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Photo courtesy of Bernardo Barrios of Lawndale Christian Health Center in Chicago, IL.

Treatment Models for Non-Opioid Substance Use Amongst Populations Experiencing Homelessness

The previous issue of *Healing Hands*, "Non-Opioid Substance Use, Mental Health, and Homelessness," contained information about the health impacts and demographic variance of substances that are commonly used by people experiencing homelessness, as well as guidance on confronting and reducing social stigmas about substance use. This issue will focus a lens on treatment by first examining treatment models and pharmacological interventions for substance use disorder, followed by information about additional tools that may assist care providers in providing comprehensive client-centered, trauma-informed physical and mental health care and harm reduction interventions. This issue will focus on treatment options and models for non-opioid substance use, including alcohol, methamphetamines, and cocaine. For an in-depth look at clinical guidelines for treating opioid use, see the National Health Care for the Homeless Council's *Adapting Your Practice: Recommendations for the Care of Homeless Patients with Opioid Use Disorder*.¹

As the National Health Care for the Homeless Council has noted, "Prevalence estimates of substance use among homeless individuals are approximately 20-35 percent; as many as 10-20 percent are 'dually diagnosed' with an

additional mental health diagnosis. In the U.S., less than one quarter of individuals in need of substance abuse treatment actually receive it; structural and interpersonal barriers to accessing [substance use disorder treatment] are exacerbated by the realities of homelessness. Thus, homeless persons have a higher need for treatment than in the housed population, yet can expect to face more difficulties in accessing the help they need."²

The numerous compounding intersections between mental health, substance use, physical health, and lack of access to housing and health care create complicated situations for patients and their health care providers. Substance use can act as both a preceding factor and a consequence of homelessness. It can be a coping mechanism for and/or a contributing factor to mental illness. It can cause, seem to temporarily "relieve," and exacerbate a wide variety of physical health conditions.

Substance use disorder is complex and multi-faceted, making it difficult to treat for all populations; these difficulties may be compounded when working with people experiencing homelessness, as issues of access, maintenance, and continuity of care may be intensified.

MEDICATION-ASSISTED TREATMENT FOR SUBSTANCE USE DISORDERS

In some cases, it may be appropriate to utilize medications for evidence-based treatment of substance use disorders. This is particularly true for the treatment of alcohol use disorder, given that there are various medications and a robust body of evidence to draw upon. **Barry Zevin**, a physician and Medical Director of Street Medicine and Shelter Health for the San Francisco Department of Public Health, notes that in the national conversation about the opioid epidemic, “we have sometimes lost track of the severe consequences—medically, mentally, cognitively—of alcohol use,” despite the fact that there is strong evidence of the kinds of outpatient and residential treatment programs that can be helpful for people with alcohol use disorders. Care providers have a well-developed toolbox of psychopharmacological treatments available for alcohol use disorder, including:

For Acute Alcohol Withdrawal:

- **Benzodiazepines:** chlordiazepoxide (Librium), oxazepam (Serax), lorazepam (Ativan), and others or phenobarbital are commonly used and effective in the treatment of alcohol withdrawal in supervised settings but can be dangerous when used in combination with alcohol or other sedating drugs and therefore may not be appropriate for outpatient treatment in this population.
- **Anticonvulsants:** carbamazepine (Tegretol), divalproex sodium/sodium valproate (Depakote), and gabapentin (Neurontin) are less commonly used in treatment of withdrawal, but all have some evidence of safety and efficacy and may be preferred in unsupervised settings.
- **Adjuvants:** propranolol (Inderal) with lorazepam or anticonvulsants are used to decrease symptoms of anxiety; antipsychotics can be used for hallucinations.

For Alcohol Relapse Prevention:

- **Opioid receptor blocker:** naltrexone (oral: ReVia, long-acting injectable: Vivitrol) cannot be used in clients prescribed or using opioid analgesics or those using methadone or buprenorphine.

- **Acamprosate** (Campral) appears to work through the GABA system; it has positive effects on craving and cue-related relapse and does not interact with most other medications. It must be dosed multiple in pills three times a day and is therefore challenging to adhere to.
- **Anticonvulsant:** topiramate (Topamax) stimulates the GABA b receptor; it needs slow titration to effective dose and may cause “brain fog.”
- **Anticonvulsant mood stabilizer:** divalproex sodium/sodium valproate (Depakote) reduces heavy drinking in comorbid bipolar disorder and alcohol dependence. It requires monitoring of blood levels, and gabapentin (Neurontin) may decrease craving and anxiety.
- **Gastrointestinal agent:** ondansetron (Zofran) is effective in trials with early onset alcohol disorder and high heritability. An autonomic nervous system agent, baclofen (Lioresal), is promising in some clinical trials for alcohol, cocaine, and amphetamine addiction.
- **Opioid antagonist:** nalmefene (Revex) is used in oral form to reduce alcohol craving⁵ (not available in USA market).

Pharmacological interventions for opioid use are also well-established, but the evidence base for medication-assisted treatment of other substance use disorders is less robust; according to Christian Schutz, “the biggest gap, specifically in the pharmacological treatment of addictive



Physician Barry Zevin and street outreach/medicine personnel at the San Francisco Department of Public Health. Photo courtesy of the San Francisco Department of Public Health.



disorders, is the lack of medications to treat stimulant use disorders such as cocaine and methamphetamine use disorders.⁴ Some evidence is emerging to suggest that stimulant use disorders may be treated using stimulant substitution therapy, but as Schutz notes, "We need carefully designed studies that further explore this potential medical approach...to test this intuitive and surprisingly little-explored course of treatment. Studies would have to closely monitor patients, weighing the damage done by untreated stimulant dependence and potential side effects of a high dose treatment. It appears worthy – if not crucial – to test the application of higher doses of slow release stimulants to treat individuals with stimulant use disorder, specifically those suffering from severe stimulant disorder such as crack cocaine and crystal-meth use disorder."

Thomas D. Huggett, a family physician and Medical Director of Mobile Health at Lawndale Christian Health Center in Chicago, Illinois, reports that they have begun using topiramate for reduction of cocaine use if a patient does not respond to first-line treatments of psychosocial interventions (including ongoing individual counseling and group therapy). Even though data on the effectiveness of topiramate in reducing cocaine use is mixed, some preliminary studies suggest that topiramate may be a useful medication for treating cocaine use disorder.^{5,6} Existing studies also make it clear that more research and more treatment options are necessary for cocaine use disorder.

Dr. Huggett also notes that the only available evidence on topiramate for treating cocaine use focuses on general populations, not specifically on people experiencing homelessness. "But we thought we would investigate it," says Dr. Huggett, "and our psychiatrist found these fairly good scientific studies, and we're willing to try. We've found that outpatients are more than willing to try it out because their lives have been so disrupted by cocaine use. We show the patients the studies, discuss the pros and cons, and most people are fairly desperate and really want to be helped. I don't want to say this is the answer, but it's something else that we can try, and we'll still be at the side of our patients doing our best to help them. We also hope this will continue to help retain patients in treatment."

With any medications for addiction treatment, it is crucial for care providers to be well-versed in possible side effects and cost-benefit analysis for individual patients. As more

research emerges on medications that may be useful for treating the use of different substances, care providers will have the opportunity to deepen their knowledge of medication-assisted treatment options.

TREATMENT CONSIDERATIONS

However, medication-assisted treatment is not a stand-alone solution to substance use disorder. Because it is so common for patients to have co-occurring substance use disorder and mental health issues, integrative care seeks to treat the whole person, rather than the addiction as a purely physiological phenomenon. Studies have shown that when mental health and substance use disorder treatment are provided separately, patients are more likely to receive contingent care, have difficulty making sense of conflicting messages about treatment and recovery, and also experience poor outcomes in general.⁷ Whenever possible, patients should be offered a menu of comprehensive services, including addiction treatment or counseling, mental health care, physical health care, peer support, and access to housing programs and other supportive services.

As Dr. Huggett notes, the most important thing within any treatment model or protocol is engagement itself: "If a person is engaged in a program and continuing to seek care and working on their care, then they die less. There are plenty of studies that show that people who are engaged in care die less frequently of overdoses and less frequently of everything else, even heart attacks and strokes and cancers. If we can engage people in a program and give people hope, letting them know we'll be with them through the battle, using a trauma-informed approach and reducing risks through harm reductions, and keep people coming back, then we are more likely to keep people alive and accomplishing the goals." His mantra, says Dr. Huggett, is: "Seek progress, not perfection. If we can work with our clients to achieve some kind of progress, then we are at least going in the right direction."

Though treatment models, relevant medications, and specific approaches may vary depending on the substance being used and its associated health risks, there are a number of tools that all care providers can use to support their interventions. Some keys to establishing care that accounts for the specific challenges involved in treating

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- THOMAS D. HUGGETT, FAMILY PHYSICIAN AND MEDICAL DIRECTOR OF MOBILE HEALTH, LAWDALE CHRISTIAN HEALTH CENTER, CHICAGO, IL

substance use disorder among people experiencing homelessness are: Understanding the connections between trauma, mental health, and substance use; facilitating access to treatment; integrating the Five Stages of Change; creating whole-person programming and treatment protocols; and working toward genuine continuums of care.

Understanding Links Between Trauma, Mental Health, and Substance Use

Andrea Denke is the Health Care for the Homeless Program Coordinator at the Community Health Center of the Black Hills in South Dakota. The program currently provides exclusively outpatient services, although they work with local inpatient resources, particularly in generating referrals for meth users who have a high need for medium- to long-term inpatient care. However, throughout South Dakota, there is a dearth of inpatient programs, particularly programs that serve women. There are also challenges with transportation and funding. Ms. Denke agrees that meth use is difficult to treat, partly because of the lack of evidence-based practice and partly because of the intensity of the addiction itself:

It's such a physical and psychological addiction combined that it's hard to beat. It's been around for a long time but the drug itself has evolved because the chemicals have been changed to accommodate what is available. For a long time the stuff coming through the Black Hills had a 90% purity rate, so it was very strong. It made it difficult for people to sustain sobriety because dopamine is completely depleted, and getting that back takes a very long time. I've had patients that had been IV drug users, especially of meth, and struggle with chronic depression because they just don't feel good. So that's usually what ends up causing the relapse: I can't take this feeling of hopelessness. So even if they had a sense of normalcy before using, it causes them to lose everything—work, friends, family, housing, property, and relationships. They just continue to crash.

Studies have shown that "exposure to traumatic experiences, especially those occurring in childhood, has been linked to substance use disorders, including abuse and dependence... and are also highly comorbid with Posttraumatic Stress Disorder (PTSD) and other mood-related psychopathology."⁸ The connections between trauma, mental illness, and substance use disorders cannot be overstated, and the traumatizing nature of experiencing homelessness can exacerbate these connections. Care providers should take into account these connections to both childhood trauma and the ongoing trauma of



Photo courtesy of Bernardo Barrios, Lawndale Christian Health Center, in Chicago, IL.

homelessness when developing treatment protocols and interacting with patients. In particular, it's important to note the ways that patients are self-medicating with substances.

Ms. Denke emphasizes that trauma can be both personal and structural: "We work with a population that has been marginalized and traumatized—one of the poorest Nations in the United States on the Pine Ridge Indian Reservation. There is historical trauma ... that also drives substance use. People are hurting. We work with youth that had been in foster care and some would try almost anything to feel better." For example, says, Ms. Denke, "I am working with a client who "has had an awful time, a lot of grief and loss, and has trouble processing that because of historical trauma, which combined with alcohol use and other drugs, bends her out of control and causes those feelings of suicidal ideation." Providing comprehensive treatment for clients like this requires careful attention to the role of past and present trauma in shaping coping mechanisms and capacities.

Facilitating Access to Treatment

Dr. Zevin cites open access as one of the keys to his clinic's success: "I would say for one thing we need to keep our communication as simple and concrete as we can. We need to see our patients more frequently than one might expect to have to see people. We work in a multidisciplinary team and work with health workers and outreach workers who are able to do the engagement and trust building. Our model includes open access clinics, so the work that we do inside of the four-walls clinic, we do with no appointments whatsoever. Appointments are the enemy of people experiencing homelessness!"

Dr. Zevin says he is “motivated to say that partly because with homeless meth users, it’s even more of an issue—appointments are a huge problem. People are able to get in, but not on the day and time exactly that we told them to. We decided not to require appointments anymore. We let people know when the clinic is open, we have a strong front-flow process, and nobody ever has to feel bad that they missed an appointment. That’s been an effective way of keeping continuity with patients. Historically lots of people miss an appointment, get scolded, feel shamed, and don’t come back. By not having any of that process, it’s much easier for people to feel like they can always have open access. That works a whole lot better. We’ve built this process particularly around the fact that many patients are meth users with a great deal of disorganization and periods of time when they literally can’t come inside the building. Bad days come and go.”

Creating Whole-Person Programming

People with substance use disorders require specific kinds of supports, offered with a “whole-person care approach,” says Dr. Zevin. At his clinic, they are able to offer one-on-one harm reduction psychotherapy to patients, utilizing motivational interviewing techniques and skilled counseling techniques. He notes that inpatient treatment can be a particular challenge when working with meth users, as most treatment centers are not set up to deal with symptoms like meth-induced psychosis. “One of my goals,” he says, “is to help develop more specialized programs that recognize what the specific problems and limitations are, including learning and cognitive problems that regular meth users have. You can look at brains of meth users and see the type of cognitive problems that they are going to have. If our programs are heavy on teaching new skills and we are working with a group that has trouble learning due to brain damage from drug use, we need to find better ways of reaching those folks.”

Part of creating this whole-person care involves learning as much as possible about the multi-dimensional impacts of substance use disorder for people experiencing homelessness. This may involve working in multidisciplinary teams, as well as gaining more expertise in symptoms and behaviors that commonly emerge in this population—for example, meth-induced psychosis. Dr. Zevin notes that although psychosis symptomology would generally be referred to a psychiatrist, “I now feel very confident that if someone is having symptoms of psychosis, we (medical doctors) need to be prepared to talk to them about that and prescribe medications. We can consult with our psychiatrist, but this is an everyday problem. Patients have psychosis both from schizophrenia and triggered by meth. Because of our model, we are reaching and caring for meth users as a regular part of our work. That’s a population that has trouble coming indoors, is often hidden, and people are not talking about it because they aren’t

regularly seeing those patients or only see them when they have an emergency. Even though methamphetamine is the number two illicit drug used globally (after cannabis), the literature on treatment of severe methamphetamine use disorder and treatment of meth-induced psychosis is minimal; there are hardly any scientific articles on that. So, we’ve got a long way to go.”

Integrating the Five Stages of Change

Care providers who work with people with addiction know that change does not occur all at once. The Five Stages of Change model posits that before any meaningful change can be made, a patient must move through the following process:

- 1. Pre-contemplation stage:** The patient feels hopeless, is resisting change, and may place responsibility for their situation entirely on outside factors.
- 2. Contemplation stage:** The patient has begun to pay attention to their problem and think through possible future actions or solutions.
- 3. Preparation stage:** The patient is still ambivalent, but has begun making some plans and arrangements for the beginning stages of behavior change.
- 4. Action stage:** The patient is applying time and energy to changing their behavior and modifying their environment.
- 5. Maintenance stage:** The patient is maintaining their changed behaviors. In this stage, relapse to the pre-contemplation or contemplation stage may occur.⁹

Patients move through these Five Stages of Change at different paces and on different timelines. Approaches such as motivational interviewing can help care providers support patients in their own process, using non-judgmental, affirming language. These approaches are more likely to promote change than stigmatizing communication styles that do not account for the complexity of addiction or the nuances of the Five Stages of Change.

Four Principles of Motivational Interviewing

- » Express empathy. Accepting people as they are frees them to change. Acceptance of the individual is not the same as agreement with or approval of his or her behavior.
- » Develop discrepancy. When a behavior is seen as conflicting with important personal goals, change is more likely to occur.
- » Roll with resistance. Arguing is counterproductive; reluctance and ambivalence are natural and understandable.
- » Support self-efficacy. A person's belief in the possibility of change can be an important motivator.

The Basic Skills of Motivational Interviewing

- » Open-ended questions. Examples include, "How can I help you?" "What are the positive things and what are the negative things about your behavior?" "What do you want to do next?"
- » Affirmations. These should be genuine statements that recognize clients' strengths and build confidence in their ability to change.
- » Reflective listening. Defined as an active form of listening where the counselor reflects back at the person the meaning of what the person is expressing; this may involve rephrasing, paraphrasing, or discussing feelings.
- » Summarizing. Reflect back to clients their ambivalence and accentuate any statements they make that indicate a willingness to change.

Adapted from NHCHC. (2003). Healing Hands: A Comprehensive Approach to Substance Use and Homelessness. Available at <http://www.nhchc.org/wp-content/uploads/2012/02/hh-1003.pdf>

"Treat people with dignity and respect, even people with psychosis. Engage and gain their trust."

- BARRY ZEVIN, MEDICAL DIRECTOR OF STREET MEDICINE AND SHELTER HEALTH, SAN FRANCISCO DEPT. OF PUBLIC HEALTH

dangerous, but we also don't want to label that person as dangerous and stop trying to engage them, because we know there will be good days and bad days." Engaging productively and compassionately with patients requires an understanding that due to the complexity of substance use disorders and homelessness, relapses will occur for many people.

Working Toward Continuums of Care

"What would a solid service continuum for homeless individuals with substance use disorders look like?" asks Dr. Zevin. "It depends on the substance and co-occurring problems. For severe alcohol use disorder, it might look like a sobering center connected with a medically supported detox. Patients who go to detox would have prioritization for a slot in a residential treatment program that would include MAT, then prioritization for clean and sober housing, with supports for relapse. The patient would not go back to the street if they relapsed, but would stay housed and get extra supports and priority for detox and treatment." The availability of actual services, however, vary from area to area, ranging from the number of available beds for medically-supported detox to the number of spots in rehabilitation centers. Moreover, the traditional settings may not work well for people experiencing homelessness who may use substances while also coping with other serious medical and mental health issues. For this reason, Dr. Zevin notes, "there are odd mismatches in what services look like for people without homes with severe alcohol use disorder, and how much of an information base is available. We continue to ask ourselves: What should a system of care be for this most common substance use disorder?"

Dr. Zevin also notes that in some countries, such as Canada, care providers engage in harm reduction through evidence-based managed alcohol use programs, where patients can consume alcohol provided by a health provider in a safe and well-managed environment, while engaging in conversation with care providers about their readiness to make changes. "We have a lot of leftover puritanical thinking in the United States," says Dr. Zevin, "and we haven't really tried managed alcohol programs here, although there is a strong evidence base to that modality. At present it is tucked away in specialized medical journals."

What it comes down to, says, Dr. Zevin, is "Basically: Treat people with dignity and respect, even people with psychosis. Engage and gain their trust. They might not come in when they are having a bad day. I'm thinking of one client—when having a bad day, he gives a signal to the outreach worker not to mess with him. On a good day, he is friendly and engaged and wants to work on his problems. Sometimes when people are paranoid and psychotic there can be a safety issue, and we don't want our outreach workers to be reaching out to someone who may be

COMPREHENSIVE SUBSTANCE USE TREATMENT

Comprehensive treatment for alcohol use and substance use disorders may include medication-based treatments, but also ideally includes education, therapy, peer support, and one-on-one case management. In fact, evidence-based best practices employ integrated care models in which mental health and addiction services are available at one location from a team of clinicians with mental health, addiction, and case management experts.¹⁰ In practice, it can be particularly difficult to incorporate all of these treatment components when working with homeless populations, given difficulties that patients may have accessing reliable housing, transportation to ongoing care, nutritious food, and supportive social networks. Some programs that serve people experiencing homelessness, though, are working to develop multi-dimensional substance use treatments that are responsive to the specific difficulties experienced by homeless populations.

The Santa Clara Medical Respite Program in Santa Clara, California, is a 20-bed facility based inside a large homeless shelter. **Sara Jeevanjee**, who is the Medical Director and a physician for the Respite Program, estimates that three-quarters of the patients who come through the facility have substance use disorder—with alcohol as the most commonly-used substance, followed by meth. Substance use disorder interacts in a variety of ways with other chronic and acute medical conditions for which clients require medical respite care. Dr. Jeevanjee explains that “some patients have alcohol-related medical issues, or they may be connected in some way to diabetes, which is worsened by alcohol use. With the meth use, we’re seeing a pretty large chunk, maybe half of those folks, who have heart failure due to meth use. Meth-induced heart failure, in particular, is really challenging to manage.”

The Respite Program is able to provide Vivitrol, “a long-acting injectable form of naltrexone, as medication for addiction treatment for people addicted to alcohol,” says Dr. Jeevanjee. “It’s great to have something to offer people in terms of medication... One thing that is remarkable about respite care is that you are often getting folks who have been using for a long time and may be in a moment of change after their recent hospitalization. Some of them may be suddenly realizing the extent to which their health was being affected by their substance use. People may be willing to prioritize their health. So it’s wonderful to have something to offer people who are ready to make changes.”

However, medication-assisted therapies have a particular set of challenges for people experiencing homelessness, including challenges associated with follow-up and continuity of care for patients who are transient. “Patients get the injection every four weeks,” explains Dr. Jeevanjee, “and some patients might not be in respite long enough to get a second injection, then may be lost to follow-up

Common Themes in Effective Substance Abuse Programs

- » Comprehensive Services: Offering a rich blend of services that address the client’s safety, health, social, and material needs, through formal and informal relationships with other service organizations
- » Integrated Services: Use of multidisciplinary clinical teams to provide simultaneous, well-coordinated treatment of co-occurring conditions at the same service site, with an emphasis on housing as an essential component of treatment
- » Client-centered Care: An individualized plan of care based on the client’s needs, wishes, capacities, and readiness for treatment, rather than on the program’s predetermined benchmarks for treatment outcomes
- » Uniquely Qualified Staff: Caregivers with compassion, empathy, patience, flexibility, and a sense of humor who are able to handle difficult situations rationally and calmly and who reflect the diversity of their clients
- » Access to Housing: A stable living situation, especially early in the treatment process, that is not necessarily contingent upon sobriety

From Kraybill, K, Zerger, S (2003). Providing Treatment for Homeless People with Substance Use Disorders: Case Studies of Six Programs. Nashville, TN: NHCHC.

after leaving the program.” In response to this difficulty, a psychoeducational program was developed to encourage people receiving vivitrol to return every week, both to facilitate ongoing access to the medication and to provide social and educational supports to the patients.

Aleksandra Cepnic, a Psychology Assistant for the program, developed this program as a psychoeducational group that could involve a multidisciplinary group, including psychology staff, medical doctors, MSWs, and RNs, to focus on some key topics:

- Addiction as a brain disease
- The cycle of addiction
- Physical and psychological aspects of addiction
- Facts and myths about addiction
- Triggers and warning signs
- Introduction to relapse prevention plans
- Overall health problems associated with addiction
- Using addiction as a coping mechanism for basic needs

- Addiction and mental health
- Introduction to Cognitive Behavioral Therapy (CBT) models, including talking about thoughts, feelings, substance use, and mindfulness techniques.

The group was initially designed, explains Dr. Jeevanjee, “for people who were receiving or eligible for long-acting injectable naltrexone, but we ended up opening it up for everyone. Anyone can come to the groups. We have also had some graduates of the program come back; even if you were in our program three months ago, if you want to reconnect, you can always come back to the group. Being located in the shelter helps foster that long-term connection.” Patients are also not required to be sober to attend the program, which runs on a multidisciplinary harm reduction model. With the participation of psychiatrists, medical doctors, social workers, a substance abuse counselor, and others, group facilitators are also able to make connections between substance use disorder and underlying mental health issues. The consistency of the group also enables the team to keep tabs on other needs that arise for patients, and to identify resources for transferring patients out of medical respite and into other programs that provide the kind of care and support each individual requires after being discharged.

The program was designed to run on a 6-week curriculum, but Ms. Cernic emphasizes that in practice, flexibility and consistency have been key to the program’s success. She notes that “sometimes the protocol or specific topic you might have assigned for that date might not work for the group that shows up. So I try to stay mindful and listen, and assess whether the topic needs to change to address issues or dynamics that are present in the group. I always have a thick folder with old handouts ready so that I can be flexible and use what is most needed even if it isn’t what I planned.”

One of the major challenges of the group is developing resources that will be useful to patients who use a variety of substances. The group was developed as a support for those with alcohol use disorder receiving long-acting injectable naltrexone, but people attend the group for support with other substances as well, and there is also a notable percentage of polysubstance users who attend. Ms. Cernic says that this is an ongoing

conversation: “How can we apply the Vivitrol treatment group to the meth users? How can we emphasize the importance of psychoeducation for addiction in general, including acquiring new skills through the group and finding a way to make it more appealing to our patients?” Part of this process, she says, is being committed to ongoing education for herself as the group facilitator—gaining training in Cognitive Behavioral Therapy and Dialectical Behavioral Therapy, adding to and adjusting her clinical skills, adding a mindfulness component, continuing to expand training and expertise in the field of addiction sciences, and so on. “Increasing my own knowledge is really important,” she says, “and it keeps me on my toes, always learning more and striving for more. That way we can serve our patients the best we can.”

CONCLUSION

Substance use disorder is a complex diagnosis in any case, and treatment presents particular challenges for patients who are experiencing homelessness. Medications for addiction treatment may be useful for some forms of substance use, particularly when provided in conjunction with comprehensive mental health care, physical health care, and access to services such as housing resources. All care providers, even under-resourced programs, can benefit from a trauma-informed lens that focuses on harm reduction and building strong relationships of trust with patients as they develop the readiness, capacity, and material supports to change their relationship with substances.



Photo courtesy of Sara Jeevanjee, MD, Medical Director of the Santa Clara Medical Respite Program at Valley Homeless Healthcare Program.

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