HOMELESSNESS, METHAMPHETAMINE, AND BEHAVIORAL HEALTH CRISIS CONTINUUM

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Learning Objectives

- Clinical presentation and intervention overview:
- Care models; current and in development
- Policy and system change
- Staff wellness, resiliency, and practicing with love


unity
center for
behavioral health

CENTRAL CITY CONCERN: AT A GLANCE

2,136 homes across 27 properties

- Recovery housing
- Transitional housing
- Permanent supportive housing
- Family housing
- Low-barrier housing, including Housing First and harm reduction
- Housing for people exiting incarceration

3,944 residents housed

9,165 health patients served

12 Federally Qualified Health Center Sites

- Integrated primary and behavioral health care
- Community mental health services
- Subacute detoxification
- Residential and outpatient recovery services
- Culturally Specific Services Pharmacy

1,348 job seekers assisted

Employment services & job training

- One-one-one supportive employment services
- Volunteer opportunities that build confidence and work skills
- Training and mentorship through transitional jobs in social enterprises

CENTRAL CITY CONCERN

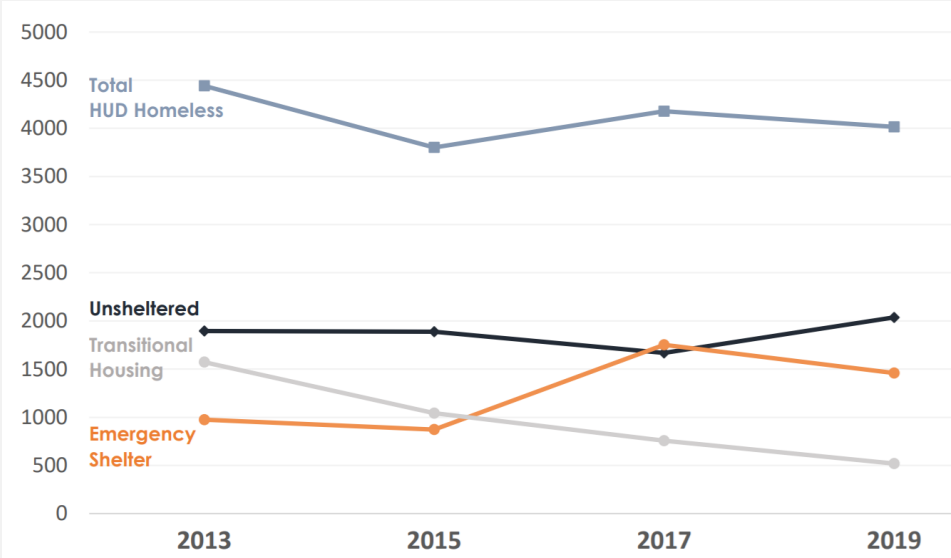
HOMES HEALTH JOBS

MULTNOMAH COUNTY 2019 POINT IN TIME COUNT

In Multnomah County:

- Total HUD homeless population has remained stable from 2015 through 2019.
- Just over half (50.7%) of HUD homeless population was **unsheltered** (+22.1% change from 2017)
- **People of color** were over-represented in homeless population (likely undercount): 38% vs 29.5% of general population
- More people experiencing **chronic homelessness;** 37% more than in 2017
- 78.7% of unsheltered report one or more **disabling conditions** (substance use, serious mental illness, chronic illness or disability

Total HUD homeless number has remained stable from 2015-2019



CLINICAL PRESENTATION AND INTERVENTIONS

METHAMPHETAMINE USE ON THE RISE

- A qualitative study done indicates that since COVID-19 and resulting service reductions homeless patients experiencing SUD and BH have been struggling to access support
- Numbers of patients with positive methamphetamine UDS's utilizing both emergency and psychiatric emergency services has been increasing,
- Emergency Departments (ED) are often the first contact point for patients with methamphetamine intoxication (MI) related presentation
- Patients arriving with acute methamphetamine intoxication are more likely going to be aggressive and violent, putting medical staff at greater risk and staying in the ED on average 90 minutes longer then non meth related cases
- One of main psychiatric related complaints tends to be psychosis and agitation leading to frequent use of chemical (10.6%) and physical (4.1%) restraints

Adams et al, 2022

BN, N.C.S., 2019

Schultz et al., 2018

METHAMPHETAMINE INTOXICATION IN THE HOUSELESS COMMUNITY

Symptoms of acute intoxication

- Warning medical signs of life threatening stimulant induced toxic syndrome- chest pain, increase in body temperature, seizures, stroke like symptoms, hypertensive crises- BP> 180/110
- Hallucinations, paranoia, delusions, agitation

Risks and impacts of methamphetamine intoxication

- Increased risk of criminal and traffic offences
- Harm to others or self due to aggressive behavior
- Trauma related- gunshot wounds, motor vehicle accidents, assaults and stab wounds
- Cardiac complications- at greater risk for cardiomyopathy or heart failure

Case Example

- Unhoused in acute intoxication

BN, N.C.S., 2019
Wodarz et al, 2017

TREATMENT OF METHAMPHETAMINE INTOXICATION AND WITHDRAWAL

Methamphetamine intoxication

- Pharmacological interventions
  - Benzodiazepines
    - Diazepam: 10 mg PO repeat q 30 min if necessary
    - Midazolam: 5-10 mg orally repeat after 30 min if necessary
    - Lorazepam: 1-2.5 mg PO repeat after 60 minutes if necessary
  - Antipsychotics
    - Olanzapine 10 mg PO repeat after 60 min if necessary
    - Risperidone 2 mg PO, reaped after 60 min
    - Haloperidol 5 mg PO, repeat after 60 min

- **<u>Essential for staff to keep own safety in mind</u>**
- Treat in a low stimulation environment
- Encourage fluid intake
- Avoid physical restraints if at all possible.

Methamphetamine withdrawal

- Prevailing withdrawal signs: depressive symptoms, anxiety, hypersomnia, exhaustion
- Some evidence that bupropion reduces cravings in methamphetamine dependance
- No evidence for treatment with SSRI's
- Clinical evidence shows olanzapine or quetiapine in management of persistent agitation, tension or insomnia
- Acute anxiety during withdawal- consider benzodiazepines

Chiang et al., 2019
Wodarz et al, 2017

METHAMPHETAMINE ASSOCIATED PSYCHOSIS (MAP)

- Two distinct groups- symptoms abate shortly after cessation of use or persist after weeks and months of abstinence
- Has been estimated to impact between 26-46% of people with methamphetamine dependence
- Risk of psychosis following methamphetamine use has been shown to be higher in survivors of sexual abuse
    - Persistent psychosis is higher risk in those with family history of psychotic disorder or those with sustained symptoms of depression
- Symptoms:
    - Persecutory delusions, delusions of reference, conceptual disorganization, depression, hostility, tactile hallucinations and auditory hallucinations
- Functional consequences:
    - Social and occupational deterioration
    - Poor treatment outcomes
    - Loss of transitional housing
    - One third of people experiencing MAP end up with a diagnosis of primary psychosis
    - Long term users are at greater risk of poor health outcomes including suicide, accidents and premature death

Case Example:

- Housed example with long term psychosis

Chiang et al, 2019, Bramness and Rognli, 2016

McKetin et al., 2016

Florentini et al., 2021

Methamphetamine psychosis

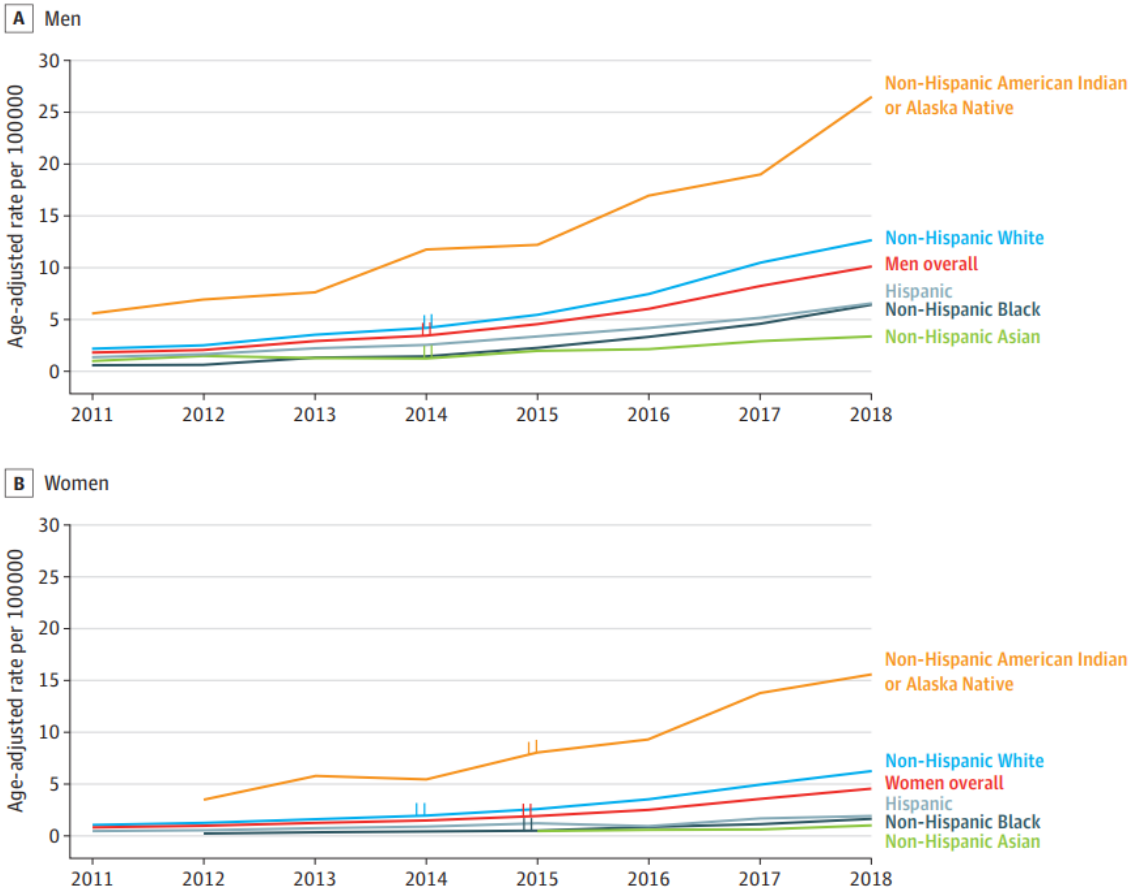
- Discernment of diagnosis: organic psychosis vs substance induced
- Psychotherapy and behavioral treatments both to treat psychotic symptoms and combat substance use
- Pharmacological treatments:
  - Second generation antipsychotics to treat psychotic symptoms including olanzapine, risperidone and quetiapine
  - Bupropion, naltrexone, mirtazapine, and methylphenidate- preliminary studies indicate benefit in reducing methamphetamine use
- Reassess psychotic symptoms after 6 months
- Matrix Model- combines CBT, family education and self help participation
- Mindfulness based relapse prevention- support coping, decrease depressive symptoms

TREATMENT OF METHAMPHETAMINE ASSOCIATED PSYCHOSIS

Chiang et al., 2019

Glassner-Edwardsa and Mooney, 2014

Figure. Trends in Methamphetamine Deaths Among US Men and Women Aged 25-54 Years Overall and by Race and Ethnicity



Cultural Considerations

Study used existing deidentified public health surveillance data

Age adjusted rates for methamphetamine involved deaths increased from 1.8 to 10.1 per 100,000 among men and from 0.8 to 4.5 per 100,000 women

Within each sex, American Indian and Alaska Native individuals had the highest death rates, with acceleration during 2015-2018 for women and consistent increases during 2011-2018 for men. (Cotto, et al., 2021)

THE DILEMMA OF TIME

Time in sobering

Time to do relapse prevention work

Time vs Reality of current billing models, care pathways, and clinical productivity expectations

CARE MODELS AND SYSTEM CHANGE

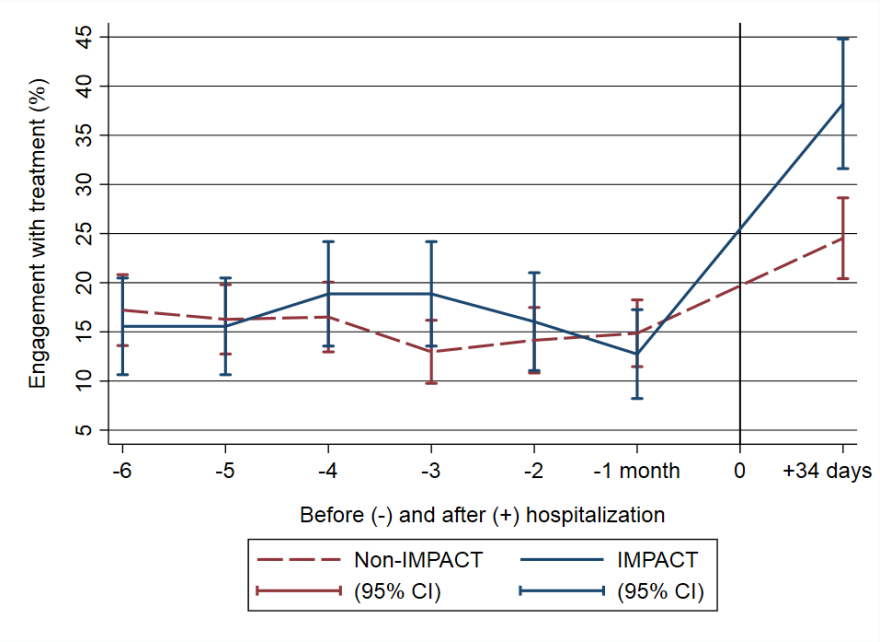
PORTLAND'S INNOVATIVE SOLUTIONS

Peer Delivered Services in health care teams: IMPACT at Oregon Health and Science University

Housing First: Cedar Commons at Central City Concern

System improvements in sobering and stabilization services: Behavioral Health Emergency Coordination Network

IMPACT: IMPROVING ADDICTION CARE TEAM @OREGON HEALTH AND SCIENCE UNIVERSITY

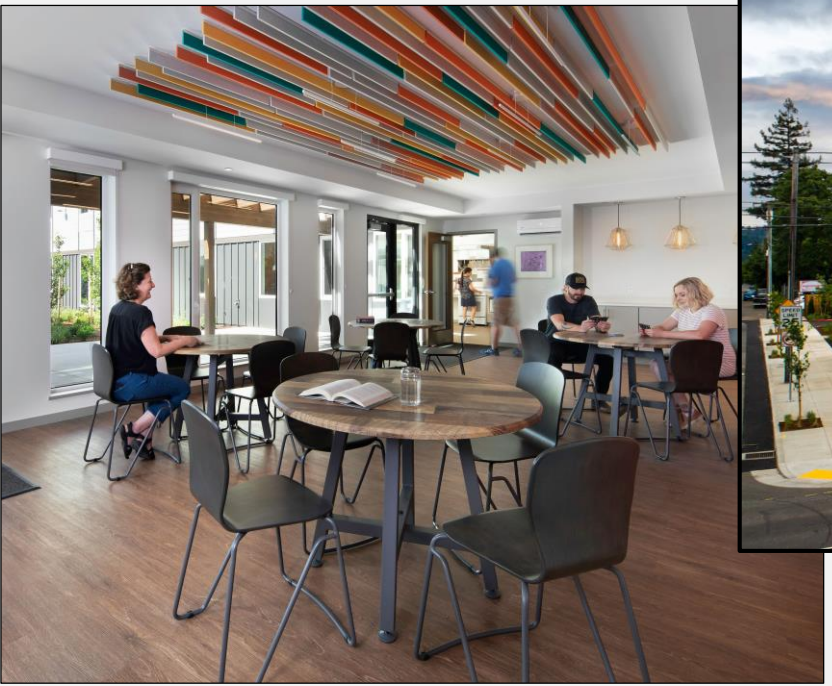


Adjusted Odds Ratio 2.39 (95% CI 1.44-3.96; p <0.01)

Reminder to all providers and staff: ***Language matters.***

Using clinically accurate and medically appropriate language matters when talking with, and documenting about, individuals who have substance use disorder (SUD) [Botticelli and Koh. *JAMA*. 2016]. Patient first language can reduce stigma, increase patient willingness to seek treatment, reduce negative provider perceptions of patients with SUD, and improve care. Please click here for examples of appropriate language to use when documenting/discussing substance use [NIDA – "Terms to Avoid"] [Goddu, et al. *J Gen Intern Med*. 2018]. *Thank you for helping make OHSU hospital a more inclusive place for people with substance use disorder.*

CEDAR COMMONS: HOUSING FIRST & PERMEANT SUPPORTED HOUSING (PSH)



For more information:

https://centralcityconcern.org/blog/ccc-opens-new-supportive-housing-building/

CLIENTS VOICE IN DEVELOPMENT OF CEDAR COMMONS MODEL

Interview Details:

30-60 minute interviews

Interview Questions:

- What kinds of services/meetings would be helpful onsite? Groups? Types of classes?
- How often would you want to engage with an onsite support staff?
- What resources are important to you?
- What community activities would you be interested in?
- What information would you want to see in the building newsletter?
- We're going to provide training/resources about cleaning/maintaining your rooms. Are there other things you'd like to see like that?
- When you think about a time that you felt successful in housing, what did that look like? What were the factors that contributed to that success?

KEY FINDINGS

- **Supportive onsite staff:** Knowing I'm not alone and that I always know who to go to.
- **Community-building:** Important to feel like I'm a part of the community and that I'm contributing my talents, skills, and interests.
- **Transparency:** Important to openly acknowledge the reality of relapse and remove the fear that seeking support might result in discharge/eviction.
- **Onsite services/resources:** Case Manager, Peer, Doctor/prescriber, Counselor, Employment Specialist, benefits support, food pantry, transportation assistance
- **Introduction at move-in:** Important that residents feel welcomed and comfortable when they first arrive and are made aware of all resources/services available.

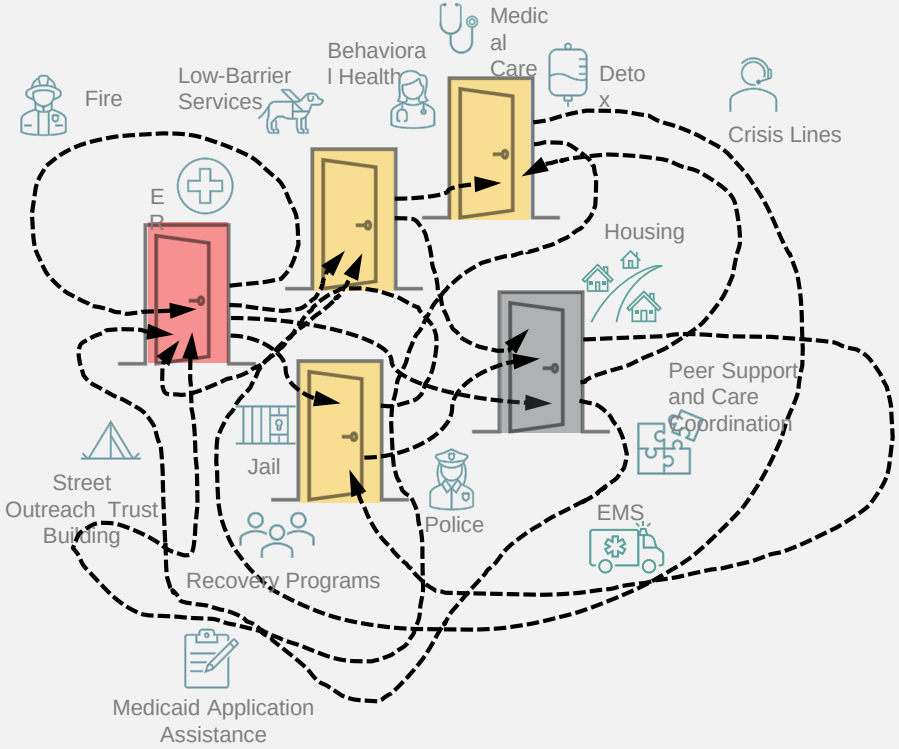
BHECN: BEHAVIORAL HEALTH EMERGENCY COORDINATION NETWORK (BHECN)

- There is a system gap and strong community stewardship is needed to fill it
- BHECN offers an actionable solution by:
  - Creating a front door and networked approach for the Portland Metro crisis system
  - Supporting first-responders by providing a logical next step and low-barrier location for them to bring people with focus on methamphetamine crisis
  - Providing sobering, crisis stabilization and peer-supported referrals and care coordination
  - Blending funding streams to support sustainability
- In line with the urgency and need in the community we are committed to a BHECN soft-launch by early 2023

Portland/Multnomah County Crisis System

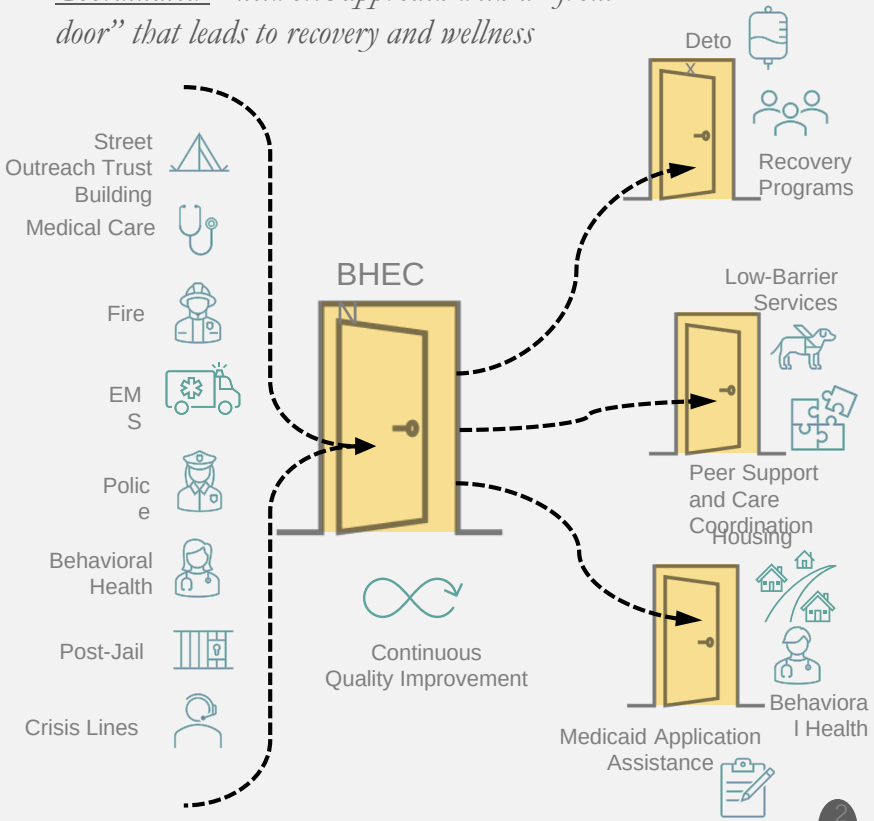
Current State

Uncoordinated – no "wrong door" but no clear path to recovery and wellness



Future Vision

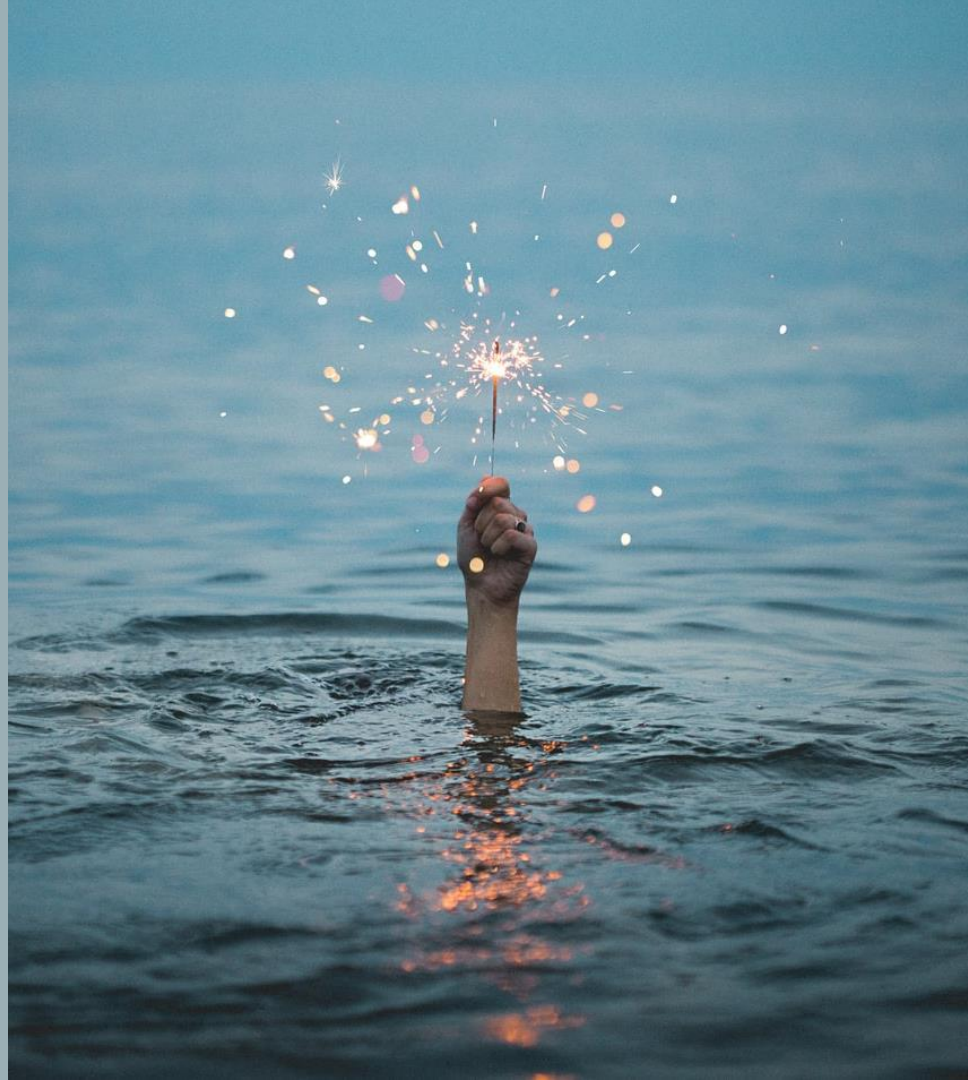
Coordinated – network approach with a "front door" that leads to recovery and wellness



STAFF WELLNESS, RESILIENCY AND PRACTICING WITH LOVE

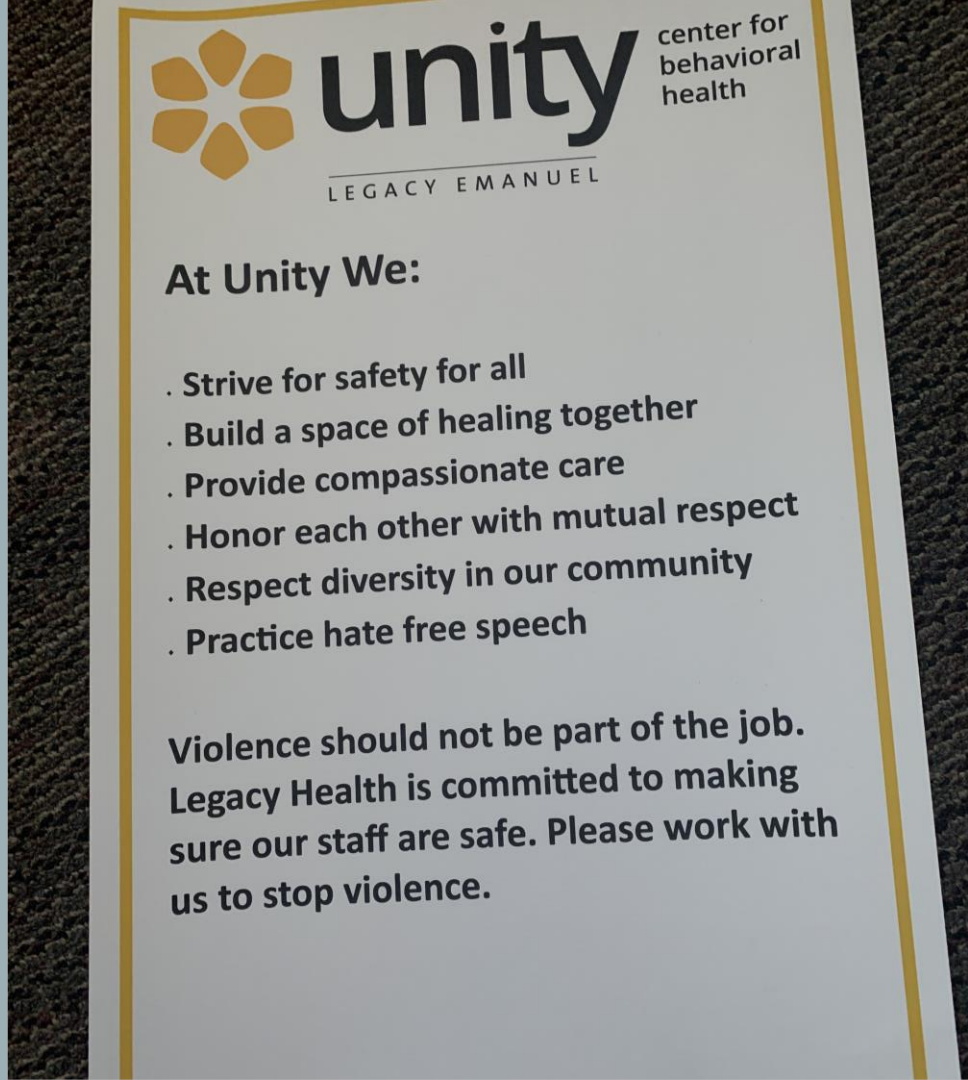
WORKFORCE WELLNESS POEM BY ADRIAN MICHAEL

healing is in the love you give yourself
healing isn't always the stiches or casts
splints or bandage wraps. sometimes there
is nothing that covers the walking wounded
better than gentle smiles of strangers and
the grace of those who may not understand
but have the willingness to sit and listen.
no desire to fix or affix judgement. healing
is in the carrying on when you just want
to carry less. Healing is in the love
you give yourself. you can be hurt
and still face the world. you are
brave and inspire others
to do the same



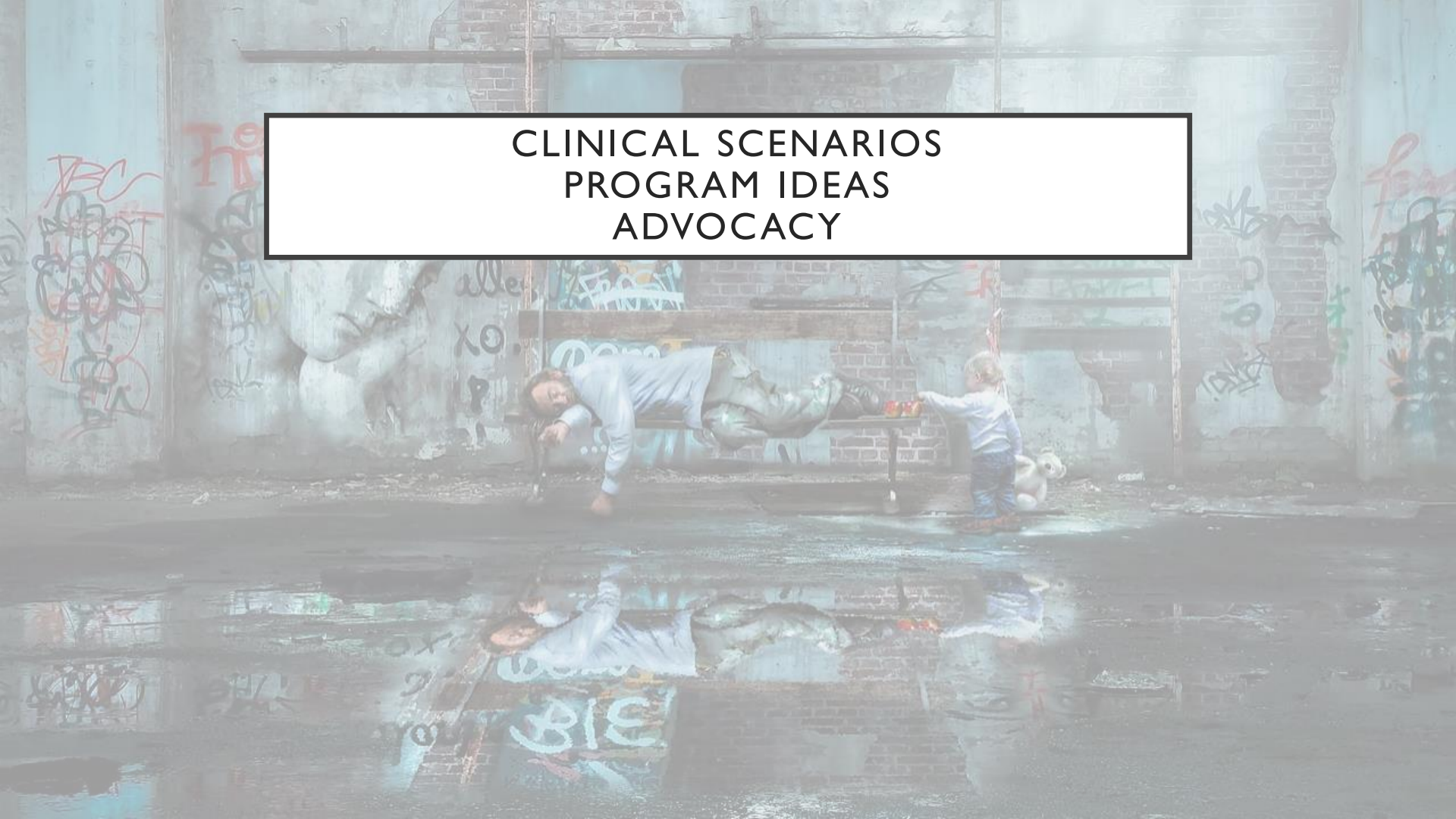
CREATING SAFETY TOGETHER & IMPACTS OF CHRONIC STRESS ON HEALTH CARE PROVIDERS

Designed and created in collaboration with staff who experience the day to day impacts of behavioral health crisis in downtown Portland.



TRAINING IN TRAUMA INFORMED DE-ESCALATION

- BETA Project (Holloman & Zeller, 2012)
- Use and selection of scales to objectively measure agitation
- Choosing a training model
- Investment in training of staff in an ongoing and consistent way



CLINICAL SCENARIOS
PROGRAM IDEAS
ADVOCACY

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