have a way to verify that information. Thus, I am not able to make any conclusions regarding

amounts of mental illness at the Salcido Center. Substance abuse and mental illness are often co-occurring disorders, so more reliable information about mental illness would have been helpful.

CHAPTER FOUR: FINDINGS

Why Did Clients Use the Sal?

Clients revealed many reasons for using the Salcido Center (Sal). Clients chose the Sal for some of the same reasons researchers found that people use homeless service providers (Morrell 2007; Snow and Anderson 1993). The most obvious reason was for the shelter. This was especially true in light of the extreme weather conditions that exist in Montana. Another general reason for using the Sal was for the various free resources it offered, such as phones, internet, word processing, and a place to rest.

Unique to the Sal, some people used the facility because it was a wet facility; meaning people were allowed to be under the influence of drugs or alcohol while inside the facility. At the Sal clients were not allowed to use substances inside the building, but no one was turned away for being under the influence. According to clients and staff, another characteristic unique to the Sal that attracted people was its anonymity. There were no sign-in sheets or anything of the sort, so clients could go in, use the resources, and be on their way, no questions asked. Finally, clients explained that the Sal also provided social interaction for a population who often faces social isolation.

Shelter from the elements. Montana's climate is often unpredictable and conditions may be extreme (cold or hot) depending on the season. One of the interviewees, Beth, forty-two at the time of her interview, was a widow and had also lost both parents due to drug and alcohol overdose. During an interview with Beth⁴, she repeated numerous times that she was thankful for the Salcido Center, and without it she feared she would have died during one of the many bitter cold Montana winters she spent living on the street and sleeping outside.

Thank God for Salcido, cause I don't know what would have happened to me if they

⁴ All names of clients and staff are pseudonyms, selected by random.

hadn't of been there. I like that they open up early in the morning then they stay open till six at night. It was the only place I could go to get warm.

Beth, along with many other clients, was very appreciative of simply having somewhere to go. For many of those with housing, it is easy to take shelter for granted and not realize how valuable shelter can be. Taking shelter for granted was not the case for Salcido Center clients, as Joe expressed his gratitude for having shelter,

This is what sucks about being homeless...it's raining outside right now. It's been raining for the past few days. It's raining and I camp outside. I have my tarp, but I have to keep it strung really low otherwise people will see it, so I could stay at camp and sit under my tarp all day, or I could come here. That's what sucks [about being homeless]...you can't chill in your own living room, naked, drinking a six pack, watching TV and eating chicken wings.

Like Joe, most clients were thankful for the shelter the Salcido Center provided. Many of the clients slept outside year-round or for a majority of the year, so most appreciated the Sal and the warmth and shelter it freely offered. During Beth's interview, she raved about how thankful she was for the Sal. She also knew that she was not the only one who appreciated its services.

I'm glad the Salcido Center is open, and I hope they stay open cause they help a whole lot of people who don't have anywhere to go. They live on the street and have nowhere to go. It's some place where they can go hang out.

The Sal provided shelter with no strings attached, and for many that made it an ideal place for them to spend their days.

Resources. Another common reason clients used the Sal was for the free resources offered there. The Sal offered resources such as internet, word processing, phones, printing, coffee, couches, reading material, and housing and social service referral materials. A young, expecting couple, Jory and Mona, frequented the Sal and used many of the resources the facility offered. They were working on getting into an apartment, and staff members were helping them with the paper work. Jory and Mona stayed at the Poverello Center. Residents of the Poverello Center are required to leave during the day so that the facility can be cleaned. As a result, they spent

much of the day time at the Sal. When asked why he used the Sal, Jory responded that he used the facility mostly for “computers and coffee.” More important than computers and coffee, Jory said the Sal was also “a place to sleep in the morning time. My girlfriend being pregnant, she sleeps a lot, but I don’t get enough sleep.” For Jory and Mona, the facility was a place where they could be together, have coffee, use computers, and catch up on sleep lost during the night.

When I first started going to the Sal I didn’t think the couches were really that important. The more I talked to clients I realized that many of them slept outside for most of the year, and the opportunity for them to nap on a couch was an invaluable resource. While chatting with an older man, Ron, at the talking table, I learned that one of his main reasons for coming to the Sal was to catch up on sleep. During our conversation he looked directly into my eyes and said, “Do you know what it’s like to sleep outside? You wake up at every noise. I’m getting too old to sleep on the ground.” For Ron and many other clients the Sal was the only place in town they could go and sleep without being reprimanded for it. The other options (still existing today) for people during the day are the public library, Missoula 3:16, or the sidewalk. The public library and Missoula 3:16 do not condone sleeping in the facility, and sleeping on the sidewalk is looked down on by society in general. Thus, the existence of couches at the Sal was an integral part of its resources.

Wet facility. The Sal was a wet facility; wet meaning that it allowed clients under the influence of substances to access its services. This characteristic of being a wet facility set the Sal apart from all other resources available to homeless people in the Missoula area. The Salcido Center was the only wet facility in the area. The Salvation Army and Missoula 3:16 are also local service providers, but they are dry facilities. When asked how the Sal was different from those facilities, Beth explained,

Well for one thing, drunks are not allowed on the property at all. I mean they'll kick you outta there quicker than anything. Salcido, they allow people to go in there who have been drinking, but you can't drink in there.

Due to the fact that there are no other wet facilities in Missoula, finding shelter for those who are under the influence is even more difficult than finding for someone who can remain sober. Compounded with extreme weather conditions, this is even more of a serious issue in Montana.

Issues surrounding the Sal as a wet facility. The Sal was a wet facility, meaning it allowed people under the influence of drugs and alcohol to access its services. This was one of the unique characteristics of the Sal that attracted people to it. I asked John, a staff member if the Sal being a wet facility attracted people, and he responded,

Oh I'm sure of that. If you've got somebody who hasn't' been able to go a day without drinking in years, then finally a place where they can go opens up...somewhere he can warm up his feet...yeah he's coming in.

When the Sal opened, it became a place for all people to hang out and relax. It gave people who were normally restricted from using facilities because of their substance use a place to go. The Sal attracted people from all over the spectrum of substance use, from those who used constantly to those who were strongly against it.

Conflict within the Sal. Some clients disagreed about whether it was a good that the Sal was a wet facility. Some clients were glad the Sal was open for everyone, and other clients wanted the Sal to adopt a no tolerance policy towards those under the influence of substances. A staff member, Tami, observed this debate among clients:

Being a wet facility attracted people, and also pushed some people away. It was one of the more beautiful things about (the fact that it was a wet facility). People kept coming back even when they were complaining about it being a wet facility. Obviously it was serving some function for the community.

Although clients disagreed about whether or not clients should be allowed to be

under the influence, even the loudest complainers continued to use the center. This provides evidence that the Sal was a highly valuable resource for its patrons. Tami continued,

There was constantly a battle between people who were sober and people who weren't. Some people would say, "You should get rid of all these drunks..." but then they kept coming. It was the same with mental illness, like they would say "these crazy people need to be locked up". Yet they would keep coming to the center as well. That's the beauty of a drop in day center. It's for all individuals.

Overall, the facility was a non-judgmental, open facility for anyone to use. Regardless of whether or not clients agreed with how the facility was being run, they continued to return for one reason or another. While many returned despite the fact that the Sal was a wet facility many came because the Sal also offered social interaction. As Tami observed, "Even the people who complained were there for company. They may not have been comfortable, but they used it. That alone makes a case for the need for this facility."

Battling social isolation. Beyond shelter, resources, and being able to be under the influence, the Sal provided its clients the opportunity to interact and form bonds that would most likely be impossible on the street. Although many consumers had friendships they made on the street, friendships made in the Sal were forged in a different kind of environment than the street; a safe environment. For many, that was a new and rare experience.

Tami, a staff member, also noted the importance of regular interactions between staff members and clients. She understood how the Sal created an environment that was usually impossible to find on the street.

They [clients] believed it [the Sal] was a place where they would be tolerated, and I choose that word carefully. It was often the only option available to them where they wouldn't be harassed. They believed that staff members actually tried to be fair.

On the street homeless people are often excluded from mainstream society and left alone by a majority of the population. A client, Beth, emphasized the importance of her

interactions at the Sal. For her, the Sal provided crucial means to overcoming social isolation. In her words, “They didn’t breathalyze us or try to kick us out or anything. They were just real good to us at all times. Sit down and talk to us or go outside and have cigarette with us, sit and b-s with us for a while.” The Sal was a place for all people to come and perhaps for just part of their day, escape the judgments often placed on them by members of the general population. Inside the Sal, the stigma of being homeless was lessened for clients.

Building friendships. Forming non-clinical or non-authoritative bonds with staff members helped clients to build healthy relationships. The Sal was a safe environment for people to freely talk to staff members or clients, which is not the case in most other environments frequented by the homeless. One client, Beth, appreciated the staff members at the Sal. The element of the Sal she appreciated the most was the opportunity to find people to talk to.

There’s people there you can visit and talk with, who actually want to talk with you and are interested in what you are saying...not just pretending (referring to staff members) The staff that work there are great. They are some of the best.

Beth, as well as many other homeless people, often are not treated as though they are members of the general population. Clearly, it meant a lot to Beth that staff members would talk to her and treat her with respect.

Staff Members’ Perspective of Their Role

Multiple roles. Staff members filled many different roles in a day’s work. They were there to help with whatever issue a client brought to them. At the same time, staff members were under pressure from the administration in the Poverello organization to get people off the streets. One day Sam, staff member, seemed rather stressed out and proceeded to explain to me why he was frustrated with his job. I recorded that conversation in my fieldnotes.

Sam said that at the last staff meeting, Salcido Center staff members were informed that they needed to keep track of every person that comes through the Sal. Their boss told them that staff members should keep track of the needs of each client, like where they are at in the process of getting housing, VA benefits, health insurance, jobs, and things like that. Their boss told them that every day they should be doing something that gets each client closer to getting off the streets. He said that that was an enormous task for their staff

Through my observation and interviews, I learned that staff members placed great value on treating clients with dignity and respect, the same way they would treat any person they came in contact with. To staff members, this is one of the qualities that set the Sal apart from other service providing organizations. Although staffers had multiple roles, in most of my observations staff activities revolved around casual conversation and helping clients with everyday tasks.

Opportunity for casual conversation. I talked with staff members while I was observing at the Salcido Center, as well as during one-on-one interviews. When asked to describe their job duties, many staffers explained that talking with clients was one of their most important duties. This talking usually included casual conversation, meaning a staffer and client conversed about anything the client needed to talk about. Casual conversation was non-medical, non-authoritative, and non-judgmental conversation. When I asked him what his most important duty was, John, a staff member who had been at the Salcido Center for most of the time it was open, explained,

I tried to be someone that people could feel free to talk to in a regular non clinical...just kind of treat them like a human being, so for whatever part of their day, they can just feel like a regular Joe...instead of whatever else in their life they were worried about.

Another staff member, Jenny, also saw a huge part of her job as talking with clients. When I asked her to describe her job she told me that, "...there would be exciting moments or emergencies, but for the most part it was shooting the breeze with people."

Deeper than casual conversation. Although casual conversation was important, occasionally clients needed more than casual conversation. One of the reasons that talking was so important, according to staff, was that many of the people using the Sal truly needed someone to talk to for their mental health. Sam, another staff member agreed that many clients have an enormous need just to talk to someone, because socializing may be more difficult for homeless people, as their social networks may have structural limitations. The homeless shelter in Missoula, the Poverello Center, is closed during the daytime. It's closed for cleaning purposes, but the fact that it's closed during the day limits opportunities for socialization between clients. I wrote the following in my fieldnotes about my conversation with Sam about Jenny, a staffer that day.

I asked him [Sam] if they had some sort of psychologist available for clients. He laughed and said, "That's what Jenny does." He said that sometimes clients will just come in and ask for Jenny and sit and talk to her about their life problems. Jenny laughed and agreed.

Staffers' approach as treating clients as equals allowed for two types of conversation: counseling-like conversation and casual conversation. John, a staffer also saw one of his main duties as being available for clients to talk to about anything they needed to talk about. He explained his approach to talking with clients, with the following, "I try to approach it like, and I'm your equal...what's up? I talk to them and treat them as an equal instead of...I'm your probation officer or I'm your psychiatrist, or I'm whatever person of authority over you."

Being an equal was John's (and other staffers') method of building relationships with clients. John believed clients would respond much differently when approached as an equal rather than as a person of lesser value than the authority figure. In the relaxed setting of the Salcido Center, it was necessary to keep people at ease and comfortable to keep things running smoothly. Perhaps John's reasoning for approaching people as equals was

rooted in his own life experiences.

John was a unique staff member in that he was in recovery for heroin addiction. He believed he could easily relate to any client because of his struggles with addiction. His life experiences benefited his interactions with clients, and his interactions with clients helped him in his own sobriety. In his words, “I have a background in drug abuse, so it helped with building relationships. And being around people at that spot in their life...helps me and it helps me help them.” John’s personal experience made it easy for him to relate to individuals at the Sal. In general, society does not have a great deal of empathy as far as substance abuse and homelessness goes. John was able to cut across some of the walls between the general public and homeless people because of his personal experience and style of interacting with clients.

Helping with everyday tasks. Apart from providing clients with casual conversation and counseling-like conversation, staff members helped clients with various types of paper work and other everyday tasks that clients were unfamiliar with or unable to do for whatever reason. The following is an excerpt from my field notes about an interaction that I observed between Jenny (staff member) and Bill (client) at the Salcido Center.

Jenny was helping Bill do some paperwork for the VA. Bill had been in a longstanding battle with the VA trying to get his veteran benefits. Jenny typed up a letter to the VA and made a copy of another paper. She gave the papers to Bill with an envelope.

This may seem like a very simple interaction, but most likely the letter would not have been typed or mailed without Jenny’s assistance. The VA is a bureaucracy that is incredibly hard to navigate for any person (Morrell 2007). By helping with everyday tasks, staffers gave clients access to other resources that they may have not known how to navigate on their own. Apart from help with navigating bureaucracies, staffers helped clients with everyday necessities. Beth, a client explained to me what staff members

helped her out with, “They told me about places where I could go to eat, to get food, shower, clean clothes, but they helped me out more than once with clean pants and stuff.” While Beth was using the Sal, she was drinking heavily. It was the only facility in town where she was allowed to go. Therefore staff members at the Sal were the only one who could provide her with clothing and other daily necessities. Whether staffers were helping with paperwork or providing clothing, their services were vital for clients.

Substance Use among Salcido Center Clients

Typology of clients. To better understand patterns of substance use among homeless clients of the Salcido Center, I divided clients into two groups: Users and Non-Users. The User category includes a spectrum of people ranging from occasional use to heavy, daily use. The Non-User category included a variety of people from those who were in recovery to those who had never had personal issues with substance abuse.

Users. Among the seventeen clients I spoke in depth with at the Salcido Center, eleven were very heavy users of drugs and alcohol. One of these two clients, Beth, was going on her fifth month of sobriety. In a matter of days after the interview, I heard from multiple clients and staff members that she was back on the street drinking liquor every day. Another client, Jim, told me he liked to get drunk, from time to time but he preferred to be high every day.

Non-users. A wide variety of clients existed under the Non-Users category. There were six total Non-Users, three of which were in recovery from drug and/or alcohol addiction. In conversations with clients, they gave me a variety of reasons why they did not use drugs. One client, Ron, had been through an inpatient treatment program and was doing his best to maintain his sobriety while living on the street. He experienced great frustration with the other clients of the Salcido Center who used drugs and alcohol, and he firmly believed the Salcido Center

needed to adopt a zero tolerance policy towards drug and alcohol use (even though zero tolerance goes directly against the Sal's purpose). In his interview, he explained that the Sal is

A place where the drunks get together to piss all over the sidewalk, piss all over themselves. They need professional help, and they aren't getting it. I believe the word you're really looking for is rehab. The solution that I would suggest, take the alcoholics and the drug addicts and put them in rehab.

Ron's solution to the substance abuse problems among clients of the Salcido Center was just to ship everyone off to a treatment center or a rehab facility. While his frustration is understandable in trying to remain sober around people who are not, his solution is not realistic. Another client, Cal, shared his view that no one under the influence of drugs and alcohol should be allowed into the facility (Cal and Ron did not use any substances. These clients contended very strongly that there should be no tolerance of drugs and alcohol at the Salcido Center.

Other Non-Users did not share Ron's perspective nor his reasons for not using. Some clients had been through their own battles with drugs and alcohol and had a more sympathetic perspective. An example of this was a female client, Mona, who had also quit using drugs and alcohol because she was pregnant. A number of other clients tolerated drug and alcohol use. Overall, views on substance abuse were all over the spectrum from participating in substance abuse to zero tolerance for substance abuse.

Types of Substances

Substance abuse was a common topic of discussion among me, staff members, and clients. While observing and interviewing clients, they told me about the substances that they used as well as the substances that others used. Overall, clients seemed to have a little more insight than staff members about the types of drugs being used at the Sal. Clients and staff were well aware of the prevalence of the issue, as one client, Jim, said, "A lot of the people that come to Salcido Center have drinking and drugging problems..." One staff member, Terry, who had been at the

Sal since the opening of the facility, reported the most commonly abused substances as alcohol, tobacco, marijuana, and methamphetamines. Most clients reported that alcohol and marijuana were the most popular drugs for other consumers at the Salcido Center.

Alcohol. Alcohol was the most commonly used substance among clients in my observations. If a client was under the influence, it was often obvious by the smell of alcohol on their breath, slurred speech, and/or inability to walk in a straight line. On most days there were at least two intoxicated people in the facility at each of my visits. There were often people standing outside under the influence of alcohol as well.

Alcohol was also the most commonly reported substance of choice. When I asked Jenny, a staffer, about substance abuse at the Sal, she explained that “It’s mainly alcoholism...that I saw.” Another staffer, John, agreed, “Probably alcohol was used most...other stuff was going on, but not as common as alcohol.” Across the board, alcohol was the most widely used substance. This could be due to many factors. Alcohol is easy to get as well as less looked down on than other drugs. It is also possible that alcohol use was easier to spot than other types of drugs that are easier to conceal.

Beth was very open with me about her substance use. Her experiences matched that of the staffers’ perspective in that alcohol was her first choice of substance. When asked about the substances she used, she replied with the following, “Straight vodka, you don’t mess it up with any chaser, you just drink that stuff straight out of the bottle.” Obviously, for Beth there was no question as to her drug of choice. She did not approve of taking any other type of medication with her alcohol, because of deaths in her family due to alcohol and pill overdoses.

Another client, Reggie, had a different perspective than Beth. Reggie chose to drink when he had a job, as that was the only time he could afford it, and he refused to panhandle

people for money. He was a middle-aged Irishman and enjoyed social drinking, but he did not make a daily routine of heavy drinking. He did much observing at the Sal, and reported to me about his observations, “I know a lot of people around here in the homeless community who are chronic alcoholics.” Although he did not consider himself an alcoholic, he was aware that chronic alcoholism was an issue for many at the Sal.

Marijuana. Clients and staff reported that marijuana was the second most commonly-reported substance of choice. Interestingly, most clients referred to their own marijuana use or the marijuana use of others as using ‘medical marijuana.’ Marijuana was not seen as a serious drug by clients or staffers, as one staffer told me about substance use among clients, “A lot of pot though...that’s technically illegal I guess. A lot of our clients have green cards...if you count that as a substance, I don’t know.” That laid back attitude towards marijuana use was consistent between staffers and clients.

Other Miscellaneous Drugs

Although staffers and clients did not speak about drugs like meth, opiates, prescription drugs, and other illicit drugs on a regular basis, some evidence showed that it did exist in some degree. It is important to recognize that illicit drug use did exist at the Sal, even if it was nowhere near the degree of use of alcohol and marijuana.

Opiates. Terry (staffer) described to me the substance abuse problems she was aware of at the Sal, “We did find a syringe once, so opiates may have been a problem.” Another staffer John also reported finding needles, “There were times when I found evidence of people shooting up in the bathroom, needles on the playground, but mostly alcohol.” However, the evidence for alcohol and marijuana use was much stronger than the evidence of opiate use.

Meth. In Montana, methamphetamines have been a popular issue in the news. Advertisements and campaigns against meth send the message that meth use is rampant across Montana (<http://www.montanameth.org/>). During my time at the Sal, I found that meth use was not common among clients. A client named Jim had been hanging around the Sal for years. He did not have a lot of evidence regarding meth. Jim reported, “as far as hardcore drugs and stuff...I’ve only seen that stuff periodically. I never see meth around here.” According to Jenny (staffer), one of the general misconceptions about the Sal was that its clients were often meth users. She said that a lot of people assumed Sal clients did meth, but that was rarely the case. This is her explanation as to why meth was a rarity at the Sal:

There may have been some prescription drugs, but, but you kind of have such a short life expectancy when you’re doing meth... I mean you’re going to live in a meth house for two year then probably die...so they don’t usually make it to the Salcido Center a lot.

According to Jenny, the Sal did not appeal to avid meth users.

Oxycontin. Reggie (client) brought up oxycontin, which was rarely talked about by staffers and clients. Reggie said, “Most people that have problems with drugs...it seems that they are pill poppers...everybody’s going around trying to hustle oxycontin.” As a client, Reggie was able to observe more regarding substance use than a staff member.

Another client, Jim had also observed some oxycontin use.

I know a couple of people who do their oxycontin and stuff. They get prescriptions for it. So they say it’s legal. A lot of them will say they sprained their ankle to go to the doctor.

Jim was able to provide details about how clients were able to get oxycontin, which staff members were not able to do. Clients like Jim and Reggie provided me with more detailed information about substance use than staff members were able to.

Everyone was in agreement that alcohol was the most commonly used substance with medical marijuana the second most frequently used substance. As Jim, a client, said, “Generally it’s just alcohol and marijuana, medical marijuana.” John (staffer) offered an explanation for the pattern of heavy alcohol and marijuana use,

I think you show up at a place like that (the Sal) with a whole bunch of drugs, then people are going to ask you to share, and drug addicts don’t really like to share...especially if you are homeless and have no money for more drugs.

Overall, drugs like meth, opiates, and oxycontin were not brought up a lot at the Sal. There was talk about those drugs, but those substances were not described as big issues for Sal clients.

Reasons for Substance Abuse among Clients

Escapism in general. For anyone, homeless or not, drugs and alcohol can be a means of escape. People in all walks of life need relief from reality when the stresses of life become overwhelming. One client, Reggie, pointed out the widespread need to escape: “You’re always going to have a certain percentage of the population who are more inclined to be escapists in some way. Some people read poetry, some people text message all day, some people drink vodka.” Reggie brought up a very interesting point that people across the entire community abused substances, not just homeless people. It just happens that substance abuse is more visible among homeless populations and their options of escapism are limited to the avenues of escape that are available to them (Morrell 2007; Gowan 2010). Their avenues of escape are often much more limited than those of a member of the general population. For homeless, people the reality they are escaping is often harsher than the reality of someone who is not homeless, as homeless people live each day unsure of how they will provide for themselves and perhaps their family.

Escaping harshness of daily life. Many Salcido Center clients used drugs and alcohol to escape a harsh reality. A client named Beth explained her experiences with drugs and alcohol as

a means to escape her reality. She started using heavily at the age of eleven after she found her brother dead from hanging himself. She also lost both her mother and father to pill and alcohol overdoses. At the time of the interview, she was 42 and she had been sober for about five months (her longest stint of sobriety in her adult life). She completed a state-run, inpatient treatment program. After Beth completed treatment, a woman who runs a mission for the homeless that is separate from the Poverello Center had an extra room with a bathroom. She allowed Beth to live there for free as long as Beth was sober. Five months was the longest Beth had been sober since she started drinking. Shortly after the interview, Beth left her apartment and began drinking again.

When asked why people on the streets use drugs and/or alcohol, Beth replied, “To forget about where you’re at, why you’re there...just to get days over with. They go by faster if you’re drunk and passed out.” Beth used alcohol to forget about her situation. Beth ‘slept rough,’ meaning she slept outside year-round (Morrell 2007). ‘Sleeping rough’ is no easy task, especially in the extreme climate conditions of Montana. A small group of Salcido Center clients slept rough, which contributed to their harsh reality. For homeless people, abusing substances was a relatively easy way to cope with daily struggles such as shelter, food, and personal hygiene.

Through conversations with clients, it was clear that escape was one of many ways to deal with the harsh realities homeless people face. A life on the streets creates many issues one might want to escape from.

Escaping physical/emotional/psychological pain. Beth was not the only client who tried to escape reality through drugs and alcohol. Jim, a long-time client in his mid-forties, drank on a regular basis but claimed to never feel the compulsion to drink. He had been homeless by choice

for most of his adult life. From Jim's perspective, a number of events in person's life could contribute to harsh conditions. Jim expressed the belief that drinking could be an avenue to gain relief from these conditions. He claimed, "Some people drink just to numb themselves. Maybe they lost family members or something like that...they've just gotten lost in the cracks or by choice." This impulse to drink in order to escape was common among Salcido Center clients.

Although alcohol was the most popular avenue of escape, it was not a first choice for all clients. During one of my visits to the Sal, I was talking to a client named CJ. Staff members as well as CJ himself reported to me that he did pills, although it was not clear what types of pills he used. During my conversation with CJ, it was apparent that he was looking for a way to escape and was very frustrated that he could not find a way to escape. He said to me, "I hate my life. I'm a drug addict and I have no money and I want something real bad. I'm not doing well today...I'm just not doing well." On most days, CJ coped with his hatred of his life through the use of pills, but on that day his escape could not be found.

Another client, Cat, did not use drugs or alcohol, but she had a good deal of exposure to clients who did. She never told me why she didn't use substances, but she was strongly against substance use. She spent time at the Sal daily, and she stayed at the Poverello Center. When asked why other clients use drugs and alcohol, she offered the following explanation,

I understand their behavior because it's an easy way to alleviate the pain they feel inside. You know, some drink because they have physical pain. Arthritis, or bones that ache or whatever, past injuries. Others drink to alleviate the psychological and emotional pain that they've had because that's the only way they know how to deal with it. Some have, like I said lost hope.

For homeless people, there is a general lack of access to health resources, so many may not have the capability to medically take care of physical or psychological pain. Without the necessary health resources it may be easier to resort to substances. Alcohol is more readily

available in the life of a Salcido Center client than medical services. For some it is easier to find money to buy alcohol than to find enough money to see a doctor.

In examining the reasons for substance abuse among clients, rational choice theory is helpful in further understanding their reasons for using. Referring back to the literature review, choices often seem irrational to outsiders, but to the actor the decisions may seem rational (Paternoster 1989; Pescosolido 1992; Coleman 1989). For many, like Beth (client), drinking was a choice, but she felt it was her best option for getting days over with.

Maintaining Sobriety on the Streets: Why Is It Difficult?

Morrell (2007) and Snow and Anderson (1993) found that homelessness increases the difficulty of remaining sober, and my research also illustrates this increased difficulty. When asked about the difficulty of maintaining sobriety on the streets, clients and staff provided a variety of explanations. Many of the reasons they provided apply to the general population; however, homelessness exacerbates the difficulty of achieving sobriety on the streets. Some clients explained substance abuse as a way to pass time when they had no job and no place to go. Some claimed that substance abuse among peers made sobriety even more difficult to maintain. Other clients believed it was a way to ease the harsh realities of life on the streets.

Passing the time. All humans experience boredom from time to time, and usually people can turn to an array of activities to fill the spare time. Homeless people have limited opportunities for healthy activities that may aid in maintaining sobriety. Homeless people lack access to money and transportation; resources which allow one to participate in a variety of activities. For a person experiencing homelessness, activities are severely limited. With fewer options for activities, boredom becomes a trigger for substance abuse and an obstacle for sobriety. Beth was a prime example of this. When I interviewed Beth, she was living in housing provided by a

community member, and she was sober for the first time in over thirty years. Beth described to me why she drank while she was on the streets. For her, it was the only thing to do, “I’d be a drunk as a skunk if I was still on the street. I mean that’s the way it is. When you live on the street...you drink regardless.” Beth did not see any other viable options for passing time.

Whether or not that was true, Beth perceived her options as limited. Thus, she truly believed that there was absolutely nothing else she could do with days she spent on the streets. This challenge of passing time served as one of the many obstacles to sobriety. Again, rational choice theory helps to understand why Beth saw no other options. In her situation, a single, homeless woman without resources, drinking was the easiest way to cope with life. Her perspective was impacted by her living situation.

Substance abuse among peers. For someone who is trying to quit drinking or using drugs, he/she usually must spend less time with their friends who do drink or use drugs and spend more time with sober people. For a homeless person, this is much more difficult, as he/she cannot retreat to his/her own apartment or house to get away from substance abusing peers. Many clients at the Sal saw each other as family, and for some, their Salcido Center family was the only family they had. This made rejecting substance abusing peers more high stakes, because they would be rejecting the only group they really felt a part of. One client, Joe, told me he thought there were many of other clients who wanted sobriety, but they did not want to go through the “torture of fighting it off.” Then he further explained to me what that torture was.

I know people that quit drinking, and when they took that initiative...they hitchhiked out of town...they left cause they had too many friends here...drinking is a social thing, so it’s too hard for them to quit drinking on their own. It’s too hard around all that, so they’ve got to go somewhere else. It’s part of the torture. If they chose to stay around, that takes even more strength to be able to be around your friends who are drunk all of the time and not drink.

In most cases, in order to quit using a substance, one must remove him/herself from old patterns and lifestyles (Hanson et al. 2009). Unfortunately, this often includes leaving behind friends, a choice Joe describes as torture.

Homeless people experience social exclusion on a daily basis, thus it is logical that a person would choose to remain with the group of friends he/she has. For Reggie, drinking was a social activity: “I come from a drinking culture. I like social drinking.” When one’s social interactions revolve around drinking, one’s social network becomes a barrier to maintaining sobriety. A life on the streets can be a lonely life, so often people will cling to the people they have in their lives, regardless of whether or not that person is a good influence.

Medicating the situation of homelessness. For people who abuse, alcohol is often a way of medicating some type of stress or emotion that one wants to get rid of. For homeless people, those stressors are different. Homeless people experience many obstacles and issues, resulting in stress that most of the general population cannot imagine. Not knowing where to go next, how to get money, how to get food, how to get shelter, etc are all part of daily life for a homeless individual. These stressors are unfamiliar to most of the general population. The situation of homelessness can both cause and perpetuate substance abuse. Those stressors are constantly present; as long as those stressors exist people may be more likely to use and less likely to seek treatment. In a conversation with a staff member, John, he explained why people on the streets abuse alcohol.

It’s a disease, like I said before. I don’t know...somebody once put it to me this way, ‘I’ve lost my home, my family, I’m on the street, I can’t find a job...fuck I might as well get drunk’ (laughs). It’s a sad truth. It’s just a human mentality.

This staff member recognized that these stressful conditions are reoccurring for a homeless person. This means that the catalyst for using substances was always there for clients. Due to the stressful experiences homeless people go through, clients resorted to alcohol or another substance as a coping mechanism. For many clients, getting drunk was a way to leave reality for a little while. A person could forget their situation, forget the losses he/she has experienced in life, and for a while not worry about a thing. Unfortunately many saw no other way of coping with the harsh realities of homelessness.

Perspectives on Treatment

For both clients and staff, the idea of substance abuse treatment often seemed like an unrealistic option for dealing with substance abuse for both clients and staff members. For many clients, substance abuse treatment was not seen as an option, because they did not believe in addiction. Drinking and drugging was a way of life for many, not a disease that needed a cure, thus treatment was usually not a consideration among clients. On the contrary, staff members believed substance abuse treatment was not a common option for clients because of the structural barriers to treatment for homeless people. The major issues brought up by staff members were funding, insurance, and the lack of treatment programs in the Missoula area.

Clients' perspectives on substance abuse treatment. Clients were mostly under the impression that institutional forms of treatment were ineffective unless a person truly wanted to quit, which was rare for most clients and their peers. Clients knew very few people who received treatment their substance abuse. Often, the people they knew with drug and/or alcohol addiction were heavily using and not looking for treatment or help of any kind. The general consensus among clients was that addiction did not really exist; it was a lifestyle choice. Therefore, treatment was not a realistic option. This exemplifies Paternoster's idea that individual decisions are impacted

by the social structure they live in (1989). Perhaps clients realized the structural barriers to substance abuse treatment, and as a result, chose not to recognize the need for substance abuse treatment.

One example of a program that was readily available to clients was Alcoholics Anonymous (AA). AA is still a popular program among all types of people today. However, AA did not appeal to most homeless people. Staff members said that there were a few clients who attended AA meetings from time to time. One reason for that is because AA fully accepts the disease model of addiction. Because most clients oppose the disease model; AA probably not the most beneficial form of treatment.

Staffers' perspectives on substance abuse treatment. Staff members did see addiction as a very real and problematic disease. Staff members saw institutional forms of treatment as effective. However, their effectiveness was undermined by the fact that in the Missoula area treatment is, for the most part, unavailable to uninsured, unemployed, homeless persons. Perspectives on addiction were important barriers to substance abuse treatment.

In his view, staff member John shared his perspective on alcoholism.

It's a disease, like I said before. It starts out as an, 'after work let's get a pitcher...to after work, let's get 10!' And that cost them their family, their job... Why people drink...I don't know...cause drinking is fun at first, or if you can do it in moderation, but not everybody can.

John also believed drug addiction was a disease; however, illicit drugs were a less common topic of conversation at the Sal, as alcohol was used the most by clients.

According to staff members, AA (Alcoholics Anonymous) was the most readily available treatment for clients. However, staff members viewed AA as an uncomfortable setting for most clients because of the stigma that is attached to homelessness. Generally, staff members believed clients did not feel welcome at AA meetings. In talking with the staff member Jenny, she

expressed that there were a few clients who were interested in or attended AA meetings. John (staffer) and I discussed the issues that existed between many Sal clients and AA: clients felt uncomfortable at AA, clients sensed tension from AA members, and many clients did not accept the disease model of addiction (a cornerstone of AA). There was a time when a local AA group held their meetings at the Sal. In regards to that meeting, John said,

The meeting wasn't designed for homeless people. It was the longest running AA meeting in Missoula, but they just weren't comfortable with homeless people coming to meetings. I think a lot of our clients were unwanted there, or just there weren't enough of them. Especially if you are chemically dependent on alcohol...an hour once a week...it's just not going to work

For various reasons, clients were not comfortable at AA meeting and often AA people were not comfortable with homeless people at the meetings.

Barriers to Substance Abuse Treatment for Clients

Structural explanations. Staff members provided insight into the structural issues faced by clients who wanted substance abuse treatment. In his interview, John (staffer) provided for these structural obstacles to treatment. He explained what he thought to be the “easiest” way for a client to get into an inpatient program:

If you wanted to get into MCDC, which is the state rehab center in Butte, the best thing to do would be to buy a lot of cocaine, then go and start selling it, get busted, plea out to go to MCDC instead of jail, and that would be the easiest way to get into treatment. I mean, if you were desperate and needed to get in there...that would be your quickest way (laughs).

Although he said this to me in a joking tone, this is proof that is incredibly difficult for a homeless person to get into treatment. From a rational choice theory perspective, a client may desire to enroll in a treatment program, but the structural barriers severely limit those options in the Missoula area (Paternoster 1989; Pescosolido 1992).

From the perspective of Salcido Center staff members, chemical dependency is a disease.

As John (staffer) explained to me:

To drink yourself into oblivion for 20 years day after day, to just all of the sudden up and quit, it's unheard of. As they go on in medicine, in the field, they are finding out that it really does affect the brain in a similar way as a disease, and a lot of people are genetically prone to it. If you come from a long line of alcoholics chances are you are already an alcoholic, and all you need is a couple of drinks. It's a little bit more difficult than saying, 'just quit doing drugs, just quit shooting up heroin...you'll be fine.'

According to John, a person cannot "just quit doing drugs." Instead, addiction must be treated through a multitude of treatments such as counseling, AA, intensive outpatient or inpatient treatment. This is referred to as the disease model of addiction. In the disease model of addiction, after a person recognizes that he or she has a problem with substance abuse he or she must choose their own route to sobriety (Hanson et al. 2009).

This route to sobriety is full of obstacles for a homeless person in the Missoula area. A staff member named Jenny told me about the options for clients of the Salcido Center if they wanted to be in an actual rehabilitation facility. During my research, Jenny mentioned two former clients who had gotten sober during her employment at the Sal. One got sober while living at the Share House⁵ and another client went through MCDC.⁶ Those two were the only clients whom I heard about getting into an actual treatment program. If a client recognized that they had a problem with substance abuse they had the following options according to Jenny: "There's some halfway houses like Turning Point, Share House (located in Missoula), but those tend to be if you've been discharged from a

⁵ The Share House is a facility that offers: 1) case management during detox, 2) monitored living while waiting drug/alcohol treatment, 3) supportive living while in outpatient treatment and 4) supportive living after treatment while seeking permanent housing (http://wmmhc.net/index.php?option=com_content&view=article&id=256&Itemid=229).

⁶ MCDC-Montana Chemical Dependency Center is a state owned facility and offers inpatient treatment (<http://mcdc.mt.gov/>).

rehab facility like MCDC in Butte, you don't really go there straight off the street." Even if a person recognizes the problem and tries to get help, he or she may encounter additional barriers. In some cases, the rehabilitation facility staff may be hesitant to accept homeless people into the program. According to Jenny, "They are really skeptical of homeless people, because they think homeless people are just trying to get housing, not like help with anything else. Which is ridiculous." By simply being a homeless person, one is immediately disadvantaged when trying to get into treatment programs. Paternoster claimed structure plays a role in decision making (1989). That is clear here, as clients' treatment choices were very limited by social structures.

Personal lifestyle choice. Instead of seeing addiction as a disease, many clients perceived substance abuse as a lifestyle choice. As one client named Cal stated quite clearly, "I don't believe you can get a disease from a bottle." Clients of the Sal viewed substance abuse and sobriety differently than staff members, while staff members agreed that addiction was a disease. One of the largest barriers to substance abuse treatment for this population was the belief that using drugs and alcohol was a way of life and not a disease. This was the perspective of most clients, as another client Reggie stated, "Certain people do it to extremes; to the detriment of their health or their lifestyle. I think if you don't want to drink you don't drink. If you do want to drink you drink! I've fought with alcohol most of my adult life, but I seriously believe it's not a disease I have, it's a lifestyle choice." Reggie's perspective is another example of the casual attitude toward alcohol use that existed at the Sal.

Joe, another client, told me his story. He used meth on and off for about four years, and he was the only client I spoke with who told me about personal experiences with meth. He said that one day he realized one of his teeth had basically crumbled to pieces. Upon this realization,

he just decided to quit. He did not go to a treatment program. He quit on his own. When I asked him if he thought there were other clients at the Sal who wanted help with their substance abuse problems he replied:

Most people that I've seen quit; they've done on their own...If they've genuinely quit. If people go into rehab or detox because they are court mandated to then as soon as they come out they say, 'ok I'm done staying sober.' They go right back to it. You can't fix things in other people. It doesn't work like that.

For Joe, the institutional methods for attaining sobriety were not valuable or effective ways to deal with substance abuse. To him, no type of treatment would help a person if they did not genuinely want to get sober. It was more important that a person make their own decision to get sober.

Beth was another example of a person who decided to get sober on their own. As stated previously, this was her first experience with sobriety since she began drinking. She did not offer a nuanced explanation as to why she decided to get sober. She said that one day she just decided to quit:

I've been court-committed to treatment 13 other times, but I just played the game. I was drunk within hours after I got out. This time was different. I asked to go. It makes all the difference in the world, cause I didn't have somebody tell me, "You have to do this!" I was saying, "No...I want to do this!"

When I asked her what made her change her mind, she said jokingly, "Maybe I got hit by lightning! I don't know." Beth's story affirms Joe's idea that a person will not remain sober if he/she does not genuinely want to be sober. The only time she maintained any sort of sobriety in her adult life was when she chose to go to treatment. During her interview, she told me that she had been court-ordered to Montana's state mental hospital in Warm Springs, and while she there she decided she wanted to go to treatment. She said she asked the people at the hospital if she could go to MCDC in Butte. That was the first

time she had ever made a personal choice to get help for her alcoholism.

Overall, most clients thought sobriety was a personal choice; not the cure to the disease of addiction. Clients believed if a person really wanted to get sober, he or she would. As Reggie stated, “Most of the people I’ve seen around here they can be sober if they want, but they chose to drink. It’s not a matter of, ‘God I’ve got to have a drink...’ It’s just, ‘I’m going to get drunk’.” For most clients, drinking was a choice. Reggie’s perspective opposes the perspectives of staff members. Staff members wholeheartedly believed in the disease model of addiction: if a person has an addiction, his or her substance use is not a choice.

Herein lays the largest barrier to substance abuse treatment for this population. To most clients, addiction is not a disease but a choice, as John described it above. However, the only treatment available to clients is based on the disease model of addiction. It is unlikely that clients with substance abuse will feel compelled to join this type of treatment program (AA or intensive inpatient rehabilitation). The core values of such programs conflict with the perspectives of clients by embracing the disease model of addiction.

CHAPTER SIX: CONCLUSIONS

“The theoretical starting point is the individual who, having preferences and being confronted with constraints, has to make choices” (Pescosolido 1992:1100). Each individual acts from his or her own perspective, with his or her own life experiences building their individual reality. Although some of the Salcido Center clients I spoke with were certain that they had complete freedom, no one is ever completely free from the effects of the structure he/she lives in. Within clients’ individual realities, they were free to make choices, but it is social structure that helped them create their own reality. The structure he/she resides in can then be used to explain the individual’s perspective.

This is America, so we are supposed to pull ourselves up by our bootstraps right? Well if we deny the problem (disease of addiction) then there is no pressure to ‘get better.’ Obviously there are no easy paths to sobriety for anyone, especially a homeless person. It makes sense to deny the issue to prevent actually having to deal with it, when as a homeless person there are few tools to deal with such issues. Among the many struggles a homeless person may experience in a single day, it is not that surprising that many avoid adding another issue like addiction.

I began this research knowing that few options existed for a homeless person struggling with addiction. I was certain that was the main reason the problem remained rampant among homeless populations in Missoula was structural. Although clients’ denial of the disease model seemed rather strange at the onset of the research, when the perspective is looked at in relation to stigma, social construction of reality, and rational choice, it is really not a phenomenon at all. It is a logical decision. In Coleman’s words it is a purposive action or a rational choice.

The stigma built into our social structure is nearly impossible to get away from for homeless people. The stigmatized reality that they experience plays a role in determining their

resources and choices. Given the environment in which Salcido Center clients are functioning, their choice to deny the disease model does not seem so strange. Even if a client did say, “I have a disease,” the options for treating it are practically nonexistent, so what is the point in even admitting to having this so called ‘disease’ of addiction for a Salcido client? It’s amazing how a change of perspective can make something that was once a phenomenon into a rational choice. It all just depends on how you look at it.

In order to do anything about this issue, it needs to be approached in an entirely new way. In the words of a client, Joe, “It’s like you’re using the wrong tool for the job.” Imposing mainstream society’s assumptions about substance abuse treatment on a population who does not embrace mainstream society’s perspective does not make sense. There is not one miracle treatment program that can solve substance abuse among homeless people. However, treating people as human beings, with dignity and respect, seeing people as people, and not problems is a good place to start. When people are put on level ground and made to feel as though they matter, the possibilities are endless.

The Harm Reduction Model of social service is one method that could be useful for overcoming the barriers to substance abuse treatment. This model can be applied to any group of people, but especially for homeless people the values of the HRM would likely draw homeless people in compared to a regulated, traditional treatment program. As stated previously, the ‘get tough’ approach to drug abuse has been largely unsuccessful among chronically homeless people (Gowan 2010). In general the homeless people I got to know at the Sal lived most of their lives without regulations and without schedules. A treatment program that requires them to change who they are in order to receive treatment is not likely to appeal to them.

The Sal was not a treatment program; however, it opened its doors to anyone and accepted people without requiring sobriety of them. The Sal showed its clients that they mattered, regardless of their sobriety. For an addict, maintaining sobriety is incredibly difficult and taking on the challenge of getting sober is a brave step. What many people do not realize is that relapse is often part of the recovery process, thus perfect sobriety is rare.

By accepting all clients, the Salcido Center encouraged some to attempt sobriety. At the Sal, relapse was not considered a failure, so people could attempt sobriety without risking the services of the Sal if they could not remain sober. If a person believes they must maintain complete sobriety in order to use a facility they may just decide not to try at all, because they are afraid they will fail. The Sal made necessary connections with members of the homeless population who had limited connections to other service providers because of their substance use. Using the method of the Sal's staff members; approaching people in an accepting manner rather than with a 'get tough on drugs' demeanor will most likely be more successful at encouraging homeless individuals to change their lives and take a first step towards sobriety.

APPENDIX A

Figure 1: Female Clients (4 Participants)

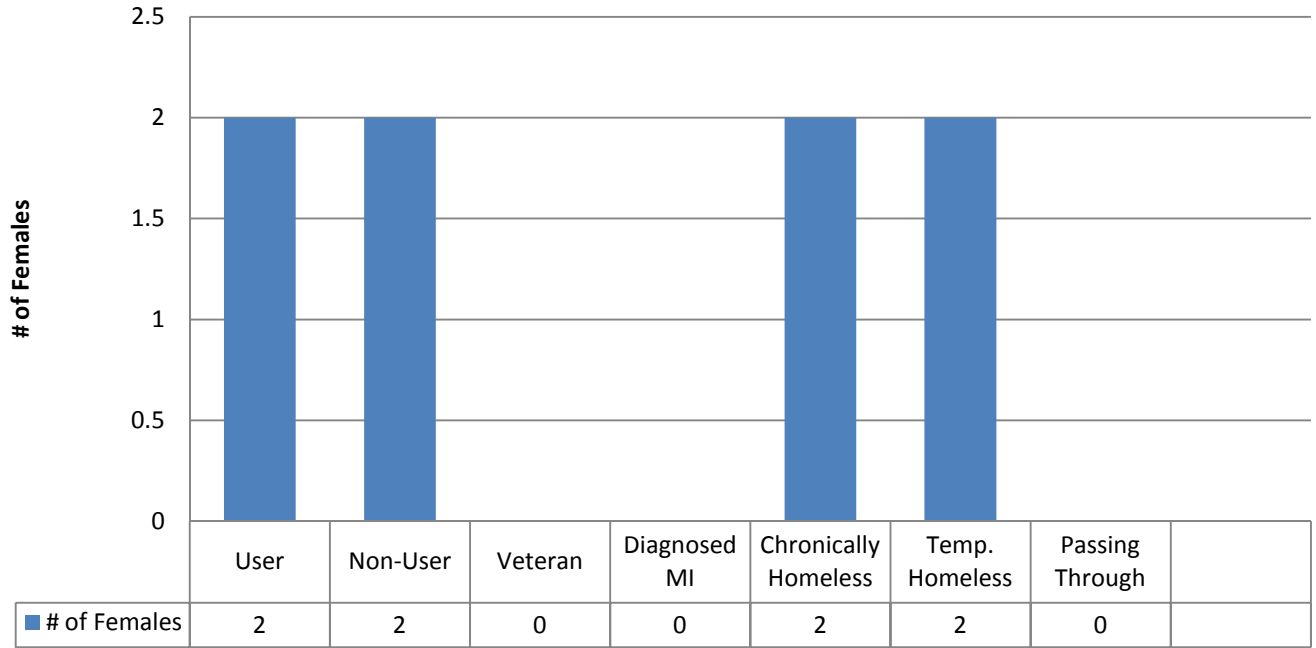
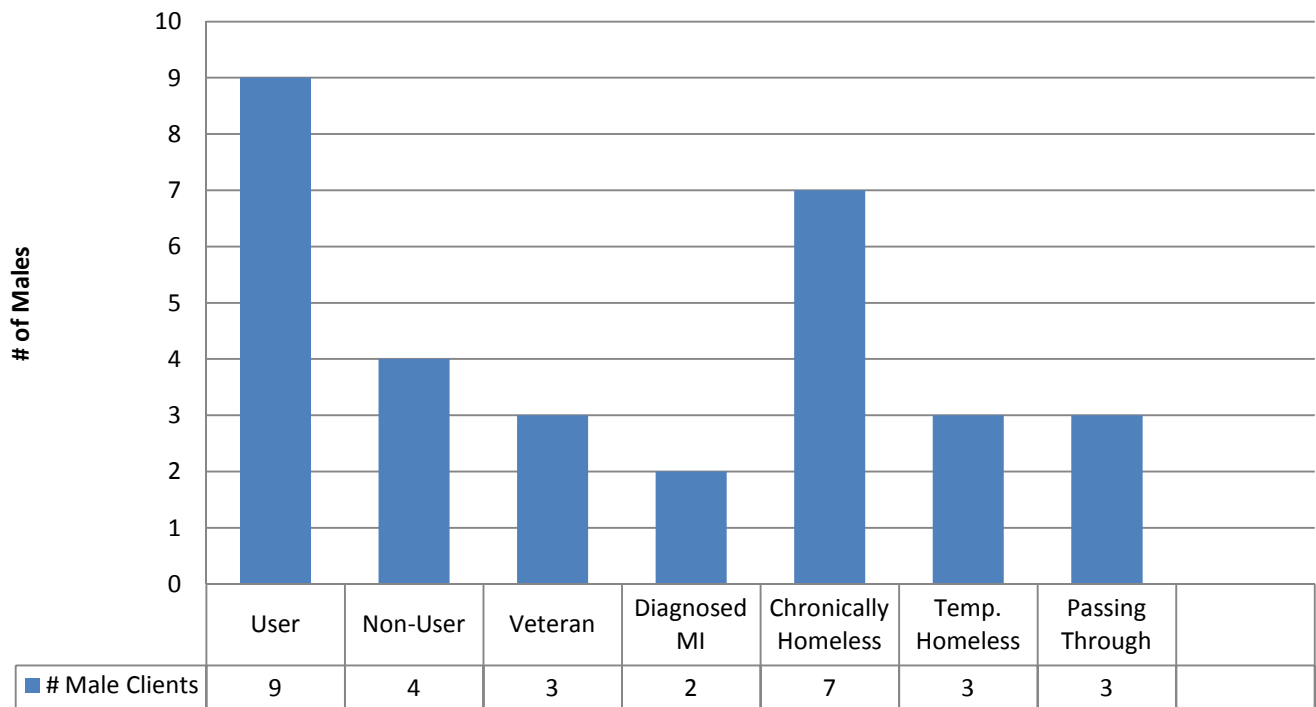


Figure 2: Male Clients (13 Participants)



APPENDIX B: CLIENT INTERVIEW GUIDELINE

The purpose of this research is to better understand the issues faced by clients of the Salcido Center. We hope to learn about the surface issues of the Sal as far as issues with the actual facility and what it provides for clients. We also hope to learn about deeper issues like substance abuse and the treatment or lack of treatment of the issue. To the interviewee: please note that you can refuse to answer any questions and you may stop the interview at any time.

1. Tell me about yourself
 - a. Where are you from?
 - b. Why did you come to Montana?
2. Please describe how you heard about the Salcido Center (the Sal) and how you got here
 - a. Why do you come to the Salcido Center?
 - b. How long have you been coming?
 - c. How often do you come here?
3. Do you feel that poverty is a problem in Missoula?
 - a. Why? How?
 - b. Causes?
4. What is your opinion of the Salcido Center?
 - a. What would you change?
 - b. How would you go about making those changes?
 - c. Improvements?
 - d. Dislikes?
 - e. What does it provide for you?
5. Why do you choose to go to the Sal?
 - a. How is it different from other facilities?
6. Do you use any other service organizations in the area? (Like the Poverello Center, the Salvation Army, or Missoula 3:16, or a mental health clinic?)
 - a. Which ones?
 - b. Why do you go there?
 - c. What do they provide?
7. Describe what a good day is like for you
8. Describe what a bad day is like for you
9. Please list some items or services that you feel you need the most
10. How do you think other members of the Missoula community see you?
 - a. Why?
 - b. How does that make you feel?
 - c. What would you like them to know about you?
11. What would you like to see change in the Missoula community as far as the way the community deals with poverty and homelessness?

12. What would you like to say to people who believe that living in poverty is a choice?
13. Has the Sal helped you create long term solutions to your situation?
14. What would you like to see change in the Missoula community as far as the way the community deals with poverty and homelessness?
15. Please list some items or services that you feel you need the most

I would like to ask you some questions about substance abuse. Please keep in mind that anything you say will be kept confidential. These questions are being asked in order to help us create a program to better serve you. I am conducting this study solely to learn more about the clients of the Pov, and I have no connections with any law enforcement agencies. These questions may be sensitive, so feel free to pass a question if you do not want to answer.

16. Do you feel that other clients of the Sal need substance abuse treatment?
 - a. Why? Please explain...
 - b. Would other clients participate in substance abuse treatment?
 - c. Why or why not?
17. Do you know clients who have participated in some type of substance abuse treatment program?
 - a. Please explain
18. Overall how do you think clients of the Sal feel about substance abuse treatment?
 - a. Why?
19. Do you have any personal experiences with substance abuse? If you are comfortable please explain your experiences
20. Would you be interested in substance abuse treatment?
 - a. If yes-please explain. If no-why?
 - b. Just pretend that you are interested...how does a person go about getting into a treatment program?
21. Have you had any experiences with a substance abuse program? If yes- please explain that to me...
22. Do you know of any treatment programs that are available to clients?
 - a. Please describe what you know about it
 - b. What do you think about this program?
 - c. Why?
23. Does the Sal provide substance abuse help?
 - a. If yes-how? OR if no-how?
24. Would you change the way substance abuse is handled by this community?
 - a. Why?
 - b. How?
25. To make sure I'm talking to a wide variety of people, I need to get some background information about you:
26. How old are you?

27. Are you married?
 - a. Divorced?
28. Do you have children?
 - a. How many?
 - b. What age?
 - c. Do you live near them?
29. Do you have any criminal history? (I'm not asking for specifics just yes or no)
 - a. Felony or misdemeanor? (the only specific info I need about that)
30. Is there anything else you would like to talk about?
31. Do you have any questions for me?
32. THANK YOU FOR YOUR TIME!!!!!!

APPENDIX C: STAFF INTERVIEW GUIDELINE

Before we begin the interview, I would like to remind you not to refer to any clients by name. Please refer to Clients only in generalities.

1. How long have you worked at the Salcido Center?
2. Why did you decide to work here?
3. What are your job duties?
4. What do you think is your most important duty?
5. Describe a typical day at the Sal.
6. What do you like most about your job?
7. What do you like the least?
8. What is the Sal's function in the Missoula community?
9. What are some other service providing organizations in the Missoula community?
10. How is the Sal different from them?
11. What types of people do you see at the Sal?
12. Do consumers of the Sal tend to be regulars or people passing through?
13. Why do you think people come to the Sal?
14. Do you think the fact that the Sal is a wet facility (allows those under the influence to access its services) attracts people?
15. What does the Sal offer people?
16. Do you think substance abuse is a problem among those who use the Sal?
 - a. How common do you think the problem is?
 - b. What kinds of substance problems have you seen?
 - c. (if yes) Why do you think it is a problem?
 - d. What types of substances do you think are most common among clients?
17. Do you think substance abuse has a role in the issue of homelessness?
 - a. Explain
18. What kind of help is there for Salcido Center clients dealing with some type of substance abuse issue?
 - a. Have you seen people using these options?
 - b. Do you think people are interested in these options?
 - c. Do you think people are aware of these options?
19. Can you tell me about any success stories of Sal clients with dealing with substance abuse?
20. What do you think is the largest barrier for people getting sufficient substance abuse treatment and making life changes?
 - a. Explain...
21. Do you think mental illness is common among those who come to the Sal?
 - a. Explain-what have you seen?
22. In your experience, is the existence of the Sal is controversial in this community?

- a. How?
 - b. Why?
23. What would you like to say to those who oppose the Sal?
 24. Any questions for me?
 25. Anything you want to add?
 26. Thank you for your time!!!

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