SBOT: A Family Shelter-Based Opioid Treatment Program in Massachusetts

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Conflicts

• We have no conflicts of interest to disclose
Age-Adjusted Opioid-related Death Rate by Year\(^4,7,8\)

Comparing the opioid-related death rate of Massachusetts to the nation overall.
The Opioid Epidemic Impacts the Most Vulnerable

- Overdose is **most common cause of death** among those experiencing homelessness

Baggett 2013
Buprenorphine is an Option for Opioid Use Disorder (OUD)

- Partial agonist—decreases illicit opioid use and overdose risk
- In office setting as part of comprehensive outpatient treatment: OBOT
OBOT Works for Homeless Adults

• 44 homeless patients (vs 41 housed patients)
  – 59% male
  – Mean age 42
• Decreased opioid use
• Increased treatment retention
• Required additional case management

Alford 2007
But **Family** Homelessness is Different

- In 2016, 35% of homeless individuals were homeless in families
- Primarily women and young children
  - 60% under 18
  - 61% female
- In MA, 4805 families received shelter in 1st quarter of 2016
Number of Families Receiving Emergency Assistance in Shelters and Hotels/Motels, FY1985–2016

1. Computed using the monthly caseload for September of each fiscal year.
Source: Data provided by DHCD.

Homeless Families Face Unique Barriers to Care

• Transportation
  – PCPs far away
  – No treatment options in shelter communities

• Children
  – Child care during appointments
  – DCF

• Complex patients
  – Comorbidities
  – Social Determinants
The Family Team at BHCHP

• Since 1986

• Team-based care: MD/NP/PA, RN, BH, CM

• Shelter-based

• In 2015, we took care of 848 adults, 481 children
Objective

Can we design a **family motel shelter-based opioid treatment program (SBOT)** that is feasible and improve access to treatment?
# SBOT Salient Features

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Study Design

• **Retrospective Chart Review** of SBOT patients

• **Setting/Population**: Twice-a-week outreach clinic in a 120-room family motel shelter
  – 55% white, 33% Black, 3% Native American
  – 31% Latino ethnicity
  – 6% prevalence of OUD

• **Outcomes**:
  – Patient demographics and comorbidities
  – Urine drug testing (1\textsuperscript{st} vs 3\textsuperscript{rd} month)
  – Overdose
  – Employment status
  – Reason for leaving the program
Setting/Population

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Outcomes

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SBOT Was Feasible

- 10 patients (unique families) enrolled
- 9 continued treatment until end of study period or moved from motel
- 7.4 months mean treatment duration
# Diverse Patients

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<tr>
<th></th>
<th>Number or mean (range)</th>
</tr>
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<tbody>
<tr>
<td><strong>Female</strong></td>
<td>6</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>6</td>
</tr>
<tr>
<td>African-American</td>
<td>1</td>
</tr>
<tr>
<td>More Than One Race</td>
<td>1</td>
</tr>
<tr>
<td>Did Not Report</td>
<td>2</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>35 (32-40)</td>
</tr>
<tr>
<td><strong>Partner in shelter</strong></td>
<td>5</td>
</tr>
<tr>
<td><strong>Number of children</strong></td>
<td>2 (1-5)</td>
</tr>
<tr>
<td><strong>DCF involvement</strong></td>
<td>5</td>
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Results: Opioid History

- Oral only
- IV only
- Both
### Decreased Substance Use

<table>
<thead>
<tr>
<th></th>
<th>1st month (n=44)</th>
<th>3rd Month (n=31)</th>
<th>P-value</th>
</tr>
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<tbody>
<tr>
<td>UDT with Opioids</td>
<td>5%</td>
<td>3%</td>
<td>0.43</td>
</tr>
<tr>
<td>UDT with Unexpected Results</td>
<td>77%</td>
<td>51%</td>
<td>&lt;0.01</td>
</tr>
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75% of positive UDTs showed marijuana
No Overdoses, More Employment

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<thead>
<tr>
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<th>Prior to Treatment</th>
<th>During Treatment</th>
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<tbody>
<tr>
<td>Overdose</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Employed</td>
<td>1</td>
<td>3</td>
</tr>
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Post-Shelter Transition

• At end of review period
  – 6 remained in shelter system
    • 4 remained in original shelter
      – 3 remained in SBOT
      – 1 relapsed, threatened clinic staff, was asked to transfer care elsewhere
    • 2 moved to a different shelter and transitioned to our OBOT program
Post-Shelter Transition

• At end of review period
  – 4 transitioned into housing, had to leave SBOT, and **ALL relapsed and ALL lost custody of children**
Lessons

• SBOT is **feasible** and may help vulnerable patients **avoid substance use and overdose**, while helping **maintain families and employment**

• Having children may be protective

• SBOT as entry into medical care
Factors that Helped

• Well-resourced clinic
  – Medicaid expansion/MA health care reform

• Team-based
  – MD, RN, BH, CM

• On-site
  – Child care
  – Transportation
Our Challenges

• Transition out of shelter is a **vulnerable period**
  – Unintended consequence of rapid rehousing
  – Few OBOT providers in the community
  – Less support
  – Transportation, child care
Future Directions

• Longer-term follow-up

• Qualitative assessment
Future Directions

• Can we promote a successful transition out of shelter?
  – Information sharing and advance planning with community OBOT providers
  – Home visits for counseling, UDT, therapy, case management, and prescriptions
  – ?Continuity clinic at our main facility
Too Ambitious?

• Making too big a deal of this might be keeping people from treatment
• Prescription Opioid Addiction Treatment Study (POATS)
• Script alone may help prevent relapse
Acknowledgements

• Our patients
• The Family Team
• Department of Housing and Community Development
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References

Questions?

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