June 7, 2016

Dear House and Senate Opioid Legislation Conferees:

On behalf of the National Alliance to End Homelessness and the National Health Care for the Homeless Council, please consider these recommendations regarding final proposed opioid legislation. The Alliance and the Council are deeply supportive of increased effort from the Administration and Congress to make progress on the opioid epidemic.

While the epidemic is notable for affecting people from any race, gender, or socioeconomic status its effects are felt in unique and notably harmful ways by people who are experiencing homelessness. Evidence indicates that substance use disorders can lead to homelessness¹, and data clearly shows that substance abuse and overdose disproportionately impact homeless people.² We encourage continued leadership and improved policy to respond to the critical rates of addiction and death within homeless populations as a part of the national response to the opioid crisis.

We have reviewed the Senate- and House-passed legislation and encourage the inclusion of the following key provisions in the final bill.

**The Inter-Agency Task Force**

The task force described in the final Comprehensive Addiction and Recovery Act (CARA) bill should be instructed to address the development of recovery best practices and that goal should be reflected in its objectives and membership.

The CARA bill that passed the Senate on March 10, 2016 described three task forces. In Title I, Section 101 of the engrossed CARA draft that was released on May 13, 2016, only one inter-agency task force is established, and it is designated to establish best practices of pain management and prescribing, only. However, recovery is an essential component of any task force to be convened, and should be specifically required.

The Alliance and the Council also propose the addition of “providers of homeless services” to Sec. 101(c)(9).

We urge conferees to consider that homeless people with opioid use disorders (OUDs) experience significant and unique barriers to treatment. Obstacles include disaffiliation or social isolation, lack of mobility or transportation, a fragmented delivery system, and complex treatment needs including co-

---

occurring conditions. Additionally, lack of income and housing impedes the effectiveness of treatment and can exacerbate their disorders or increase morbidity and mortality. Therefore, an individual who has expertise in homeless services has additional and unique perspective into the needs of people experiencing homelessness and suffering from OUD, and should be added to the membership.

Community-based Coalition Enhancement Grants

We recommend that the conferees restore the language of Section 103 (from the March 10th Senate bill) to the final legislation, and that some of this crisis funding be authorized to provide housing supports as a component of the strategies.

Section 103 of the March 10th Senate bill proposed awarding coalition enhancement grants to communities experiencing drug crises. This section has been excluded from the May 13th draft of the bill.

States and communities are experiencing significant increases in opioid use, overdoses, and death, and some of these rates are well above the national average. Some states, such as Maine and Massachusetts, have previously declared the epidemic an emergency. The task forces and subsequent strategies and reports from these states indicate that housing and homeless services are an important part of the solution.

The grants authorized in this section would allow implementation of community-wide strategies for communities in crisis. These grants include housing as a component of the approach, and should be retained in the final bill.

Communities of Recovery

The conferees should restore the language of Section 304 (from the March 10th Senate bill) to the final legislation.

Section 304 of the March 10th bill authorized grants for recovery community organizations. These grants would be awarded to “develop, expand, and enhance community and statewide recovery support services” and the definition of these services included housing services. This section has also been excluded from the May 13th draft of the bill.

Integrated treatment that incorporates housing and employment leads to better health outcomes than usual care for people who are homeless. And with increased clinical support and connections to homeless services, including housing, homeless patients are as likely as stably housed patients to successfully complete medication assisted treatment (MAT). Stability and treatment are intrinsically linked and interdependent, and community supports are a key element to recovery.

The grants authorized in this Section encouraged MAT and behavioral health interventions for OUD to be coordinated with social supports and housing. This should be retained in the final bill.

---

In the final bill, under Title III, Section 302(e)(C), the Alliance and the Council propose adding “veterans who are experiencing homelessness and misusing opioids” to the list of veterans who are at risk for overdose.

A 2015 study of veterans initiating MAT screened each of these patients for risk of homelessness and found that the prevalence of homelessness in veterans with OUD is 10 times more than in the general veteran population.\(^5\) It is necessary to recognize this trend in order to improve the quality of care and outcomes for veterans who experience homelessness and have OUD.

Under Title XVII, the Alliance and the Council request the permanent expansion of prescribing rights of buprenorphine for MAT to nurse practitioners and physician assistants, striking from Section 1703(a)(3)(B)(iii)(II) “during the period” and “and ending on the date that is 3 years after such date of enactment,” which imposes a limit on the period of time prescribing rights are expanded.

Limiting prescribing rights to physicians creates an additional barrier to accessing treatment and is incongruent with the existing scope of many clinical practices. Expanding prescribing rights to Nurse Practitioners, Physicians Assistants, and other clinicians who are authorized to prescribe Class III, IV, and V CDS drugs will expand treatment opportunities and decrease barriers to care. Clinicians who can prescribe opioids for pain should also be able to prescribe buprenorphine to treat the addictions that sometimes result.

We recommend increasing patient caps for MAT to 250. Congress should strike Section 1704 of this title, the Sense of Congress, and should replace the language in Section 1703 with language from H.R. 4981, Section 3, which was reported by House Committee on April 27, 2016.

Existing limits are arbitrary and create barriers to accessing treatment. While put in place to mitigate diversion, cap limits may inadvertently aid diversion by limiting the supply of MAT, leading to individuals pursuing self-treatment by purchasing diverted drugs. As there are no limits to the number of patients to whom a physician can prescribe more addictive opioid drugs that present a much greater risk for causing overdose and death (e.g., methadone, oxycodone, hydrocodone, and fentanyl), increasing the caps will allow providers to determine the number of patients they are able to treat based on the capacity of their practice and other factors, thereby increasing access to treatment.

Finally, we request the addition of the phrase “including connections to housing and employment services” after “recovery services” in Section 1703(a)(3)(A)(IV)(ee) of this title.

---

Overdose Reversal Medications

Language in the final bill should make it possible for homeless services providers, housing providers, and law enforcement officials to access overdose reversal medications.

The Alliance and the Council support the various sections of the current draft bill which authorize prevention, education and treatment grants to states with policies that allow easier access to overdose reversal medications. Homeless adults are up to nine times more likely to die from an overdose than their counterparts who are stably housed. And evidence supports the effectiveness and necessity of policies, including third-party prescription standing order and so-called “Good Samaritan” laws, to prevent overdose deaths. The language included in the amendment in Title XIII, Section 1302(b), which prioritizes grants to communities that authorize standing orders to community-based organizations and other non-profits, is particularly impactful to prevent overdose deaths among people experiencing homelessness, including those in the shelter system or encampments.

The National Alliance to End Homelessness and National Health Care for the Homeless are grateful to Congress for responding to the opioid epidemic, and we offer our continued support to pass effective legislation.

Nan Roman  
President and CEO  
National Alliance to End Homelessness

John Lozier  
Executive Director  
National Health Care for the Homeless Council

---