

Sheltered from the Storm

A Shelter-Based Program for Treating Opioid Addiction

by Mari Rich

It's hard to pick up a newspaper or magazine lately that does not have some dire coverage about the epidemic of opioid abuse raging across the country, from large urban centers to rural hamlets that might once have been described as bucolic. Officials from the Centers for Disease Control and Prevention estimate that more than 90 Americans die each day from an opioid overdose.

While substance abuse affects those of every age, gender, ethnicity, and socioeconomic group, the problem impacts the nation's homeless population in a particularly disproportionate way; according to the Substance Abuse and Mental Health Services Administration (SAMHSA), one in five people experiencing homelessness has a chronic substance use disorder.

An innovative program by Boston Health Care for the Homeless Program (BHCHP) conducted on-site at a family shelter in Waltham, MA is aimed at treating those with barriers to accessing traditional office-based opioid treatments.

The Road to Addiction

In a study conducted of some 30,000 patients who had received care from BHCHP over a five-year period, researchers discovered that drug overdose had replaced HIV as the leading cause of death among the homeless in that city—and that prescription opioids and heroin were involved in more than 80 percent of those overdoses. People aged 25–44 experiencing homelessness were an astonishing nine times more likely to die from an overdose than their stably housed counterparts, and in one United States Conference of Mayors survey on hunger and homelessness, many cities reported that substance abuse was one of the top causes of family homelessness.

The numbers, while horrifying, are abstractions to most of us. Tracey Kinsman, a 38-year-old mother of six, can all too easily put a personal face on those harsh statistics, however. “It’s not unusual for me to log onto Facebook and find out that another one of my friends has ODeD,” she says. Kinsman, who lives with three of her children and her fiancé in a family shelter outside of Boston, has overdosed twice herself. “You can boost the high you get from injecting heroin by taking another drug like Xanax, but it’s really hard to get the proportions right,” she explains. “That’s what happened to me. The first time I ODeD, I took a half of a Xanax and shot up a while later. I remember falling face-first onto the bed right after shooting

Boston Health Care for the Homeless Program medical director Jessie Gaeta spearheaded the development of SPOT, or Supportive Place for Observation and Treatment, a Boston drop-in center for those in need of a safe place to come after using (see sidebar). Photo Credit: Jesse Costa, WBUR



Understanding Opioid Use Disorder and Medication-Assisted Treatment

When opiates are introduced into the body, whether taken as prescribed or illicitly, they bind to and activate receptors in the brain responsible for regulating pain and feelings of well-being. Repeated use actually changes the physical structure and physiology of the brain, causing physical dependence. Opioid use disorder is clinically diagnosed when at least two criteria are met from a list that includes: opioids being taken in larger amounts or over a longer period than was intended; a persistent desire or unsuccessful efforts to cut down or control opioid use; large amounts of time spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects; use resulting in a failure to fulfill major role obligations at work, school, or home; continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by their effects; recurrent opioid use in situations in which it is physically hazardous; a need for markedly increased amounts of opioids to achieve intoxication or desired effect.

Medication-assisted treatment helps to reduce withdrawal symptoms and ameliorate continuing cravings, thereby lowering the risk of relapse. Its length can vary, even being continued indefinitely if the patient is prone to regular relapse.

All medications used in MAT are approved by the Food and Drug Administration (FDA) and work to repair brain chemistry, block the mood-altering effects of opioids, and normalize body functions without the detrimental effects of the abused drug.

The most common prescribed medications include Naltrexone, an opioid antagonist, which means that it locks onto the opioid receptors in the brain and prevents the “high” typically experienced by those with opioid use disorder; Buprenorphine, a partial opioid agonist, which provides some of the same euphoric feelings the patient seeks; and Suboxone, which contains both buprenorphine and naloxone (an antago-

nist sold under the name Narcan to block the effects of opioids, especially in situations of overdose).

Laypeople may think most readily of Methadone, a long-acting opioid that is often mentioned in news coverage of the epidemic or in popular culture, but Chatterjee explains that his clinic is not deeply involved in its use. Methadone is itself addictive and typically requires daily visits—most often early in the morning when parents are readying their children for school. “If a patient told us that they are having trouble making it to their methadone appointments due to logistical barriers, we would probably consider helping them make the switch to buprenorphine instead,” he explains.

Although some of the same drugs have been proven to aid in treating addiction to alcohol, they are much more effective in treating opioid addiction. While they are welcome to access onsite individual and group therapy, clinic staffers typically direct those affected by alcoholism to the many Alcoholics Anonymous (AA) meetings available in the community.

The Best SPOT

In 2016, the Boston Health Care for the Homeless Program launched a new facility they dubbed the Supportive Place for Observation and Treatment (SPOT). Housed in a renovated conference room at their main building in the city’s South End, the drop-in space contains 10 reclining chairs in which those needing a safe alternative to the street can ride out their high while being monitored by nurses, prevented from overdosing, and, once they are no longer high, counseled about addiction-treatment options, if they are receptive.

In its first year of operation, SPOT personnel had logged more than 3,000 encounters with homeless patients (some of whom came multiple times). They calculate that a third of the visits would have resulted in a trip to the emergency room had SPOT not been in operation, and that ten percent of their visitors went into treatment immediately afterwards.



Dr. Avik Chattejee (left) created the first shelter-based opioid treatment program (SBOT) in Massachusetts, at a 120-room motel-shelter housing families outside of Boston. Tracey Kinsman (right) was grateful the family shelter she moved to offered SBOT.

up, and then the next thing I remember was waking up in a cold shower with my ex standing over me. If he hadn't been there I would probably have died. He told me I had turned totally blue." (Heroin, when combined with central nervous system depressants like Xanax, Valium, or Ativan—a class of drugs known as benzodiazepines—can cause a user to slip gradually into unconsciousness, followed by coma, and, if they are not discovered in time, ultimately death.)

Kinsman has abstained from illicit opioid use for three years now. Before landing on the floor of that cold, life-saving shower, she had traveled a tortuous road that included being molested by her mother's boyfriend and becoming entangled in a physically and emotionally abusive relationship with the man who is now her ex. One night, when she was in her mid-20s, she was attacked on the street, with her assailants viciously pummeling her and yanking large sections of hair from her scalp. In pain, she readily accepted the Percocet and Vicodin that her mother, who purported to suffer from a bad back, had procured via a legal prescription from a less-than-scrupulous doctor.

Kinsman soon began visiting the doctor herself, filling prescriptions of her own for the highly addictive painkillers. It was not until four years later, when she became pregnant with her third child, that the physician began refusing to pull out his prescription pad. Undergoing abrupt withdrawal, she was receptive when an acquaintance told her that cheap, easily obtainable heroin would closely mimic the effects of her prescription opioids. She was far from alone;

one recent report found that four in five new heroin users started out by misusing prescription painkillers and that of those in treatment, 94 percent had made that leap because prescription opioids were pricier and harder to get.

Kinsman's subsequent journey found her selling herself on the street to obtain drugs; watching her mother and ex also descend into heroin addiction; doing four months in prison for possession and intent to sell; and being the subject of multiple reports of suspected child neglect and abuse. While she often dreamed of getting clean, that goal seemed far out of reach, especially with her then-husband insisting they get high together and her mother regularly demanding that Kinsman help her shoot up.

An Uphill Climb to Recovery

It was thus something of a step in the right direction for her when Kinsman's husband left one day in 2014, and she went on Facebook to announce her newly single status. Much to her surprise she heard from her childhood sweetheart, Dave Ford, an aspiring chef who was then living not far away in New Hampshire. "Dave paid someone to come get me and drive me to New Hampshire to try to get clean," she recalls. "He has been by my side ever since."

Even with Ford's steadfast support, the process of weaning herself from heroin was arduous. With his help, she began weekly Medication-Assisted Treatment (MAT)—the use of medications in combination with counseling to treat substance use disorders—but reaching the New Hampshire clinic he had found for her required a bus ride of more than an hour each week from her mother's home in Massachusetts and lengthy periods in unpleasant waiting rooms, where it was not uncommon to see fights breaking out among frustrated, strung-out, or just plain combative clients. "We had to take my youngest, Nevaeh, along, and it was terrible to be bringing her into that environment," Kinsman recalls. Still, determined to kick her addiction, she persevered despite those difficulties.

Just as her husband's abandonment ultimately turned into something of a blessing in disguise, so, too, did the next upheaval she suffered. By 2015 Ford and the children who remained in Kinsman's custody had all moved in with her and her mother, but when the home became unlivable and overrun with roaches and bedbugs, they were forced to enter the shelter system.

Dedicated to MAT and her new-found sobriety, Kinsman was grateful to discover that the family shelter to which they were assigned was home to an innovative program called Shelter-Based Opioid Treatment (SBOT).

Surmountable Barriers

In mid-2015, a group from BHCHP, including Harvard-trained physicians Avik Chatterjee and Aura Obando, created the state's first SBOT program at a 120-room motel-shelter housing family groups in Waltham, a city just outside of Boston. Aimed at treating those who had barriers to accessing traditional office-based opioid treatments, the program was staffed by a physician, a nurse (who would handle the day-to-day tasks of handing out medication and getting urine samples), two case managers, and a behavioral health practitioner. The group found their services in immediate demand; an estimated 6% of the facility's adult residents were suffering from opioid use disorder.

As Suzanne Zerger of the National Health Care for the Homeless Council wrote in her comprehensive paper "Substance Abuse Treatment: What Works for Homeless People?": "The relationship between chemical dependence and homelessness is interactive; one condition does not necessarily cause the other, but each can exacerbate problems associated with the other. Substance abuse can be both a precipitating factor and a consequence of homelessness."

Experts now realize that many of the factors leading to homelessness also contribute to the development of addiction—untreated mental-health problems, physical or sexual abuse, lack of social supports, and insufficient resources to meet basic human needs, among them. In a cyclical chicken-and-egg situation, those experiencing homelessness often lack access to safe, clean locations in which to use their drugs of choice, and as a result they engage in rushed and risky drug-taking behaviors. Similarly, homelessness makes it difficult for them to adhere to the regular, long-term treatment plans required to manage the chronic health problems that often accompany substance abuse, including HIV and soft-tissue infection.

In the course of their work, Chatterjee and his colleagues frequently met patients experiencing the wide variety of consequences associated with the abuse of opioids, including the loss of child custody, an inability to maintain gainful employment, and the aforementioned physical comorbidities. (Young women and their children—the major constituents of

families experiencing homelessness—face especially devastating health consequences of opioid use, with both neonatal abstinence syndrome and hepatitis C among women of child-bearing age on the rise, according to Chatterjee.)

In a paper recently published in the *American Journal of Public Health*, Chatterjee explains that the barriers to office-based opioid treatment (OBOT) for the homeless go far beyond the sometimes-lengthy bus rides and unpleasant conditions Kinsman described. These include other patient-based issues, such as the stigma many associate with frequenting a public clinic and the competing priorities (including finding work and obtaining sufficient healthy food) faced by those navigating homelessness along with opioid use disorder; the fact that there are relatively few providers licensed to prescribe buprenorphine and other opioid antagonists (see sidebar); and system-level issues, such as restrictions on how many patients each physician can treat.

He points out that families experiencing homelessness, who comprise more than one-third of his city's homeless population, have additional barriers to treatment that homeless adults without dependents do not face. Unlike Kinsman, who had her fiancé to keep Nevaeh safe in the waiting room until her medication was dispensed, many have no safe, reliable source of childcare. Additionally, with family shelters often situated in out-of-the-way areas, some are physically unable or simply unwilling to undertake the grueling journey by public transportation to an OBOT location.

Dispensing opioid treatment drugs on site, within a clinic set up at the shelter, greatly decreased those barriers. Transportation and childcare concerns were alleviated, and the intensive case management that was a key component of the program helped families cope with competing priorities. Additionally, the behavioral clinician on staff helped patients address any comorbid mental-health conditions they exhibited, and if the team believed a patient needed resources beyond the scope of the SBOT program, those were found and referrals made.

Case manager Maria Peguero cautions that operating an SBOT comes with its own set of issues, including some loss of privacy for clients, whose fellow residents can be judgemental initially. "Still, once people get to know one another and realize what a good thing it is that someone is seeking treatment, they become happy that we're here as a resource," she says. "They begin to look

out for one another and come to us for help if they see anyone struggling with their treatment plan or addiction.”

A Small but Encouraging Study

Chatterjee’s American Journal of Public Health article details a study he completed of 10 patients (all with concurrent diagnoses of chronic pain and anxiety) enrolled in the SBOT program that first year. He and his co-authors reviewed the charts of those who received buprenorphine prescriptions for at least three months (choosing that timeframe because a 12-week endpoint had been employed in previous peer-reviewed studies of buprenorphine). Participants had from one to five children, and half had a partner in the shelter. The Massachusetts Department of Children and Families was involved in the care of children in five families with parents previously accused of abuse or neglect.

The results were encouraging. While four had reported a history of overdose prior to SBOT, no overdoses were documented during the study period. Although nine of the 10 had unprescribed controlled substances in their systems upon initial evaluation, by the third month that number had dropped to just one, and by the final days of the study, three were employed, compared to just one at the start.

Chatterjee admits, however, that transitioning back into the community was a significant challenge to his patients—particularly when housing became available without sufficient notice, allowing too little time to devise a new treatment plan. While patients were provided with prescriptions for opioid antagonists until new providers could be found and scheduled, other vital components, like mental-health services and intense case management, were harder to come by outside of SBOT. Chatterjee believes that a team specifically tasked with transition care, including home visits, might mitigate those problems and prevent relapse.

“We demonstrated that SBOT is safe and feasible, and it definitely increases access to addiction treatment for vulnerable patients,” he says. “We have already launched SBOT at a second shelter and hope for it to be replicated widely by other groups.”

Kinsman would like to contribute to that mission one day. “I’m doing well on Suboxone, and I foresee a time when I won’t need MAT at all,” she says. “I hope to go back to school and become an addictions counselor. I truly believe that former addicts make the best counselors, because they’re the only ones who know what this struggle is really like.” ■

Resources

Centers for Disease Control and Prevention <https://www.cdc.gov/drugoverdose/epidemic/> ■ Substance Abuse and Mental Health Services Administration <https://www.samhsa.gov/homelessness-housing> ■ Boston Health Care for the Homeless Program <https://www.bhchp.org/> ■ Baggett TP, Hwang SW, O’Connell JJ, Porneala BC, Stringfellow EJ, Orav EJ, Singer DE, Rigotti NA. Mortality Among Homeless Adults in Boston Shifts in Causes of Death Over a 15-Year Period. *JAMA Intern Med.* 2013;173(3):189–195. doi:10.1001/jamainternmed.2013.1604 ■ United States Conference of Mayors <https://www.usmayors.org/> ■ Meges D., Zevin B., Cookson E., Bascelli L., Denning P, Little J, Doe-Simkins M., Wheeler E., Watlov Phillips S, Bhalla P, Nance M, Cobb G, Tankanow J, Williamson J, Post P (Ed.). *Adapting Your Practice: Recommendations for the Care of Homeless Patients with Opioid Use Disorders.* 102 pages. Nashville: Health Care for the Homeless Clinicians’ Network, National Health Care for the Homeless Council, Inc., 2014. ■ Avik Chatterjee et al. “Shelter-Based Opioid Treatment: Increasing Access to Addiction Treatment in a Family Shelter”, *American Journal of Public Health* 107, no. 7 (July 1, 2017): pp. 1092–1094. ■ National Health Care for the Homeless Council. (May 2016.) *Medication-assisted Treatment: Buprenorphine in the HCH Community.* (Authors: Matt Warfield, National Health Policy Organizer, and Barbara DiPietro, Senior Director of Policy.) Available at: <https://www.nhchc.org/policy-advocacy/reform/nhchc-health-reform-materials/>.