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Social Relationships, Homelessness, and Substance Use Among Emergency Department Patients

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Abstract

Background: Emergency department (ED) patients commonly experience both substance use and homelessness, and social relationships impact each in varied ways not fully captured by existing quantitative research. This qualitative study examines how social relationships can precipitate or ameliorate homelessness and the connection (if any) between substance use and social relationships among ED patients experiencing homelessness.

Methods: As part of a broader study to develop ED-based homelessness prevention interventions, we conducted in-depth interviews with 25 ED patients who used alcohol or drugs and had recently become homeless. We asked patients about the relationship between their substance use and homelessness. Interviews were recorded, transcribed, and coded line-by-line by investigators. Final codes formed the basis for thematic analysis through consensus discussions.

Results: Social relationships emerged as focal points for understanding the four major themes related to the intersection of homelessness and substance use: 1) Substance use can create strain

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AUTHOR CONTRIBUTIONS
KMD, DS, and DKP conceived of the study and developed the interview guide. LG and RPM additionally contributed to study content and design. DGC and KMD conducted the interviews. DGC, ZR, and KMD coded the interviews. AJ and DKP conducted additional thematic analysis. AJ drafted the manuscript with DKP and KMD. All authors provided critical feedback and approved the final version.

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in relationships; 2) Help is there until it's not; 3) Social relationships can create challenges contributing to substance use; and 4) Reciprocal relationship of substance use and isolation. Sub-themes were also identified and described.

Conclusions: The association between substance use and homelessness is multifaceted and social relationships are a complex factor linking the two. Social relationships are often critical for homelessness prevention, but they are impacted by and reciprocally affect substance use. ED-based substance use interventions should consider the high prevalence of homelessness and the impact of social relationships on the interaction between homelessness and substance use.

Keywords

substance use; homelessness; emergency department; social relationships

INTRODUCTION

Homelessness and substance use have a well-known bidirectional relationship, with substance use noted as both a cause and consequence of homelessness.[1–5] Previous studies of homelessness and substance use have been largely quantitative, finding, for example, prevalence of variably defined substance use among people experiencing homelessness ranging from 4.5%–58.5%, as compared to an estimated substance use disorder prevalence of 7.7% in the general population.[6,7] Prior qualitative studies of people experiencing homelessness have emphasized the salience of social relationships, with many citing depleted social networks.[2,3,8–11] Yet little past research has specifically examined the intersecting role of these relationships both in becoming homeless and in substance use.

Social relationships are known to play a multivalent role in the lives of individuals experiencing homelessness.[9,10,12] As many as 75% of homeless families seek help from their social networks in the year leading up to becoming homeless.[11] Lack of supportive social relationships sometimes contributes to the 'institutional circuit,' with some people experiencing homelessness cycling among shelters, correctional facilities, and healthcare institutions.[3,5,13–15] The emergency department (ED) is a common stop on this circuit, especially for those who have a substance use disorder or other medical needs.[13,16,17]

Housing instability is common among ED patients, with studies finding a reported prevalence of 18.1%–43.8%.[18–20] Open 24 hours per day, the ED is uniquely accessible to people experiencing homelessness. ED providers, who may be for some patients the first, only, or most frequent points of contact for health care, are called upon to address the complex and intertwined health and social needs of their patients who are experiencing homelessness.[18,19,21] A growing field of "social emergency medicine" acknowledges the role of EDs in addressing the health-related social needs of patients and seeks to determine best practices for assessing and addressing those needs.[22,23] As part of a broader study to develop ED-based homelessness prevention interventions, we conducted qualitative interviews with ED patients who had recently become homeless. In a prior paper, we described ED patients' pathways to homelessness.[24] The current analysis expanded upon some findings from our prior work and ultimately provided an in-depth examination of social relationships as they relate to substance use and homelessness that was not previously

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described. In particular, qualitative interviews offered the opportunity to study how social relationships helped or hindered the stress of being newly homeless and the role of substance use. We examined the following questions:

1. What role do social relationships play in precipitating and/or ameliorating homelessness in study participants who use drugs and alcohol?
2. How do study participants view the connection (if any) between their substance use and their social relationships?

METHODS

This study analysis drew from a larger qualitative study conducted with ED patients who had recently become homeless.[24] The study was approved by the NYU Grossman School of Medicine Institutional Review Board.

Study Setting

The study took place in the ED of an urban, public hospital in the northeastern U.S. The hospital is adjacent to a large men's intake shelter. Patients were eligible for participation if they were 18 years or older, English-speaking, and had become homeless within the past six months. We defined homelessness as living in a shelter or unsheltered, and patients were eligible if this was their first episode of homelessness or if they had experienced homelessness previously. Patients were ineligible if they were unable to provide informed consent (e.g., dementia, intoxicated), in police custody, psychologically distressed, or otherwise medically unfit (e.g., critically ill).

Sampling and Recruitment

The majority of participants were recruited through identification by ED staff (nurses, doctors, physician assistants, and nurse practitioners) who were asked to alert researchers if they knew a patient had become homeless in the past six months. A smaller number were recruited by research staff who directly screened randomly approached ED patients.

Interview Procedures

Interviews were conducted April 2017 to June 2018 by a research coordinator with training in qualitative interview techniques (DGC) or a physician with training in qualitative research and experience working with people experiencing homelessness (KMD). Interviewers were not part of participants' medical care teams. Interviewers took measures to ensure participant privacy, including conducting interviews in separate rooms or in a curtained area away from other patients. Participants provided informed consent and received $20 compensation.

Interviewers used a semi-structured interview guide (Figure 1) which allowed for standardization of questions across interviews while also allowing for probes and further elaboration by participants.[25] The interview guide was pilot tested with two patients and minor adjustments were made. Interviewers probed for key factors that influenced a participant's substance use and homelessness. Interviewers recorded demographic

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information, information on current unhealthy alcohol and drug use (using validated single-item screening questions), and brief field notes.[26,27] Interviews were digitally recorded and transcribed by a professional transcription service, then checked for accuracy against the original audio recordings by DGC and/or KMD, who made edits where necessary.

Data Analysis

Interviews were continued until theoretical saturation (no new key information identified in subsequent interviews) was achieved. Broad predetermined code domains were identified based on goals of the study, and additional codes emerged organically from the text in the modified grounded theory tradition.[25,28] Three researchers (DGC, KMD, and ZR [a social worker]) coded groups of 2–3 interviews independently and conferred on codes during meetings and in discussion with a senior faculty member with qualitative methods expertise (DKP). Codes were refined in an iterative manner until the final codebook was solidified with 27 codes after review of 12 interviews. We used Dedoose software to assist in data management and organization.[29]

For the purposes of this study, 6 interviews (of 31) were excluded from the analysis, as these participants did not report current or former drug or significant alcohol use. To address our research questions regarding the role of social relationships among the remaining interviews, AJ (a medical student) and DKP selected all coded excerpts pertaining to social relationships from the dataset. They independently reviewed the selected material and identified themes related to social relationships. They conferred regularly to reach consensus on themes and subthemes. Themes were identified inductively, guided by the text itself, rather than deductively based on a pre-identified theoretical model.[25,28]

RESULTS

Sixty-six patients were screened for eligibility; 33 were ineligible (primarily due to a lack of recent homelessness episode) and 2 declined to participate. In total, 31 interviews were conducted (N=25 for this analysis as described above). The average interview length was 42 minutes (range: 19–87 minutes). The sample was largely male, with an average age of 48 years (Table 1). Participants were racially and ethnically diverse. Approximately two-thirds reported a previous episode of homelessness before their current episode.

Four themes emerged in the context of our two research questions. Addressing the question "What role do social relationships play in precipitating and/or ameliorating homelessness in study participants who use drugs and alcohol?" were themes: 1) Substance use can create strain in relationships and 2) Help is there until it's not. Addressing the question "How do study participants view the connection (if any) between their substance use and their social relationships?" were themes: 3) Social relationships can create challenges contributing to substance use and 4) Reciprocal relationship of substance use and isolation. The themes were distinct yet interrelated and intertwined, which speaks to the interconnectedness of social relationships, substance use, and homelessness.

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Themes and sub-themes

The study's findings, themes and associated sub-themes, are summarized in Table 2 and described in greater detail below.

Theme #1: Substance use can create strain in relationships—Two subthemes emerged in our inductive analysis: Participants felt that they were on their own, without anyone to turn to for help, and they felt judged by those whom they could ask for help.

"I am on my own.": For some participants, past experiences with friends or family members had caused these relationships to be tenuous or nonexistent, which prevented them from reaching out for help. For participant 56, a man in his 60s, these experiences were related to his own history of substance use as well as the substance use of his abusive stepfather, who he believed was mistreating his mother while intoxicated. He stated,

> My brother that got killed, he was staying with my mom and he also saw the same thing when he was living with her. And they all made it look like he was the crazy one, just like what's happening now with me. My family, my sisters --- I don't talk to them…I'm totally…I am on my own.

The family rift created by substance use extended to his mother. He professed, "I'm not gonna have a relationship with my mom again as long as she's with that man." Participant 50, a man in his 30s, also had difficulties with a stepfather who used drugs, stating "We're always arguing because he's a [heroin] abuser."

"I'm just being judged.": Participants felt palpable stigma associated with both substance use and homelessness. Some reported they felt judged because of their substance use, and they avoided people who could otherwise potentially be helpful. Participant 10, a man in his 50s, described an incident that led him to become homeless: "I was hospitalized while I was there, a blackout…my family…lives that tough love thing and they wasn't understanding…I pretty much ran away." This brought him to New York City, where he was unable to find housing and lived doubled-up with a friend.

> Participant 60, a man in his 40s, described the judgment of friends in his local Alcoholics Anonymous program. The stigma of being known as a "constant relapser" and his history of returning to substance use with a friend from AA led him to leave his home area in search of a place where he could find support in recovery and avoid the familiar scenario of "when I raise my hand, I'm just - I'm judged."

Theme #2: Help is there until it's not—Our earlier report found that several participants stayed with a family member or friend during prior episodes of homelessness, but for a variety of reasons this help was only temporary. This analysis revealed how social networks, especially those strained by substance use, became less accessible because of overuse, disintegration of relationships, or personal loss.

"We had a fall out.": For some participants, conflict in social relationships directly precipitated homelessness due to a "falling out." In some cases, these difficulties were

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with people the participants knew for a long time, causing years of conflict to coalesce into one final argument where they were pushed out of their current living situation. Participant 50, a man in his 30s who reported former heavy alcohol use, explained that his stepfather made his living situation unbearable: "I can't be around him…I told my mother…[and] she chose him over me." He also feared his stepfather's use of drugs would cause his mother to return to use after completing a treatment program. Participant 25, a man in his 50s, encountered a different situation while renting from his former girlfriend and her partner: "When they opened the door, they started screaming at me about crazy stuff. All my clothes are packed…And I'm like 'what is wrong with you people? I pay rent.'" They cited his coming back to the apartment intoxicated from alcohol at late hours as a main reason for wanting him to leave.

Loss of a loved one.: Some participants became homeless because they left their housing to live with and care for a friend or family member who later died. Being left not only homeless but also with the emotional trauma of loss in turn affected their substance use in some cases.

> Participant 29, a man in his 60s, said: "I gave up everything to move in with him [father] because he was very ill. I knew he was getting on in age and he needed someone to be there." After his father's death, he began drinking more alcohol: "I was just very depressed and drunk...if my cousin hadn't been there, there would have been no one to manage the funeral." Participant 4, a man in his 30s who reported current heavy alcohol use and former heroin use, described his emotional pain after the death of his close friend: "the last few weeks of his life, I took care of him in my home, and he died in my bed…I mean I was questioned. The police came, like I was a criminal and…questioned me for hours." The police investigation and active substance use by participant 4 and his partner cast suspicion on him in the eyes of his landlord, who later "gave me problems re-signing my lease."

Theme #3: Social relationships can create challenges contributing to substance use—Participants described negative impacts of various social relationships that either introduced them to drugs or alcohol or reinforced their use. Some participants tried to physically separate themselves from certain individuals, but they were often the same friends or family who could potentially help them avoid homelessness.

Early exposure.: Participants described issues that family members had with alcohol and/or drug use, which they connected with initiation of their own use. For participant 65, a man in his 60s, alcohol use had taken a toll on his family. When asked why he first began drinking alcohol, he remarked, "that run in the family…My brother, my father. They all die. I only have two [relatives] left." He also described his friends as "no good" in their ability to help him exit homelessness because "they all drink," and thus would facilitate his own alcohol use, which he felt was the main cause of his homelessness. Participant 56, a man in his 60s, reported that his stepfather who used alcohol and cocaine was the first to expose him to drugs: "He got us all hooked on coke when we were very young, me and my three brothers."

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Coping with relationship stress.: Some participants remarked that stress stemming from strained relationships with romantic partners or family led them to increase their use of alcohol or drugs. In one case, this emotional response required a practical compromise. Participant 4, a man in his 30s with a past history of opioid use, explained how his abusive spouse "kept acting up," forcing the couple to move multiple times. "My spouse kept acting up and I didn't want him using street drugs, so I was giving him my [methadone]…And I would drink [alcohol] instead." Participant 25, a man in his 50s, increased his alcohol use after returning home to Puerto Rico to find his brother in poor health. He stated, "So he was hooked on heroin. And he had caught HIV. So I couldn't endure it, so I started drinking more---my mother was like - give me the guilt trip and then I would have to take care of him." His brother later died, leaving participant 25 to care for his ailing mother.

"I want nothing to do with these people.": Several participants described trying to avoid people who may trigger their substance use, subscribing to the *people, places, and things* adage of Alcoholics Anonymous. For some participants, avoiding such people even precipitated homelessness. Participant 20, a man in his 40s, left Camden, New Jersey to seek detoxification services in New York City, where he knew he would be homeless. He elaborated, "so right there [Camden] it's the most drugs in the USA...you go down like at any corner and you go to dealers and drugs. That's why it's too easy to be addicted because they offer you. That's why I'm here." Participant 60, a man in his 40s, reported a similar experience in Trenton, New Jersey. He explained, "this is a smart move for me; it really is because of [my ex-girlfriend] and…the drugs and stuff, the people I know. See, here, I don't even know where to cop [drugs]." Others reported that they avoided shelters because of open substance use by shelter residents. "I'm homeless right now. I'm scared to go into the shelters 'cause I don't know how to stay away from it [substance use]," explained Participant 21, a man in his 40s.

Theme #4: Reciprocal relationship of substance use and isolation—Participants described ways in which substance use played a role in their becoming isolated, including by creating practical barriers to interaction (e.g., losing/selling their phone). This exacerbated the isolation of being homeless and made it more difficult for them to draw on social networks for help. Isolation sometimes also preceded substance use and was cited as an initial reason for using alcohol or drugs.

"I have lost everything.": Some participants spoke of what they perceived as far-reaching effects of their substance use, which they reported left them without money, a home, or people to help them. After being incarcerated for selling drugs, participant 2, a man in his 40s, revealed that he did not have any address to list, as he lost contact with friends and family who moved away and could only remember the addresses of old associates. "I have some old friends that I could put their address down but that's like kind of self-destruction….so I told them that I have nobody."

Participant 8 described how he perceived the toll of his opioid use:

> I'm a heroin addict. I'm 40. I touched heroin for the first time when I was 16 and I haven't stopped yet. I have lost everything due to heroin…lost family…lost

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> self-dignity and…financial stuff I've lost. Material stuff I've lost. Friendships I've lost. Partnerships I've lost.

"I never fit in.": Isolation as a child was cited as the reason why some participants began using drugs or alcohol at an early age, both to fit in and as a coping mechanism. Growing up, participant 60, a man in his 40s, was physically and emotionally abused by his grandmother and father. He found solace in a group of friends who introduced him to alcohol. He explained, "And then when I started hanging around with some people who, you know, showed that they cared about me, 'Yeah, hey, come on, we're gonna have a couple of beers,' you know. I – this scared little boy that didn't know, really have much direction and...never felt loved – I fit in." The idea of "fitting in" with a crowd of friends who drank alcohol was also present in Participant 29's, a man in his 60s, story. Participant 33, a man in his 20s, also mentioned that he felt like an outcast in his own family: "I come from a very cracked out, like horrible family, you know…I'm the only male in my family that hasn't been to prison…I smoked a lot of weed because I had pain." He explained further that his current marijuana use was to cope with the isolation of being homeless.

DISCUSSION

Our analysis of in-depth qualitative interviews revealed that ED patients who had recently become homeless reported multiple ways in which use of drugs or alcohol affected their social relationships. Themes were related to individuals' substance use contributing to strain in relationships, limited availability of resources from social relationships, the sometimes negative impact of social relationships on substance use, and the interrelationship between substance use and isolation both early and later in life.

Our findings add to prior research documenting depletion of social networks among people with substance use disorders and individual and structural challenges related to the absence of social capital.[9,11,13,14,30,31] Our data revealed that substance use was a factor in the dissolution of some social relationships. However, in some cases, participants had several close ties and a way to contact these individuals, but they did not ask for help, a finding consistent with Shinn et al.'s study of newly homeless mothers that found women were likely to have contact with social relations but felt unable to utilize them to help with their housing needs.[11] For our study participants, such avoidance may have been related to the compounding stigma they felt related to both their homelessness and their substance use. On a practical level, participants noted ways in which substance use of family members contributed to premature death or other limitations in their ability to help the participant with their homelessness. Altogether, whereas most participants did have friends or family members in their social networks, there were various limitations—sometimes exacerbated by substance use—in the utility of these relationships in preventing their homelessness.

Relatedly, another finding from our analysis is that social relationships can be a double-edged sword. For some, participants' closest relationships created triggers for substance use, or had been instrumental in their initiation and continuation of substance use, a finding well-characterized in the literature.[2,3,32] Our analysis adds to our understanding of the complicated interplay between relationships and substance use by revealing a specific

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dilemma faced by some study participants: what is a person to do when their most available option for housing is with a person whom they perceive might put them at risk for heavier substance use or a return to substance use?

The ED is a uniquely accessible location for people experiencing homelessness who present not only with medical needs, but also with social needs that providers often struggle to address.[33] Understanding these multifaceted needs is important, as the ED may be especially suitable for implementing interventions due to greater flexibility in visit timing and higher patient volume.[34] With the backdrop of a high prevalence of housing instability among ED patients, our results suggest the potential importance of considering information not only about a patient's housing status, but potentially about their key social relationships to better assess and address vulnerability to homelessness.[18–20] Our findings may be particularly important to consider for ED-based substance use interventions, such as screening, brief intervention, and referral to treatment (SBIRT) approaches. Especially given observed mixed results of ED SBIRT in reducing patient drug use, more research is needed on potential modifications to increase its effectiveness, such as whether there may be a benefit to concurrently assessing and addressing patients' intersecting challenges with housing and social relationships.[35,36]

The salience of social relationships in the lives of patients who frequent the ED, some of whom are homeless, is exemplified in the success of in-depth case management interventions to decrease ED use and improve housing stability.[37] While few, though relatively successful, interventions to date have attempted to explicitly assist ED patients with their housing, social needs screening in health care settings including EDs is an area of growing interest, with recent proliferation of screening tools.[38–40] For example, the Centers for Medicare & Medicaid Services developed the Accountable Health Communities Health-Related Social Needs Screening Tool, a multi-dimension screener that includes 2–4 questions each on housing insecurity, social supports, and substance use, which has been used and studied in both clinic and ED settings.[34]

Our findings about limitations in existing social relationships among ED patients experiencing homelessness also speak to the potential role of peer navigator programs. Some EDs have employed peer navigators who not only screen patients for substance use and provide information and referrals to treatment, but also provide social and emotional support.[41,42] Past ethnographic research discovered that ED staff themselves may form "networks of sociality" for patients experiencing homelessness, thus an ED visit may also fill a role of providing some form of "relationships."[43] One randomized controlled trial even found that when ED patients who were homeless received "compassionate care" from trained volunteers they had fewer future ED visits, which researchers postulated was due to their needs being better met.[44] Relatedly, several participants in our study described how emotional or physical trauma affected their lives, highlighting the importance of trauma-informed care when addressing homelessness and substance use among ED patients.[45]

An earlier study conducted at the same hospital as the current study found that 5% of ED patients who were not currently homeless entered a homeless shelter within a year of their ED visit, indicating the possible utility of the ED as a site for homelessness prevention.[46]

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Our current study contributes a more detailed understanding of the common threads, like complex social relationships, that link substance use and homelessness, which may inform future ED-based homelessness prevention interventions. For example, our finding that "help is there until it's not" suggests that ED patients with heavy use of drugs or alcohol who are living doubled up with friends and family may need additional support to help stabilize those relationships and/or assist them in finding independent housing. However, we also note that our themes centered at the individual and interpersonal levels are influenced by larger structural forces including poverty, criminalization of drug use, and inadequate social safety net funding (themselves driven by factors including structural racism) that are known to impact relationships, health outcomes, access to housing, and much more.[47–50]

This study has a few limitations. First, interviews did not include specific questions about the role of social relationships in the intersection of homelessness and substance use. However, social relationships emerged organically as a frequently discussed topic in the interviews, highlighting their salience. Also, we note that our study elicited primarily negative observations about participants' lives and their social relationships. We do not wish to discount the strengths of our study participants including, in some cases, the positive roles that social relationships played in their lives. We suspect that being in an ED setting, along with using an interview guide that focused on the experience of having recently become homeless, contributed to the negative valence of the results. Further, given the challenges of reaching people after the initial interview, we did not conduct member checking (participant validation of themes). Future research should specifically seek to examine the potentially positive contributions of social relationships as they pertain to substance use and homelessness.

Conclusion

The results of this qualitative interview study shed light on the multidimensional role of social relationships within the complex interactions between substance use and homelessness. Further research is warranted on how ED-based interventions for substance use can best assess and address the interplay of patients' social relationships and homelessness.

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REFERENCES

1. Doran KM, Rahai N, McCormack RP, et al. Substance use and homelessness among emergency department patients. Drug Alcohol Depend. 2018;188:328–333. [PubMed: 29852450]
2. McCormack RP, Hoffman LF, Norman M, Goldfrank LR, Norman EM. Voices of homeless alcoholics who frequent Bellevue Hospital: a qualitative study. Ann Emerg Med. 2015;65:178–186.e6. [PubMed: 24976534]

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3. Mabhala MA, Yohannes A, Griffith M. Social conditions of becoming homelessness: qualitative analysis of life stories of homeless peoples. Int J Equity Health. 2017;16:150. [PubMed: 28830515]
4. Hamilton AB, Poza I, Washington DL. "Homelessness and trauma go hand-in-hand": pathways to homelessness among women veterans. Women's Health Issues. 2011;21:S203–209. [PubMed: 21724142]
5. Ross-Houle K, Venturas C, Bradbury A, Porcellato L. An exploration of the role of alcohol in relation to living situation and significant life events for the homeless population in Merseyside, UK. Alcohol Research UK. 2017.
6. Fazel S, Khosla V, Doll H, Geddes J. The prevalence of mental disorders among the homeless in western countries: systematic review and meta-regression analysis. PLoS Med. 2008;5:e225. [PubMed: 19053169]
7. Center for Behavioral Health Statistics and Quality. Results from the 2019 National Survey on Drug Use and Health: Detailed tables. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2020. https://www.samhsa.gov/data/. Published August 2020. Accessed February 6, 2021.
8. Henwood BF, Padgett DK, Smith BT, Tiderington E. Substance Abuse Recovery After Experiencing Homelessness and Mental Illness: Case Studies of Change Over Time. J Dual Diagn. 2012;8:238–246. [PubMed: 22962547]
9. Padgett DK, Henwood B, Abrams C, Drake RE. Social relationships among persons who have experienced serious mental illness, substance abuse, and homelessness: Implications for recovery. Am J Orthopsychiatry. 2008;78:333–339. [PubMed: 19123752]
10. Pahwa R, Smith ME, Yuan Y, Padgett D. The Ties That Bind and Unbound Ties: Experiences of Formerly Homeless Individuals in Recovery From Serious Mental Illness and Substance Use. Qual Health Res. 2019;29:1313–1323. [PubMed: 30499369]
11. Shinn M, Knickman JR, Weitzman BC. Social relationships and vulnerability to becoming homeless among poor families. American Psychol. 1991;46:1180–1187.
12. Padgett DK, Smith BT, Choy-Brown M, Tiderington E, Mercado M. Trajectories of Recovery Among Formerly Homeless Adults With Serious Mental Illness. Psychiatr Serv. 2016;67:610–614. [PubMed: 26876661]
13. Hopper K, Jost J, Hay T, Welber S, Haugland G. Homelessness, severe mental illness, and the institutional circuit. Psychiatr Serv. 1997;48:659–665. [PubMed: 9144820]
14. Johnson TP, Fendrich M. Homelessness and drug use: evidence from a community sample. Am Journal Prev Med. 2007;32:S211–218. [PubMed: 17543713]
15. Metraux S, Cusack M, Byrne TH, Hunt-Johnson N, True G. Pathways into homelessness among post-9/11-era veterans. Psychol Serv. 2017;14:229–237. [PubMed: 28481609]
16. Vandyk AD, Harrison MB, VanDenKerkhof EG, Graham ID, Ross-White A. Frequent emergency department use by individuals seeking mental healthcare: a systematic search and review. Arch Psychiatr Nurs. 2013;27:171–178. [PubMed: 23915694]
17. Doran KM, Raven MC, Rosenheck RA. What drives frequent emergency department use in an integrated health system? National data from the Veterans Health Administration. Ann Emerg Med. 2013;62:151–159. [PubMed: 23582617]
18. Doran KM, Kunzler NM, Mijanovich T, et al. Homelessness and other social determinants of health among emergency department patients. J Soc Distress Homeless. 2016;25:71–77.
19. Malecha PW, Williams JH, Kunzler NM, Goldfrank LR, Alter HJ, Doran KM. Material Needs of Emergency Department Patients: A Systematic Review. Acad Emerg Med. 2018;25:330–359. [PubMed: 29266523]
20. Bisgaier J, Rhodes KV. Cumulative adverse financial circumstances: associations with patient health status and behaviors. Health Soc Work. 2011;36:129–137. [PubMed: 21661302]
21. Salhi BA, White MH, Pitts SR, Wright DW. Homelessness and Emergency Medicine: A Review of the Literature. Acad Emerg Med. 2018;25:577–593. [PubMed: 29223132]
22. Anderson ES, Hsieh D, Alter HJ. Social Emergency Medicine: Embracing the Dual Role of the Emergency Department in Acute Care and Population Health. Ann Emerg Med. 2016;68(1):21–25. [PubMed: 26921967]

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23. Anderson ES, Lippert S, Newberry J, Bernstein E, Alter HJ, Wang NE. Addressing Social Determinants of Health from the Emergency Department through Social Emergency Medicine. West J Emerg Med. 2016;17(4):487–489. [PubMed: 27429706]
24. Doran KM, Ran Z, Castelblanco D, Shelley D, Padgett DK. “It Wasn’t Just One Thing”: A Qualitative Study of Newly Homeless Emergency Department Patients. Acad Emerg Med. 2019;26:982–993. [PubMed: 31418514]
25. Padgett D Qualitative Methods in Social Work Research. 3rd ed. Los Angeles, CA: Sage Publications; 2017.
26. Smith PC, Schmidt SM, Allensworth-Davies D, Saitz R. A single-question screening test for drug use in primary care. Arch Gen Intern Med. 2010;170:1155–1160.
27. Smith PC, Schmidt SM, Allensworth-Davies D, Saitz R. Primary care validation of a single-question alcohol screening test. J Gen Intern Med. 2009;24:783–788. [PubMed: 19247718]
28. Patton M Qualitative Research and Evaluation Methods. 3rd ed. Thousand Oaks, CA: Sage Publications; 2002.
29. Dedoose Version 8.0.42 Web Application for Managing, Analyzing, and Presenting Qualitative and Mixed Method Research Data. Los Angeles, CA: SocioCultural Research Consultants, LLC; 2018.
30. Eyrich-Garg KM, Cacciola JS, Carise D, Lynch KG, McLellan AT. Individual characteristics of the literally homeless, marginally housed, and impoverished in a US substance abuse treatment-seeking sample. Soc Psychiatry Psychiatr Eidemiol. 2008;43:831–842.
31. Hawkins RL, Abrams C. Disappearing acts: the social networks of formerly homeless individuals with co-occurring disorders. Soc Sci Med. (1982) 2007;65:2031–2042. [PubMed: 17706330]
32. Booth BM, Sullivan G, Koegel P, Burnam A. Vulnerability factors for homelessness associated with substance dependence in a community sample of homeless adults. Am J Drug Alcohol Abuse. 2002;28:429–452. [PubMed: 12211359]
33. Doran KM, Raven MC. Homelessness and Emergency Medicine: Where Do We Go From Here? Acad Emerg Med. 2018;25:598–600. [PubMed: 29455453]
34. Rojas Smith L, Haber S, Armstrong Brown J, et al. Accountable Health Communities (AHC) Model Evaluation First Evaluation Report. Center for Medicare & Medicaid Innovation;2020.
35. Young MM, Stevens A, Galipeau J, et al. Effectiveness of brief interventions as part of the Screening, Brief Intervention and Referral to Treatment (SBIRT) model for reducing the nonmedical use of psychoactive substances: a systematic review. Syst Rev. 2014;3:50. [PubMed: 24887418]
36. Barata IA, Shandro JR, Montgomery M, et al. Effectiveness of SBIRT for Alcohol Use Disorders in the Emergency Department: A Systematic Review. West J Emerg Med. 2017;18(6):1143–1152. [PubMed: 29085549]
37. Moe J, Kirkland SW, Rawe E, et al. Effectiveness of Interventions to Decrease Emergency Department Visits by Adult Frequent Users: A Systematic Review. Acad Emerg Med. 2017;24(1):40–52. [PubMed: 27473387]
38. Formosa EA, Kishimoto V, Orchanian-Cheff A, Hayman K. Emergency department interventions for homelessness: a systematic review. CJEM. 2021;23(1):111–122. [PubMed: 33683611]
39. Walter LA, Schoenfeld EM, Smith CH, et al. Emergency department–based interventions affecting social determinants of health in the United States: A scoping review. Acad Emerg Med. 2021;00:1–9.
40. Social Interventions Research & Evaluation Network. Social Needs Screening Tool Comparison Table. The Regents of the University of California; 2021. https://sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison. Published 2019. Accessed June 5, 2021.
41. Welch AE, Jeffers A, Allen B, Paone D, Kunins HV. Relay: A Peer-Delivered Emergency Department–Based Response to Nonfatal Opioid Overdose. Am J Public Health. 2019;109:1392–1395. [PubMed: 31415200]
42. Goedel WC, Marshall BDL, Samuels EA, et al. Randomised clinical trial of an emergency department-based peer recovery support intervention to increase treatment uptake and reduce recurrent overdose among individuals at high risk for opioid overdose: study protocol for the navigator trial. BMJ Open. 2019;9:e032052.

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43. Salhi BA. Who are Clive's friends? Latent sociality in the emergency department. Soc Sci Med. 2020;245:112668. [PubMed: 31739143]
44. Redelmeier DA, Molin JP, Tibshirani RJ. A randomised trial of compassionate care for the homeless in an emergency department. Lancet. 1995;345:1131–1134. [PubMed: 7723543]
45. Clark HW, Power AK. Women, Co-occurring Disorders, and Violence Study: A case for trauma-informed care. J Subst Abuse Treat. 2005;28:145–146. [PubMed: 15780543]
46. Doran KM, Johns E, Schretzman M, et al. Homeless Shelter Entry in the Year After an Emergency Department Visit: Results From a Linked Data Analysis. Ann Emerg Med. 2020;76(4):462–467. [PubMed: 32331843]
47. Link BG, Phelan JC. Conceptualizing Stigma. Annu Rev Sociol. 2001;27:363–385.
48. Phelan JC, Link BG, Tehranifar P. Social conditions as fundamental causes of health inequalities: theory, evidence, and policy implications. J Health Soc Behav. 2010;51 Suppl:S28–40. [PubMed: 20943581]
49. Link BG, Phelan J. Social Conditions As Fundamental Causes of Disease. J Health Soc Behav. 1995:80–94. [PubMed: 7560851]
50. Ahern J, Stuber J, Galea S. Stigma, discrimination and the health of illicit drug users. Drug Alcohol Depend. 2007;88:188–196. [PubMed: 17118578]

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Excerpted questions

Can you tell me about the most recent time you became homeless?

Probe: How long have you been living in the shelter or on the street?

Probe: Where were you staying right before you became homeless?

Have you ever had other times in your life where you've been homeless? Can you tell me about those?

Probe: How were those past times you've been homeless resolved?

What do you think led to your becoming homeless this time?

Before you became homeless this time, did you turn to any organization, person, or place for help?

Can you tell me about your use of alcohol and/or drugs?

Probe: How often/how much do you drink or use drugs?

Probe: What types of drugs do you use [if applicable]?

Probe: How does your use of alcohol or drugs affect your life?

How do you think your use of alcohol or drugs influenced your becoming homeless, if at all?

Has your being homeless changed your use of alcohol or drugs?

Probe: For example, sometimes people tell us that they [drink more / use more drugs] when they are homeless because they are bored or because other people are doing it, and some other people have told us that they [drink / use drugs] less because they have less money.

FIGURE 1.

Interview guide questions

Selected interview guide questions most relevant to the current paper are excerpted from the complete interview guide used for the larger study. While the interview guide was not designed specifically to examine the role of social relationships, participant discussions of social relationships emerged strongly and organically in the inductive analysis of interview transcripts.

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Table 1.

Participant Characteristics (n=25)

	n(%)
Gender	
Male	23 (92)
Female	2(8)
Race/Ethnicity	
Hispanic/Latino	10 (40)
Black	7(28)
White	8 (30)
Asian	2(8)
Age, mean (SD), years	48 (11.5)
Age, range, years	20–66
Homelessness history	
First episode	8 (32)
Not first episode	17 (68)
Substance use history[a]	
Current drug use	13 (52)
Current unhealthy alcohol use	17 (68)
Former alcohol or drug use only	5(20)
Reason for ED visit	
Substance use related	6(24)
Not substance use related	19 (76)

[a.]Participants responded to screening questions about alcohol or drug use within the past year. Unhealthy alcohol use was defined as at least one day of binge drinking. Drug use was defined as at least one day of using any drug, including marijuana?[24,25]

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Table 2.

Summary of Themes

Theme and Subthemes	Brief Description	Illustrative Quote
Theme 1: Substance use can create strain in relationships *1A: "I am on my own"* *IB: "I'm just being judged"*	Substance use, through various mechanisms, may strain social relationships and participants were less likely to call on people for help who they felt estranged from or judged by	"I have an older brother and older sister...They're on a straight and narrow, you know? *Interviewer:* Are you in touch with them? Just through text messages...and...that took years...they don't like the lifestyle I live, you know?" (Participant 8; man in his 40s)
Theme 2: Help is there until it's not *2A: "We had a fall out"* *2B: Loss of a loved one*	The help that social relationships, especially those strained by substance use, could provide was sometimes limited or inaccessible	"After we came home from celebrating, I felt like going back outside to have more drinks...When I come back at 4:30 in the morning, and I put the key in, there's a latch on the door... [They said] 'take your stuff out of the house...You lied to us. You said you were going out for a half hour.'" (Participant 25; man in his 50s)
Theme 3: Social relationships can create challenges contributing to substance use *3A: Early exposure* *3B: Coping with relationship stress* *3C: I want nothing to do with these people "*	Participants reported that social relationships sometimes contributed to the initiation or continuation of substance use, which led some participants to avoid interactions with certain people	"The people that I used to hang out with, they're still upstairs [in the shelter]. It's a distraction. Because if I end up and be back friends or anything with these people then I'm gonna end up in the same predicament that I'm in right now. So, I mean to say is people, places, and things that I should stay away from, stay away from the same people, the same places, and - and don't pick up the same things." (Participant 64; man in his 40s)
Theme 4: Reciprocal relationship of substance use and isolation *4A: " I have lost everything"* *4B: "I never fit in"*	Isolation was cited as both a contributor to and a consequence of substance use, and isolation was further exacerbated by homelessness	"Once I begin using, money has no value. Like a normal person would say, 'Look, you - you gotta pay your rent.' You know what I mean? 'The electric bill's due,' I don't do that...To the point where I sell my cellphone because this guy wants a Galaxy S8...my lifeline to the world and everyone who could possibly help me, there you go, you know." (Participant 60; man in his 40s)