



VA NATIONAL CENTER ON HOMELESSNESS AMONG VETERANS

Promoting data-driven, evidence-based solutions to end Veteran homelessness

HOMELESS EVIDENCE AND RESEARCH SYNTHESIS
(HERS) ROUNDTABLE PROCEEDINGS

Opioid Use Disorders and
Homelessness

February 2, 2017

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Introduction

We are in the midst of an opioid epidemic in the United States that has had a profound and deadly impact in our communities. A decade of rising prescription opioid use and misuse (1999-2009) followed by a surge of illicit opioid use has led to high rates of overdose and death (1,2,3). But while the disease of opioid use disorder (OUD) has gained public consciousness and stakeholders have promulgated initiatives and guidance to address the epidemic (4,5), the impact on vulnerable and traditionally disenfranchised populations, such as people experiencing homelessness and particularly Veterans who are homeless or at risk for being homeless, is often less appreciated(6).

This epidemic affects individuals experiencing homelessness in ways often not noticed and possibly different from how it affects those who are housed. These individuals have difficulty accessing ambulatory health care and integrated service delivery due to perceived and actual stigma and face structural barriers that make establishing ongoing care challenging (6,7). They also have disproportionately high rates of comorbid conditions that place them at risk for developing opioid use disorder. Mental health conditions, use of substances other than opioids, and acute and chronic pain conditions are all highly prevalent among persons experiencing homelessness. For example, the dynamics of homelessness and re-housing can both facilitate and impede recovery efforts. Individuals with fragmented social networks may have additional obstacles. Housing First, where placement in housing is not contingent on abstinence, can also introduce its own set of challenges and opportunities (8). Taken together, these conditions and circumstances pose problems not necessarily encountered by other populations.

Much has been done within the Veterans Health Administration (VHA) to curb and reduce the use of prescribed opioids for pain (9); similarly, efforts to identify those Veterans most at risk for a use disorder have also been developed to assist in care planning. How practical and applicable these approaches are in settings where persons experiencing homelessness typically get their care and how well adopted these approaches are in these contexts is less clear. More research is needed in this area.

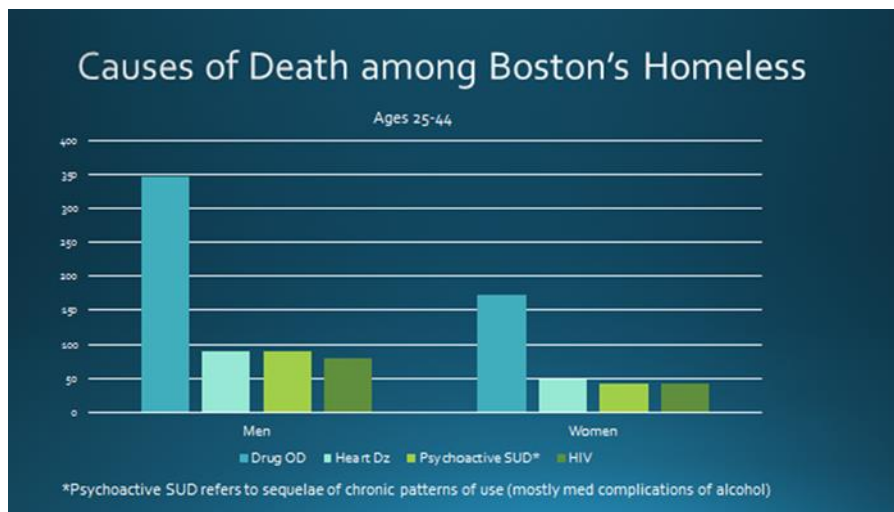
The National Center on Homelessness among Veterans in the VHA Office of Homeless Programs convened a group of clinicians, researchers, and advocates in homelessness and substance use to consider how policies and practices might be adjusted to meet the needs of Veterans affected by OUD who are experiencing homelessness or have been recently housed. Based on a review of research and work that is being done in VHA, the group compiled a list of policy recommendations for further vetting and deliberation through the Homeless Evidence and Research Synthesis (HERS) Roundtable symposium held on February 2, 2017: Opioid Use Disorders and Homelessness.

Dr. Stefan Kertesz discussed the rise of drug overdose as the primary cause of mortality among younger adults experiencing homelessness, the place of opioids in the substance abuse mix, and the efficacy of medication assisted treatment for individuals in general experiencing homelessness. Dr. Karen Drexler focused on the emergence and trajectory of the OUD epidemic and VHA's multi-pronged effort to address it. Dr. Tom O'Toole framed the recommendations for policy and practice from the perspectives of engagement, treatment, and housing.

Opioid Use Disorder (OUD) Among Persons Who Are Homeless | Stefan Kertesz, MD

Opioid overdoses are very high among persons experiencing homelessness. A large study of individuals experiencing homelessness treated by Boston Health Care for the Homeless in 2003-2008 found drug overdose to be a leading cause of death (Figure 1), with opioids present in 81% of overdoses (10). Compared to a 1988-1993 cohort, the death rate from overdose had tripled. The trend is mirrored nationally, where drug overdoses have significantly increased mortality rates for young whites, ages 25-34, particularly men (11).

Figure 1

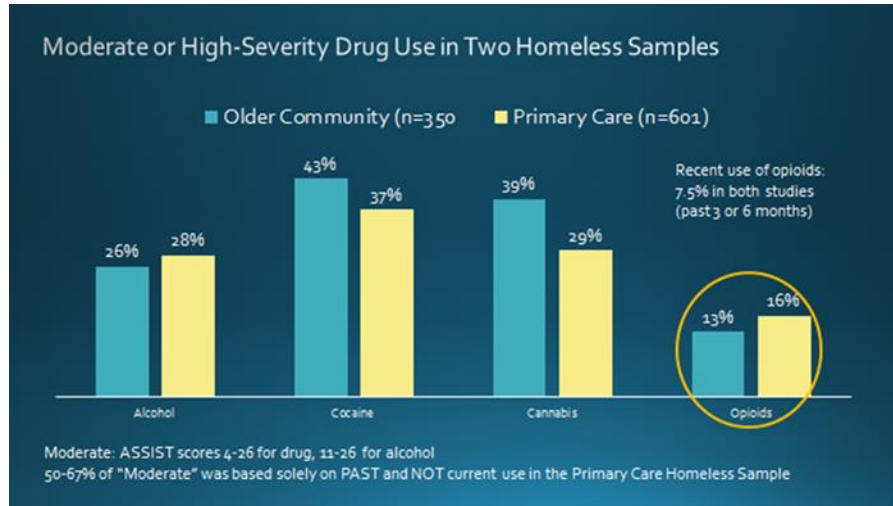


While the focus on OUD is understandable, abuse of alcohol and other drugs is more prevalent among persons experiencing homelessness. A meta-analysis of 29 studies conducted between 1979 and 2005 found alcohol dependence at 38% for this population, compared with 24% for drug dependence (12). Since these older studies tend to have younger samples, two studies of today's middle-aged (primary care patients sample) and older adults experiencing homelessness (shelter sample) shed light on current trends. Both used the ASSIST survey from the World Health Organization to assess use and consequences by substance. Moderate or high severity use of opioids was found in 13% of the older community, compared with 43% for cocaine, 39% for cannabis, and 26% for alcohol; a similar distribution was seen in the middle-aged group (13,14). (See Figure 2)

Chronic pain is extremely common in adults experiencing homelessness and is a risk factor in opioid use disorder. Findings from surveys of this population show that 50-63% of adults in shelters reported chronic pain and only half said it was being treated (15,16). Among Health Care for the Homeless clinicians, only 23% believe they adequately manage pain (17). The HCH Clinicians' Network has issued chronic pain management guidelines to respond to this problem.

Buprenorphine/naloxone therapy, methadone maintenance, and extended release injectable naltrexone are medications proven to be highly effective for opioid use disorder. There is evidence that individuals experiencing homelessness can be successfully treated with buprenorphine in a primary care setting. A comparative study of homeless and housed patients showed similar outcomes in urine tests and use of additional treatment (18).

Figure 2



Homeless Patient Aligned Care Teams (HPACT) are likely to have four categories of patients with OUD or at risk for the disorder: OUD is unknown to the team; OUD is known and can be managed if the patient is compliant; presentation of chronic pain that may involve care management challenges; and chronic pain that is being successfully treated with or without opioids. In each case the team can use VA tools and protocols, discussed below, to mitigate risk.

VA's Initiatives Targeting Opioid Abuse | Karen Drexler, MD

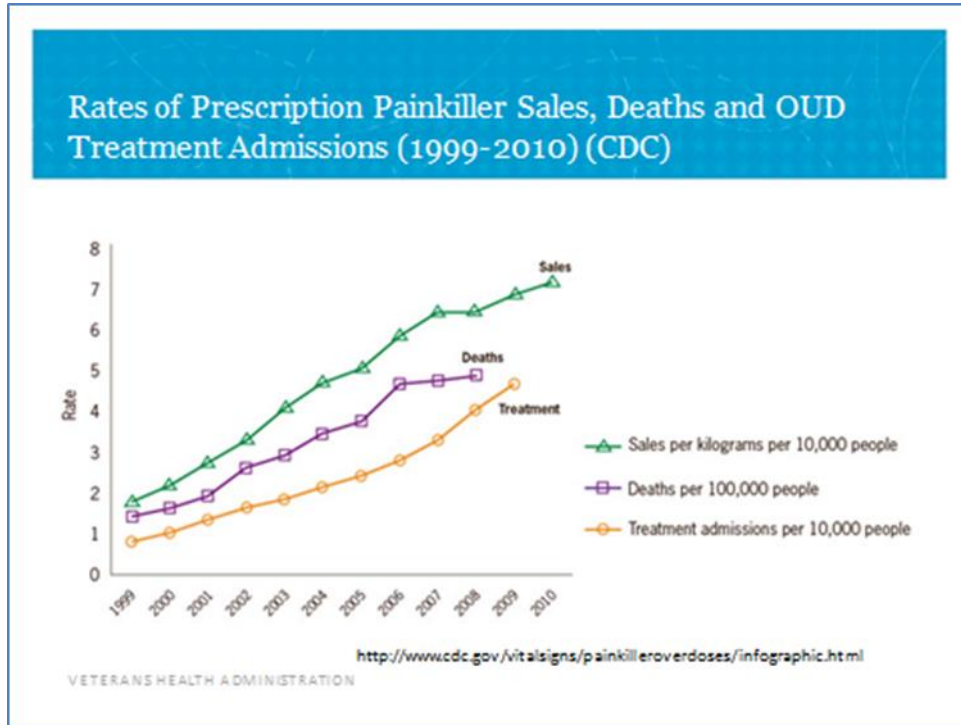
There has been a steady increase in the prevalence of OUD and overdose deaths from 1999 to 2010 that corresponded with a dramatic rise in sales of prescription pain killers (19). (Figure 3). By 2008, for every prescription painkiller death, there were 10 treatment admissions for abuse; 32 emergency department visits for misuse or abuse; 130 people who abused or were dependent; and 825 non-medical users (20). When buprenorphine became available as an effective treatment for OUD in 2007, VA launched the Buprenorphine in VA Initiative. In 2009 VA established a National Office for Pain Management Practices, creating standardized metrics for pain management therapies in 2011. The Opioid Safety Initiative was activated in 2013 and targeted interventions for opioid reduction began in 2014. As a result of these efforts, between 2012 and 2016 there

- **170,000** fewer Veterans were prescribed opioids (**25%** reduction)
- **51,000** fewer (**42%** reduction) concomitant use of opioids and benzodiazepines
- **19,000** less (**32%** reduction) in dosage of those on chronic opioids

Impact of VA Initiatives targeting opioid use: 2012-2016

was a 25% reduction in the number of Veterans who were prescribed opioids; a 42% decrease in the number who were using both opioids and benzodiazepines – a deadly combination with high risk of overdose; and a 32% reduction in dosage for Veterans being prescribed chronic opioids.

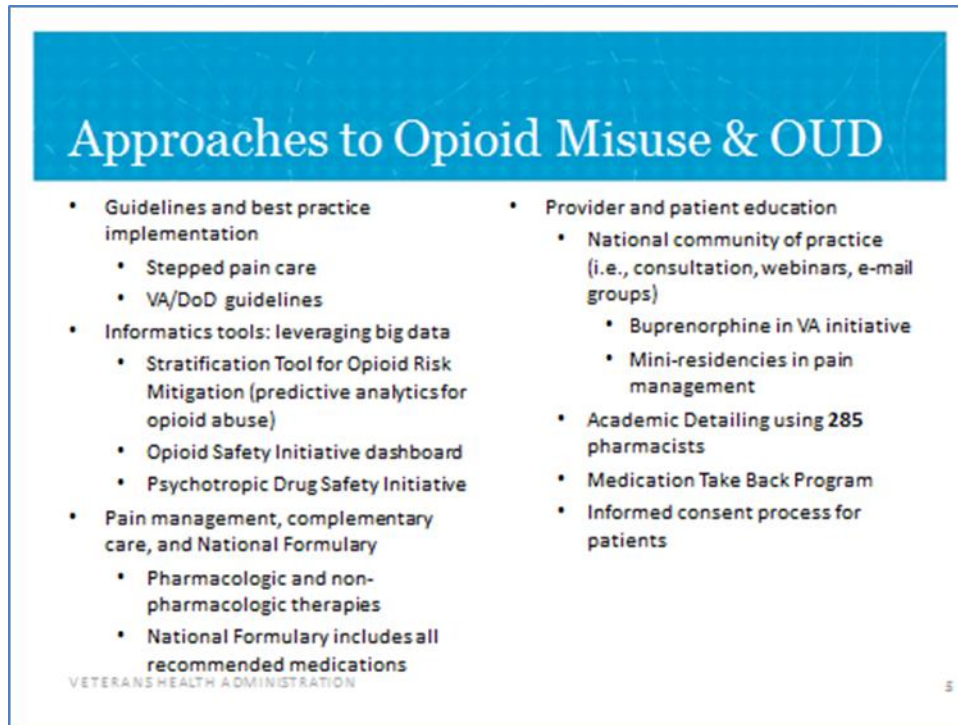
Figure 3



VHA has a broad array of resources for identifying and treating opioid misuse and OUD, including guidelines and best practice implementation; pain management and complementary care; informatics tools to identify Veterans at risk; and provider and patient education programs and initiatives (Figure 4). Of particular note is the Stratification Tool for Opioid Risk Mitigation (STORM) that can predict adverse outcomes, including accidental overdose and suicide for individual Veterans over the next one and three years (21). This tool allows primary care physicians and facilities to prioritize attention and resources for the highest risk patients.

There is strong evidence that medication assisted treatment can be effective and life-saving for individuals with opioid use disorder. Clinical practice guidelines indicate opioid agonist treatment (OAT) of buprenorphine and methadone as a first line measure. If this is not available or feasible for the Veteran, extended release injectable naltrexone is recommended. Access to OUD medications within the VA has increased steadily between 2004 and 2015 due to rising demand. In FY 2010, 12,000 patients (27% of OUD patients) received buprenorphine or methadone, compared with 20,000 patients (30% of OUD patients) in FY 2015. In the second quarter of FY 2016, 34% of OUD patients received OAT plus extended release naltrexone.

Figure 4



Looking at policy and practice recommendations for homeless Veterans from the perspectives of engagement, treatment, and housing | Thomas O'Toole, MD

Dr. O'Toole framed the discussion of policy and practice recommendations to address opioid use disorders among Veterans experiencing homelessness within three key domains: identification, assessment, and engagement in care; treatment; and housing policies.

Identification, Assessment, and Engagement

Substance use is frequently self-identified as a major or contributing factor to becoming homeless. Case managers have a unique relationship, points of contact, and perspective with their homeless and formerly homeless clients. To what extent can their role be appropriately expanded to improve VA efforts to identify, assess, and engage Veterans with OUD or at risk?

From a care management and coordination perspective, this requires a focused attention to individualized risks, the ability to identify potential warning signs and indicators of use and presence of opioid use disorder, and the capacity to engage the Veteran in medication assisted treatment if indicated. From a practice and possibly policy perspective, the issue is how well these skills are being taught, reinforced, and monitored among outreach and case management staff working with high risk Veterans who are experiencing or have recently experienced homelessness. From a systems perspective, this also requires enhanced effort to assure that a rapid referral pathway to medication assisted treatment is in place, that the Veteran is able to engage in ongoing primary and mental health care to ensure that associated care needs are also being addressed, and that there is an intensified focus on cultivating alternative behavioral rewards such as work and recreation (22).

Treatment

As discussed earlier, medication assisted treatment is highly effective for OUD with and without additional psychological interventions. Additionally, while not a treatment for opioid use disorders per se, naloxone, originally as an injectable and now available for intranasal administration, is a useful patient- and first-responder intervention aimed at reversing the effects of an opioid overdose. While the VA has greatly expanded capacity for MAT, there are questions of whether homeless Veterans can effectively access these treatments, to what extent alternative Points of Care may need to be developed, and how MAT interfaces with Housing First and a harm reduction approach.

Housing Policies for Veterans with Opioid Use Disorders

Ending homelessness among Veterans has been a VA priority focused on getting Veterans into housing that follows a Housing First policy and paradigm. How does opioid use treatment intersect and at times conflict with current housing policies and practices?

The relationship between housing and participation in substance use disorder treatment introduces potential conflicts (10). Some VA housing efforts, notably Health Care for Homeless Veterans (HCHV) emergency contract housing and VA domiciliaries, may be closely aligned with substance use disorder treatment programming so that an integration of housing and treatment can be achieved. However, in other settings, particularly when housing is through a contracted agency or community organization, policies and/or staff resistance towards accommodating Veterans with OUD can be less well-defined or even counterproductive. This is the case when housing policies exclude client participation in either buprenorphine-based or methadone maintenance-based therapy. Anecdotal reports of obstacles to the level of integrated care and treatment needed by homeless persons reference the logistics of patient self-management, particularly of weekend and take-home dosing, the safe storage of these medications in congregate settings, as well as the challenges of patient transportation to and from a treatment site for daily and weekend dosing,. The result is often that the homeless Veteran has to choose between participating in an evidence-based effective treatment for OUD and staying or returning to homelessness, especially if treatment-based housing is not available. Finally, mixing populations of Veterans engaged in a treatment/recovery model with those actively abusing drugs and alcohol in the same housing complex can be disruptive.

Panel Discussion and Recommendations

To frame the discussion of recommendations, Matthew Doherty, Executive Director of the U.S. Interagency Council on Homelessness (USICH), commented on the implications of OUD for the ongoing effort to end homelessness among Veterans. He expressed optimism that the problem could be addressed effectively. The national effort to end homelessness in the U.S. initiated in 2010 through Opening Doors: Federal Strategic Plan to Prevent and End Homelessness has reduced Veteran homelessness by 47% and put in place systems and partnerships among the VA, other federal and state agencies, and community organizations that have been successful in addressing a wide range of needs, including substance use disorder. It is clear that these networks and resources can also be marshalled to help Veterans access the resources they need to combat OUD. USICH has issued a brief that identifies strategies that communities, providers and policymakers can use to address the intersection of homelessness and the opioid crisis and highlights resources developed by federal and national partners to support such efforts (23).

Dr. O'Toole presented six recommendations for consideration by the panel. The rationale and caveats reflect the panelists' discussion and incorporate relevant comments and information from individuals who provided input through the symposium's on-line chat room. All recommendations are offered as suggestions to VA leadership for consideration and possible implementation.

1. *Require education and training of homeless program staff on opioid use identification and effective means/channels for engaging Veterans in appropriate treatment.*

Rationale/Caveats:

There was general consensus on this recommendation with the summarized comments:

- Homeless program staff (outreach workers, case managers, peer support specialists, and substance use disorder specialists) are more likely than others to have potentially frequent contact with Veterans actively using opioids.
- Requiring participation in ongoing VA training and skill development in identification, use of risk assessment tools, and effective counseling and referral to treatment is a means to developing an important knowledge base and skill set needed in caring for this population.
- The educational process will not only improve care but also help staff identify resources for referral purposes to assist with treatment and recovery at the local level, including work and recreation opportunities.
- Contingency management may be a useful component of training.
- This initiative will help staff put as much effort, creativity, and focus into helping Veterans maintain housing and build a fulfilling life as they have traditionally invested in getting them housed.

2. *Increase the availability of medication assisted treatment (MAT) in settings more accessible to Veterans experiencing homelessness (i.e., HPACTs, within domiciliaries, Departments of Housing and Urban Development-Veterans Affairs Supportive Housing [HUD-VASH] nurse practitioners, etc.).*

Rationale/Caveats:

While the concept was supported, caveats to implementation were also identified:

- Medication assisted therapy has been shown to be effective in the treatment of homeless Veterans with opioid use disorders but its availability to homeless Veterans who may have difficulty accessing opioid treatment programs in traditional settings can limit its use.
- This recommendation seeks to increase the availability of this level of care in settings oriented towards or more easily accessed by Veterans experiencing homelessness. There may, however, be site-specific limitations, both structural and from staff resistance, that would need to be addressed or accommodated to accomplish this.
- Within the VA, MAT is only provided in VA substance use disorder specialty clinics, where same-day access is not universally available. To move toward the goal of making same day access available at all points of care (POC), it would be useful to know what minimum resources would be needed at each POC.
- There is also a need to build new models of delivery that better coordinate care among VA health services and provide a hand-off capacity from SUD specialty clinics to primary care clinics.

3. *Survey the field to identify and then work to address barriers to Veterans enrolled in medication assisted treatment (buprenorphine, methadone) programs being able to secure housing in*

VA-contracted housing (Grant and Per Diem [GPD], project-based HUD-VASH, and non-VA housing serving our homeless Veterans (state homes).

Rationale/Caveats:

Considerations of this recommendation included:

- While VA policy supports Veterans receiving medication assisted treatment in VA housing, this policy does not necessarily extend to contract-based community housing or in non-VA housing serving homeless Veterans. We need to understand how prevalent this practice is in these settings and why it is occurring in order to develop strategies to address it.
- Decisions should be made at the community and system level, rather than by individual program.
- Providers have expressed a need for education and training in this area.

4. *Equip and train HUD-VASH case management staff to conduct on-site urine toxicology screening to help them identify and monitor risk for opioid abuse if and when it may be appropriate in the context of their case management duties.*

Rationale/Caveats:

While no consensus was reached, pros and cons of the issue were identified:

- A more active approach to assessing risk and need for treatment among recently re-housed homeless Veterans who may be susceptible to relapse and opioid use is called for. As case managers are on the front line in providing routine assessments, they need to be better equipped to facilitate the necessary referral steps for treatment, especially for Veterans in HUD-VASH who are not engaged in ongoing clinical care. The challenge is ensuring that having this capacity does not diminish their ability to establish and maintain a therapeutic relationship or interfere with Housing First principles.
- Some panelists and members of the audience expressed strong disagreement that case managers should conduct toxicology screenings, arguing that this was beyond their competence and scope of responsibilities and would threaten the therapeutic alliance.
- Other panelists, particularly SUD clinicians, emphasized the importance of screening as a source of data for measuring results and gauging progress.

5. *Ensure accessibility to naloxone rescue kits at VHA-contracted congregate living settings where homeless Veterans reside (i.e., GPD transitional housing, HCHV contract housing) with appropriate training for supervising on-site staff on administering these kits in the event of an opioid overdose.*

Rationale/Caveats:

- Naloxone rescue kits have been shown to save lives. The VA has dispensed 60,000 naloxone kits to date for individual Veterans.
- The Comprehensive Addiction and Recovery Act passed in November 2016 legislates maximizing the availability of antagonists, including naloxone, to each pharmacy on any Veteran campus and to all Veterans identified as at risk for overdose. The legislation also eliminates copays for Veterans determined to be at risk.
- Another avenue for expanding availability of naloxone within VA is to add regulations to allow shelter staff and housing providers to obtain their own naloxone prescriptions.

- The availability of naloxone kits in settings where homeless Veterans reside and in Community Resource and Referral Centers (CRRCs), together with the training of supervisory staff, represent a sound public health practice necessary in the context of this epidemic. Currently, the VA is working on a policy to enable staff to administer the kits.
- Additional considerations related to safe storage, VA prescribing restrictions, and local policies will all need to be considered.

6. *Target efforts to engage high risk Veterans who are not assigned to a primary care team (Patient Aligned Care Team [PACT] or HPACT) or receiving ongoing mental health/substance use disorder services into longitudinal care teams.*

Rationale/Caveats:

There was also general consensus on this recommendation:

- Underlying mental health, substance use disorders, chronic and acute pain, and disabling conditions can all make a homeless Veteran more susceptible to developing an opioid use disorder. Proactive and ongoing care of these underlying issues is an important preventive measure, yet, all too often, the emphasis on securing housing is not coupled with engagement in primary and mental health care. How effective referrals are at getting these Veterans into care will likely be dependent on facilitated access, capacity, and care team flexibility and adaptability to the unique challenges associated with treating this population.
- Use of STORM (Stratification Tool for Opioid Risk Mitigation) and other screening databases to identify Veterans with OUD or at risk, together with motivational interviewing, can be effective tools for targeting.
- Increase efforts to make pain treatment more available to Veterans, particularly alternative therapy resources.

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