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LETTER TO THE EDITOR

Finding stability amidst the COVID-19 pandemic: The impact of emergency temporary housing for people who use drugs

The experience of homelessness in Canada is common and is rooted in historical and ongoing violence and trauma, colonisation, poverty and failure of state systems [1,2]. People who use drugs (PWUD) are overrepresented among the homeless population in Canada, and the stigmatisation of PWUD further limits opportunities to access stable housing [3]. The COVID-19 pandemic has prompted mitigation measures across Canada [4]. For people deprived of housing, the call to physically distance or self-isolate is challenging when shelters are overcrowded congregate settings and many essential services are closed [5].

PWUD are facing the dual public health crises of an increasingly lethal street drug supply and COVID-19 [6]. New barriers to accessing care, closure of treatment facilities and changes to drug distribution patterns have further marginalised these communities and compounded the devastating effects of drug policy failures [6–8]. In an effort to enable physical distancing, shelter capacities in Hamilton, Ontario, were expanded in part by use of three city-and-shelter-run hotel sites where residents could stay in private rooms and connect with health services and supports [9]. Residents had 24-h access to their rooms, including hotel phones, and opioid agonist therapy (OAT) was delivered and dispensed on-site.

Here, we present two cases of PWUD experiencing homelessness who were temporarily housed in hotels during COVID-19 and examine the impact on their stability and substance use. Written informed consent for publication of their clinical details was obtained.

Case One

Patient 1 was a 42-year-old woman with opioid use disorder and stimulant use disorder residing in a woman's shelter at the onset of the COVID-19 pandemic. Prior to March 2020, Patient 1 had been on a therapeutic dose of methadone 90 mg daily and had eliminated use of fentanyl, while continuing to use methamphetamines. A minor infraction of shelter policy resulted in her being ejected from the shelter and she was forced to sleep outdoors or in an overnight drop-in site. She faced significant social isolation, including limited contact with her husband, who resided in a men's shelter. Due to these stressors and survival drug use when sleeping outdoors, she quickly resumed fentanyl use and increased methamphetamine use. She continued methadone maintenance treatment, though had more frequent missed doses. She was refused a space in city-and-shelter-run hotels multiple times over a 2-month period due to her substance use. With significant advocacy from health-care providers and community groups, she was eventually provided a shared hotel room with her husband in June 2020. Her methadone was delivered daily to the hotel and she had no missed doses. Within 3 weeks of being in the hotel, she had eliminated all substance use and had a negative urine toxicology. She identified accessing the hotel space as a highly motivating opportunity to stabilise, reconnect with her children and work towards permanent housing.

Case Two

Patient 2 was a 46-year-old Indigenous man with severe opioid use disorder and stimulant use disorder. He had chronic hepatitis C infection and HIV and was deprived of housing. He started OAT in 2018 but was unable to get past the early stabilisation phase and achieve a therapeutic dose of methadone due to his unstable social situation. He took his HIV antiretroviral therapy intermittently and remained virally detectable. During the COVID-19 pandemic, he was able to get a room in one of the hotels. His methadone was delivered daily and he was able to use the hotel phone to have regular phone appointments with his OAT prescriber. Within 2 weeks of residing at the hotel, his methadone dose was therapeutic at 90 mg and he had significantly reduced his fentanyl use. He was taking antiretroviral therapy more consistently, had reconnected with his sister and daughter and was pursuing volunteer opportunities to occupy his free time. Unfortunately, he had an altercation with another resident of the hotel and was ejected back to homelessness. He immediately began missing doses of his methadone, increased his fentanyl use and subsequently had to restart methadone.

These cases highlight the importance of prioritising safe shelter spaces outside of the traditional shelter during an emergency response. Many people who are experiencing homelessness have co-occurring substance use disorders [10] and access to a safe and supported shelter space can promote recovery and facilitate access to treatment [11,12]. Our cases demonstrate that having more secure shelter with appropriate supports can have a positive impact on substance use, treatment retention and self-determined function. Prioritising stable housing before expectations of treatment or recovery for PWUD affords people the opportunity to gain control of substance use and engage with their communities [1,10,13].

Flexibility in treatment provision is a key takeaway from these cases. Homelessness has been negatively associated with engagement in OAT, consistent with the notion that instability in housing is associated with instability in drug use [14,15]. Traditional models of OAT require daily pharmacy visits for observed dosing, frequent in-person appointments with prescribers and provision of urine samples for toxicology [16]. The competing priorities that people experiencing homelessness face and the lack of consistent access to transportation can make this unfeasible, often resulting in missed medication doses or appointments [16]. In our patients, the increased flexibility of OAT prescribing, use of telemedicine and on-site medication dispensing removed some of these barriers and supported their stabilisation while in temporary hotel housing.

The COVID-19 pandemic has resulted in rapid mobilisation of temporary housing outside the traditional congregate shelter setting. Coupled with a flexible addiction treatment model, this housing approach contributed to increased stabilisation using OAT for these two patients with severe opioid use disorder. We suggest that these models be examined outside the context of an emergency pandemic response and that rapid alternative housing be considered more broadly for PWUD. Future work should incorporate a greater range of client and community voices and consider the clinical outcomes of a flexible OAT model over a longer period of time.

Conflict of Interest

The authors have no conflicts of interest.

Key words: COVID-19, homelessness, temporary housing, flexible treatment approach.

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