



Successfully Connecting People Affected by Opioid Use to Housing: DESC in Seattle, Washington

Every year, DESC moves hundreds of men and women who are disabled by serious mental illness and/or substance use disorders off the streets and into supportive housing using a Housing First approach. Their supportive housing programs – totaling more than 1,200 units across Seattle -- have been [studied by researchers](#) for more than a decade. Those studies show that participants have high housing retention rates, are much less likely to use emergency services or be sent to jail, and have improved health.

To understand more about how DESC successfully houses people with opioid use disorders through Housing First, we spoke with Daniel Malone, DESC’s Executive Director. That conversation is summarized here.

USICH: What housing, services, and supports does DESC provide?

Daniel: DESC offers a spectrum of housing and services for individuals experiencing homelessness in Seattle. Approximately half of our 3,600 daily program participants have exited homelessness and are living in DESC’s permanent supportive housing and/or receiving ongoing behavioral healthcare from DESC. The other half are currently homeless and receiving help from DESC through survival services like shelters and day programs, or a range of behavioral health services, including outpatient treatment, street outreach, and crisis stabilization. Overall, the typical person served is highly vulnerable, multiply-disabled, and has spent many years on the streets.

USICH: Can you describe the scope of the opioid crisis in Seattle and the impact on individuals in DESC’s housing programs and those experiencing homelessness?

Daniel: We’re definitely seeing an increase in opioid overdoses, which suggests to me an increase in opioid use—or at least a shift in use from pharmaceutical opioids to heroin, which is less predictable for users. Experiences of overdoses, both those that are fatal and those that are intervened in and reversed, makes this feel particularly stressful to staff and people we serve. We’re certainly accustomed to a lot substance use and harmful outcomes from substance use behaviors, but generally those are things that don’t involve people dying from acute ingestion.

USICH: How has DESC responded to the increase in opioid overdoses among the population you serve?

Daniel: Hopefully this will become less unique as more of these approaches are proliferating within housing and service programs. Two years ago, we did an agency-wide training program on naloxone administration. DESC purchases naloxone and stocks it at every one of our locations. We have found ourselves needing to use that supply and training more than once a month on average since we implemented the program.

We’ve worked with others in the community to more widely distribute naloxone kits to people experiencing homelessness and formerly homeless people themselves. There are other entities in our community who have been in the lead in getting naloxone kits distributed to people who are opiate users or who spend time with people who are opiate users. We have collaborated with them and worked with our clients to understand the availability of naloxone and the importance of ensuring that people around them know where they keep their kit, especially for people in supportive housing.

To make sure that staff are comfortable using the naloxone kits quickly, we have adopted the pre-manufactured nasal sprays that don't require you to assemble nasal aspirators on the spot.

USICH: Beyond overdose response, how is DESC working to connect people to housing and opportunities for longer-term recovery supports?

Daniel: We have long had Housing First practices where we don't screen people out, so we are screening in those who appear to have the greatest needs and least ability to resolve their own situations. As a result, we have a lot of people with various challenges, such as behavioral health disorders that include chronic addiction problems. We're naturally encountering a lot of people in supportive housing who have opioid use disorders. We are attempting to serve those clients individually to find the best arrangement for health care generally, including addressing opioid use disorders.

The catch is that a significant portion of the population we serve is not prepared to utilize health care services in conventional settings. They're eligible and clinics are open to serving them, but those environments very often don't work for the clients we serve. They've had bad experiences in the past or they aren't comfortable with the structure of crowded waiting rooms or scheduled appointments. These clients very often don't get adequate health care in general.

DESC is a licensed behavioral health treatment provider. We learned long ago that you've got to adjust how and where you deliver services to people in order to get people to fully utilize them. We go out and find people and we see them where they're staying in temporary or permanent locations. Opportunities like this don't really exist in physical health care, but in our community, most access to medication-assisted treatment (MAT) is only through site-based physical health care clinics or methadone clinics.

By and large, our client population doesn't have easy access to buprenorphine (a drug often used in MAT to treat opioid addiction). Our intent is to bring more of those services to our clients in locations where they are or where they are comfortable. We have partnerships with different physical health care providers in our emergency shelters, at outpatient behavioral health clinics, and at our supportive housing locations.

In some cases, we have physicians who are waived to administer buprenorphine. They're able to start somebody on the treatment right in the housing setting, without people having to go to the clinic. That's what we want to do more of. It will be helpful as more [nurse practitioners get waived](#) to become buprenorphine providers, because a lot of the physical health care service that we bring into our programs through partnerships are delivered by nurse practitioners rather than physicians.

USICH: DESC is known for its creative, assertive, and holistic approaches to serving those in need. How do those approaches challenge or enhance your ability to successfully house and serve individuals struggling with opioid use or misuse?

Daniel: It all starts with a willingness to house and provide services to people regardless of their current conditions and behaviors. And when our focus is on providing what people want most, which for people currently experiencing homelessness is almost always housing—a place they control and can call their own—we are far more likely to bring people into care. When we offer units in Housing First programs to people experiencing chronic homelessness, our documented acceptance rate is 95%—compared to acceptance rates of below 60% for mandatory service programs that include housing.

While our approaches are backed by research, we first and foremost have what social workers call a genuine positive regard for the people we're serving. That may sound hokey, but I think it's something worthwhile to spend some time talking about within an organization. If you're set up as a service provider that's really structured and has all the answers for the clients being served, you're going to have a portion of the client population who's not interested in your care.

We're trying to foster an environment of inclusion and welcome people who need our help, and sometimes that's easier said than done. Some of the folks we encounter can express difficult behaviors from time to time. Sometimes it's just plain difficult for service providers to be around people who are suffering and not making the kinds of improvements they want to make and we want them to make. This can lead to service providers imposing rules that sometimes backfire and drive people away from care.

That's the number one thing: being welcoming and providing access to permanent housing to people however they are, wherever they are, whatever condition they're in. That's the key first step in forging a service alliance with people. One thing that's definitely true is that nobody wants to be in pain. Nobody wants to be living in squalor. Nobody wants to have these really difficult lives where they feel poorly all the time—physically and emotionally. It's important to know that and use that to craft a way to form an alliance with people, as opposed to assuming that people who don't want what you have to offer are subhuman. People are far more likely to get better and do better when they have care and support than when they're ruled out from support or scolded or coerced into behaviors.

USICH: What advice do you have for communities that are looking to expand access to MAT and to housing opportunities for individuals experiencing homelessness?

Daniel: People are far more likely to reliably access and use MAT when they are housed, so the first thing people who have opioid use disorder and are experiencing homelessness need is housing. Access to housing opportunities can and should be enhanced by lowering barriers, such as criminal background rule-outs (which are very common among people with substance use disorders who are experiencing homelessness), as well as active outreach to this population group.

Communities should also pay attention to efforts like those underway at SAMHSA to expand MAT to places where individuals experiencing, or those who have experienced, homelessness are more likely to access treatment. Washington state's Medicaid 1115 waiver would also bring projects to our state to expand access to MAT.

A local task force in Seattle-King County has produced a number of different recommendations to prevent opioid use disorder and to improve the lives of those who have it, ranging from doctor prescribing practices, to expanded MAT, to the establishment of safe consumption spaces for people still using heroin or other illicit substances. In addition to these efforts, I'm seeing a lot of receptivity among federally qualified health centers and neighborhood health clinics to think through partnership opportunities to bring care to the places where it's needed. My advice is to start talking about issues of access, if you're not already, with community health clinics and major health systems in the area to see if there's interest by those entities to figure out ways to become, if not mobile, at least occasionally out-stationed in other program spaces to reach those in need.