

Integrating Harm Reduction and Homelessness Services

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Objectives

- ▶ To understand the philosophical basis of "Harm Reduction", the movement's historical roots, and how it relates to the homelessness field.
- ▶ To understand the synergy between "traditional" Harm Reduction programming and mainstream homelessness service delivery models.
- ▶ To leave with concrete "next steps" for integrating Harm Reduction into your programming.

Outline

1. Harm Reduction: Philosophy, History, and Practice
2. Substance Use Disorder, Opioid Use Disorder, and Homelessness
3. Integration of Harm Reduction Services into the Homelessness System
4. Reframing Existing Homelessness Services Through a Harm Reduction Lens

Harm Reduction Coalition: Who We Are

- ▶ Founded in 1994 to work with individuals and communities at risk for HIV infection due to drug use and high risk sexual behaviors.
- ▶ Committed to reducing drug-related harm by initiating and promoting local, regional, and national harm reduction education, interventions, and community organizing.
- ▶ Offers specific expertise in how to best integrate the principles of health and safety promotion for people who use drugs.

Some Quick Definitions...

- ▶ **Syringe Services Program:** SSPs, which have also been referred to as syringe exchange programs (SEPs), needle exchange programs (NEPs) and needle-syringe programs (NSPs) are community-based programs that provide access to sterile needles and syringes free of cost and facilitate safe disposal of used needles and syringes. SSPs also engage their participants into broader systems of care.
- ▶ **PWID:** People Who Inject Drugs
- ▶ **PWUD:** People Who Use Drugs
- ▶ **MAT:** Medication-Assisted Treatment (buprenorphine, methadone, or naltrexone – the Gold Standard treatments for OUD)
- ▶ **SUD/OUD:** Substance Use Disorder/Opioid Use Disorder

Some Quick Questions...

- ▶ How many outreach staff/programs are in the room?
- ▶ How many shelter staff/programs are in the room?
- ▶ How many rapid re-housing staff/programs are in the room?
- ▶ How many permanent supportive housing staff/programs are in the room?
- ▶ How many case managers are in the room?
- ▶ How many CoC or other "systems" staff are in the room?
- ▶ How many programs in the room operate from a "Housing First" model?
- ▶ How many of you work in a jurisdiction which has implemented Coordinated Entry?

What does the term Harm Reduction mean?



Harm Reduction Is...

"...A set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built upon the belief in, and respect for, the rights of people who use drugs."*

Harm Reduction can further be defined as "a set of policies, programs, and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop. The defining features are the focus on the prevention of harm, rather than on the prevention of drug use itself, and the focus on and respect for people who continue to use drugs."*

*Definitions paraphrased from the Harm Reduction Coalition and International Harm Reduction Association

The Principles of Harm Reduction

Harm Reduction...

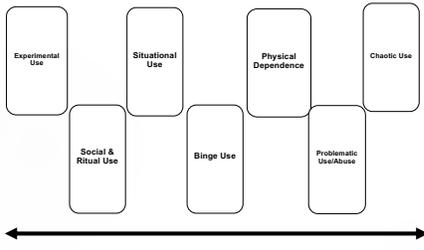
- ▶ Accepts, for better or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
- ▶ Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledges that some ways of consuming drugs are clearly safer than others.
- ▶ Establishes quality of individual and community life and well-being – **not necessarily the cessation of all drug use** – as the criteria for successful interventions and policies.
- ▶ Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.

The Principles of Harm Reduction

Harm Reduction...

- ▶ Ensures that drug users, and those with a history of drug use, routinely have a **real voice** in the creation of programs and policies designed to serve **them**.
- ▶ Affirms drug users themselves as the primary agents of reducing the harms of their drug use, and seeks to **empower users to share information and support each other** in strategies which meet their actual conditions of use.
- ▶ Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination, and other social inequalities effect both people's vulnerability to **and** capacity for effectively dealing with drug related harm.
- ▶ Does not attempt to minimize or ignore the real and tragic harm or danger associated with licit and illicit drug use.

Continuum of Use



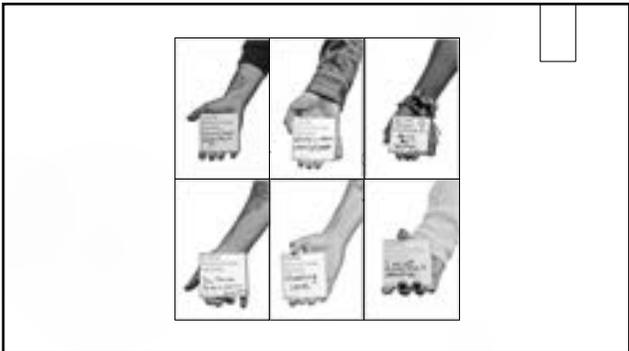


Questions?

Harm Reduction is non-judgmental and non-coercive.

The term Harm Reduction is generally used to refer to...

Harm Reduction	H.R. Services	(h)arm (r)eduction
The philosophical and political movement, as well as the community which makes up that movement. The philosophy provides the foundation for a set of drug user health interventions.	A set of specific substance use, infectious disease, and health interventions typically associated with the movement.	The application of the harm reduction framework broadly in other contexts – such as smoking cessation, heart health, wearing a seat belt, etc.



The History of Harm Reduction – "Nothing For Us Without Us"





US Harm Reduction has its roots in the early days of HIV/AIDS activism

As research demonstrated that contaminated injection equipment was linked to the rapid spread of HIV/HCV among people who inject drugs (PWID), public health researchers and community activists rushed to open underground syringe exchanges.

At the same time, drug users in Vancouver, Canada were founding the Portland Hotel Society, one of the first Housing First programs – just one year after Pathways to Housing was founded.

Harm Reduction Services

As a consequence of the movement's origins at the start of the HIV epidemic, Harm Reduction has become intrinsically linked to a variety of specific drug user health & substance use interventions, namely:

- ▶ Syringe Services Programs
- ▶ Overdose Prevention/Naloxone
- ▶ Medication-Assisted Treatment
- ▶ Wound Care Clinics
- ▶ Peer Outreach/Navigation
- ▶ Maintenance Support Groups



The History of Harm Reduction – "Nothing For Us Without Us"

People coming together to protect each other and to save the lives of their friends, families, and communities. This was the **foundation** of Harm Reduction.



— whether it was legal or not, even as society large was **content to let them die.**



Questions?

Opioid Use Disorder and Homelessness

Why does it matter?

There are direct correlations between homelessness and substance use disorders (SUD). Individuals struggling with an SUD are at increased risk for becoming homeless, have a harder time exiting homelessness, and are more likely to experience co-morbidities and high acuity. Further:

- ▶ Studies among veterans suggest that the presence of an SUD may have the highest impact on relative risk for homelessness, even more so than bipolar disorder or schizophrenia.
- ▶ People struggling with a SUD are 10x more likely to experience homelessness than the general population.
- ▶ Comorbidities like HIV/HCV and mental/behavioral health issues are significantly heightened among people with SUDs.

Opioid Use Disorder (OUD) in particular poses significant risks...

- ▶ While HIV/HCV rates among all PWID have been increasing, among PWID experiencing homelessness those increases have been even more pronounced.
- ▶ Homelessness correlates with riskier drug taking, including injection initiation and riskier injection practices – increasing risk for infectious disease and complications like endocarditis.
- ▶ PWID who are also homeless bear a disproportionate burden of our nation's overdose crisis.
- ▶ There were 64,000 fatal overdoses in 2017. Of those, 33,332 were caused by licit or illicit opioids.
- ▶ Homeless adults, 25-44, are **nines times more likely to suffer a fatal overdose** than their counterparts who are stably housed.
- ▶ Research out of Boston has found that, among their chronically homeless adults, overdose has surpassed HIV as the leading cause of death. Fatal overdose now accounts for 80% of all such deaths.
- ▶ Even being placed into housing carries risks: overdose rates increase in the first year of housing unless adequate supportive services are provided.

In the last year...

- ▶ How many of you know a participant who has been lost to an opioid overdose?
- ▶ How many of your programs have lost a participant to an opioid overdose while they were staying in a site-based housing program (whether shelter, transitional housing, or supportive housing)?
- ▶ How many of you have been trained in overdose prevention? Feel capable of providing overdose prevention education to your participants? Been trained to intervene during an overdose and know how to administer naloxone?

Integrating Harm Reduction Services with Homelessness Interventions

"If HIPS could do it..."



Most harm reduction organizations exist outside of the homelessness service industry.

As a result, many harm reduction agencies are not integrated into their local Continuum of Care.

Distrust of harm reduction philosophy from mainstream treatment providers with ties to the homelessness service industry furthers that divide.

Harm reduction agencies have **always** served people experiencing homelessness – often the majority of an SSP's participants are chronically homeless.

Despite this fact, many people – including harm reduction activists and service providers – struggle to view harm reduction organizations outside of the framework of infectious disease prevention, since this component has largely come to define the domestic harm reduction movement.

Integration of Harm Reduction Services Into The Homelessness System

- ▶ Many harm reduction agencies serve almost exclusively homeless or housing unstable clients.
- ▶ Due to stigma, many PWID – despite being chronically homeless and with significant health needs – distrust mainstream providers and don't access services with them.
- ▶ Harm Reduction Programs, such as Syringe Services Programs, have connections to high needs homeless communities that mainstream homelessness outreach providers can't reach or don't even know exist.
- ▶ The nature of syringe access outreach, person centered service delivery, and "meeting clients where they're at" make harm reduction outreach programs **perfect** platforms from which to provide PATH or even ACT services.
- ▶ Case managers and community health workers at harm reduction agencies can play a critical role in housing navigation and maintaining service engagement to mainstream providers.

Integration of Harm Reduction Services Into The Homelessness System

- ▶ Harm reduction drop-in centers and maintenance groups offer alternatives to abstinence-based homelessness providers.
- ▶ Harm reduction peer navigators are perfectly positioned to do assessment as part of mobile outreach in a coordinated entry system.
- ▶ Harm reduction services integrate well with medical & behavioral health services, and the "Healthcare for the Homeless" model is already co-locating all of these systems to great effect.
- ▶ Syringe Services Programs can now be funded using federal dollars.
- ▶ The Department of Health and Human Services is already laying the groundwork for the integration of Syringe Services Programs into "comprehensive service delivery systems", which is inclusive of homelessness/housing.
- ▶ Homelessness programs receiving funding from the Substance Abuse and Mental Health Services Administration may be surprised to know that SAMHSA funding can support SSPs.

Syringe Services Programs in Ohio

Per the North American Syringe Exchange Network (NASEN)

- ▶ **Ohio Valley Harm Reduction Coalition**
Brooke & Hancock County, WV; Jefferson County, OH
- ▶ **Project SWAP**
Canton, OH
- ▶ **Cincinnati Exchange Project**
Cincinnati, OH
- ▶ **Free Clinic of Greater Cleveland**
Cleveland, OH
- ▶ **Safe Point Program**
Columbus, OH | *Equitas Health*
- ▶ **SafeTrade**
Greene County, OH
- ▶ **Prevention Protection**
Newark, OH
- ▶ **Prevention Not Permission**
Portsmouth, OH | *Portsmouth City Health Department*
- ▶ **Northwest Ohio Syringe Services**
Toledo, OH



Questions?

Reframing Existing Homelessness Services Through a Harm Reduction Lens

Even if your program isn't ready to begin offering syringe exchange, or your area doesn't have an established harm reduction program, there are still ways you can reexamine your programming and systems to make adjustments through a harm reduction framework.

Across the System: Questions to Consider

- ▶ What proportion of your housing stock is Housing First?
- ▶ Are your "Housing First" programs actually able to successfully work w/ individuals who are actively using?
- ▶ Does your system have burdensome eligibility or entry requirements?
- ▶ Is abstinence-based housing the default program model within your system?
- ▶ Is your system focused on linkage-to-care & outreach, or are PWUD required or expected to come to you?
- ▶ Does your system have partnership with "mainstream" harm reduction providers like Syringe Services Programs?

Within Your Programs: Questions to Consider

- ▶ Are your policies oriented towards keeping people housed, or do they facilitate exits into homelessness?
- ▶ Do your policies focus on de-escalating conflict and finding collaborative solutions? Or do they focus on punishing participants who violate the rules?
- ▶ Are **all staff** trained in, and committed to, a harm reduction approach? Is your staff trained in overdose intervention? Does your staff carry naloxone?(from front desk to maintenance staff)
- ▶ Is the goal of your Housing First or low-barrier services that participants will eventually become abstinent? Or is the purpose of adopting Housing First or harm reduction approaches to help participants exit homelessness and maintain their housing?

Within Your Programs: Questions to Consider

- ▶ Do your case managers view their role as working with participants to help them achieve **the participant's goals** or **the case manager's goals**?
- ▶ Do your case managers view their role as "exposing lies" or to separate the "worthy" vs "unworthy" participants?
- ▶ Do your staff view their role as **servicing their participants**, or are they **enforcing program compliance**?
- ▶ Does your staff believe that PWUD can lead fulfilling, self-directed lives? Do they believe PWUD have expertise in their own lives and lived experience?
- ▶ If you must exit a participant from your program, are there other options **realistically available to them**?

Low Barrier Emergency Shelter

Low barrier shelters should:

- ▶ Evaluate whether or not they are truly sheltering those most in need of shelter, and if not, determine why that is.
- ▶ Make entering into shelter easy, with as minimal documentation as possible.
- ▶ Be truly low barrier – don't require sobriety to stay in the shelter.
- ▶ Examine building layout and client flow that may be hindering service utilization.
- ▶ Offer both abstinence based AND maintenance/harm reduction based substance use counseling or groups.

Low barrier shelters should not:

- ▶ Kick clients out of their program or ban people from entering as a means of resolving conflict. There are only three legitimate reasons to bar a client from services:
 - ▶ The client has committed violence against staff or another shelter resident.
 - ▶ The client has committed significant property damage against the shelter.
 - ▶ The client has engaged in serious theft from the program or other participants.

Permanent Supportive Housing & Rapid Re-Housing

PSH / RRH Providers Should:

- ▶ Remember that Housing First is supposed to be low barrier of entry and high barrier of exit.
- ▶ Remember that wrap around supportive services need to be both accessible and culturally competent.
- ▶ Remember that the supportive services component should **never** be mandatory. Participants should not be punished for opting out.
- ▶ Train all staff on how to recognize an opioid overdose and train them in the use of naloxone to reverse overdose.

PSH / RRH Providers Should Not:

- ▶ Require abstinence for continued housing, nor use relapse as an excuse for termination of services.
- ▶ Make substance use cessation an integral part of a client's case plan unless **they** prioritize it for themselves.
- ▶ Forget to provide overdose prevention education to all participants, and targeted education to those at high risk for overdose.
- ▶ Use waiting lists, instead of acuity scales, to prioritize housing decisions.

Outreach Providers

Outreach Providers Should:

- ▶ Utilize progressive engagement models like PATH, and meet their clients where they're at in their journey.
- ▶ Be patient and willing to navigate the instability of chaotic drug use.
- ▶ Do outreach to drug corners, open air drug markets, shooting galleries, and crack houses.
- ▶ Either train staff until they are comfortable around individuals who are high or are able to manage their discomfort.
- ▶ Distribute naloxone and provide overdose prevention education.

Outreach Providers Should Not:

- ▶ Involuntarily invite law enforcement into their client's lives.
- ▶ Require homeless clients to become abstinent, while still on the street, before providing housing navigation or placement.
- ▶ **Force** clients into crisis psychiatric units or detox programs except in **extraordinary, life or death** circumstances.
- ▶ Forget that their clients, whether drug users or not, are human beings who are experts in their own lives and deserving of dignity and respect.

Harm Reduction housing ***honors the inherent dignity and agency*** of people experiencing homelessness and/or using drugs.

Questions? Comments?



Thank you for attending!

After the break we'll help
programs assess their
readiness to implement
harm reduction!

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