Title

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Integration of Mental Health/Substance Use Treatment and HIV Care for People Experiencing Homelessness: A Call to Action

Homelessness is common in high-and middle-income countries, with an estimated 580,000 Americans experiencing homelessness on any given night.[1] People living with HIV/AIDS (PLWHA) have an increased risk of experiencing homelessness; 8.3% of PLWHA in the United States having had a recent episode of homelessness, compared to 0.2% annually in the US.[2] This overrepresentation is due to many factors, including that PLWHA, particularly those with multiple marginalized identities, face discrimination in housing and employment markets and that there are shared risk factors for both HIV infection and homelessness. People who use drugs, those living with mental health problems, and members of ethnic/racial and gender and sexual minority communities experience an increased risk of both HIV and homelessness.[3,4] The underlying drivers of homelessness are structural, including the lack of affordable housing, income inequality, and racism. However, individual factors such as mental health and substance use problems are common precipitants because people with these face barriers to income and housing. Moreover, homelessness worsens the severity of these conditions and decreases access to treatments.[5]

Mental health problems and substance use disorders are associated with suboptimal HIV treatment outcomes, including lower retention in HIV care and a lower likelihood of achieving viral suppression.[6] Receiving mental health treatment is associated with better HIV treatment adherence.[6] Opioid substitution therapy (OST) is associated with increased odds of a reduction in viral suppression, an almost 70% increase of recruitment into and two-fold increase in adherence to antiretroviral therapy.[7]

Homelessness is a grave threat to health. The chaotic environment of homelessness (whether rough sleeping or living in shelters/hostels) leaves individuals unprotected from violence, interferes with sleep and healthy eating, and complicates people’s ability to engage in medical care or adhere to medications. Homelessness presents challenges to PLWHA, whose health depends on repeated engagement with the health care system and adherence to chronic medications. These challenges are exacerbated for PLWHA who experience homelessness and co-occurring mental health and substance use problems. In this multiply marginalized population, societal conditions, such as discrimination, stigma, and lack of accessible affordable housing or treatment, interact in a syndemic way to contribute to HIV diagnosis and treatment disparities.

PLWHA who experience homelessness are more likely to have uncontrolled viral load.[8] Obtaining housing is associated with better HIV outcomes, as measured by increased likelihood of maintaining continuous HIV care, beginning and adhering to antiretroviral therapy, and having suppressed viral loads.[8] For PLWHA who are homeless, obtaining housing is an essential health intervention. Neither mental health problems, substance use, nor HIV infection interfere with successful housing outcomes, if housing is offered on a Housing First basis (providing permanent housing before requiring engagement with services). Studies in Canada, France,

and the United States have demonstrated successful housing for those with significant behavioral health impairments by providing permanent supportive housing, subsidized housing with voluntary but linked supportive services, including case management, medical care, mental healthcare, and substance use treatment.[9]

For those who remain homeless, improving HIV outcomes requires flexible approaches that address the circumstances of homelessness. Integrating HIV treatment with mental health and substance use treatment is valuable for all PLWHA, but arguably more important for those facing homelessness for whom navigating multiple, distinct systems presents another barrier to care. Practitioners and public health officials have expanded the repertoire of low barrier treatments to address these concerns. One such example is street outreach, where trained professionals go into the community to offer a variety of services to individuals experiencing homelessness who are rough sleeping in encampments or staying in shelters. These interventions include low-barrier medical care, mobile directly observed medication therapy, mental health, and substance use treatment. Mobile health clinics can increase access to treatment to PLWHA experiencing homelessness by providing antiretroviral therapy, case management, medical care, and drug treatment.[10]

The vast overrepresentation of homelessness among PLWHA demands a solution. Housing, for PWLHA without homes, is healthcare. For those with significant behavioral health disabilities, permanent supportive housing has shown consistently high rates of housing retention by integrating housing with medical, mental health, and substance use services. Doing so holds the promise of improving HIV related outcomes. Providing care for PLWHA who remain homeless and have co-morbid behavioral health conditions requires reducing barriers by bringing coordinated care to where people are. The onus of care coordination should fall on health systems, rather than individuals the systems are designed to serve.

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