Role of Housing in Drug User Health & Overdose Prevention

An unregulated drug supply, the trauma and chronic stress of homelessness, physical and mental health issues, and limited safe places to use drugs all contribute to higher risks of overdose for people experiencing homelessness (PEH).[1,2,3] Further, PEH lack access to "safe, adequate healthcare… with higher unmet needs and lower rates of access to a family doctor, resulting in significantly more hospitalizations and visits to emergency departments."[4]

Jim found that his drug use helped him cope with the day-to-day stress of homelessness because "when you're outside, all you… want is the time to go by." However, many of the shelters and housing programs Jim encountered required abstinence, presenting a high bar to entry. Once he was securely housed, Jim says that he didn't have the desire to use drugs every day, especially not to the same degree as when he was living outside.

GEORGE

George feels that having stable housing not only contributed to his overall health but was responsible for keeping him alive. "It gave me a safe place to use, and being in that safe place, I always had Narcan," George says. A supportive and non-judgmental relationship with his case manager was also crucial. "The first time I received [naloxone] was from my case manager. If I hadn't received it from him and then walked my ex-girlfriend through how to use it, I'd be dead." George explains:

> *The first time I was ever brought back with naloxone by my ex, we were in my apartment, and it was 15 minutes before I had a probation appointment in Kentucky and my case manager(CM) was taking me. He knocked on the door and I was in that bathroom because I just got back [revived with naloxone]. And my case manager was like, "if you can't go, we can call it," and I was like, 'if I don't go, they'll put a warrant out for me," and he was like, "well I'll take ya," and so I went with him. I had my head sticking out of his car window, just vomiting. And [the CM] was so cool about it and said, "do your thing man, don't worry about it. Anything can be washed."*

KEY TERMS

CM: Case Manger

HCV: Hepatitis C Virus

MOUD: Medication for Opioid Use Disorder

PEH: People Experiencing Homelessness/ Houselessness

PSH: Permanent Supportive Housing

PWUD: People Who Use Drugs

RSS: Resident Support Specialist

SDoH: Social Determinants of Health

SSP: Syringe Services Program

SUD: Substance Use Disorder

One study shows that PEH in Los Angeles County, CA, between 2017 and 2019 had a drug overdose rate that was 36 times higher than for the general population.[5] Among a study cohort of 60,092 PEH who received healthcare at Boston Health Care for the Homeless from 2003 to 2017, 7130 died by the end of the study period and of those that died, 1727 people had died from a drug overdose.[6]

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Considerations and Recommendations

Health departments, drug user health and harm reduction programs, housing service providers, policymakers, and other stakeholders can jointly address health and safety risks related to homelessness and drug overdose in the following ways:

- Drug user health and housing service providers can work together to assess their respective capacity to meet the needs of shared service populations.
- Housing First programs and other social and medical service providers working with PEH should offer harm reduction services and supplies relevant to community needs and experiences.[7,8]
- Programs should also maintain regular opportunities for internal and programmatic review, including mechanisms for participant input, to ensure that services are tailored and use best practices for the needs and cultures of communities served.[9,10]
- Increase co-located and wraparound services through partnerships between housing programs, Syringe Services Programs (SSP) and harm reduction programs, and other local service providers. Permanent supportive housing sites can work with SSPs to support secondary exchange with staff and residents. Programs and service providers can develop streamlined and bi-directional referral mechanisms to better care for participants and avoid duplication of effort.[11,12]
- The trauma of homelessness does not simply disappear once someone enters stable housing. Traumas and stresses from living outside may be exacerbated by chaotic drug use or untreated substance use disorder (SUD), mental illness, or dual diagnosis. The transition into stable housing is, in part, a transition into a new social system – and it may take several years and require specialized support. Wraparound services, like housing retention plans and intensive case management, can be helpful during the process. Incorporating aspects of the Critical Time Intervention Model and trauma-informed counseling that draws on the Transtheoretical Model/stages of change framework may be beneficial.[13,14,15]
- SSPs and other harm reduction programs can prioritize outreach to local encampments and understand how changes in the housing landscape can disrupt networks of care which could force people into unfamiliar drug markets, leading to increased overdose risk.[16,17,18]

Harm reduction supplies may include but are not limited to:

- Sterile syringes and injection supplies
- Safer smoking and snorting supplies
- Sharps containers and safe disposal
- Naloxone access
- Planning and education related to overdose prevention and response
- Education, resources, and referrals related to drug checking
- Safer use education
- Information about and connections to MOUD providers and other SUD treatment options
- Safer sex materials and information
- Safety planning and resources for people doing sex work
- Integrated physical and mental health services, including testing and care for HIV, viral hepatitis, sexually transmitted infections, and skin and soft-tissue infections
- Information about and access to PrEP
- Low-barrier medication storage

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