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RE: Joint Senate Task Force on Opioids, Addiction and Overdose Prevention

Thank you for the opportunity to address this Task Force today.

My name is Kevin O'Connor, and I'm the executive director of Joseph's House & Shelter. Our agency's mission is to **provide non-judgmental services to end homelessness**. Each year, Joseph's House & Shelter serves 1,500 men, women, and children in Rensselaer & Albany Counties through our street homeless projects, our emergency shelters, and our permanent supported housing programs for formerly homeless households.

We appreciate this opportunity to share our experiences with the current opiate crisis. Homeless service providers are much more than canaries in the coal mine. Homeless shelters have been on the front lines of a range of social problems. We are the ones who continue to provide a thin last safety net for individuals when health and welfare policy fails to meet citizens' basic needs. And in our challenges to meet those basic needs, we often adapt unique perspectives and approaches to vexing social problems.

Since January 2019, our agency staff has **intervened in 13 opiate and fentanyl overdoses**. During each of these incidents our staff directly administered naloxone to persons in apparent overdoses either in the streets or in our shelter – with accompanying emergency medical team response. We are aware of 5 overdose deaths since January.

My testimony today - as it relates to opiate overdoses – emphasizes 3 points;

- 1) We know that **low-barrier shelters SAVE LIVES**.
- 2) We know that ***Housing-First* Permanent Supported Housing SAVES LIVES**
- 3) And from these lessons, we know that **safe injection sites once permitted in NYS, WILL SAVE LIVES**.

First let me talk about Joseph's House & Shelter's work as a **LOW BARRIER shelter** provider.

Most of the individuals we administered naloxone to during their overdose episodes were people we knew beforehand. Previously our staff had conversations with most of them about entering drug treatment programs. Nearly all of them declined the offer. In professional terms these individuals were in pre-contemplation about making change. What pre-contemplation means is that these users declined offers for drug treatment; either because they don't think they had a problem requiring abstinence, or they felt incapable of changing behaviors tied to their drug use. Some tried treatment before and failed, and others found the system just too complicated, inaccessible, and unattractive.

Here's where **Low-barrier shelters** come in. We accept anyone who is homeless and needs shelter. The only conditions for shelter stays are that, 1) the person is indeed homeless and has no other option, and 2) the person can be relatively safe in our shelter. A **low-barrier shelter** acknowledges the causal link between drug use and homelessness, and encourages persons to come into safe shelter without pre-conditions of sobriety, treatment compliance, or compliance with DSS regulations that often mandate treatment to receive entitlements (a big obstacle in Upstate New York shelters).

We utilize a low-barrier, harm reduction approach; we realize it is safer for both the individual - and the community - for that person to be in a protected and reasonably supervised setting; where their health and safety can be monitored.

We acknowledge many of our guests are still using drugs while they are staying in our shelter. Over the past 6 years we've been aware of a sharp increase in opioid use and injections. In response, we host **needle exchange** programs in our shelter. We have staff trained as **trainers in naloxone administration**. We not only train our direct shift staff, we also offer training and naloxone to our shelter guests. Upon intake, every shelter guest is asked if they would like naloxone training.

We have installed 'dirty' **needle depositories** in each of our private use bathrooms.

In one bathroom situated by our front desk we have instituted a **10-minute-safety-check rule**; that is, staff monitors and knocks on the door 10 minutes after a person enters the bathroom, and then listens for a response. If no response, we open the door to check on the guest's safety. Guests appreciate this service.

We've altered at least one of our smaller bathrooms; so the bathroom door opens out – to facilitate emergency response in the case of a collapsed user.

We haven't had an overdose death in the shelter in many years.

The **five overdose deaths** our staff became aware of this year occurred outside of our shelter; on the streets, homeless encampments, or vehicles: places not meant for human habitation. These are places that are not obviously monitored or supervised like our low barrier shelter is.

Unfortunately, most other shelters in the region don't practice as low barrier shelters. There are many reasons for this, but a primary reason is that most upstate shelters are heavily reliant on per-diem shelter cost reimbursements from their local Department of Social Services. These per-diem reimbursements vary from County to County, but are always limited to persons who are **COMPLIANT** with public assistance benefits – compliance that often requires persons coping

with addiction to be enrolled in and receiving drug treatment\*. (*\*This is quite different in NYC shelters, where a municipal 'Right to Shelter' law exists, and shelter providers are paid for delivery of services to all those who seek shelter – not just those who are 'welfare-compliant'*). As a result, the most vulnerable drug users are often prevented from entering shelters, increasing their danger.

NYS needs to figure out how to fund homeless shelters differently so the most vulnerable in their communities – not just individuals who are DSS compliant – get shelter beds.

**Low barrier shelters save lives.**

Second, our permanent supported housing programs practice a *Housing First* approach. *Housing First* employs harm reduction techniques in all its practices. Our programs; 1) accept that drug use is part of our world. We work to minimize harmful effects of these decisions rather than condemn or ignore them, 2) We understand that substance use is complex. We recognize that some ways individuals use drugs are clearly safer than others, 3) We focus on the quality of life for the individual and community; not necessarily cessation of drug use as the criteria for success, 4) while at the same time, we are prepared to support tenant commitments to recovery in every possible way.

*Housing First* prioritizes the most vulnerable and most disabled individuals who are homeless in the community, and moves them into housing directly from the streets and shelters without preconditions of sobriety, treatment compliance or a source of income.

- There are volumes of research that support the benefits of this *Housing First* approach for persons who are chronically homeless, coping with disabling addictions. A University of Washington study found that tenants in *Housing First* permanent supported apartments **reduced their daily consumption of substances by 40%**. A New York University Study showed how *Housing First* **improves housing stability for formerly homeless persons - 88% of *Housing First* residents in their sample retained housing**

after 5 years, compared to 47 % residing in traditional treatment-based residential programs. A study in Colorado showed how Housing First **Reduces crime** – HF residents spent 76% fewer days in jail compared when they were previously homeless.

At Joseph's House's *Housing First* programs we've reduced costly emergency room admission by 71%. Our annual housing retention rate is 93% and the average length of tenancy in our *Housing First* programs for formerly homeless persons is 5.5 years.

Currently, we believe nearly 2/3 of our 200 tenants are still active with substances. Perhaps a dozen of our tenants are opiate users. We know of two who are enrolled in Methadone maintenance programs. We believe that nearly all of our tenants have significantly REDUCED their drug and alcohol use since moving into housing – not because it is a requirement we enforced, but rather personal choice. We know of several tenants who have at least suspended their personal heroin use.

Similar to our shelter, our **housing staff** members are trained in naloxone intervention. We have clean needle exchange programs, and have dirty needle depositories in confidential locations. Tenants are offered training in naloxone use.

We have not had an overdose death in our housing first programs in nearly 10 years.

**Housing First permanent supported housing saves lives.**

We applaud OASAS' preliminary commitment to include Housing First models into its repertoire of abstinence-only housing programs.

We also applaud NYS in its commitment to provide tens of thousands more permanent supported housing units to formerly homeless persons coping with disabilities. We salute OTDA's Bureau of Housing Support Services in their stewardship of this initiative.

**Finally, it is our conclusion that the introduction of safe injection sites will save the lives of New Yorkers.**

Substance use is complex. We recognize that the realities of poverty, racism, social isolation, past trauma, gender- and sex-based discrimination and other inequities affect both peoples' vulnerability to - and capacity for - effectively dealing with self-harming and community-harming behaviors.

Our approach calls for a non-judgmental and non-coercive provision of services to vulnerable persons who use drugs and avoid treatment. The goal is to help reduce harmful behaviors.

Homeless services providers have learned if you treat someone with dignity and respect, and provide that person with basic needs they seek . . . 9 times out of 10 they make healthier decisions for themselves and their communities.

Safe injection sites will do just that. And they will save lives.

Thank you for your attention to these matters.