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"Housing is harm reduction: a commentary"

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Reddon et al.'s article[1] "Experiencing homelessness and progression through the HIV cascade of care among people who use drugs" describes findings from the first published longitudinal prospective study exploring relationships between homelessness and HIV care cascade outcomes in ACCESS, a Vancouver-based open cohort of people living with HIV (PWH) who use drugs. Consistent with the robust extant literature showing HIV disparities for unhoused PWH, this study found homelessness was associated with deleterious downstream outcomes across the HIV care cascade. Understanding how structural factors such as homelessness influence HIV outcomes is critical for developing interventions to reduce health disparities among people who use drugs (PWUD). The persistence of HIV-related health disparities by housing status even in Canada, which offers universal healthcare, is of great import for countries like the United States (US), where healthcare is more fragmented and beyond the reach of many, especially our unhoused.

In the US, Housing Opportunities for People with AIDS has been funded since 1992. Nonetheless, it is apparent that current infrastructure is insufficient, and it is well-established that a syndemic of psychosocial health conditions, including substance use, depression, and violence victimization are key drivers of virologic failure[2, 3] and highly prevalent among homeless populations[4]. Thus, there is a strong need for seamless integration of housing with harm reduction, psychiatric support, and social services given the complex challenges they experience.

While the US has not invested in universal health care like Canada, some programs have attempted novel service integrations. One Alabama-based program found HIV testing at a homeless shelter was highly acceptable; however, linkage to care was successful for only 50% of unhoused PWH[5]. POP-UP (Positive-health On-site Program for Unstably-housed

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Populations) provides drop-in HIV care services for unhoused PWH in San Francisco who use drugs; the rapid ART re-start incidence was 79% [6]. Findings suggest the potential for HIV care services to be accessible to people experiencing homelessness, but even more innovative and low-barrier programming is needed. Shelter-based programs, offering health services within homeless shelters, demonstrate feasibility and acceptability in areas such as mental health [7] and primary care[8], though none to our knowledge currently exist that provide HIV care.

In the US, services for unhoused adults are partitioned into emergency shelter, transitional living facilities, and permanent supportive housing. Few services under these umbrellas have been developed or tailored specifically to the needs of PWUD, and in many jurisdictions, PWUD are restricted from using these services, either as a matter of policy or practice. Medical home models that integrate multiple social services, including housing linkage and behavioral health, into HIV care hold promise[9, 10], but are not yet widely incorporated within housing programs. The US Health Resources and Services Administration (HRSA) has proposed a goal that <5% of PWH in care will be unhoused by 2030[9]. But available national data, such as the Ryan White HIV/AIDS Program Services Report, only captures housing status from PWH receiving Ryan White services, thereby excluding the most vulnerable PWH. Indeed, there is no systematic capture of homelessness in the US. The primary national source is the US Department of Housing and Urban Development (HUD), which only reports on “point-in-time” counts on a single night in January. This data gap obscures the true extent of homelessness in the US.

Interventions incorporating relational and structural harm reduction principles [11] show enormous promise for PWH who use drugs. While shelter-based and low-barrier services provide important stopgaps for unhoused individuals, Housing First has been identified by HUD as a best practice[12]. This approach prioritizes access to permanent housing as quickly as possible without prerequisites and acknowledges that autonomy is critical for both housing engagement and for participation in other services such as substance use treatment. The Open Door, a harm reduction-based Housing First program for PWH in Pennsylvania who use drugs, has shown that low-threshold transitional living supports were associated with higher rates of viral suppression[13].

Despite research showing the effectiveness of Housing First in keeping people housed, with somewhat more limited evidence of reducing health care costs and improving health outcomes, this approach remains controversial in the US[14–17]. Policymakers have campaigned against Housing First efforts, proposing prerequisites including sobriety[18–21]. Substance use stigma negatively impacts PWUD in their experiences of care and in their service-seeking behavior [22–25]. Thus, for housing initiatives to be effective for PWH who use drugs, harm reduction must be the foundation upon which they are built. Though typically thought of as syringe service programs, harm reduction is much more: it reflects an anti-stigmatizing commitment to service provision without any presumption of substance use abstinence. By removing requirements of substance use treatment, harm reduction allows unhoused PWH who use drugs to meet their basic needs without forfeiting their ability to make decisions about their health and healthcare.

In addition to emphasizing services that mitigate stigma and center autonomy, there is a need for low-barrier programs for unhoused people that incorporate status-neutral care, critical for both reducing HIV stigma and reducing HIV transmission and acquisition. Status-neutral care, which builds on the HIV care cascade by including HIV prevention and treatment for co-occurring disorders, is increasingly highlighted in strategies promulgated by the Centers for Disease Control and Prevention and HRSA. In the US, the emphasis on pre-exposure prophylaxis (PrEP) has obscured the importance of targeting structural and psychosocial concerns, such as housing, mental health, and substance use, key predictors of HIV incidence [26]. Status-neutral approaches that 1) emphasize co-ownership and engagement of communities most at risk, 2) bring comprehensive, harm-reduction-based HIV prevention and care services to those communities, and 3) incorporate on-site housing assistance, mental health care, and substance use harm reduction and treatment services, among others, are necessary to end the HIV epidemic [27, 28].

We will simply not meet Ending the HIV Epidemic goals without committing to safe, affordable, harm reduction-based housing that is wide-reaching and responsive to the complex challenges experienced by PWH who are unhoused, and in particular those who use drugs. Harm reduction, which meets the needs of PWUD without judgment or expectation of abstinence, is the answer.

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