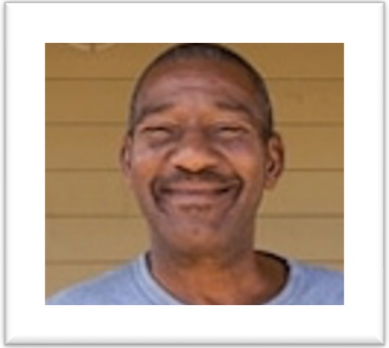
Providing **Equitable** & **Effective Addiction Care** for People Experiencing Homelessness: ***Lessons from Lived Experience***

Penny Hunt



John “JR” Rogers

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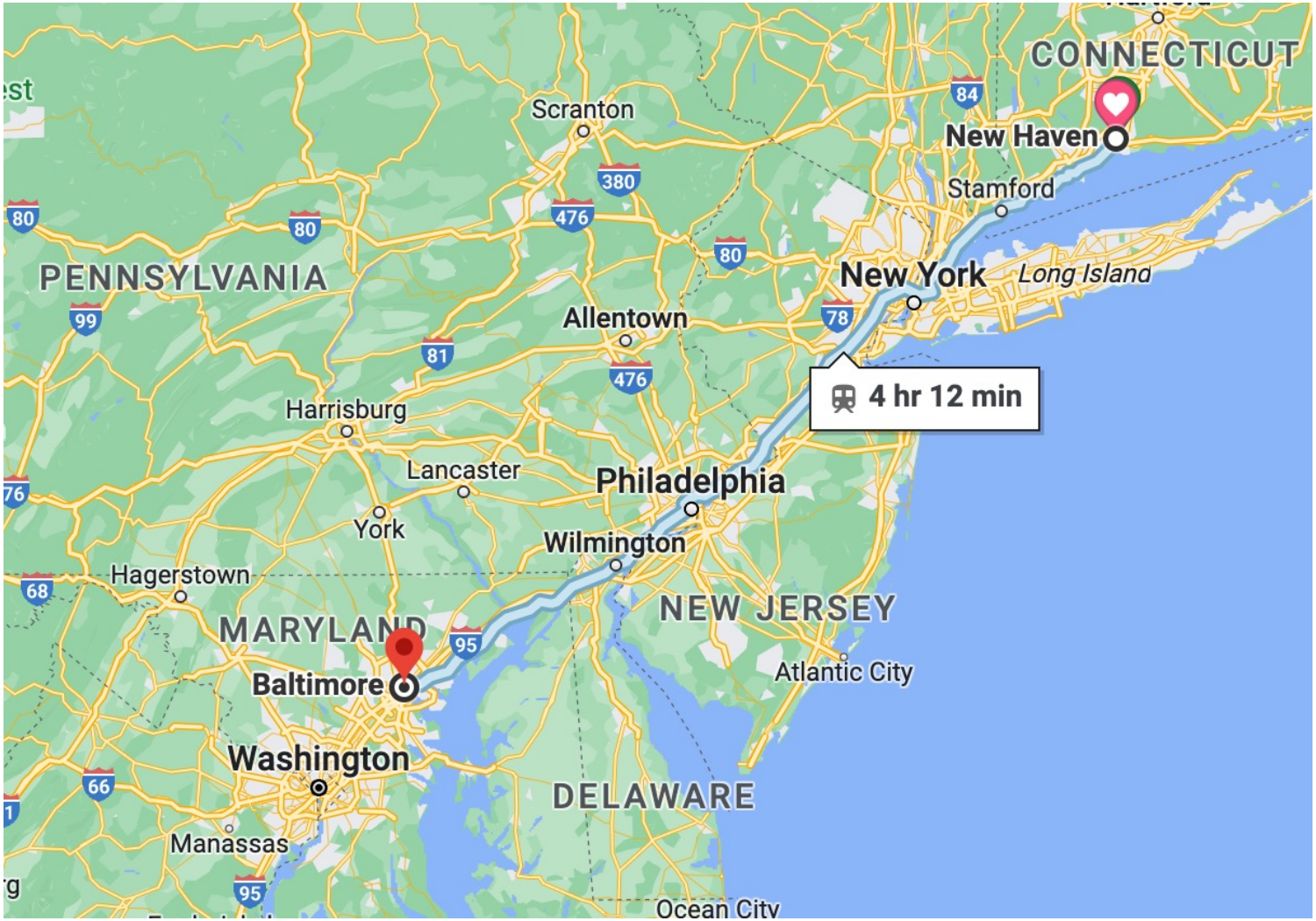
Nicholaus Christian, MD, MBA
Jeremy Weleff, DO

May 16th, 2023
NHCHC
Baltimore, MD

Conflicts of Interest

None


CONNECTICUT
New Haven
Stamford
Scranton
84
380
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PENNSYLVANIA
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New York
Long Island
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Allentown
81
476
4 hr 12 min
Harrisburg
Lancaster
Philadelphia
76
York
Wilmington
Hagerstown
68
NEW JERSEY
MARYLAND
95
Atlantic City
Baltimore
Washington
66
DELAWARE
Manassas
95
Ocean City


7
Mobil
2343T
2343 T
2343 MT. LB RECT
2243 TT

Raise your hand if you wear prescription glasses, contacts, or had laser eye surgery (and keep it up)

87% of those with OUD do not receive treatment

Int J Drug Policy. 2022 Dec;110:103786. doi: 10.1016/j.drugpo.2022.103786. Epub 2022 Aug 4.

Has the treatment gap for opioid use disorder narrowed in the U.S.?: A yearly assessment from 2010 to 2019"

Noa Krawczyk [1], Bianca D Rivera [2], Victoria Jent [2], Katherine M Keyes [3], Christopher M Jones [4], Magdalena Cerdá [2]

PEH are consistently less likely to be in or received outpatient treatment for their opioid use

(Bauer et al., 2016; Deck and Carlson, 2004; Dunn et al., 2019; Eyrich-Garg et al., 2008; Kelly et al., 2018; Krawczyk et al., 2020; Lundgren et al., 2003; Reynoso-Vallejo et al., 2008; Rivers et al., 2006; Royse et al., 2000; Shah et al., 2000).

Something has to change…

We don’t tolerate these levels of inequity and unnecessary death in other diseases…

Agenda

12:30-12:45: Why is recovery different for people with housing instability?

12:45-12:55: What are the components of an addiction care plan for a PEH?

12:55-1:15: Case: How to manage alcohol use disorder?

- Naltrexone/Acamprosate/Disulfiram

1:15-1:35: Case: How to manage opioid use disorder?

- Buprenorphine/Methadone/Naltrexone

1:35-1:45: Models of care, questions, wrap-up

3-minute Discussion

- Introduce yourself!
- Reflection on Penny’s comments

By the numbers…

580,466 people experiencing homelessness

226,080 unsheltered homelessness

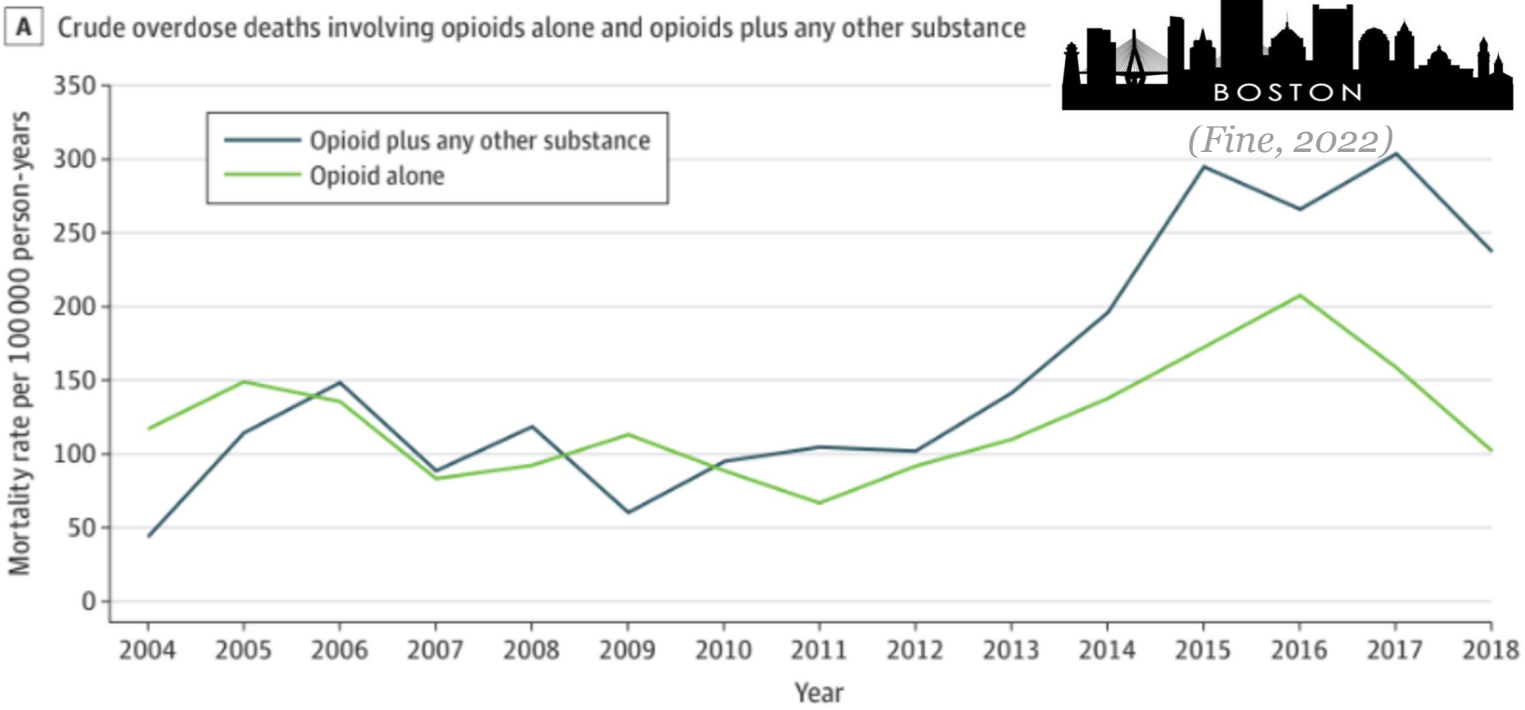
44% w/ substance use disorder

PEH have ↑ rates of SUD & overdoses

12x more likely to die of overdose than general population

3x higher overall mortality

(1)HUD 2020 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulation
(2) Morse, G., Shields, N., Hanneke, C., McCall, G. J., Calsyn, R. I., & Nelson, B. (1985). Homeless people in St. Louis: A mental health program evaluation, field study, and follow-up investigation. Jefferson City: Missouri Department of Mental Health IN Dennis, Deborah. "A decade of Research and Service for Homeless Mentally Ill Persons: Where do we Stand? American Psychologist . November 1991. Vol. 46, No. 11, 1129- 1138.
(3) Fine DR, Dickins KA, Adams LD, et al. Drug Overdose Mortality Among People Experiencing Homelessness, 2003 to 2018. *JAMA Netw Open*. 2022;5(1):e2142676. Published 2022 Jan 4. doi:10.1001/jamanetworkopen.2021.42676



BOSTON

(Fine, 2022)

SAN FRANCISCO

(Cawley, 2021)

- 76% of samples +polysubstances
- 54% amphetamines

PEH have ↑ rates of polysubstance use/deaths

SUBSTANCE USE ⇌ HOMELESSNESS

↑ social instability

Trauma
Education
Financial Instability
Mental Illness

SUBSTANCE USE

HOMELESSNESS

McVicar (2015),
O'Toole (2004)

Intersectionality of SUD With Other Stigmatizing Identities

PEH face multiple levels of stigma

Strong social network effect among PEH

The System Leaves People Stranded

YALE PROGRAM IN ADDICTION MEDICINE

Agenda

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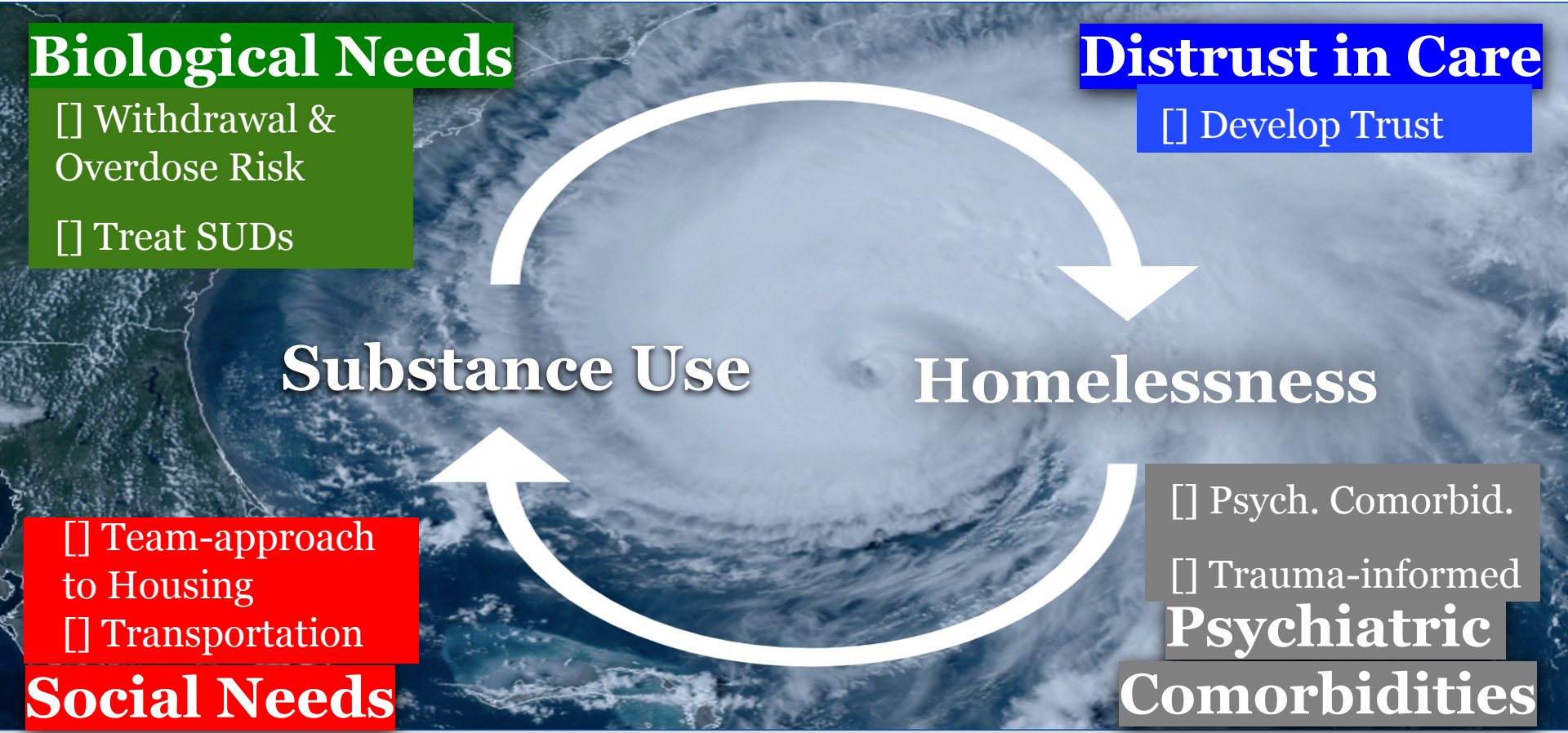
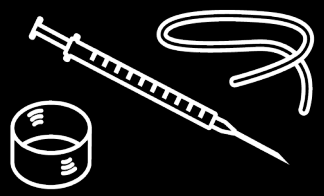


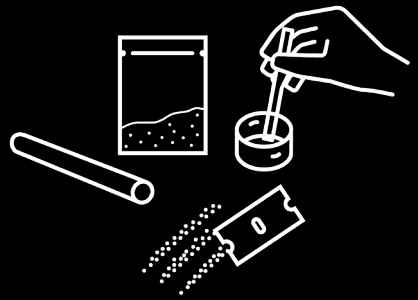
YALE PROGRAM IN ADDICTION MEDICINE

Harm Reduction Services

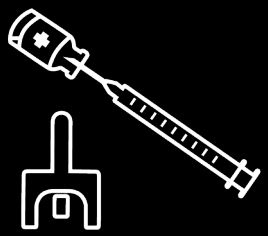


Syringe Access

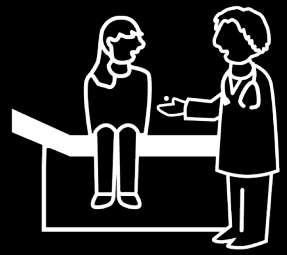
Syringe Disposal



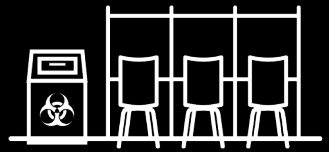
Safer Drug Use



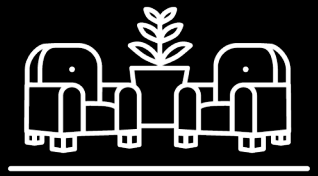
Naloxone



Medication Treatment



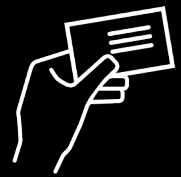
Supervised Consumption Services



Drop-In Centers

Housing First

Pharmacy Access



Referrals

Approach to Addiction Treatment

Our Attitudes

-Be patient; trust builds slowly
-Respect and caring
-Curious vs condemning
-Expect initial testing; people with addiction learn to expect criticism and mistrust

Anticipate Early Struggles

-Ambivalence about total sobriety
-Competing needs
-Response to stress

Approach to Recurrences

-Patients need to be reassured that they are welcome back
-Return to medication ASAP
-Analyze the recurrence process→ what can we learn?
-Opportunity to intensify treatment
-Don’t add to the guilt

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1:35-1:45: Models of care, questions, wrap-up

First Encounters with Bobby

8/5/2020: *(Seems under the influence of alcohol)*

***Wakes up and can only think about alcohol**. He is currently unemployed and uses his time during the day trying to find money, **but then he spends it on alcohol.** He is currently homeless and does not want to share where he sleeps.*

He became irritable when asked to move for a car to get out. As a result, got frustrated and did not want to resume conversation with team.

8/18/2020:

He wanted to talk to the team but when told he needed to wait 10min he said, "nobody helps me," started cursing loudly and threw a chair. He appeared to be talking to himself.

- What are our concerns from the mental health and substance use perspective? What do we prioritize?

AUD, psychotic spectrum disorder, SAFETY

- What is the next best step for assessing and addressing Bo's concerns?

In first encounter, team did not pressure Bo to stay. In second encounter, team prioritized safety & told Bo team was not feeling safe, and it will be leaving.

In the next 4 months…

August-November

- Numerous ED visits due to alcohol intoxication and suicidal ideation in the context of not having a place to stay
- Had a psychiatric admission (Zyprexa 20mg→not taking after discharge)
- Expressed interest to go to a "program" but insurance was a barrier→ he had Massachusetts' Medicare & he was in Connecticut

December

- Already removed from 2 emergency hotels given behavioral disturbances
- Team brought up topic of medication (AUD) but he was reluctant to take, **"I need stability first" (housing)**

- What can we do to improve Bo’s whole health?

Connecting him to case manager, helping him getting CT insurance, keep seeing him and building trust.

- How do we adjust our plans to Bo’s priorities?

His priority is housing

Now we are in 2021

April to July

- Bobby starts to tell the team “I like to see you all”
- Continues to use alcohol and have ETOH-related ED visits
- “Not well.” More paranoia and seen responding to internal stimuli
- Two separate legal involvements (arrests). On probation.

August to December

- Open to medications, but not ready to take them
- Connected to case manager/recovery coach
- Formally enrolled with our team (Street Psychiatry)
- Housed! Still ongoing alcohol use

- How do we decide what treatment options to offer Bo and how do we offer it?

  ✓*Know his goals (it is to reduce use or complete remission?)*
  ✓*Has Bo used MAT before?*
  ✓*Do Bo have a preference of MAT?*
  ✓*How easy is to follow the treatment plan (number of pills and frequency)*
  ✓*Adverse effects*

FDA-approved MAT for AUD

	DISULFIRAM	ACAMPROSATE	NALTREXONE	VIVITROL
Dosage	250-500mg/day	1996mg/day	50mg/day	380mg/month intramuscular
Most common adverse effects	Drowsiness Rare→ hepatitis, psychosis, neuropathy, optic neuritis, confusional states	Diarrhea	Somnolence, nausea, vomiting, ↓appetite, abdominal pain	Same as naltrexone plus injection site reaction
Clinical notes	**Only makes sense if patient's goal is sustained remission**	**Need to take multiple times per day→ not ideal for unsheltered folks** **FDA-approved to sustain remission from AUD in those who are in remission at Tx initiation**	**Can block the effects of opioid** **Precipitated withdrawal in patients with physical dependence to opioids** **Efficacy in reducing risk of recurrence and heavy drinking**	**Same as naltrexone**

Kranzler HR, Soyka M. Diagnosis and Pharmacotherapy of Alcohol Use Disorder: A Review. *JAMA*. 2018;320(8):815-824. doi:10.1001/jama.2018.11406

Now we are in 2022

Jan to March

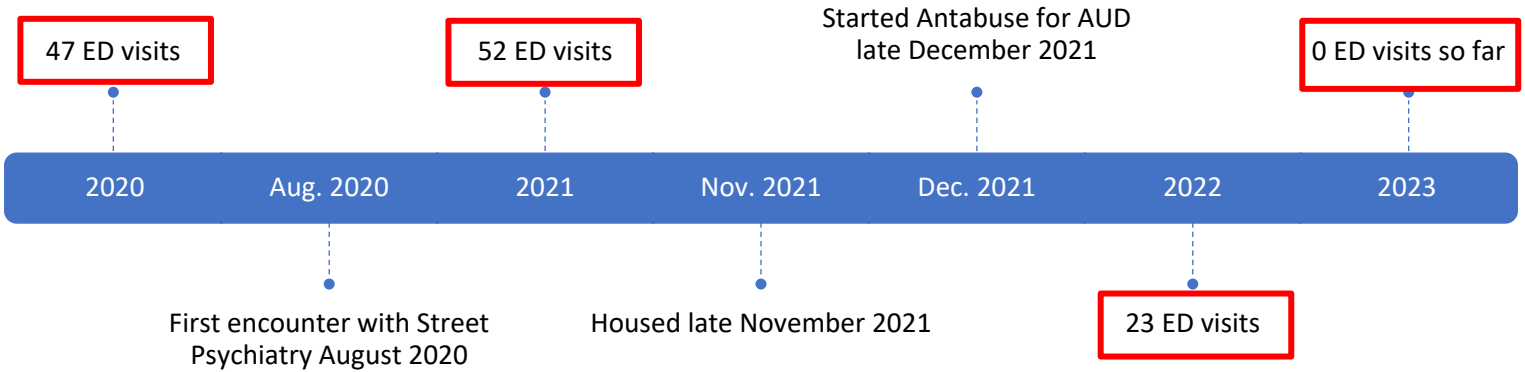
- Taking Antabuse→ “Things are moving towards progression, “I’m thinking positively”.
- Conversation with Probation Officer (PO). **PO unaware Bo has AUD and SMI**. Case transferred to MH specialist PO (mitigate risks of reincarceration)
- Ongoing paranoia (e.g. Does not want team to say his phone # out loud in his apartment, being targeted by other residents).

April to December

- **Stopped Antabuse,** drinking again. Wants to move to a different apartment.
- Team meeting (case manager, BH care, police). New apartment obtained.
- Interested in cutting down on alcohol and wants to do it by “myself and meetings”.
- Restarts Antabuse, but ongoing paranoia and worse thought process.
- Lost to follow up from Oct to Dec (EPIC review showed out of state ED visits)

Dec 2022: Returned to CT (team work!)
Jan 2023: Restarted Antabuse

Timeline


47 ED visits
52 ED visits
Started Antabuse for AUD
late December 2021
0 ED visits so far
2020
Aug. 2020
2021
Nov. 2021
Dec. 2021
2022
2023
First encounter with Street
Psychiatry August 2020
Housed late November 2021
23 ED visits

Pearls from working with Bobby

- Be patient and focus on building trust
- Adjust team's plan to patient's priorities
  - ✓ *Housing first made a difference*
- Collaboration is crucial
- In SUD, expect recurrences

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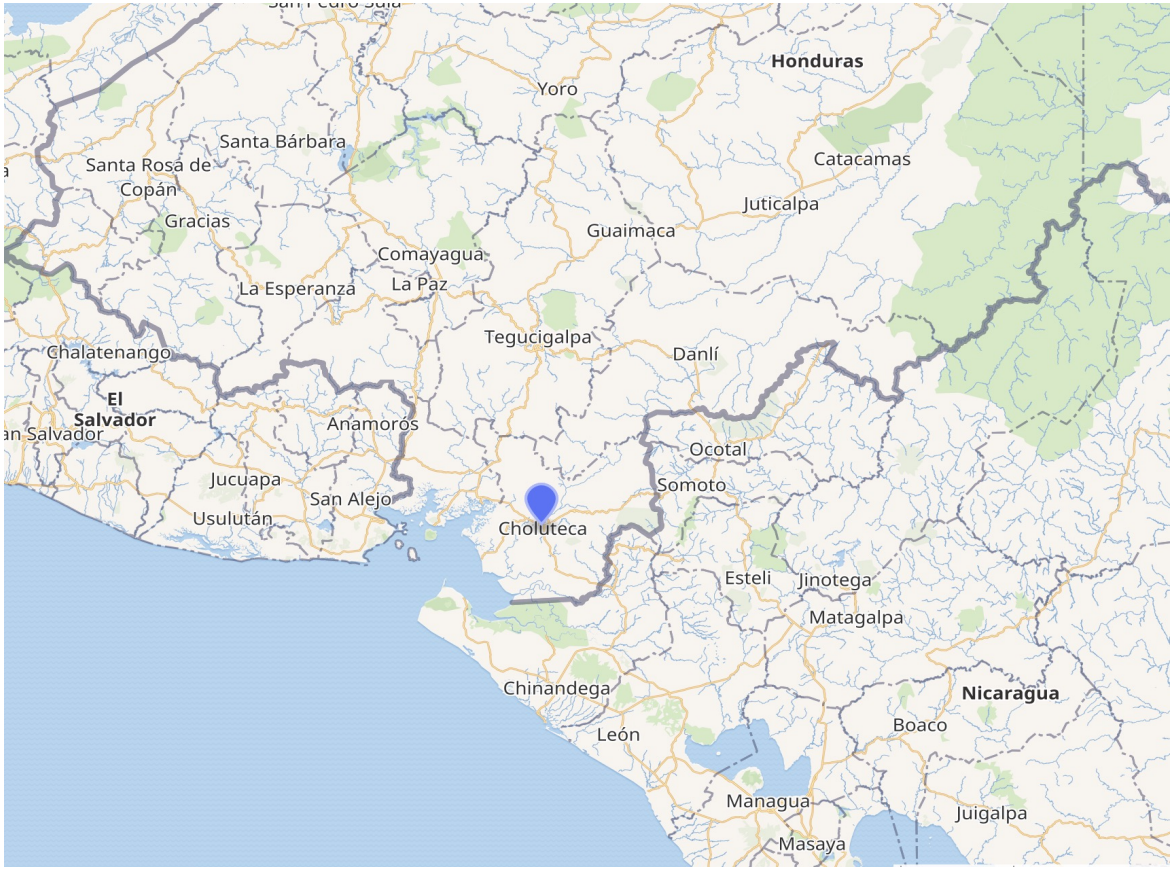
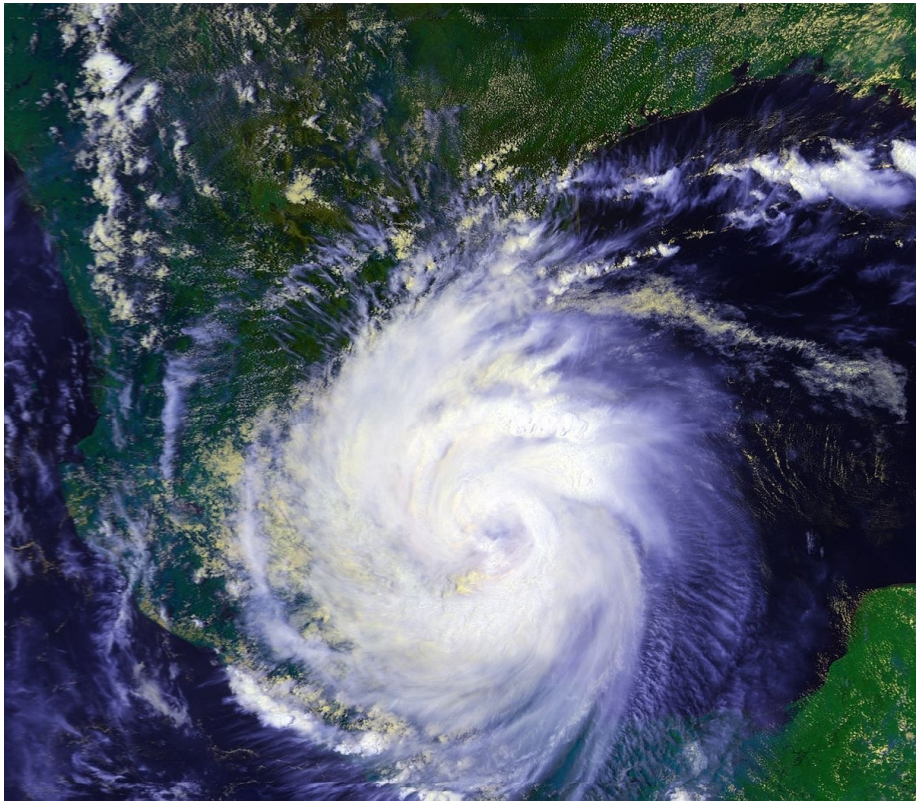
Choluteca Bridge



1998 – a great feat of engineering

1998 – Hurricane Mitch comes along…

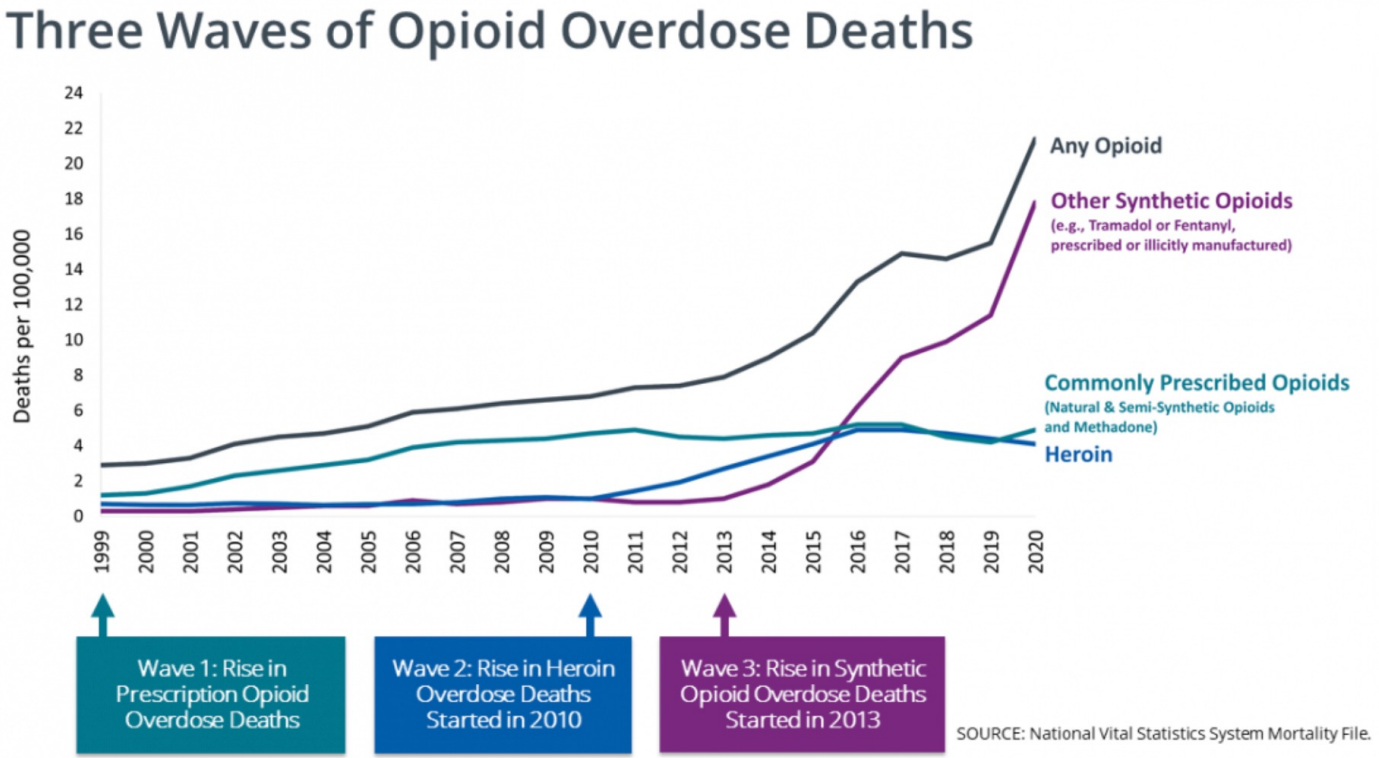


And the bridge survives completely intact…

The river moved…

The bridge looks great.
“The Bridge to Nowhere”

This is our system…



https://www.cdc.gov/opioids/basics/epidemic.html

Many hurricanes and a river of fentanyl…

Int J Drug Policy. Author manuscript; available in PMC 2020 Dec 1.
Published in final edited form as:
Int J Drug Policy. 2019 Dec; 74: 76–83.
Published online 2019 Sep 25. doi: 10.1016/j.drugpo.2019.09.003

PMCID: PMC6914257
NIHMSID: NIHMS1543668
PMID: 31563098

"Everything is not right anymore" Buprenorphine experiences in an era of illicit fentanyl

Sydney M. Silverstein,[a] Raminta Daniulaityte,[b] Silvia S. Martins,[c] Shannon C. Miller,[d,e] and Robert G. Carlson[f]

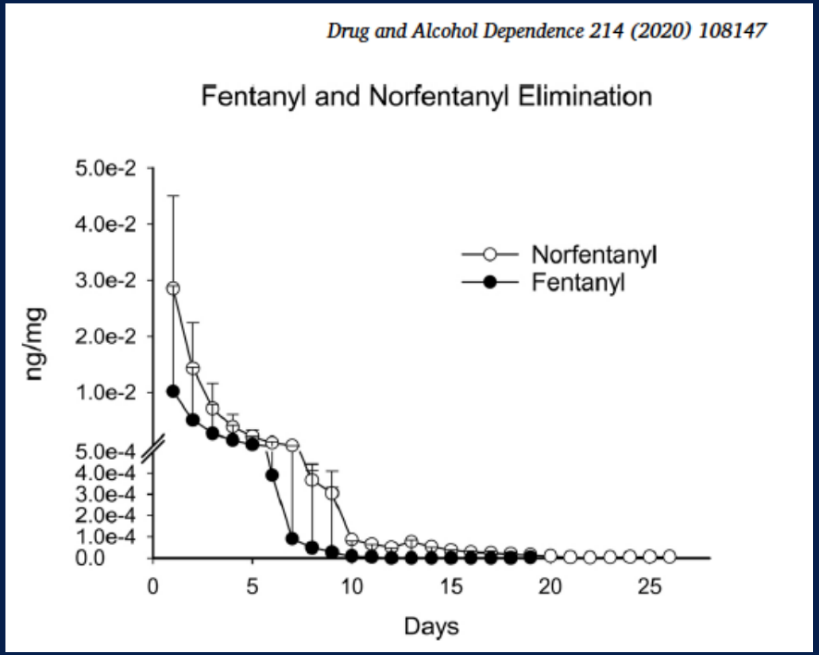
Our continued slow response/rigid framework is the Choluteca bridge…

10 years in and:

- **Relatively unchanged regulatory frameworks**
- **Slow uptake re: Harm Reduction**
- **Limited innovative/new drugs or treatments**
- **Starting MOUD; Buprenorphine inductions (low dose, high dose, etc)**

Characteristics of "Fentanyls"

- Fast onset and high potency
  - Fentanyl rapidly crosses the blood-brain barrier
  - 50-100 x more potent than morphine
- Short action
  - Fentanyl levels rapidly decline due to redistribution to body fat
- Sequestration leads to fentanyl accumulation
  - Chronic use causes accumulation in adipose
  - Unknown changes to withdrawal course



Huhn, A.S., Hobelmann, J.G., Oyler, G.A. and Strain, E.C., 2020. Protracted renal clearance of fentanyl in persons with opioid use disorder. *Drug and alcohol dependence*, *214*, p.108147.

And are we already behind?

Most Recent Recommendations from Q1 2023

Benzodiazepines		Opioids		Stimulants & Hallucinogens		Synthetic Cannabinoids	
TIER ONE *(STRONGLY RECOMMEND)*							
Etizolam	1-10	N-Desethyl Isotonitazene⬆	<1	NN-Dimethylpentylone	>10	MDMB-4en-PINACA	<1
Flualprazolam	1-10	Isotonitazene	<1	Pentylone	>10	ADB-BINACA (-BUTINACA)	<1
Bromazolam	1-10	Metonitazene	<1	Eutylone	>10	ADB-5'Br-BINACA	<1
Flubromazepam	1-10	o/m/p-Fluorofentanyl	1-10	N-Propyl Butylone	>10	CH-PIATA⬆	<1
Clonazolam	<1	Carfentanil	<1	alpha-PHP / alpha-PiHP⬆	>10	ADB-FUBIATA	<1

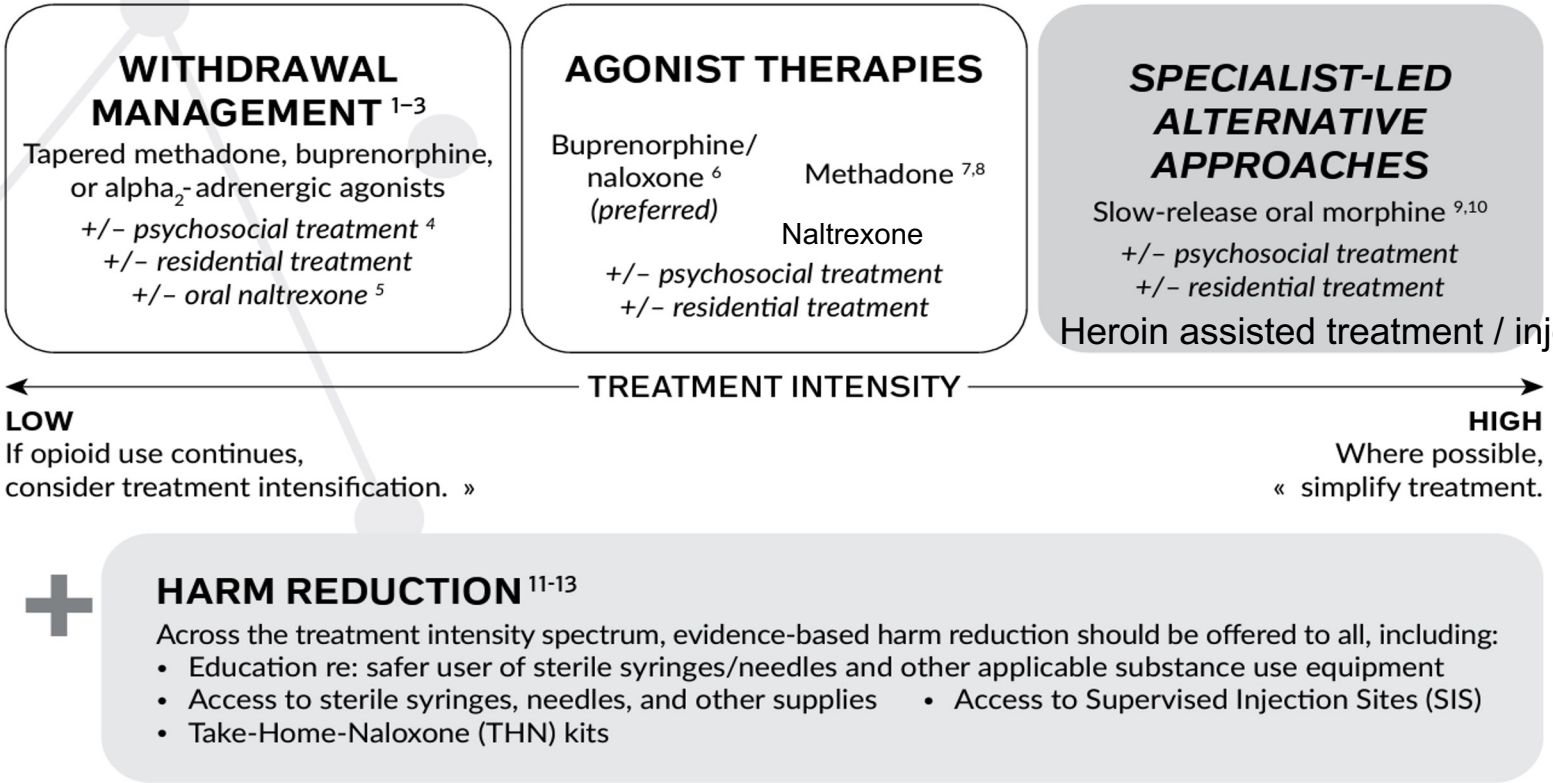
- Center for Forensic Science Research and Education (CFSRE) laboratory recommendations for the detection of novel psychoactive substances (NPS) in the USA

https://www.cfsre.org/nps-discovery/scope-recommendations

Opportunities and the future - USA

All of these many “structures” within the system that gives us these currently undesired outcomes in the age of fentanyl / the Opioid Epidemic

- Regulatory frameworks around treatment
  - X-Waiver recent example ; Other barriers to addiction care + OTPs etc.
- Expansion of Harm Reduction / Safe Consumption
- Novel medications for OUD (novel and repurposed)/ International perspectives* and treatments such as iOAT, “heroin-assisted treatment”, SROM


WITHDRAWAL MANAGEMENT [1–3]
Tapered methadone, buprenorphine, or alpha2-adrenergic agonists
+/– psychosocial treatment [4]
+/– residential treatment
+/– oral naltrexone [5]
AGONIST THERAPIES
Buprenorphine/ naloxone [6] (preferred)
Methadone [7,8]
Naltrexone
+/– psychosocial treatment
+/– residential treatment
SPECIALIST-LED ALTERNATIVE APPROACHES
Slow-release oral morphine [9,10]
+/– psychosocial treatment
+/– residential treatment
Heroin assisted treatment / injectable OAT
TREATMENT INTENSITY
LOW
If opioid use continues, consider treatment intensification. »
HIGH
Where possible, « simplify treatment.
HARM REDUCTION [11-13]
Across the treatment intensity spectrum, evidence-based harm reduction should be offered to all, including:
• Education re: safer user of sterile syringes/needles and other applicable substance use equipment
• Access to sterile syringes, needles, and other supplies
• Take-Home-Naloxone (THN) kits
• Access to Supervised Injection Sites (SIS)

- Story I've decided to tell is one in which our system doesn't meet the needs of those we are tasked with caring for from the perspective of a prescriber working inside a methadone clinic

- And how our drugs / systems can't keep up with the poisoned drug supply*

Jimmy

- 37-year-old male, veteran
- In 2017, severe 3rd burns to >60% of his body in a house fire
- Prolonged; 3-month hospital stay ; traumatic for multiple reasons*
- Started on oxycodone ; shortly after many dose escalations started to have other opioids in urine... and then cocaine... and then the oxycodone was stopped

- Two trials of buprenorphine (stopped due to not effective for pain, precipitated withdrawal) ; he doesn’t want to try again
- Assessed by the pain clinic / opioid reassessment clinic multiple times throughout this
- Now Hep C +
- Eventually starts in the methadone clinic / OTP

- Becomes sort of a “legend” at the clinic ; “disconnected” ; “hard to reach”
- Homeless throughout this time ; often living with others or squatting ; mostly coming in for doses still
- On methadone – and not at low doses (~120mg) – continues to use IV fentanyl and cocaine daily *(doesn’t want/can’t increase)*
- Hand / arm lesions (suspected xylazine); likes tranq for sleep

- Takes a couple of months for me to meet him ; finally start to build a relationship
- Expansion of Harm Reduction supplies in our VA Clinic that fall
- Now coming regularly to clinic
  - And hanging around(!)

CTHRA
Connecticut Harm Reduction Alliance

Discussion

- How would you address Jimmy’s opioid use disorder?
- What do you do for a patient like Jimmy?

- Have now built a relationship to work towards better pain control and management *(“… no no see you in two weeks, doc”)*
    - Reports decrease in his use and now on other medications for pain and open to other non-pharm strategies

- Had appt for Hep C at the liver clinic last week (!)

- Continues to prefer living in warehouse despite HUD-VASH connections and options for apartment (doesn’t like the check-in rules / cleanliness etc.)

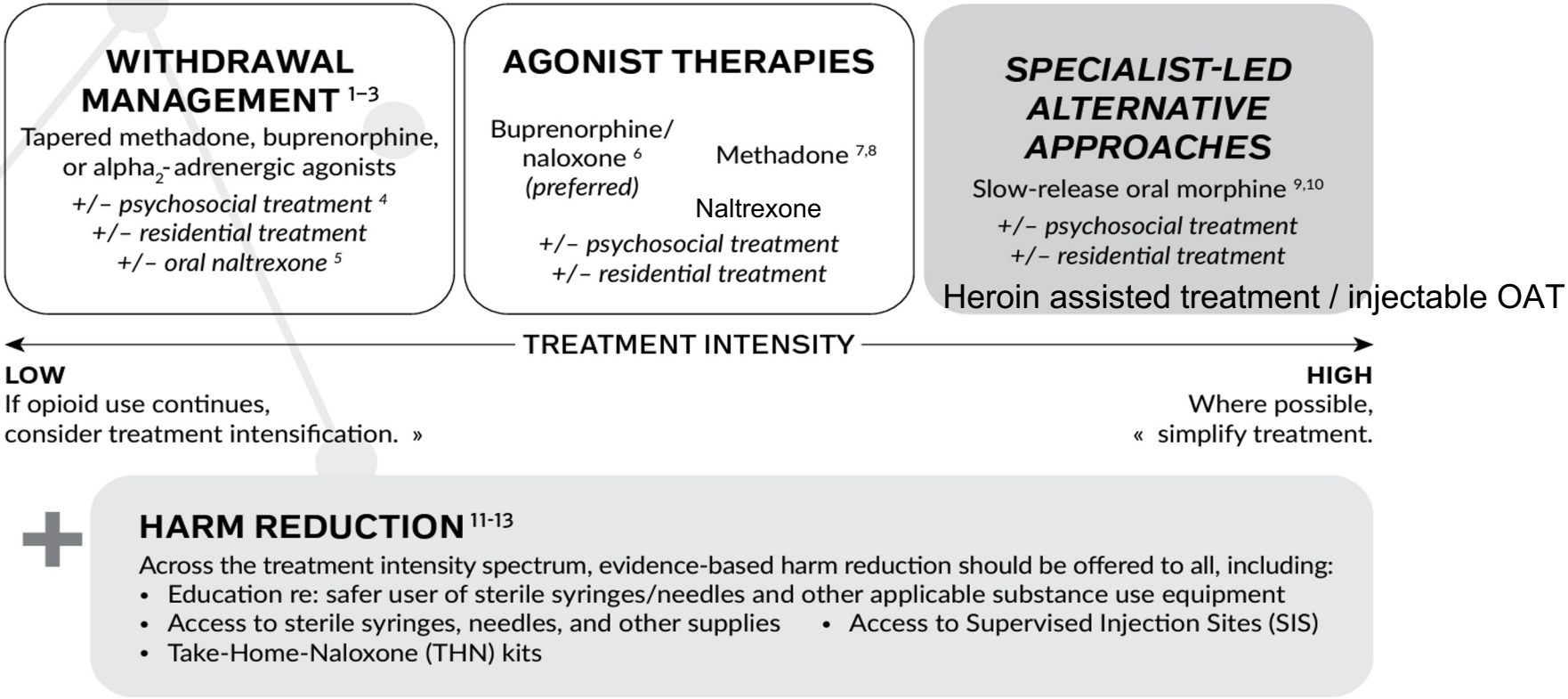
Lessons

- Our medications are **NOT** as good as what is out there in the poisoned drug supply (and we need to hustle to fix that!)

- The goals of abstinence (and sometimes stable housing) sometimes aren't the goals for everyone… important to check our goals… and assess for what is missing within our options to actually meet people where they are at

- Harm Reduction expansion **INCREASES** opportunities for deeper connection/trust building and moving towards personal and therapeutic goals (while increasing safety!) – should be universal for all clinics*

OUD Treatment Overview



- Canadian medical association journal (CMAJ) 2020 guidelines
  - Other than basic medical and infectious disease…
  - **OUD and addiction treatment are the cornerstones of medical treatment guidelines for those experiencing homelessness***

- **https://www.cmaj.ca/content/192/10/E240**

- **It goes without saying that [HOUSING ←→ SUD]**

Advanced buprenorphine techniques in age of fentanyl

Practice-Based Guidelines: Buprenorphine in the Age of Fentanyl

PCSS Guidance—May, 2023

Table 2. A Comparison of Buprenorphine Induction Approaches

	Standard	Low-dose	High-dose	Micro-dose with cross taper
Post-agonist washout duration	16h (short acting) 48→72h (long acting)	24 - 36h	16→24h	No washout Usual dose of agonist continued
First dose of buprenorphine	2 mg	0.5 - 1 mg	2→16 mg	0.25→0.5 mg
First day total dose of buprenorphine	8→12 mg	8 mg	16→32 mg	0.5→1 mg
Adjuntive medications	As needed	Standing doses up to maximum tolerability	As needed	None

Advanced methadone techniques in age of fentanyl

- Methadone regulations require a slow starting titration
  - Likely not enough to adequately treat fentanyl*
  - International options include slow-release oral morphine (SROM) and other opioids started at same time
- Proposals for rapid titrations that maintain within these regulatory frameworks

Outpatient Rapid Titration Protocol From San Francisco General Hospital OTOP

- Inclusion: OUD using fentanyl with history of high tolerance (usually self-reported use of 1 gram of fentanyl or more daily)
- Exclusion: CHF, advanced COPD, CKD

- Day 1: Methadone 30mg, first dose, plus additional 10mg
- Day 2: Methadone 60mg
- Day 3-5: Methadone 80mg
- Day 6-8: Methadone 100mg
- Day 9: methadone 120mg.
- Thereafter, generally wait 5 days before increasing dose

OHSU's Rapid Inpatient Guideline

Day	Max TDD Methadone	Recommended Dosing
1	60mg	30 or 40mg x1 + 10mg q3hrs PRN x 2 or 3 doses
2	70mg	50mg x1 + 10mg q3hrs PRN x 2 doses
3	80mg	60mg x1 + 10mg q3hrs PRN x 2 doses
4-7	100mg	70mg (or average of TDD from prior days) x1 10 mg q3h PRN x 3 doses

Advanced methadone techniques in age of fentanyl

- **Meta phi guidelines re: fentanyl/poisoned drug supply**
  - **Inclusion of clonazepam if suspected contamination with benzodiazepines** *(high rates of etizolam and other designer benzodiazepines in the drug supply*)*

Agenda

12:30-12:45: Why is recovery different for people with housing instability?

12:45-12:55: What are the components of an addiction care plan for a PEH?

12:55-1:15: Case: How to manage alcohol use disorder?

 Naltrexone/Acamprosate/Disulfiram

1:15-1:35: Case: How to manage opioid use disorder?

 Buprenorphine/Methadone/Naltrexone

1:35-1:45: Models of care, questions, wrap-up

- **Syringe Services Programs**
  - High utilization by PEH, reduces needle sharing, possible site for low barrier MOUD *(White, 2020) (Hood, 2020)*

- **Low Barrier Buprenorphine**
  - Homeless clinic group visits → high retention rates (70% at 6mos!) *(Doorley, 2017)*
  - Street buprenorphine
    - Yale Street Psychiatry *(Gibson, 2023)*
    - San Francisco *(Carter, 2019)*
    - Boston HCHP: CCIR, CareZone
    - Peer driven model, New London, CT *(Alliance for Living)*

- **Overdose Prevention Sites/Drop-In Centers**
  - SPOT and Roundhouse Hotel in Boston
  - OnPoint NYC
  - HaRRT: Alcohol harm reduction in Seattle

The future

- Full expansion / universal Harm Reduction supplies
- Advocacy for Substance Use Disorder Treatment as Human Right (directly alongside Housing as Human Right)
- Relaxation of regulations for OUD prescribing (physicians can prescribe opioids for pain than OUD)
- International perspectives brought to USA
- Partner with your local academic centers(!) ← → goes both ways

Thank you!

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YALE PROGRAM IN ADDICTION MEDICINE

Learning Objectives

1. Recognize the drivers of substance use among people experiencing unsheltered homelessness.
2. Formulate an addiction care plan for a patient experiencing homelessness or unstable housing.
3. Discuss strategies to initiate medications for alcohol use disorder (naltrexone/acamprosate/disulfiram) and medication for opioid use disorder (buprenorphine/methadone/naltrexone) for patients experiencing homelessness.

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“Sick and tired of being sick and tired”: Exploring initiation of medications for opioid use disorder among people experiencing homelessness

Natalie Swartz [a,*], Tatheer Adnan [a], Flavia Peréa [a], Travis P. Baggett [b,c,d], Avik Chatterjee [d,e]

Timing: Overdoses	“Right after I overdose, there's no interest in treatment because I feel terrible. I just want to get high, so I don’t feel terrible. Then, once I get high, then I’ll think about treatment.”
Timing: Chronic opioid use consequences	“I just was sick and tired of being sick and tired. I just gave it a shot.”
Medication benefits	“I know that it’s saved a lot of my friends' lives.”
Medication concerns	“To me it’s just substituting one drug for another.”
Perceived readiness	“Nobody can stop you from using. You have to want it yourself.”

Swartz N et al, J Subst Abuse Treat. 2022

“All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.” -UN

Diagnose Substance Use Disorder (DSM-5)

Impaired CONTROL	1. Larger amounts/longer periods of time 2. Repeated attempts to quit/control use 3. Much time spent using drug 4. Cravings, urges
SOCIAL Impairment	5. Activities given up to use 6. Neglected major roles 7. Interpersonal problems related to use
RISKY USE	8. Hazardous use 9. Use despite knowledge of physical/psychological problems
Pharmacologic Criteria	10. Withdrawal 11. Tolerance

5 "C's"
Control
Cut back
Cravings
Compulsion
Consequences

Mild = 2-3
Moderate = 4-5
Severe = 6+