Addressing the Drug War and Overdose Crisis **Harm Reduction Housing First**

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ABSTRACT

People who use drugs (PWUD) are disproportionately represented among persons who are unsheltered or lack stable housing. The absence of safe and consistent housing worsens substance use and substance use disorders, often leading to fatal overdose events and other intersecting health conditions, such as endocarditis and sepsis. Many housing assistance programs have traditionally excluded PWUD from accessing benefits, even while simultaneously acknowledging that relapse is a symptom of substance use disorder.

Since the 1980s, PWUD have received vital support from syringe service programs (SSPs) and other harm reduction organizations—organizations that are commonly led and staffed by PWUD or people who have formerly used drugs and center their lived experience. These organizations strive to reduce the harms of drug use and frequently make referrals to healthcare and social supports which include housing services.

The purpose of this project is to embed a Critical Time Intervention for Rapid Rehousing model into the Queen City Harm Reduction (QCHR) SSP to provide low barrier housing assistance to PWUD, and to engage members of the harm reduction community in determining how to meet the needs of unsheltered PWUD while simultaneously identifying causes of living unsheltered and barriers to accessing housing services among PWUD in the American South.

Wellness Center & safe haven for people who use drugs

Peer Distribution (pop-up)

INTRODUCTION

Safe and stable housing is a structural determinant of substance use, relapse, and overdose. Persons who live in unsheltered locations tend to have higher rates of substance use, including opioid use, which may make it more difficult for them to access emergency shelter and affordable housing. Persons who live in unsheltered locations tend to have higher rates of substance use which may make it more difficult for them to access housing and healthcare supports. Additionally, living in unsheltered locations can cause or worsen a substance use disorder (SUD), worsen SUD treatment outcomes, and increase risk of death. People who use drugs (PWUD) that lack stable housing are more likely to experience the harms associated with drug use. National studies have demonstrated that people who are homeless are significantly more likely to experience an opioid overdose. Unhoused PWUD are more likely to score higher on measures of addiction severity. Even after controlling for HIV infection and drug use patterns, unstable housing is a predictor of all-cause mortality for PWUD. Additionally, persons with criminal convictions for certain drug offenses, many of whom are disproportionately persons of color, are barred from some housing assistance programs, thus compounding inequities created by racial disparities in punitive criminal-legal drug enforcement. Moreover, safe and stable housing is necessary to improve well-being and treatment outcomes for PWUD. People who remain unsheltered are less likely to stay in and complete substance use disorder treatment.

Housing First programs were developed as an alternative emphasizing the need to house people first – before asking them to change behaviors (such as substance use). One type of Housing First program, which was created to address the needs of persons with serious mental illness, is Critical Time Intervention for Rapid Rehousing (CTI RRH). CTI RRH is a time-limited, evidence-based, person-centered model that employs a case manager to systematically engage persons in defining goals within 1-3 domains of self-improvement (such as financial, education, health, and more) while simultaneously working to find the individual permanent housing and connecting the individual with existing services and resources that will help the individual maintain their housing and improve their health. While the success of CTI RRH has led to its adoption by some state and local governments, it has yet to be tailored in its implementation to meet the needs of PWUD, with some state governments, like North Carolina, only willing to pay for CTI RRH services that are provided to persons with a primary diagnosis of serious mental health condition (not SUD).

METHODS AND MATERIALS

Training: QCHR staff and project contractors were all trained in CTI RRH through the Center for Advancement of Critical Time Intervention in New York City. A co-founder, and LSW, provided training facilitation and consultation for CTI RRH implementation tailored to PWUD. CTI RRH consist of 4 phases:
Pre-Phase: a contemplative stage and/or the time in which ppl collect ID's and other materials needed to apply for housing
Phase 1: "Transition" is when the participant is engaged with the case manager who assess the persons strengths, a housing stability plan is established, emotion support and linkage to support services if gauged and offered upon need, and the person is moved into alternative housing
Phase 2: "Try Out" is a continuous assessment of participant strengths and needs. This helps the case manager evaluate protective factors and supports that will either need to be strengthened or sustained. This will enable a person's success at achieving long term shelter and better health outcomes.
Phase 3: "Transfer" is when the case-manager and participant begin to let go of one another and the case manager assumes the role of a friendly guide than manager. The case manager ensures that strong connection between the participant and local communities' resources are secure. The participant is engaged with socio-economic that support upward mobility and wellbeing.
Safety Net Contingency: If participants need additional support after 6 months, needs are assessed case by case to determine what supplemental support still need to be provided and for how long. If a person has successfully completed the CTI RRH program and after several months has an emergent need, QCHR will step in to remedy the gaps that may include eviction prevention, healthcare support, and other interventions that not only helps the individual in real-time, but also lets them know that they have an arsenal of support that will meet their emotional, physical, and mental needs. It helps remind them that their life matters, that they are worthy.
Subject matter: PWUD who are justice involved, chronically homeless, and/or engaged in sex work are the focus group for service provision.
Service hub: Queen City Harm Reduction is a syringe service program (SSP) in Charlotte, NC. To most effectively reach the priority population this project is centered on, utilizing an SSP offers a safe and familiar space for PWUD to receive critical support services and linkages to care.
Data Collection: Google forms were developed for participant meetings, intakes, recovery capitol assessment, and housing status change forms.
The forms were developed to be mindful of participants that have been exposed to intense screening protocols. They populate critical real-time data, while offering streamlined ease for both the participant and case-manager.
Voucher supplements: support housing assistance (applications, security/move-in deposits, and monthly rent for 6 months), utility and transport aid, and food/nutrition assistance.
Harm reduction Housing Team: consists of a people with living and lived experience with substance use, a certified prevention specialist, a master's in social work, a professor and researcher, and a master's in public health.
The team will expand to include a licensed clinical social worker, and a peer support specialist and linkage navigator.
Team Partners: Mecklenburg County Government, NC Division of Health and Human Services, Alliance Health, private landlords, housing management companies, public defenders, and local healthcare organizations.

DATA DEVELOPMENTS

Current Living Situation:
At program start, 77% of participants resided on the streets, in a tent, and/or encampment
13 PWUD are housed and in CTI RRH.
7 PWUD are in Phase 1, 2 PWUD are in Phase 2 , and 4 PWUD are in Phase 3.

Total Catchment ≈ 30 PWUD	Pre-Program Intake Baseline	From 9/1/23 - 11/30/23 (3-month duration)
Employment status	77% unemployed	30% found FT work, 17% found PT work, 7%received a pay increase, 3% lost their job
Benefits (SNAP, Medicaid, SSI/SSDI, WIC, etc.)	73% have preexisting benefits	53% received confirmation of new enrollment
Legal history (including evictions)	53% are justice involved	3% (1 person) has accrued new charged
Overdose events	14% reported a history of overdose	0 overdose event reported
Health status/comorbidities (SUD, HIV, HCV, SMI, etc.)	40% reported preexisting diagnoses	No changes in health status. *Preliminary trend of a reduction in drug use.

DISCUSSION

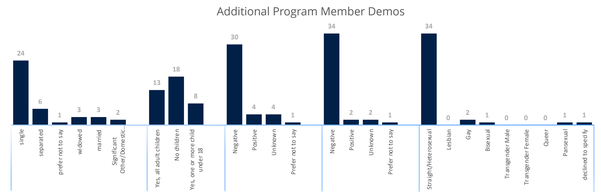
Current findings illustrate substantial racial disparities among PWUD experiencing chronic homelessness and barriers to housing. When looking at data from QCHR's syringe service program (SSP) there is consistently more PWUD that are White enrolled than PWUD that are Black. Presently, the demographics from this Harm Reduction Housing pilot have consistently shown that PWUD who are Black are experiencing greater barriers to housing and residing in unsustainable environments than most other races and ethnicities.

When PWUD have been housed and begin moving through CTI RRH, employment rates and healthcare retention improve, and overdose events and fatalities are null. As the majority of harm reduction housing participants are people of color who are justice involved, utilization of CTI RRH models that are embedded into SSPs for PWUD appears to be an evidence-based intervention that – with more research – can address racial disparities and reduce substance misuse, overdose fatalities, recidivism, and associated comorbidities (i.e., substance use disorder, severe mental illness (SMI), HIV, etc.) among historically marginalized populations.

Traditional housing organizations and section 8 authorities do not accept people who have not abstained from drug use. All participants engaged in this pilot have been sheltered through alternative management companies and private landlords who look past stigmatizing biases and do not discriminate against PWUD who are experiencing homelessness and justice involvement. This highlights critical policy considerations when it comes to how our government supports housing first and funds housing organizations aimed to support people with SMI and SUD.

Furthermore, Pre-phase CTI RRH highlights a grave disconnect between PWUD and healthcare and socio-economic support services. Eligible participants of the Harm Reduction Housing program have required the case manager and supportive staff to navigate needs-based (and evidence-based) linkage to over half of the participants for a variety of benefits and aids that support healthier outcomes for PWUD. This points directly to a serious gap in comprehensive services and is often the difference between life and death among historically marginalized people.

People who do not abstain from drug use are still worthy of human connection and deserve to receive critical shelter services that will improve their mortality and overall health outcomes. How does our nation move forward in a meaningful way that acknowledges Housing 1st as just that – housing that comes first. Our nation and its government can – and should - support states and territories in innovative, practical ways that address racial disparities that continue to place property before people.



CONCLUSIONS

Housing is a human right. This pilot study highlights an urgent need for further research to explore CTI RRH as a viable model that effectively shelters historically marginalized people who use drugs (PWUD) and addresses racial and socio-economic disparities. By offering low barrier housing assistance through an SSP, preliminary successes unveil that mortality is sustained and individuals are more able to engage in healthcare and employment opportunities. Unpacking structural and social determinants that cause racial disparities will lead to understanding and newly forged solutions that proactively reduce homelessness, recidivism, and overdose fatalities. In addition to researching the efficacy of CTI RRH for PWUD, calls for action include policy reform that reduces current fiscal limitations and empowers fewer restrictions with federal and state housing monies; and more funding for initiatives that provide rapid rehousing to organizations that are not traditionally housing organizations. Lastly, technical assistance to states and territories implementing housing first interventions is critical and can address the overdose crisis and other syndemic conditions that perpetuate homelessness.

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References

1. 1 Richards J, Kuhn R. Unsheltered Homelessness and Health: A Literature Review. AJPM Focus. 2023;2(1):100043. doi:10.1016/j.focus.2022.100043
2. 2 Friesen E, Young S. Experiencing homelessness as a risk factor for negative treatment outcomes among individuals receiving outpatient treatment for opioid use disorder in the United States. Univ Tor Med J. 2021;98(2):56-62
3. 3 Tuten LM. A Comparison of Treatment Outcomes for Participants Receiving Reinforcement-Based Treatment (RBT) versus Participants Receiving RBT plus Recovery Housing (RBT + RH). Ph.D. University of Maryland, Baltimore. Accessed July 16, 2021.
4. 4 Zivanovic R, Milloy M, Hayashi K, et al. Impact of unstable housing on all-cause mortality among persons who inject drugs. BMC Public Health. 2015;15(1):106. doi:10.1186/s12889-015-1479-x
5. 5 Yamamoto A, Needleman J, Gelberg L, Kominski G, Shoptaw S, Tsugawa Y. Association between homelessness and opioid overdose and opioid-related hospital admissions/emergency department visits. Soc Sci Med 1982. 2019;242:112585. doi:10.1016/j.socscimed.2019.112585
6. 6 Buchholz JR, Malte CA, Calsyn DA, et al. Associations of Housing Status With Substance Abuse Treatment and Service Use Outcomes Among Veterans. Psychiatr Serv. 2010;61(7):698-706. doi:10.1176/ps.2010.61.7.698
7. 7 Rosenberg A, Groves AK, Blankenship KM. Comparing Black and White Drug Offenders: Implications for Racial Disparities in Criminal Justice and Reentry Policy and Programming. J Drug Issues.
8. 2017;47(1):132-142. doi: 10.1177/0022042616678614. Epub 2016 Dec 21. PMID: 28966392; PMCID: PMC5614457.
9. 8 Williams EP. Fair Housing's Drug Problem: Combatting the Racialized Impact of Drug-Based Housing Exclusions alongside Drug Law Reform. Harv CR-CLL Rev. 2019;54:769.
10. 9 Friesen E, Young S. Experiencing homelessness as a risk factor for negative treatment outcomes among individuals receiving outpatient treatment for opioid use disorder in the United States. Univ Tor Med J. 2021;98(2):56-62
11. 10 Tuten LM. A Comparison of Treatment Outcomes for Participants Receiving Reinforcement-Based Treatment (RBT) versus Participants Receiving RBT plus Recovery Housing (RBT + RH). Ph.D. University of Maryland, Baltimore. Accessed July 16, 2021.
12. 11 Center for Advancement of Critical Time Interventions. "CTI Model". https://www.criticaltime.org/cti- model/. Accessed July 11, 2023.
13. 12 Szalavitz M. Undoing Drugs: How Harm Reduction Is Changing the Future of Drugs and Addiction. Hachette Go; 2021.

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