

HEALING HANDS

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Consultation at the Bud Clark Commons at Central City Concern in Portland, OR. Photo courtesy of Central City Concern.

Non-Opioid Substance Use, Mental Health, & Homelessness

Research suggests that roughly half of people experiencing homelessness have diagnosable substance use disorders at some point in their lives.¹ The relationship between homelessness and substance use is bi-directional; the expenses and symptoms associated with substance use and addiction can create financial and social conditions that lead to homelessness, while the stress and trauma of being unhoused can cause people to turn to alcohol and drugs as coping mechanisms, or as self-medication to alleviate acute and chronic mental and physical health conditions. Substance use disorder is often connected with serious mental illnesses, as well as with acute and chronic medical conditions, including diabetes, liver disease, upper respiratory infections, serious dental health problems, tuberculosis, and AIDS. Research shows that individuals with alcohol disorders have particularly poor health outcomes.²

This issue of *Healing Hands* will discuss the following:

- The current opioid crisis in the United States;
- The use of non-opioid substances amongst people experiencing homelessness;
- Key issues that intersect with substance use and mental health in homeless populations;
- Commonly-used substances such as alcohol, methamphetamines, cocaine and rock cocaine,

and synthetic cannabinoids (K2/Spice);

- The ways in which stigma around substance use occurs at multiple levels; and
- Strategies that providers can use to decrease the impact of stigma on service provision.

THE OPIOID CRISIS

The American opioid epidemic is at an all-time high, as deaths due to overdoses continue to rise across the country. **Mike Savara**, Clinical Supervisor of Bud Clark Commons, a permanent supportive housing center at Central City Concern in Portland, Oregon, notes that the high numbers of deaths associated with opioid use and overdose have generated increasing attention from both public health professionals and mainstream information sources. This attention is crucial for crafting public health and medical responses to the epidemic of overdoses. However, as a result of the growing focus on the opioid crisis, some feel that the ongoing health impacts of other substances are being neglected. "People, including people experiencing homelessness, are still struggling with methamphetamine (meth), cocaine, crack, alcohol, and all kinds of other drugs," says Mr. Savara.

Mr. Savara notes that there is also historical precedence for particular mainstream attention that focuses on specific substances. For example, when mainstream attention was first drawn to the impact of crack cocaine on urban African-American communities, the problem was constructed as social breakdown and then heavily criminalized through targeted drug policy that disproportionately affected low-income communities of color, with lasting impact on the community in the form of discriminatory policies resulting in mass incarceration. Though crack and powder cocaine are the same substance, crack was treated as a criminal justice issue while cocaine—which is more often used by white people—was treated as an addiction and therefore a medical problem.



Client and consultation area at Central City Concern's Bud Clark Commons in Portland, OR. Photo courtesy of Central City Concern.

Some feel that a similar phenomenon is occurring with opioids—as more people in middle-class and white communities become addicted to painkillers and overdose deaths in these communities rise, the visibility of opioids increases and mainstream discourses move toward treating opioids as a public health issue. Mr. Savara notes that, “as people in powerful and privileged positions have sons and daughters getting sucked into opioid abuse, the problem is being constructed as a public health problem rather than a criminalization issue ... This recent change in discourse doesn't seem to be applied to other drugs; crack is still viewed as an African-American problem where the solution is imprisonment.” (Mr. Savara emphasizes, all addiction is a medical issue and public health concern—not a criminal issue.) Moreover, mainstream narratives about the opioid crisis as being driven by initial addiction to prescription painkillers may not hold up among homeless populations, who may come to opioids initially through heroin rather than pills.

Because of the robust information available on the opioid epidemic in both the scientific literature and mainstream sources, this issue of *Healing Hands* will focus on the impacts of non-opioid substances that are widely used by people experiencing homelessness. For more detailed information on how the opioid epidemic specifically affects homeless populations, see NHCHC's fact sheet, *Addressing the Opioid Epidemic: How the Opioid Crisis Affects Homeless Populations*.³

INTERSECTING ISSUES

Substance use does not occur in a vacuum. The roots of substance use amongst individuals experiencing homelessness generally trace back to the presence of Adverse Childhood

Experiences (ACEs) during the person's childhood and adolescence. ACEs are traumatic or stressful events experienced or witnessed by a child, and may include such occurrences as abuse (physical, emotional, or sexual), neglect, domestic violence, poverty, substance misuse within the household, volatile parental relationships, or the death or incarceration of family members. ACEs lead to social, emotional, and cognitive impairments that may result in the adoption of high-risk behaviors that lead to disease, disability, and earlier deaths than individuals who did not experience ACEs.⁴ A history of ACEs has been robustly associated in scientific literature with homelessness,⁵ mental illness,⁶ alcohol abuse,⁷ and drug abuse.⁸ The role of ACEs in driving substance use amongst people experiencing homelessness and untreated or undertreated mental illness cannot be overstated.

Barry Zevin, a physician and Medical Director of Street Medicine and Shelter Health for the San Francisco Department of Public Health, notes that it is also important to stress the heritability of addiction disorder. A growing body of research looks at the complex interactions between genetics, life experiences, and addiction:

Millions of people are exposed to addictive agents each year, for instance, in the course of medical care for treatment of pain. The vast majority do not become addicted, even if temporary tolerance and dependence are elicited. The probability of initial use and the probability of progression toward a pathologic pattern of use are influenced by intrinsic factors (e.g., genotype, sex, age, age at first use, preexisting addictive disorder, or other mental illness), extrinsic factors (e.g., drug availability, peer influences, social support, childhood adversity, parenting style, socioeconomic status), and the nature of the addictive agent (e.g., psychoactive properties, pharmacokinetics, mode of use or administration). The relative importance of these factors varies across the lifespan and at different stages of addiction. For example, peer influences and family environment are most important for exposure and initial pattern of use, whereas genetic factors and psychopathology play a more salient role in the transition to problematic use.⁹

“The war on drugs has not been helpful. We disproportionately incarcerate people of color even though we know people of all races use drugs at pretty even rates.”

- SUSIE KOWALSKY, TEAM LEADER,
MINDSTRONG, CHICAGO, IL

Dr. Zevin adds that “of course, genetics and ACEs are closely related, since if your parents have an addiction disorder you will have a higher chance of experiencing many ACEs.”

Due to both the ongoing impact of ACEs/trauma and the physical and psychological impacts of certain substances, there is also a bi-directional relationship between substance use and mental illness. An estimated 50 percent of homeless adults with serious mental illnesses have a co-occurring substance use disorder, and people with co-occurring disorders have more problems, need more help, and are more likely to remain homeless than other groups of people.¹⁰ Moreover, “non-substance-related mental illnesses—including

mood, anxiety, personality, and schizophrenia-spectrum disorders—are all associated with an increase in substance-related (substance use or substance-induced) disorders; and individuals with the most severe mental illnesses have the highest rates of co-occurring substance-related disorders.”¹¹ This bi-directional relationship between substance use and mental illness is highly individualized and can be difficult to parse in practice. While substances may be used to cope with mental illness (like using alcohol or heroin to make PTSD nightmares or flashbacks go away), the use of certain substances can also create or exacerbate mental health conditions; for example, cocaine crash and recovery are associated with acute dysphoria and/or suicidality.

Susie Kowalsky, the Team Leader for Mindstrong in Chicago, Illinois, notes that it is also important to look at how ACEs interact with structural inequalities around race and class and the institutionalization of racialized policies: “The other piece that is very relevant is the role of the criminal legal system and incarceration and what that looks like for people who use drugs and experience homelessness and mental illness. Then layer race atop that, and access to services. The war on drugs has not been helpful. We disproportionately incarcerate people of color even though we know that people of all races use drugs at pretty even rates. Whether someone who has a felony in their background can get housing or a job—these things are really closely related. We need to be thinking historically about drug laws, and which are illegal is very racially driven.”

These intersections of poverty and homelessness, mental illness, genetic factors, family histories, physical health problems, and criminalization of both substance use



The Bud Clark Commons at Central City Concern in Portland, OR. Photo courtesy of Central City Concern.

and homelessness mean that substance use is a complex and multifarious issue, and that different people will have different reasons and motivations for their substance use. One formerly homeless individual explained some of these intersections in his own experience: "We know that a large percentage of homeless folks do use drugs, but through my own lived experience—I was homeless for 25 years, incarcerated for 9 years, and used drugs for 25 years—I know that all I cared about was how I was going to mask my emotions with drug use. It's really no fun being homeless. But on the other hand, there's a sense of freedom; you don't have to show up to work, pay rent, pay a car note, deal with coworkers. All you have to worry about is not being harassed by police or having your stuff stolen. But there's a huge mental health aspect to it. Many individuals with untreated substance abuse issues have untreated mental illnesses." The stresses associated with homelessness and chronic mental illness can cause substance use to feel like an escape or a coping mechanism.

Valarie Dowell is a Community Outreach Advocate and peer educator with the city's Office of Human Relations in Cincinnati, Ohio. Describing the results of a focus group on individuals experiencing homelessness that she attended, she says, "I learned a lot about when I was homeless on the streets versus homelessness today. With all the assaults, you really have to sleep with one eye open and one eye closed. One day you see someone with a black eye and you find out it happened because he had something someone else wanted. There's a rise in homelessness and assaults, homelessness and hurting others. But it goes back to the substance use and alcohol. It's twofold: Committing assault because you know someone else has a substance and you are feeling sick, or being intoxicated may give you the courage to fight someone for it."



Valarie Dowell, Community Outreach Advocate. Photo by Rick Brown.

Ms. Dowell explains the importance of peer-to-peer services for organizations grappling with these complicated intersections around substance use: "It's different when you get someone who has been through similar situations and can go back and reach and assist individuals. There are many organizations doing this work, but it's different when someone comes to you who has been through the exact same thing that you have been through. There are not enough of us out there. What agency really wants to hire someone to do that kind of work? In our agency there are nine of us hired specifically to do this kind of work to go back out." Peer support, she says, "makes it easier for people to trust you, when their trust issues are so huge. Because of my experience, I am able to develop a relationship with people on the streets. I want to create a model—how to reach the younger generation, and pass my knowledge and information on to them so they can be the next leaders in the community."

COMMONLY-USED SUBSTANCES

In addition to opioids, as previously discussed, some of the most commonly-used substances amongst homeless populations across the country are alcohol, methamphetamines, cocaine, and synthetic cannabinoids (commonly known by other names including K2, spice, and synthetic weed). Additionally, polysubstance use, when substances are knowingly or unknowingly combined, can create additional impacts on consumers.

There appears to be regional and demographic variation around which substances have the greatest impact on homeless populations. Different cities and regions grapple with different rates of usage of these substances, and polysubstance use also varies from place to place and is constantly in flux depending on which substances are available on the streets, and in what combination. Moreover, substance use may look different for demographic groups, including race, age, ability/disability, housing status, gender, etc. This means that care providers in different locations need to be engaged with their own communities to understand the specific landscape of substance use in which clients are existing.

Alcohol: The prevalence of alcohol abuse amongst individuals without homes, and the severe medical and cognitive impacts of chronic alcohol abuse, is sometimes glossed over due to its commonality. But alcohol is widespread and linked to premature death among the homeless population. Barry Zevin explains that "in our review of homeless deaths in San Francisco, deaths related to alcohol (in the form of medical diseases and intoxication-related accidents, such

as falling down, experiencing head trauma, etc.) rank a very close second to overdoses as a cause or underlying factor in homeless deaths.” He explains that particularly in conjunction with cigarette use, alcohol use disorder is prevalent throughout the country and linked to both acute and chronic health problems as well as premature death. In addition to increasing the risk of accidents, long-term alcohol use is linked to a plethora of health conditions, including liver disease, pancreatitis, immune system dysfunction, malnutrition, heart disease, and brain damage.¹²

Methamphetamines: **Andrea Denke** is the Health Care for the Homeless Program Coordinator at the Community Health Center of the Black Hills in South Dakota. Methamphetamine use is a huge public health problem in this region, and Ms. Denke states that “meth use goes across all SES levels, across racial lines, and in the professional world, although it is not always evident who is using it... The homeless population uses at about the same frequency as other populations but they are certainly more vulnerable to some of its worst impacts.” Ms. Denke notes that meth use is related to other health issues like high blood pressure, dental issues, and drug-induced psychosis, which is almost impossible to treat and may last a lifetime. Statistically, she says, “less than 10 percent of meth users will fully recover from their meth use... 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-percent purity rate and so 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... Even if they had a sense of normalcy before using, it causes them to lose everything—work, friends, family, housing, property, relationships.”

Cocaine: Cocaine is sometimes used in its powdered form by people without homes, but in most regions is more commonly used in the form of rock cocaine. (Ms. Kowalsky suggests using the term “rock cocaine” to avoid reinforcing historical stigmas associated with the word “crack.”) Both types of cocaine are powerful stimulants, although powdered cocaine is typically snorted or injected while rock cocaine is smoked. Cocaine is best known for its impact on cardiovascular health, and is also associated with blood pressure changes and cognitive impairment. **Thomas Huggett**, a physician and Medical Director of Mobile Health for Lawndale Christian Health Center in Chicago, Illinois, reports a strong connection between cocaine and homelessness in the area where he works, due to the expense associated with cocaine, but also notes

that, “Cocaine and heroin cycle a little bit. Cocaine was bigger during the ‘crack epidemic’ in the 1990s... Our team has been doing this since 1995, so I certainly remember the mid-1990s when cocaine was the main issue, not necessarily heroin... Now cocaine is gradually decreasing on the west side.”

K2/Spice: A significant problem in Washington, D.C., and communities across the country, K2—also known as synthetic marijuana, although it has nothing in common with plant strains of marijuana—consists of chemicals mostly compounded overseas and sent to the U.S.

Catherine Crosland, Director of Homeless Outreach Development at Unity Health Care DC, explains that K2 can be sold legally as “plant food” or other chemicals in certain stores and in the street, and is sometimes laced with fentanyl. “So people have all kinds of reactions to K2

Provider Narrative: The Challenges of Sustained Care Provision

Unfortunately, patients who use meth and other street drugs often are transient, and I see them for a brief period of time. Many leave the area for another community or disappear and reappear off and on. Another challenge is that determining meth use is dependent upon patients self-reporting. Some are scared to do so. I also see patients who abuse and sell prescription drugs along with abusing/using street drugs and alcohol in an attempt to mask physical pain as a result of physical and/or psychological trauma. Patients can be aggressive, even threaten the provider in their demand for pain meds or other medications such as opiates or Adderall, insisting that this is the only thing that helps the pain. To be fair to the individual, this is true. Drugs are the one thing they have tried that makes the pain go away, at least until they wear off. On occasion, I am able to build adequate rapport to have an open discussion of why opiates work on both physical and psychological pain. We further discuss alternate ways to treat pain long term. Sometimes the pain is caused by an injury that can be repaired surgically or with physical therapy. In addition, we discuss ways to heal psychosocial pain. Physical and psychological therapy is often labor intensive, not to mention expensive, and is not always feasible or available. I work with the local resources to help patients gain access to specialty care whenever possible.

Submitted by Andrea Denke

depending on what is actually in it. Straight K2 can make people pass out; we see people down and rigid, almost like they are seizing but not quite seizing... Bad batches of K2 can cause people to overdose and die¹³... There was a young guy I saw who previously had normal affect, but after he smoked K2 could barely say his name and was stuttering. He was staying in the shelter so we called EMS to have him evaluated for altered mental status. A few weeks later, I would see him sitting on the curb outside the shelter rocking with a vacant stare. It's a very scary drug, because it's essentially an unknown poison that we don't know how it will affect you. It's like playing Russian roulette—it's not dose-dependent, there's nothing predictable about it; you could smoke it and die the first time."

Polysubstance use and inadvertent combinations:

Polysubstance use can occur when individuals simultaneously use multiple substances, and their impacts are combined and may interact. However, for people

sourcing substances from the streets, polysubstance use can also occur inadvertently and with extremely dangerous effects. Part of the deadliness of the opioid epidemic is fentanyl being mixed into street heroin. As another example, Dr. Huggett notes, "Sometimes folks think they are getting heroin but there is cocaine mixed in. Sometimes we also see cocaine cause an opioid overdose when person thought they were buying cocaine in the streets. We recently saw a mini-epidemic of opioid overdoses related to cocaine contaminated with fentanyl in Chicago." Ms. Denke refers to cases in South Dakota in which marijuana laced with meth has been sold, which causes addiction for users. Dr. Zevin says that a common substance use pattern in San Francisco is "opiates, mostly heroin, some fentanyl, combined with meth. Which is quite unusual compared to most of the country except some other west coast cities like San Diego, Denver, Portland, Seattle. But not LA or Vancouver. I don't know why that is—you'd have to ask drug dealers."

Case Study: Substance Use at the Intersections of Race and Trauma

Jason is a 59-year-old African-American man with a below-the-knee amputation and amputations of his toes on his other foot. He has lived at the Bud Clark Commons, a permanent Supportive Housing facility that uses a Single-Site Housing First design, for three years. He is a person with complex medical conditions, serious mental illness and drug addiction—"tri-morbid". He struggles to manage his diabetes care, with blood sugars that are regularly too high. He uses an electric wheelchair to get around, and sometimes a prosthetic. He's tall and strong, and he's very proud when he can use his prosthetic to ambulate. He has a high-intensity medical outreach team that works with him on his medical needs and his psychosocial struggles. Additionally, Jason works closely with clinical staff onsite at his housing. He is regularly contemplative around his needs connected to drug addiction and whether or not he should get into treatment. As an African-American man in a city that has a majority Caucasian population, he vocalizes a sense of not being understood, not feeling connected with some of his providers. He says "a black man in America, that's the worst possible scenario" and discusses police violence and how the criminal justice system has been used to destroy his life. He is very aware of the institutional racism that is present in nearly every arena of society.

Jason uses crack cocaine on a regular basis. He does this, he reports, because he struggles with severe depression, and this is the only thing he has found that brings him out of his dark moods.

He wants to stop sometimes, saying he is thinking about treatment. He also worries when he dabbles with heroin, saying that he doesn't want to become someone who uses heroin, who gets hooked. He worries about his future and what it would mean if he became a regular heroin user. He sees heroin as a big step up from crack and completely rejects the medication-assisted treatment movement, saying that back in the 80's, they just locked people like him up. His ambivalence is most intense when he becomes so depressed that he contemplates suicide. He has told me that he wants to "blow his brains out" and "he has nothing to live for" because of being a black man in America who uses drugs. We talk regularly about how the people in his life, even his providers, care about him and want him to stay alive. It's a daily struggle with bouts of severe suicidal thoughts.

Jason continues to work through his multiple levels of trauma and loss and the teams are working to find culturally congruent services that can work with him from the standpoint of a black man who has faced untold challenges to get where he is today and to simply stay alive. He is currently thinking about his options and working to use coping strategies to stay safe, while also working toward a future where he can find meaning and purpose in his life.

Submitted by Mike Savara

SUBSTANCE USE AND STIGMA

The ways in which mainstream attention is drawn to the issue of substance use amongst marginalized populations reflects broad social stigmas around who uses substances and why. Historically, this stigma has been enacted as policy and resulted in the criminalization of certain substance-related behaviors, substance use in public, and substance use by certain kinds of bodies; homeless and poor people, people of color, and people with other marginalized identities experience additional layers of stigma around substance use that white, wealthy substance users are able to avoid. This stigma manifests itself both in social attitudes and concrete, material consequences of substance use—for example, the disproportionate incarceration of people of color for drug-related offenses.

This broader social stigma is often internalized by substance users themselves and reenacted within consumer populations. For example, Mr. Savara explains that people who use substances are conscious of the history of drug use around this country, as these discourses “get filtered down to folks who are using... [People] who were drug users during the war on drugs, experienced the stigma of cocaine as criminals and pariahs, and experienced a lot of alienation from the system and from friends, see now how opioids are treated as a disease... [and may feel] betrayal, shame and guilt... Societal pressure affects the way users think about themselves and other users, and the stigma can become self-directed.”

OVERCOMING STIGMA AS CARE PROVIDERS

Because care providers have lived their lives as participants in the broader culture, the stigmatization of substance use can also find its way into organizational policies, treatment plans, and the quality and tone of interactions between providers and clients. The work of untangling the layers of stigma around substance use requires sustained self-reflection and effort. Some tools that can help care providers identify and overcome their own stigmas and prejudices are an understanding of implicit bias and its antidote: education; attention to the importance of person-centered care; harm reduction approaches, techniques, and mindsets; and constant attunement to a trauma-informed lens for engagement.

Assessment of Implicit Bias

As members of broader cultures, care providers may also carry implicit bias or overt stigma around clients who use substances or have diagnosable substance use disorder.

Van Yu is a psychiatrist and the Chief Medical Officer at Urban Community Services’s affiliate Janian Medical Care, located in New York City. According to Dr. Yu, it is crucial for care providers to engage in self-reflection in order to uncover how bias may be affecting their interactions with clients: “One way to address any tendency to stigmatize or discriminate is to understand substance use disorder as well as possible and educate yourself about the learning model of substance use... Included in this education is learning about what the possible interventions are and why they exist. I think that knowing about what is out there and what is effective gives you tools to bring to bear

on the problem, reducing the space for stigmatization, since stigmatization is a defensive stance to take when you feel hopeless in the face of a situation.”

Dr. Yu also emphasizes the importance of cultural competence: “The more you can walk in the shoes of the person you’re providing care for, the more compassion and empathy you’ll feel and the more effective your interventions will be. The person you’re working with needs to feel like you get what’s going on with them in order to be likely to engage with you and accept the care you are offering. The more you endeavor to know the people

you’re working with, the more you experience them as other people and the less room there is for stigma and discrimination.”

Dr. Yu acknowledges that this level of empathy for folks who are experiencing homelessness can be challenging if the care provider does not have similar personal experiences as the client; however, “the stigma issue is the same as racism, the same as gender-based discrimination or discrimination against the LGBTQ community—in all cases it is the same kind of experience. Anything you can do to surface your own prejudices and grapple with them will help you in this kind of work... of noticing the automatic thinking that happens when we are working with people.”

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- DR. VAN YU, CHIEF MEDICAL OFFICER,
JANIAN MEDICAL CARE, NEW YORK, NY

Person-Centered Care

Paul Tunison is a member of the Homeless Outreach and Client Engagement Team at the County Office of Supportive Housing in Santa Clara, California. A proponent of person-centered care, Mr. Tunison says, "The best advice I can provide to any service provider or any individual that is out here doing the work is to really listen—to have a skill set around motivational interviewing and really listen to these individuals, who have often had bad experiences with social workers and case managers." Instead of walking into interactions with a sense of "power over," says Mr. Tunison, providers can go into interactions with "a sense of shared power, listening to the client's story for long enough that you can identify their strengths and tell them what those strengths are in order to give them a sense of hope." When asked what he thinks client-centered care looks like in practice, Mr. Tunison points to the importance of:



*Paul Tunison, Homeless Outreach and Client Engagement Team Member.
Photo by Rick Brown.*

- **Being consistent in engagement with clients:** "We're really good at putting band-aids on things, enrolling people to get general assistance or emergency food stamps, or getting them into an emergency shelter, food pantries, hot meal services, clothing services, whatever. But we're not really good at long-term solutions. We can provide these immediate services, but they're not enough. They know they're in a bad situation and addicted to drugs, so you can give them a sense of hope and then enter into regular contact to start building a plan by asking questions like: How can we get you off the streets, get you connected to income, get you into permanent supportive housing? These things are long processes, so you've got to be consistent in your engagement."
- **Constantly developing a muscle for empathy:** "I think that is what makes me more effective—part is my lived experience, but I believe in walking in and being able to identify with that client. Meeting the client where they are."
- **Developing a plan that is focused on the client's needs and goals:** "This is not my plan, but a plan that the client would like to see happen. We start building small, attainable goals, which gives a sense of hope when they accomplish them."
- **Paying attention to the role of trauma and attachment:** "You should always walk into a situation thinking, 'What is the attachment?' Sometimes we don't have a whole lot of time to work with these folks. We want to get them into

a place where they can start developing a plan and live a more protected life. We talk about attachment theories and attachment styles, and does this play a part in our homeless population? There's a whole lot to look at."

- **Working to understand the client's value system:** "Often our organizational rules and policies are based on middle-class values. But what is the client's value system like? Sometimes theirs are better than ours! We're asking our clients to understand our organization's middle-class values and live up to those policies in order to participate in programs. So in general we need to fight for policy change and rule changes—not around safety, because we need to keep staff and clients safe at all times—but with an openness to the value systems of clients."

Harm Reduction

According to Dr. Crosland, "My take on intervention is very much in education within a harm reduction model of letting people know the dangers out there and expressing my concern and then using motivational interviewing techniques. So asking questions like: Are you concerned about this? Have you thought about stopping? What gets in the way? What can we do to support you? Then educating the patient about the dangers and the deaths that we've seen occur [as a result of using this particular substance]." Dr. Crosland notes that integrating a harm reduction approach into conversations can help care providers "walk that line between nonjudgment and also being honest that this may not be the best choice" for the client's health, because "as a health care provider educating about the dangers, no matter how compassionate you are about it, some people just may not be ready to hear it. That's something I struggle with."

One approach that Dr. Crosland uses to avoid appearing judgmental or stigmatizing to clients who use substances is to focus on health impacts, using nonjudgmental language. For example, “for crack cocaine users, I educate folks about cardiovascular risks: the risks of heart attack, and also the fact that chronic cocaine use increases the risk of premature atherosclerosis and heart diseases, at earlier ages than the general population. So I approach it in the same way as I approach smoking.” Their clinic also integrates other harm reduction strategies, such as publicizing information about contaminated batches of K2 when they circulate in the community, to support the value of sharing objective and useful information in a non-stigmatizing fashion.

Trauma-Informed Lens

Mindstrong is a first-episode psychosis program that works mostly with adolescents and young adults experiencing recent onset of psychotic symptoms in Chicago, Illinois. According to **Susie Kowalsky**, who works as the Team Leader for Mindstrong at Thresholds, the sponsoring mental health agency, the importance of being trauma-informed when working with people at the nexus of homelessness, mental illness, and substance use cannot be overstated. A trauma-informed lens requires recognizing the impact of personal and multi-generational trauma, and modifying communication approaches in acknowledgment of the impact of trauma on individuals. “Understand,” says Ms. Kowalsky, “that when we are working with people experiencing mental illness, homelessness, and generations of trauma, coming in and telling them what to do is harmful. It tells someone, you don’t seem to me to be a person. A well-intentioned mistake of substance use treatment providers is to tell someone, ‘you need to stop’ or ‘you’re in denial’ or ‘you need to go to a meeting.’ For some people those things are really helpful, but we’re missing the people for whom they aren’t helpful. That also isn’t typically what people need in order to make changes in their lives. These aren’t novel ideas; what people don’t have is someone to listen to them and ask: What would you like to be different in your life? What are you doing already? What have you tried? What’s important to you?”

Ms. Kowalsky also notes that “sometimes we underestimate how observant and bright the people we serve are. Especially thinking about people who experience homelessness, they are experts in being able to read people and environments. They know how to assess whether they are safe or whether to be on edge. A lot of their day-to-day existence is being able to observe their level of safety. They know immediately whether a care provider is someone who sees them as a partner and values their input on whatever it is we are doing together. We may not always hear that feedback because we aren’t always open to it or don’t have a way to receive it—so the way that feedback gets delivered is through disengagement.” Establishing bi-directional communication, grounded in attention to the

individual’s background and needs, is crucial for delivering care with as much nuance, impact, and compassion as possible.

MOVING TOWARD EVIDENCED-BASED TREATMENT MODELS

Despite the many complexities and difficulties involved in supporting and treating people who are using substances while experiencing homelessness, there are emergent evidence-based treatment models, ranging from medication-assisted treatments to therapeutic approaches; depending on the history and needs of the individuals, these can be applied in the form of brief interventions, outpatient care, or more comprehensive and long-term inpatient programs. The next issue of *Healing Hands* will go into more detail about treatment models and approaches for non-opioid substance use amongst populations experiencing homelessness.

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