

Substance Use Disorder in People Experiencing Homelessness

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Disclosures

No conflicts of interest or relationships to disclose

Data presented in this presentation offer a limited glimpse of health inequities that exist within a larger social context. Racism, not race, creates and perpetuates health disparities.

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Learning Objectives

1. Describe current epidemiology of substance use and HIV among people experiencing homelessness (PEH)
2. Identify 2 updates in treatment for substance use disorder during the COVID19 pandemic
3. Describe 2 innovative models of care for treatment of substance use among people experiencing homelessness

Epidemiology

Definition of Homelessness

- 1987 Stewart B. McKinney Homeless Assistance Act
 - A person who lacks a fixed, regular, and adequate nighttime residence (literal homelessness)
 - Person who lives in a shelter or a place not designed for human habitation (imminent homelessness)
- 2009 HEARTH Act
 - Persons at imminent risk of housing loss < 2 weeks
 - People fleeing domestic violence

Point in Time Counting (Point Prevalence)

- Used by U.S. Department of Housing and Urban Development (HUD) for funding purposes
 - First counts began in Jan 2005
 - An unduplicated count on a single night of people in a community experiencing homelessness
 - Includes both sheltered and unsheltered people



Period Prevalence

- HMIS – state and local government records of all PEH
- HOMES – VA centralized data for VA-funded homeless programs
- Annual Homeless Assessment Report to Congress (AHAR)
 - Includes the point in time count and HMIS database

**HOMELESS
MANAGEMENT
INFORMATION
SYSTEM**

The 2020 Annual Homeless
Assessment Report (AHAR)
to Congress



Homelessness is increasing



- 580,000 PEH in 2020
 - Increased by 2% from 2019
 - 40% slept unsheltered
 - 21% were chronically homeless
 - 39% of sheltered PEH are women
 - Families represent 30% of PEH in the U.S
- Black/African Americans
 - Represent 12% of the U.S. population
 - Account for 39% of PEH and 53% of homeless families



Health Consequences

- Life expectancy is 42-52 years old
- Mortality Rate is 3.5x higher than general population
- Unsheltered PEH have 3x higher mortality rate than sheltered and 10 times higher than general population
- “Trimorbidity” of medical dx (HIV), psychiatry dx, and substance use disorder had 4x risk of mortality than PEH without these conditions

HIV in PEH



- 3-11% of PEH are living with HIV (compared to 0.4% of general population)
- Majority of PEH have good ART adherence -> improved by once-daily medication regimens

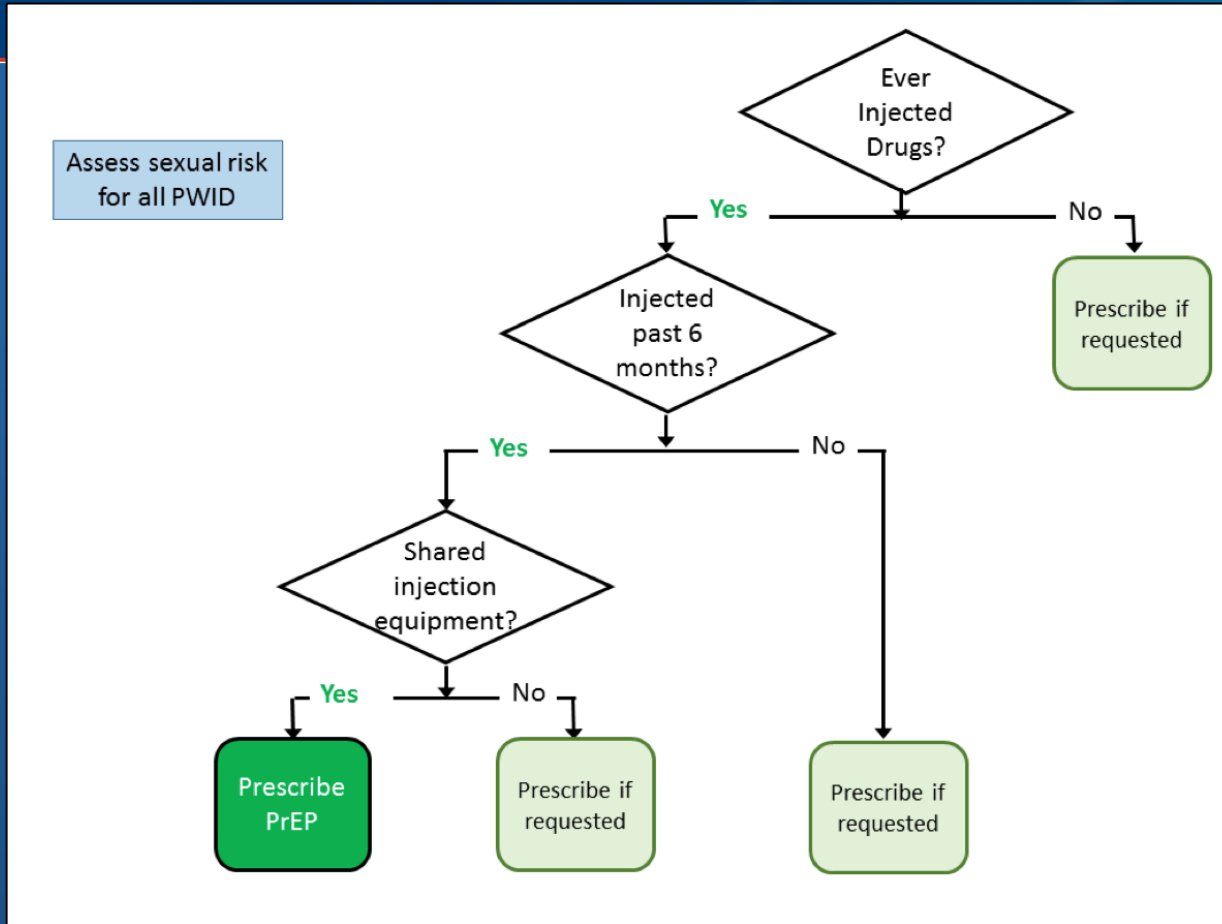


- Homelessness is still a risk for uncontrolled HIV
 - Longitudinal study in Vancouver, Canada
 - 922 PLWH
 - Odds of HIV viral suppression decreased by 30% for every 6 months a person is homeless

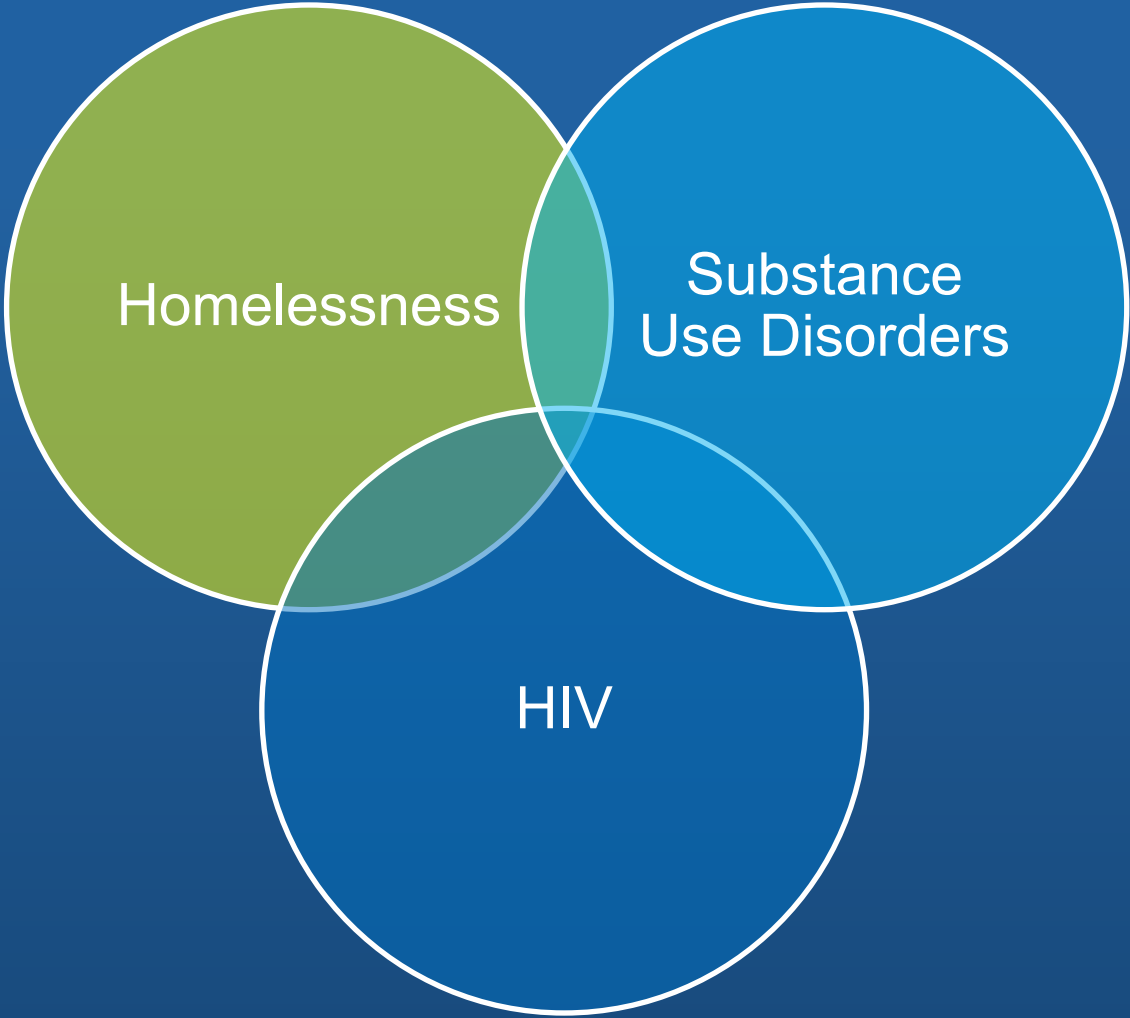
Substance Use Disorders in PEH

- 68-81% of PEH have a tobacco use disorder and 30-60% have an alcohol use disorder
 - 10x higher rate of alcohol related mortality than general population
- 20-60% PEH with a drug use disorder
 - One half of deaths among PEH are related to substance use
 - Drug overdose is leading cause of death in PEH (1/3 deaths in those < 45 years old)

HIV Prevention: Injection Drug Use



- TDF/FTC remains the only guideline recommended medication for HIV prevention in people who inject drugs (PWID)



Summary

- The numbers of PEH is increasing, especially unsheltered individuals
- Health consequences, HIV, and substance use are all higher in PEH than the general population
- Drug overdose deaths are the number one cause of death among PEH

Treatment Strategies

Evidence-Based Treatment

- Opioid Use Disorder: buprenorphine, methadone, naltrexone
- Alcohol Use Disorder: naltrexone, acamprosate, gabapentin, topiramate
- Tobacco Use Disorder: NRT, varenicline, bupropion
- Stimulant Use Disorder*: bupropion, naltrexone, mirtazapine, topiramate, prescribed stimulants

- PEH have lower rates of retention in SUD care and receive less medication treatment than housed people
- Consider long-acting IM medication (buprenorphine, naltrexone) options

COVID-19 OUD Flexibility

- Methadone/OTP
 - Prior to COVID: daily dosing for minimum of 30-90 days
- Post COVID:
 - Stable patients can receive 28 days of take homes
 - “Stable” for at least 60 days, negative UDS
 - Less-Stable patients receive 14 days of take-homes
 - In txt for at least 30 days, negative UDS
 - OTPs can make own judgment on “carries” for less-stable patients
 - Home deliveries ok

COVID-19 OUD Flexibility

- Office-based buprenorphine
 - New patients can be started on buprenorphine via telephone call only (no video or in-person visit needed)
- X-Waiver Changes
 - Training requirement no longer needed
 - 30-patient limit (unless training completed)
 - Apply via SAMHSA

[\(DEA-DC-022\)\(DEA068\) DEA SAMHSA buprenorphine telemedicine \(Final\) +Esign.pdf \(usdoj.gov\)](#)

[FAQs About the New Buprenorphine Practice Guidelines | SAMHSA](#)



OD Flexibility: Outcomes

Original Investigation

March 1, 2022

Association Between Increased Dispensing of Opioid Agonist Therapy Take-Home Doses and Opioid Overdose and Treatment Interruption and Discontinuation

Tara Gomes, PhD^{1,2,3,4}; Tonya J. Campbell, MPH¹; Sophie A. Kitchen, MSc²; [et al](#)

» [Author Affiliations](#) | [Article Information](#)

JAMA. 2022;327(9):846-855. doi:10.1001/jama.2022.1271

- Increased take home doses in patients on methadone/bup in Ontario, Canada
- 16,000 pts on methadone, 4,400 pts on bup/nx
- Lower risk of opioid overdose, treatment discontinuation and treatment interruption

Engaging PLWH/PWID in Care

Systematic review of HIV treatment adherence in people who inject drugs, which included 20 studies

Factors enabling ART adherence included:

- Substance use treatment, including MOUD
- Self-efficacy, empowerment and social support
- Stable housing
- Health insurance
- Trust in providers and good patient-provider relationships
- Accessibility of health care services
- Directly administered ART

Engaging PEH in care

- Scoping Review of OUD txt for PEH
 - 60 articles, 43 descriptive, 17 intervention trials
 - PEH experience more barriers to txt, access inpatient/withdrawal txt more than pharmacotherapy
 - Pharmacist outcomes do not differ between PEH and non-PEH
- Take home points
 - Clinics should adopt flexible policies to improve engagement among PEH
 - Housing may improve OUD txt outcomes

Summary

- Same recommendations for evidence-based treatment for PEH as general population
- COVID-19 pandemic relaxed guidelines around OUD that has allowed for innovation and flexibility in treatment
- Preliminary studies have showed benefit of take-home dosing and no increase in overdose rates


Novel Programs in SUD treatment

REVIEW



Open Access



Early innovations in opioid use disorder treatment and harm reduction during the COVID-19 pandemic: a scoping review

Noa Krawczyk^{1*} , Adetayo Fawole², Jenny Yang³ and Babak Tofighi⁴

Scoping review, 25 studies

- 1) ↑ in telehealth services
- 2) ↑ take-home allowances for methadone/bup
- 3) Expanded uptake of long acting MOUD 
- 4) Home delivery of services 
- 5) Increased outreach

Co-located Engagement Strategies

- Integrating PrEP in SSP for women
 - Philadelphia, WWID
 - 95 Women (70% transactional sex, 63% unhoused, 46% shared needles)
 - 63 Women received TDF/FTC, 68% at 12 weeks, 37% at 24 weeks
- Co-located, low barrier services
 - Seattle, unhoused women
 - Community center/SHE Clinic
 - 49% ↑ to be prescribed PrEP
 - 44% ↑ in MOUD prescriptions

Table: Utilization of HIV harm-reduction services among 76 women accessing day-shelter services in north Seattle, by care at SHE Clinic

Characteristics	SHE Clinic patients (n=41)	SHE Clinic non-adopters (n=35)	p-value
Recent STI screening	34 (83)	22 (63)	0.03
Recent STI treatment	13 (32)	3 (9)	0.06
Opioid replacement*	21/36 (58)	3/22 (14)	0.001
PrEP prescription*	18/37 (49)	0/22 (0)	<0.001

*calculated for those eligible for intervention (OUD or HIV negative)

Mobile Van Services

- Youth Opioid Recovery Support Team
 - 2-person mobile team
 - RN and LCSW
 - Point of Care Urine Testing
 - Home delivery of extended-release naltrexone or buprenorphine



Tele-Health for SUD Txt

- Harm Reduction Primary Care Program
 - Urban and Rural Clinics in New York State
 - Partner with Syringe Service Program (SSP) – 32/55 referrals led to telemedicine buprenorphine
- Street Based Mobile Clinic “The Spot”
 - Baltimore, MA
 - Txt 150 patients in 1 year. 90% black men, 80% engaged in care at 1 year

Tele-Health for SUD Txt

- Low barrier telemedicine consult line
 - Los Angeles County, CA, 1 year time period
 - 713 phone calls, 557 patients, 50% PEH
 - 90% of prescriptions for bup-nx

TABLE 2. Number of Calls, Caller Location, Patients, and Medications Prescribed Via the Telephone Consultation Service From March 2020 to March 2021

Calls	713 Total calls 142 Calls from patients calling more than once 14 Calls not involving patients
Caller location	338 Outreach 139 County jail 132 Ambulatory clinic 57 Patient calls 29 Other 18 Hospital/urgent care
Patients	557 Total patients 369 Patients with documented medication services 188 Patients without documented medication services
Medication	662 Total medications prescribed 589 Buprenorphine/naloxone 35 Nicotine replacement therapy 18 Oral naltrexone 12 Buprenorphine monotherapy 1 Disulfiram

Summary

- Health consequences, HIV, and substance use are all higher in PEH than the general population
- Same recommendations for evidence-based medication for PEH as general population -> increase medication prescriptions and decrease barriers to engagement
- Several innovative programs exist to support PEH with SUD including co-located care, mobile care and telemedicine

Conclusions

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