

# **SUPPORTIVE HOUSING AND THE OPIOID CRISIS**



***About CSH:***

CSH is the national champion for supportive housing, demonstrating its potential to improve the lives of very vulnerable individuals and families by helping communities create over 335,000 real homes. CSH funding, expertise, and advocacy have provided \$1 billion in direct loans and grants for supportive housing across the country. Building on nearly 30 years of success developing multi and cross-sector partnerships, CSH engages broader systems to fully invest in solutions that drive equity, help people thrive, and harness data to generate concrete and sustainable results. By aligning affordable housing with services and other sectors, CSH helps communities move away from crisis, optimize their public resources, and ensure a better future for everyone. Visit us at [csh.org](http://csh.org).

***Acknowledgements:***

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***About this Report:***

CSH conducted a survey of supportive housing agencies across New York State to examine opioid use and overdose among supportive housing tenants, and to identify what services and support agencies could use to better assist their tenants who have an opioid use disorder. This report outlines the following:

- I: Purpose
- II: Introduction
- III: Methods
- IV: Results
- V: Discussion and Recommendations
- Appendix

## Executive Summary

Opioid overdose continues to be a key health concern in the United States. There were 67,367 deaths due to overdose in 2018 alone,<sup>1</sup> with over two-thirds involving opioids.<sup>2</sup> Past research has suggested that people experiencing homelessness have above average risks for opioid overdose.<sup>3</sup> Drug overdose is now a leading cause of death among people experiencing homelessness.<sup>4</sup> Less is known, however, about risk for overdose among residents of permanent supportive housing. To begin to gather information on this topic, the Corporation for Supportive Housing (CSH) conducted a survey of supportive housing agencies across New York State to examine opioid use and overdose among supportive housing tenants, and to identify what services and support agencies could use to better assist their tenants who have an opioid use disorder.

This report compiles survey responses received from 49 supportive housing agencies, 25 in New York City and 24 from the rest of New York State. Overall, 65% of agencies surveyed reported feeling the opioid epidemic was a large or very large concern for their organization. Two-thirds of the agencies surveyed reported having opioid overdoses occurring at their supportive housing buildings in the past year, amounting to at least 142 suspected tenant opioid overdoses. Across all agencies that responded to the survey, at least 118 tenants had died of a suspected opioid overdose in the past five years, with 60% of agencies responding to the survey reporting at least one death.

Agencies varied in services they offered for tenants with opioid use disorder and in their preparedness to respond to a tenant overdose. Approximately one-third (35%) of agencies reported that less than half of their staff were trained to administer naloxone. Most agencies reported that their staff were at least moderately comfortable with tenants receiving medication for opioid use disorder (MOUD) such as methadone and buprenorphine. Respondents cited barriers for tenants receiving MOUD and harm reduction services including stigma related to opioid use, insurance coverage, lack of provider availability, lack of transportation, perceived tenant readiness, and lack of provider education.

### **Key Findings and Recommendations include:**

1. Two-thirds of agencies identified additional “training” as a resource that would be useful to better serve tenants with opioid use disorder. ***Even agencies that already offered relatively robust services to assist tenants with substance use requested and would benefit from additional trainings, specifically naloxone training.***
2. Permanent supportive housing providers require support in resolving practical barriers to assisting tenants in accessing MOUD such as lack of transportation and adequate treatment provider options. The COVID-19 pandemic has resulted in expansion of new models for substance use treatment, such as telehealth, that could help address some of these barriers. For example, NYC Health and Hospitals created a virtual buprenorphine clinic to continue to provide their patients treatment during the pandemic.<sup>5</sup>
3. Nearly one-quarter of agencies reported “stigma” to be a barrier preventing tenants from receiving harm reduction services or treatment including MOUD. Stigma is held not only by staff but in many cases among tenants themselves. ***Providing additional education to staff and***

<sup>1</sup> <https://www.cdc.gov/nchs/products/databriefs/db356.htm>

<sup>2</sup> <https://www.cdc.gov/mmwr/volumes/69/wr/mm6911a4.htm>

<sup>3</sup> <https://pubmed.ncbi.nlm.nih.gov/29852450/>

<sup>4</sup> <https://www.sfdph.org/dph/hc/HCAgen/2019/February%2019/Homeless%20Mortality%20-%20Health%20Commission%20Background%20Reading%2020180219.pdf>.)

<sup>5</sup> [Virtual Buprenorphine Clinic | NYC Health + Hospitals \(nychealthandhospitals.org\)](https://www.nychealthandhospitals.org/virtual-buprenorphine-clinic)

*tenants on opioid use disorder, MOUD, and related stigma may foster an environment where staff are more likely to openly talk about these topics with tenants.*

## I. Purpose

The goals of this survey and report were:

- To understand more about the landscape of permanent supportive housing tenant opioid use, overdose, and substance use treatment, as well as related services currently offered to tenants;
- To identify barriers and gaps in connecting tenants with medication for opioid use disorder (MOUD) and other services; and,
- To develop recommendations for future initiatives to assist permanent supportive housing providers and tenants in reducing risk of tenant overdose.

## II. Introduction

Opioid use and overdose continue to affect many across the country. According to the CDC, in 2018 alone there were 67,367 drug overdose deaths in the U.S., with over two-thirds (69.5%) involving an opioid.<sup>1,2</sup> Drug overdose death rates increased in 35 of 50 states, plus the District of Columbia, from 2013 to 2017.<sup>8</sup> Deaths involving synthetic opioids, such as fentanyl, continue to increase,<sup>1,2</sup> due in part to increases in the presence of fentanyl and its analogs in the last several years.<sup>9</sup> Although the opioid epidemic is sometimes portrayed as an epidemic of middle class white suburban youth, rates of drug overdose involving fentanyl are increasing most rapidly among non-Hispanic black Americans.<sup>10</sup>

In New York City (NYC), fentanyl was the most common substance involved in drug overdose deaths in 2018. Of the total 1,444 unintentional drug overdose deaths reported in NYC in 2018, more than half (60%) involved fentanyl. Overdose deaths involving fentanyl are disproportionately occurring in residents of high poverty neighborhoods.<sup>11</sup> Beyond NYC, opioid use and overdose have affected many individuals across the entire state of New York. Statewide data shows that from 2010 to 2017, deaths from all opioids increased 200%, from 1,074 to 3,224 yearly.<sup>12</sup> Once again, synthetic opioids, specifically fentanyl, are the primary driver of this increase.<sup>12</sup>

Studies have suggested that homelessness is associated with a higher than average risk for opioid use and overdose.<sup>13</sup> Homelessness is also strongly associated with known risk factors for overdose, including polysubstance use, incarceration, IDU, lack of access to MOUD, and prescription opioid misuse. Drug overdose is now the leading cause of death among individuals who are homeless in New York City and other cities in which it has been examined.<sup>4-7</sup> While some elements of

### Terminology

**Opioids:** substances that interact with opioid receptors on nerve cells in the body and brain to reduce intensity of pain signals. They can be categorized as natural (e.g. heroin, morphine), synthetic (e.g. methadone, fentanyl), or semi-synthetic (e.g. oxycodone, hydromorphone) opioids. Opioids, whether illicit or prescription, can produce euphoria in addition to pain relief and lead to addiction, increasing the risk of overdose.<sup>19</sup>

**Naloxone (Narcan):** a safe and effective drug that can be administered by anyone (not only health care providers) to immediately reverse an opioid overdose and prevent death.<sup>20</sup>

**MOUD (medication for opioid use disorder):** long term treatment option for opioid use disorder that includes methadone, buprenorphine (trade names include Suboxone and Subutex), and naltrexone. These medications help decrease withdrawal symptoms and cravings, and do not produce the same feelings of euphoria that other opioids do. MOUD was previously also known as “medication-assisted treatment” or “MAT.”<sup>21</sup>

health may improve, the risk for overdose does not disappear once individuals are placed in permanent supportive housing. Many supportive housing tenants have substance use disorders, including opioid use disorder. Overall, little is known about rates of opioid use or overdose among supportive housing tenants, or about best practices for serving tenants with opioid use disorder. However, previous research conducted in San Francisco has shown high rates of overdose deaths in single room occupancy buildings, which include supportive housing.<sup>14,15</sup>

The Corporation for Supportive Housing (CSH), a national leader for solutions that use housing as a platform for services to improve the lives of homeless individuals, developed an Addiction 101 webinar series, in which providers can learn more about addiction related topics. CSH has hosted events in the past like the Substance Use Treatment & Housing Forum, which bring together experts across the fields of substance use treatment, mental health, and supportive housing to promote discussions around finding new ways to better serve individuals experiencing homelessness who have substance use disorders. CSH wishes to continue its work providing supportive housing providers with information and resources on how to best serve tenants with opioid use disorder, including identifying and serving tenants who may be at risk for overdose. To gain a better understanding of current practices and the needs faced by supportive housing agencies, CSH undertook a survey of supportive housing providers in New York.

### III. Methods

CSH conducted a survey of supportive housing provider agencies in New York State (NYS) to determine their experiences with tenant opioid use, overdose, receipt of treatment for opioid use disorder, and needs related to the opioid crisis.

The survey, consisting of 23 multiple choice and free answer questions, was sent via email to 160 supportive housing agencies throughout NYS on October 29, 2019. Agencies were identified through comprehensive provider listings. All surveys were emailed to key contacts at each supportive housing agency. There were four survey reminders sent between October 29, 2019 and February 2020. The full survey appears as Appendix 1 to this report. Agencies were asked how many supportive housing buildings they operated or served, and questions were answered at the agency level (i.e., not by individual facility or building). Survey questions examined attitudes of agencies and their staff regarding the opioid crisis; status of opioid use and overdose among supportive housing tenants and visitors; agency preparedness in regard to opioid use and overdose; barriers in tenant use of MOUD; substance use related services offered by the agencies; and resources agencies would find useful in serving tenants with opioid use disorder.

At the conclusion of the survey period, 52 completed surveys had been returned representing 49 different agencies (30.6% response rate). The three duplicate responses for agencies that completed the survey twice were consolidated by combining the free answer responses of each agency and considering only the most recent responses for the rest of the survey questions. We present aggregate results from the survey.

### IV. Results

In total, 49 unique permanent supportive housing provider agencies completed the survey; 25 agencies were located in NYC and 24 were located in the rest of NYS. Of the agencies responding to the survey, 41 operate scattered site units and 33 operate congregate (single site) units. There was an average of 261 tenants served per agency, with a median of 164 tenants and a range of 0 to 2,300 tenants.

Survey results are organized below by topic, including tenant opioid use and overdose, MOUD use in PSH, and substance use services and needs in supportive housing.

## TENANT OPIOID USE AND OVERDOSE

Overall, 65.3% of respondents reported that the opioid epidemic was a very large or large concern for their agency's supportive housing work.

### How much of a concern is the opioid epidemic for your agency's supportive housing work?

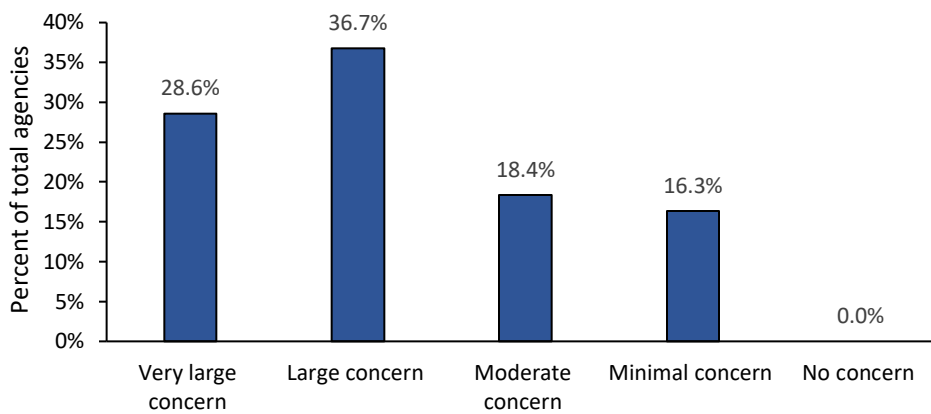


Figure 1

### Tenant use of opioids

Agencies were asked to approximate what percentage of their agency's total supportive housing tenants "used illicit opioids including heroin, fentanyl, or prescription opioids other than as prescribed?"<sup>6</sup> Of the agencies that responded to this question (n=48), 21 (43.8%) estimated that 1-10% of their tenants used illicit opioids, 21 (43.8%) estimated that 11-50% of their tenants used them, and three (6.3%) estimated that over 50% of their tenants used them. Further details are shown in Figure 2.

<sup>6</sup> The majority of agencies provided a response representing a full integer percentage. Four agencies provided irregular responses including "<30%", "below 5%", "less than 10%", and "less than 1%", which were consolidated and included in data as "29%", "4%", "9%", and "0%", respectively. One agency responded with "we do not track this," resulting in total of 48 responses for this question.

## Percentage of total tenants estimated to use illicit opioids

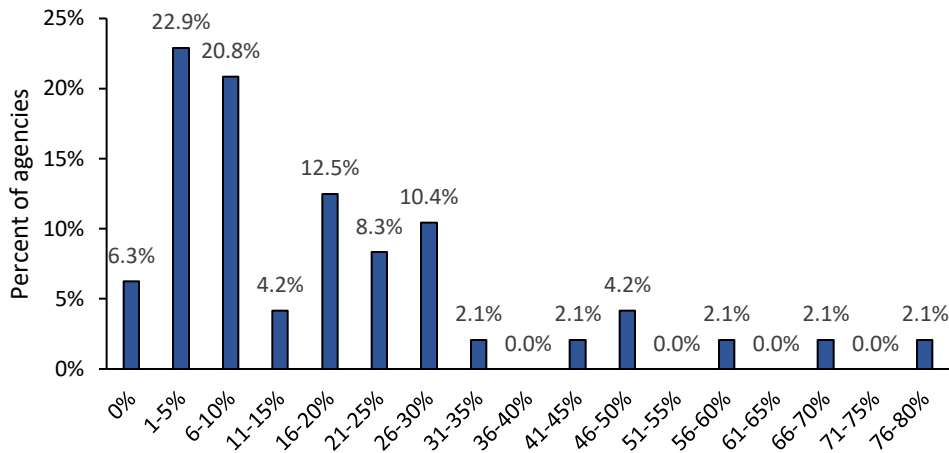


Figure 2

### **Past year opioid overdose**

Agencies were asked to estimate the total number of fatal and nonfatal suspected overdoses involving opioids among their supportive housing tenants in the past year. Agencies were instructed to include any overdose that may have involved opioids, even if other drugs were involved too, and to count each episode separately if the same tenant had more than one overdose.

Overall, 31 (63.3%) agencies reported at least one opioid-involved overdose among supportive housing tenants in the past year. Across agencies responding that there was an overdose, at least 142 suspected opioid-involved overdoses were reported, including fatal and nonfatal, among tenants in the past year.<sup>7</sup>

**In the past year, at least 142 suspected opioid-involved overdoses, fatal and nonfatal, occurred among supportive housing tenants across the responding agencies (n=46).**

Overall, 23 (47.9%) agencies reported between 1-5 opioid-involved overdoses among tenants in the past year, while eight (16.7%) agencies reported more than five overdoses among their tenants in the past year. Overall, overdose appears unequally distributed across agencies, with approximately one-third of agencies (n=17, 35.4%) reporting no tenant overdose in the past year but four agencies (8.3%) reporting over 10 tenant overdoses in the past year.

### **Past year opioid overdoses among non-residents**

Agencies were also asked to estimate the total number of fatal and nonfatal suspected overdoses involving opioids among *non-residents* (visitors, etc.) in their agency’s facilities in the past year. Across all

<sup>7</sup> Three agencies reported “<5,” “10%,” and “0.02%” and therefore could not be included in the total overdose count calculation but are included in the count of agencies reporting at least one opioid overdose. The agencies reporting “<5” and “0.02%” are included in the 1 to 5 overdose category (the agency reporting “0.02%” clarified there was at least one overdose). The agency reporting “10%” is not included in the categorical calculations.

agencies surveyed, 64 suspected overdoses involving opioids occurred among non-residents in supportive housing buildings in the past year. Twenty (40.8%) agencies reported at least one overdose involving opioids among non-residents (Figure 4).

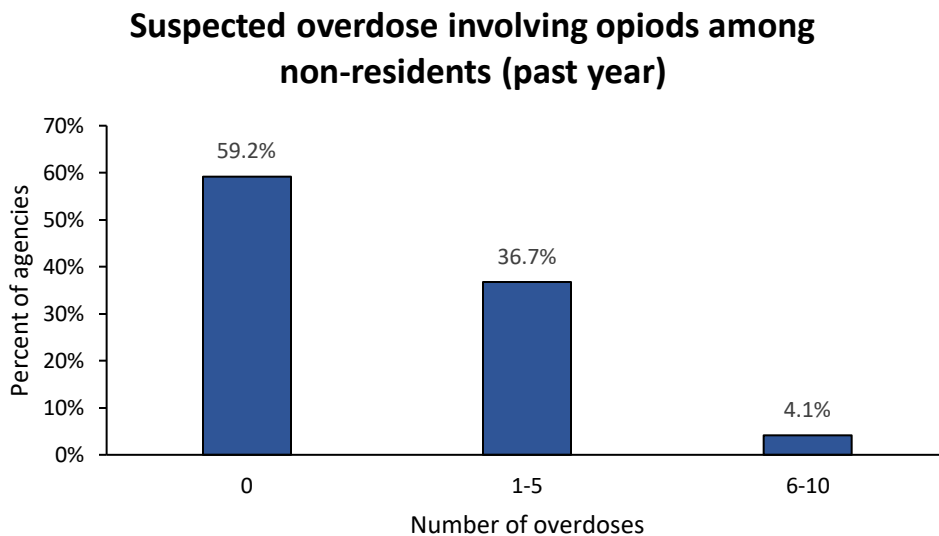


Figure 4

### **Overdose location**

Survey respondents were asked where tenant overdoses had occurred, and they selected pre-specified location types from a list or wrote in other locations. “Tenant apartment” was the most commonly reported location for tenant opioid overdose, with 31 agencies reporting opioid overdoses occurring in this location. This location was followed by “outside the grounds of the supportive housing building” (11 agencies), “other supportive housing common areas” (six agencies), “sidewalk or other outside area contiguous to the supportive housing building” (six agencies), and “supportive housing building lobbies” (three agencies). Additional locations written in by five respondents included “friend’s house,” “in store,” “outside near office locations,” “hospital,” and “at client’s mother’s home and at [a] harm reduction agency.” Ten agencies did not provide a location and indicated there were no reported overdoses at their agency or indicated “N/A” as a response.

### **Naloxone administration**

Agencies were asked to approximate how many times naloxone (Narcan™) had been administered by a staff member at their facilities in the past year. Across all agencies surveyed, naloxone had been administered 37 times by a staff member at a supportive housing facility in the past year. Overall, 40 (81.6%) agencies reported never administering naloxone, three (6.1%) reported one use, two (4.1%) reported two uses, one (2.0%) reported three uses, one (2.0%) reported five uses, one (2.0%) reported seven uses, and one (2.0%) reported 15 uses.



### ***EMS response for opioid overdose***

Survey respondents were asked to approximate how many times emergency medical services (EMS) had been called to their supportive housing facilities for a suspected opioid overdose in the past year. Across all 45 agencies who responded,<sup>8</sup> EMS has been called a total of 164 times to supportive housing facilities for a suspected opioid overdose, an average of 3.6 times per agency. Categorizing the responses, 21 (45.7%) of the 46 agencies who answered this question reported never calling EMS, five (10.9%) reported calling EMS one time, four (8.7%) called 2-3 times, five (10.9%) called 4-5 times, six (13.0%) called 6-10 times, three (6.5%) called 11-15 times, and two (4.3%) called 20-25 times.

### ***Deaths from overdose***

In the past five years across 46 agencies responding, at least 118 permanent supportive housing tenants were reported to have died after suspected overdose involving opioids.<sup>9</sup> Overall, 29 (60.4%) agencies reported at least one death in the past five years after a suspected opioid-involved overdose. Four (8.7%) agencies reported 10 or more deaths involving opioids, with one agency reporting 30 deaths in the past five years.

**In the past five years across 46 agencies, 118 tenants had died after a suspected overdose involving opioids.**

## **MEDICATION FOR OPIOID USE DISORDER (MOUD) IN SUPPORTIVE HOUSING**

### ***Methadone and buprenorphine acceptance in supportive housing***

Survey respondents were asked if their supportive housing agency allowed tenants who are taking methadone and buprenorphine to treat opioid use disorder (OUD). All 49 agencies responding to the survey reported that they accepted tenants who were taking methadone, though two (4.1%) reported allowing tenants who were taking methadone at only some of their buildings. Similarly, all 49 supportive housing agencies reported allowing tenants who were taking buprenorphine (Suboxone), though two (4.1%) allowed this at only some of their facilities.

### ***Staff comfort with tenant use of MOUD***

Agencies were asked to estimate the comfort level of their staff with tenants who take MOUD, including methadone and buprenorphine (Suboxone). Overall, 28 (57.1%) respondents reported that their staff were “very comfortable” or “extremely comfortable” with tenants who use medications for opioid use disorder (Figure 5).

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<sup>8</sup> One agency reported “<10” and therefore could not be included in the total and mean calculations but is included in the 6 to 10 category in the categorical analysis.

<sup>9</sup> Most agencies provided a response representing a full integer. One agency provided a percentage, “10%”, instead of a full integer as a response; 10% of the agency’s total tenants would have been >30 but given ambiguity about what “10%” referred to results are only reported as “at least one overdose death” and not included in count or categorical calculations. The second irregular response provided was “<10” which was not included in the total count of overdoses or categorical calculations but is included in the count of agencies reporting at least one overdose death. One agency did not provide a response to this question and is not included.

## Staff comfort level with tenants who take MOUD

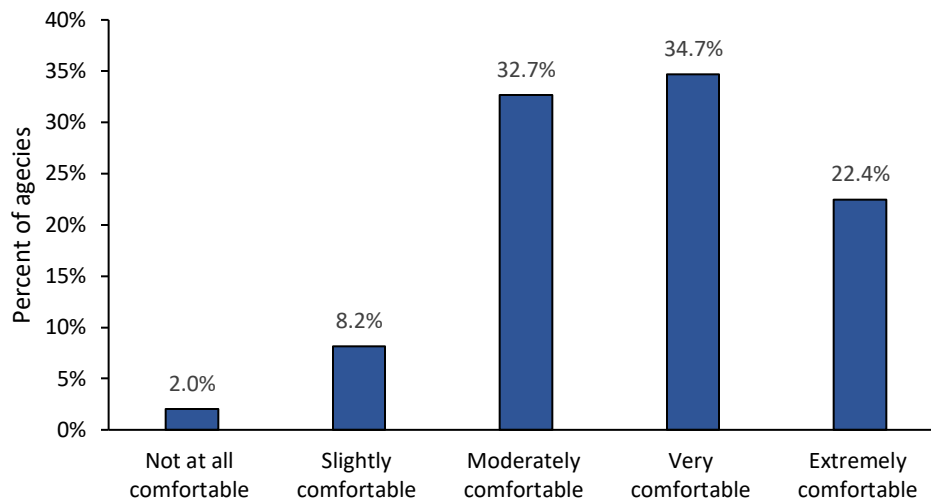


Figure 5

Agencies were asked to elaborate on their response to this question. Agencies that reported their staff being “not at all comfortable” stated this was because none of their clients use opioids as far as they are aware and as a result they have no practical experience with tenants using MOUD and noted budgetary concerns to “support the more highly skilled staff that we would need if we were to have a sudden influx of clients dealing with opioid addiction.” Agencies that reported their staff to be “slightly comfortable” noted that staff have “varying degrees of understanding” in regards to MOUD and that more training was needed for their staff on this topic.

Agencies that reported their staff to be “moderately comfortable” elaborated on their responses with varying sentiments. One agency reported that staff members were comfortable working with tenants taking MOUD as a result of multiple years of experience. Others stated that their agencies promoted a “harm reduction” approach with tenants. Regardless of the reason behind their comfort level, multiple agencies (n=4) reported that they are open to additional trainings for their staff. Notably, some agencies reported that tenant use of MOUD can be a controversial topic with certain staff members. One agency stated, “Some staff continue to struggle with the concept of MAT [MOUD] in addiction treatment when they observe the addictive/abusive behavior carry over to the MAT [MOUD] substance.” Another agency reported, “... There is a mix of opinions on MAT [MOUD] and how it relates to sobriety.”

Agencies that reported staff were “very comfortable” with tenants who take MOUD noted that their staff were well trained on the topic of harm reduction and treatment options for substance use disorder, and as a result staff had little concerns working with tenants who were taking MOUD. Notable responses included, “We provide ongoing training on Harm Reduction and substance use agency-wide so housing staff are very comfortable working with people who use MAT [MOUD].” Another agency stated, “Staff have been educated on the benefits of our consumers seeking out and receiving MAT [MOUD] Services. There have been no reports of staff feeling uncomfortable regarding this area of service.” However, one agency did report, “Generally staff [are] very comfortable, but we have one or two members that believe MAT [MOUD] is not effective. Quite a few of our residents are using illicit substances along with their MAT [MOUD].”

Agencies that stated their staff were “extremely comfortable” with tenants taking MOUD also credited successful staff training and years of experience with this tenant population. Many agencies also reported a positive sentiment towards MOUD by noting that they believed they were “effective” and “safe.” Further, one agency stated, “We have a CASAC [Credentialed Alcoholism and Substance Abuse Counselor] on our staff that works directly with the residents ... We receive internal trainings on engaging individuals with substance use in housing.” Another agency elaborated, “Our staff understands the benefit that MAT [MOUD] has for some individuals. We are happy that those we serve are putting in the work to accomplish their goals and we will be here to assist them in any way we can.”

## OTHER OPIOID USE SERVICES AND NEEDS IN SUPPORTIVE HOUSING

### *Naloxone use staff preparedness*

Agencies were asked to approximate what percentage of their staff working at supportive housing buildings or with supportive housing tenants are trained in the use of naloxone to reverse an opioid overdose. Overall, 18 (36.7%) agencies reported that over 90% of their staff are trained in the use of naloxone to reverse an opioid overdose, though a significant number of agencies had fewer staff trained (Figure 6).

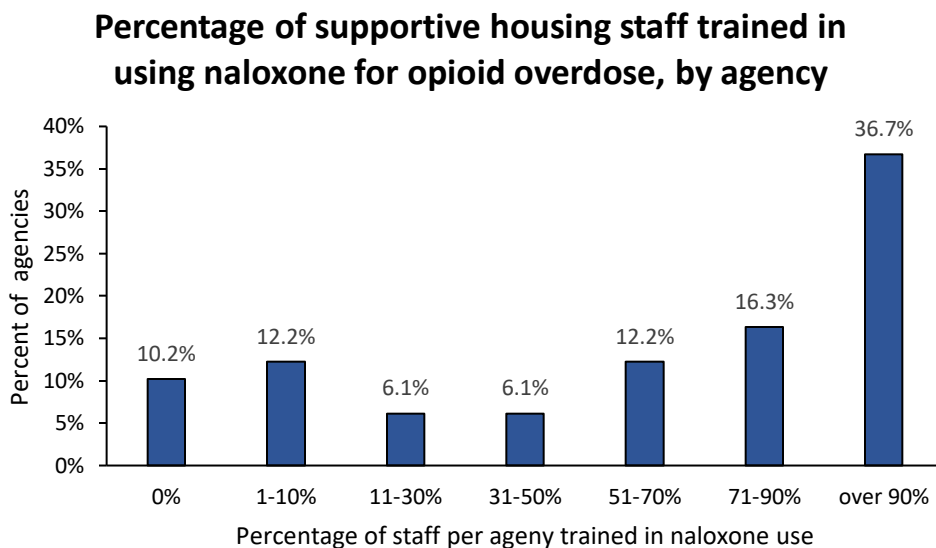


Figure 6

### *Services offered to supportive housing tenants with OUD*

Agencies were asked what services they offered for tenants with opioid use disorder (OUD) by selecting services from a list or writing in other services. Most agencies offered referrals to various substance use services: 45 (91.8%) agencies offered referrals to outpatient substance use programs, 43 (87.8%) offered referrals to inpatient substance use programs, 37 (75.5%) offered referrals to 12-step programs, and 30 (61.2%) offered referrals to MOUD (MAT).

Fewer agencies reported onsite services for OUD: 23 (46.9%) reported offering harm reduction services, 21 (42.9%) offered groups/counseling for substance use, and six (12.2%) had visiting physicians or nurse practitioners for OUD treatment/MOUD. Other services offered provided as free response answers included medical students providing medical related outreach twice monthly onsite, “onsite groups and programming from community service agencies and stakeholders,” and referrals to Health Home care managers.

Agencies were also asked whether they had a memorandum of understanding (MOU) with service providers for MOUD, harm reduction, or addiction treatment. Of the agencies responding, 25 (51.0%) reported having a MOU with any addiction treatment program, 22 (44.9%) had a MOU with any harm reduction program, and 13 (26.5%) had a MOU with any MOUD program. Fewer agencies noted other relevant MOUs including with a medical van and medical center. Two agencies noted that they had their own harm reduction programming. Some agencies without MOUs wrote in further explanation such as, “our housing program staff are trained in harm reduction approach and we have several community providers in the neighborhood,” “there is no explicit document that outlines the available services, but staff is aware of the resources and educates their clients about these resources when appropriate,” and “we are exploring options for MOUs for all of the above.”

### ***Supporting tenants who have opioid use disorder***

Respondents were asked a free response question about how their agency supported tenants who have opioid use disorder and other substance use disorders. The question specified that support could include services offered to tenants, staff trainings, and other such supports. Thirty (61.2%) agencies volunteered that they provided support in the form of trainings. These trainings included harm reduction training, naloxone training for staff and tenants, and trainings on the topic of substance use disorder and MOUD. One agency elaborated on how they used trainings and other resources to support their tenants, stating, “We are constantly training our staff to increase their knowledge base about addiction in order to better understand this disease so that they can support our tenants through their addiction journey. This includes, but [is] not limited to Trauma Informed Care, Harm Reduction, DBT, Wellness Self-Management and trainings about treatment options. ... Most importantly, we offer an environment where tenants feel comfortable discussing their addictions and know that they are not being judged.”

Approximately one-third of agencies volunteered that they support their tenants by providing referrals to treatment providers, detox and rehabilitation facilities, and substance use counseling. One agency elaborated, “Referrals for clean needles, available sharps containers, supportive counseling, onsite psychiatry, harm reduction trainings, wellness groups, informational flyers and referrals to detox and inpatient treatment.” Two agencies also stated that they have memorandums of understanding with multiple community organizations that are able to provide a variety of services including MOUD.

Other ways in which agencies stated they support tenants with substance use disorders included peer support resources in the form of peer support groups, recovery and empowerment groups, wellness groups, and sober support networks. One agency elaborated on this form of support: “We operate a true Housing First model apartment program that provides a home to individuals regardless of where they are in treatment. We also have a Dual Recovery program with groups three times a week, peer support services and social connections to provide a healthy and sober support network for those seeking assistance. We also have close relationships with [substance use treatment] providers in our area providing a warm hand off and working together to best help those we serve.”

Several agencies also stated they provide tenants with supportive counseling, social work counseling, one-on-one counseling, and substance use counseling. Other agencies stated that they provide workshops and NA (Narcotics Anonymous) meetings for their tenants. A few agencies noted their connection with mental health and services they provide to support tenant mental health.

### ***Resources needed to better serve PSH tenants with opioid use disorder***

Agencies were asked what training, technical assistance, or other resources would be useful in serving tenants with OUD. Approximately two-thirds of agencies listed some form of “training” as a resource that would be useful to serve their tenants with opioid use disorder. Specific training topics mentioned by respondents included:

- Naloxone trainings for staff and tenants
- Harm reduction trainings
- Motivational interviewing training
- Training on working with tenants with OUD and co-occurring disorders
- Trainings on MOUD
- OUD Education
- Trainings on how to better serve tenants with OUD
- Trainings on identifying signs of substance use and OUD
- Trainings to help reduce OUD-related stigma

Certain agencies mentioned a desire for educational opportunities to be made available for staff on the topic of OUD more generally, for example “... medical provider provide a training [on] how opioid[s] affect the brain and body.”

Other agencies reported that providing resources for peer support for their tenants would be useful. Another notable response included one agency stating, “An informal survey that can be included in assessments and reassessment to open a dialogue with clients who have opioid use disorder.” One agency also provided the following comment regarding how resources would be most useful, “It would be nice to have rehab programs that were more substantial, longer, and less connected to insurance limitations...”

### ***Barriers to MOUD for supportive housing tenants***

Respondents were asked what barriers their tenants faced in receiving MOUD (including methadone and buprenorphine). Barriers cited included difficulties with transportation to clinic or treatment facilities, provider availability, and health insurance.

Seven agencies — generally those outside NYC — reported transportation to and from clinics or treatment facilities as a barrier to tenants receiving MOUD. One agency summarized this sentiment, stating, “Transportation to providers is the largest barrier. Methadone clinics are at least an hour away from most locations...”

Provider availability was another barrier to receiving MOUD cited by eight agencies, of which two were located in NYC and six in the rest of New York State. Examples mentioned included “long waiting list” to see a provider, “lack of programs,” and “limited locations” to receive MOUD. One agency stated, “... Provider availability is limited due to low number of providers for MAT [MOUD] vs. population requiring

access.” One agency noted dissatisfaction with local MOUD programs: “Dissatisfied with available programs including location, lack of programs, stigma, program won't accept clients with co-occurring disorders such as mental health, structure/strict attendance policy.” Five agencies specifically cited insurance as a barrier for tenants to receive MOUD.

Agencies also reported problems with existing programs, including issues with accessibility for individuals with co-occurring disorders, a need for non-punitive MOUD programs, and complex screening processes to receive MOUD. Examples mentioned included, “methadone treatment is often time[s] very punitive” and “complicated intake processes at MAT [MOUD] providers.”

Other agencies reported “lack of education and understanding amongst providers” as a barrier for tenants to receive MOUD. Some providers and staff have an incorrect or incomplete understanding of harm reduction and MOUD as a treatment modality for individuals with OUD. For example, one agency stated, “MAT [MOUD] is seen as a permanent solution rather than a temporary tool to help them ultimately get clean” (evidence suggests that MOUD should be viewed similarly to medications for other chronic diseases, which are not time-limited, and experts suggest that language such as “clean” be avoided as stigmatizing). Further, some supportive housing agency respondents reported concerns about diversion of medications, reporting worries about tenants “abusing those medications/selling those medications for street value.”

Other barriers for tenants in receiving MOUD reported by agencies included childcare, tenants transitioning from jail/incarceration, stigma, varying patient readiness levels, and continued substance use. Some agencies raised concerns about tenants “returning to using heroin ... opioids on the streets,” “opioids being readily available,” and “other clients using.” Agencies also reported concerns related to “tenants who do not want to discontinue use,” tenant “readiness to commit to MAT [MOUD],” and continued “chaotic substance use.”

### ***Other service barriers for supportive housing tenants***

Respondents were asked about other barriers to care for their tenants in accessing harm reduction or treatment services. Responses were largely similar to those for the more specific question on barriers to MOUD. Major reported barriers included stigma, individual tenant readiness/compliance, transportation, insurance, and accessibility of care.

Nearly one-quarter of agencies reported stigma as a barrier to care for tenants when accessing harm reduction or substance use treatment services. In many cases, this stigma seemed to stem from feelings of guilt about their drug use and lack of acceptance from the community. For example, one agency wrote, “Our tenants’ barriers can be not wanting to attend, due to having to admit they have an issue (shame and guilt).” Another agency suggested, “Perhaps there might be self-shame that could potentially serve as a potential barrier for receiving MAT [MOUD].” One agency offered multiple barriers, including stigma, “Stigma and community members, families, other addicts in recovery, not buying into ‘harm reduction’ as a reasonable alternative.”

Seven agencies cited tenant compliance or readiness to accept treatment services as a barrier. One agency elaborated, “Client[s] in denial that there is no problem with using.” Other agencies stated, “Another barrier is client willingness to accept referrals for higher levels of care and treatment” and “For residents is their resistance to accept changes and learn to adapt to a new healthy lifestyle.” These comments

suggest the potential need for further education for permanent supportive housing providers on harm reduction approaches rather than “all or nothing” treatment approaches.

Transportation and insurance were again cited as barriers (by six and five agencies, respectively) to harm reduction and substance use treatment services more generally, as they were for MOUD specifically. More generally, care accessibility at multiple levels was reported as a barrier by multiple agencies. Regarding this barrier one agency stated, “Facility needs to be accessible to accommodate people with disabilities.” Other agencies reported accessibility to be a barrier in terms of ease with which tenants can receive services. For example, one agency stated, “Accessibility to care continues to be an issue; wait times for appointment are too long.”

Other notable barriers included harm reduction/treatment program provider availability, tenant co-occurring disorders, tenant need for childcare, and inconsistent quality of services provided. Regarding the inconsistent quality of services, one agency stated, “There are different standards from program to program with regard to what is expected from the tenant. Some programs insist on full abstinence while others follow a harm reduction model, and this sends a mixed message to the tenant.”

Some providers also noted barriers from continued substance use among other tenants and the lack of an environment conducive to recovery/improvement. For example, one agency stated, “Congregate settings in particular present challenges when some tenants are actively using, and others have completed treatment and are in recovery.”

## V. Discussion and Recommendations

Our survey of New York supportive housing providers has confirmed that opioid overdose among permanent supportive housing tenants is a concern that warrants urgent attention. The Housing First approach is guided by the belief that people need a stable place to live, without prerequisites such as sobriety. Permanent supportive housing agencies will therefore be called upon to provide services and support for tenants who use drugs, including opioids. To assist tenants in maximizing their health and avoiding consequences such as overdose, permanent supportive housing providers will need appropriate resources, support, and knowledge. Below we describe a few key findings and recommendations.

**Key Finding 1:** Permanent supportive housing agencies desire more training on a range of topics related to OUD and overdose.

**Recommendations:** Overall, 63.2% of agencies responding to the survey listed some form of “training” as a resource that would be useful to better serve tenants who have opioid use disorder. Even agencies that already offered relatively robust substance use services requested additional trainings. Naloxone training was commonly mentioned by surveyed agencies. Other critical areas of training are in understanding MOUD, including dispelling common myths and stigma around MOUD, as well as harm reduction approaches to drug use.

**Key Finding 2:** Providers cited a variety of barriers to assisting tenants in accessing MOUD, including practical barriers such as lack of transportation and adequate treatment provider options.

**Recommendations:** Permanent supportive housing providers require support in resolving practical barriers to assisting tenants in accessing MOUD. Notably, fewer agencies reported referring tenants to

MOUD than referring to 12-step program, despite scientific evidence favoring efficacy of MOUD. Several agencies cited transportation and provider availability as barriers. Only a minority (12.2%) of agencies had visiting physicians or nurse practitioners assisting tenants with opioid use disorder treatment/MOUD. Given the data, making MOUD providers more physically accessible to tenants may increase the number of tenants receiving MOUD. Developing formal partnerships between supportive housing agencies and agencies that provide MOUD may also be useful. Only one-quarter of agencies responding to the survey reported having a Memorandum of Understanding with an agency that provided MOUD. During the COVID-19 pandemic, we witnessed expansion of innovative models including telehealth, virtual/telephonic buprenorphine clinics,<sup>16</sup> and even onsite methadone delivery.<sup>17</sup> Such models may be particularly useful for permanent supportive housing settings.

**Key Finding 3:** Stigma related to opioid use remains a barrier preventing supportive housing tenants from accessing harm reduction or treatment services.

*Recommendations:* Nearly one-quarter of agencies reported “stigma” to be a barrier preventing tenants from receiving vital harm reduction services or treatment including MOUD. In addition to stigma, a general misunderstanding about the role of MOUD itself was evident in several programs. Stigma is held not only by staff but in many cases by tenants themselves. Providing additional education related to opioid use disorder, MOUD, and related stigma can foster an environment where staff are more likely to openly talk about these topics with tenants and offer much needed harm reduction services. Further, tenants may feel more comfortable openly broaching these topics with staff members and their healthcare providers and seeking treatment. Use of peer navigators or other peer support might also be an effective way to reduce stigma while also providing harm reduction education and connection to treatment.<sup>18</sup>

### **Limitations**

The survey was optional. There may be response bias contributing to who completed the survey; for example, agencies who were more interested in the topic or who already provided more services relevant to the topic might have been more likely to respond to the survey. However, the response rate (30.6%) was acceptable for an e-mailed survey and respondents were diverse in geography, knowledge, and experience with OUD, and other characteristics. Survey responses might have also been influenced by social desirability bias (in other words, respondents might not have wanted to answer in a way that would come across negatively for their agency). This survey also only includes provider agencies in New York. However, we believe that many of the findings will still be applicable throughout the country. Future surveys should query about drugs other than opioids, particularly since polysubstance use is common. Future research should also examine whether any location-, agency-, or tenant-level factors are associated with higher overdose rates, and should study how to effectively implement evidence-based best practices for reducing overdose risk in PSH settings.

### **Conclusion**

The COVID-19 pandemic has exacerbated the ongoing opioid crisis and more generally continues to exacerbate stress, mental health, and wellbeing for all of us. In particular, people with substance use disorders may be at heightened risk for recurrence and overdose during this time due to isolation, unstable community treatment, and mental health symptoms and stressors. It is important now more than ever to continue to educate, ensure access to resources, and develop effective practices for tenants living in supportive housing



The results from this survey clearly indicate that supportive housing providers need additional support and resources for their tenants who have opioid use disorder. Responding to the needs of New Yorkers is critical and the following are a few key steps that may help us move toward implementation of the recommendations listed above to assist in reducing overdose deaths in supportive housing.

1. **Targeted Trainings.** Supportive housing providers should be offered specific training that allows them to put appropriate policies and procedures in place. Needed training topics may vary by agency but include both basics and more complex topics related to OUD and MOUD, as well as training in use of naloxone and harm reduction. Additionally, given the continued stigma related to drug use, this must be an area of training and planning.
2. **Developing Partnerships.** Supportive housing providers should develop partnerships with clinical providers of MOUD. Additional partnerships can be made with existing resources in the community including harm reduction programs (such as syringe service programs). In settings with less rich availability of community substance use services, new models such as telehealth may be beneficial.
3. **Include People who Use Opioids in Program Development.** When policies and programming around opioid use interventions are developed in supportive housing, people who use opioids should be included in the planning process. They can provide crucial information to increase safety of use, prevent future overdoses, and decrease stigma.

## Appendix – Supportive Housing Opioid Survey

We are conducting a survey of supportive housing providers to understand needs related to the ongoing opioid crisis. Please respond for your agency. We know that you may not know exact answers for all questions; please make your best approximation. If you have no idea of an approximation, you may write “don’t know” for the question. Your responses will help us assess what types of future research, education, and services would be valuable. For any reports that we make using the survey results, we will not be identifying individual organization’s responses. For any questions or concerns please contact us. Thank you for your time

### 1. Please enter your contact and agency information

Organization Name:

City/Town:

State:

ZIP:

Email Address:

2. How many permanent supportive housing scattered site units does your agency operate?

3. How many permanent supportive housing congregate (single site) units does your organization operate.

4. How many supportive housing tenants total (in all single site buildings or scattered site) does your agency serve?

5. How much of a concern is the opioid epidemic for your agency’s supportive housing work?

- Very large concern
- Large concern
- Moderate concern
- Minimal concern
- No concern

6. Approximately what percentage of your agency’s total supportive housing tenants would you estimate use illicit opioids including heroin, fentanyl, or prescription opioids other than as prescribed?

7. Approximately what percentage (out of 100%) of your agency’s supportive housing tenants are currently using medication-assisted treatment (MAT) for opioid use disorder? These medications can include methadone, naltrexone, and buprenorphine (brand name Suboxone or Subutex)?

8. In the past year, how many total suspected overdoses involving opioids (including fatal and nonfatal) occurred among your agency’s supportive housing tenants? Count overdoses that may have involved

other drugs in addition to opioids. If the same tenant had more than one overdose, count each episode separately.

9. In the past year, how many total suspected overdoses involving opioids (both fatal and nonfatal) occurred among non-residents (visitors, etc.) in your agency's supportive housing units/buildings?

10. In the five years, how many of your agency's' tenants have died after a suspected overdose involving opioids?

11. Where have supportive housing tenant opioid overdoses occurred? Select all that apply.

- Tenant apartments
- Supportive housing building lobbies
- Other supportive housing common areas
- Sidewalk or other outside area contiguous to the supportive housing building
- Outside the grounds of the supportive housing building
- Other (please specify)

12. Approximately how many times has emergency medical services (EMS) been called to your supportive housing facilities for suspected opioid overdose in the past year?

13. Approximately, what percentage of your staff working at supportive housing buildings or with supportive housing tenants are trained in the use of naloxone (Narcan) to reverse an opioid overdose?

- 0%
- 1-10%
- 11-30%
- 31-50%
- 51-70%
- 71-90%
- Over 90%

14. Approximately how many times has Narcan been administered by a staff member at your supportive housing units/buildings within the past year?

15. What services are offered for tenants with opioid use disorder at your supportive housing program? Select all that apply.

- Referrals to 12-step programs
- Referrals to inpatient substance use programs
- Referrals to outpatient substance use programs
- Referrals to medication-assisted treatment (MAT)
- On-site harm reduction services
- On-site groups/counseling for substance use
- On-site visiting physicians or nurse practitioners for opioid use disorder treatment / MAT
- Other (please specify)

16. Does your agency have a Memorandum, of Understanding with any of the following? Select all that apply.

- Any medication-assisted treatment (MAT) program
- Any harm reduction program
- Any addiction treatment provider
- Referrals to medication-assisted treatment (MAT)
- None
- Other (please specify)

17. Do your agency's supportive programs/projects allow tenants who are on methadone?

- Yes, all facilities
- Yes, some facilities (specify percentage of facilities allowing tenants on methadone)
- No (specify reasons)

18. Do your agency's supportive housing programs/projects allow tenants who are taking buprenorphine (Suboxone)?

- Yes, all facilities
- Yes, some facilities (specify the percentage of facilities allowing tenants on buprenorphine/Suboxone)
- No (specify reasons)

19. Across your supportive housing programs/projects, what would you estimate is your staff's comfort level with tenants who use medicine-assisted treatment for opioid use disorder (MAT, including methadone, naltrexone, buprenorphine / Suboxone)?

- Not at all comfortable
- Slightly comfortable
- Moderately comfortable
- Very comfortable
- Extremely comfortable

Please elaborate on your response to the previous question (optional):

20. In what other ways is your agency supporting tenants with opioid use disorder and other substance use disorders? These could include services offered to tenants, staff trainings, partnerships with other organizations, etc...

21. What barriers do your tenants face in receiving medication-assisted treatment (MAT) for opioid use disorder (i.e., methadone, naltrexone, buprenorphine / Suboxone)?

22. What other barriers to care do you see for your residents when accessing harm reduction or treatment services?

23. What training, technical assistance, or other resources would be useful to your agency in serving tenants with opioid use disorder?

24. Please share any other comments.

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