

NASMHPD Commissioners Meeting

Issues and strategies for crisis programs when working with individuals who are homeless and/or living with substance use disorders

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Crisis Service for Persons Experiencing Homelessness

Background

- 20% of homeless are “severely mentally ill,” while nearly 16% experience “chronic substance abuse” (HUD AHAR, 2019)
- These percentages more than double (55% and 42% respectively) for those who were unsheltered
- Prevalence of co-occurring mental illness and substance use disorders among persons experiencing or at risk of homelessness at nearly 41% (SAMHSA PATH annual report FY2018)
- Trauma can be the cause of homelessness just as homelessness can lead to further traumatization
- Higher prevalence of suicidal ideation and attempts among people experiencing homelessness as compared to the general population
- African Americans, Native Americans, and Hispanics/Latinxs remain overrepresented among people experiencing homelessness.

24/7 Call Center Considerations and Strategies

- Calls about individuals experiencing homelessness are more likely to be from shelters, providers, and first responders than the individuals themselves
- Part of the clinical assessment is a housing assessment
- Crisis “Differential Diagnosis”: Understanding the root of the problem
- In addition to behavioral health system, knowledge of homeless system and social services is critical
- Importance of warm handoffs

Mobile Response Considerations and Strategies

- What was learned from the initial call?
- Engagement is critical
- Crisis “differential diagnosis” – is it a behavioral health crisis or need for housing, a meal, or a social service?
- Clinical interviewing best practices apply (e.g. Motivational Interviewing; trauma-informed; culturally responsive)
- But so do the basics, such as offering food or getting out of the elements.
- Be sensitive to the belongings that a person does have (e.g. pets, clothing)
- Responding to encampments
- Incorporate individuals who have experienced mental illness, SUDs, and homelessness into teams

Crisis Stabilization Considerations and Strategies

- How does homelessness factor into need for crisis stabilization and crisis residential?
- Managing personal belongings
- Incorporate individuals who have experienced mental illness, SUDs, and homelessness into teams
- Provide an opportunity to stabilize the behavioral health crisis and begin linkage to housing and other supports
- Move with urgency in transition planning

Working with the Homelessness System

- Cross system training to understand the resources and roles of each, and to encourage best practices
- Information-sharing, data-sharing, and warm hand-offs
- Formalizing partnerships and roles through memorandums of understanding (MOUs) and other opportunities for formal cross-system involvement

Working with Law Enforcement and First Responders

- Training
- Information-sharing and warm handoffs
- Formalizing partnerships and cross-system involvement

Training Topics

Clinical

- Motivational Interviewing
- Trauma informed
- Culturally responsive

Logistical

- Homeless System
- Law Enforcement
- Social services and portals into
- Housing resources
- Local knowledge – encampments, local homeless policies and/or ordinances (e.g. loitering, sleeping in cars in parking lots, etc.)

COVID-19 Issues

- Decreased provider contact + increased homelessness may mean more crisis system encounters
- Personal Protective Equipment (PPE)
- Tele-behavioral health options may be more limited with those experiencing homelessness, but possible with other callers and responders
- Universal Precautions when conducting mobile response, especially to encampments or other unsheltered areas.
- Decreased capacity in crisis stabilization and crisis residential programs due to physical distancing requirements
- Use of hotels in many communities for quarantine and temp housing
- State budget impact TBD

Takeaways

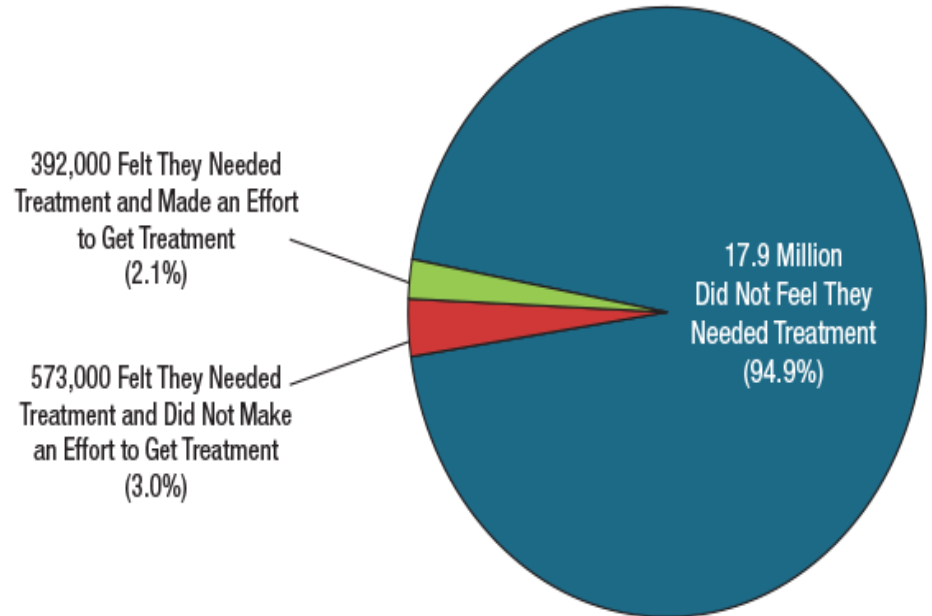
- Understanding the crisis at hand; Finding the Foundation
- Quick disposition versus extended engagement
- Cross system and clinical training must consider individuals with behavioral health conditions who are experiencing homelessness
- Crisis providers need capacity to develop and sustain relationships with the homeless system, first responders, and others.
- 911 or police non-emergency lines
- Law Enforcement and First Responders
- Structural racism
- Crisis services may encounter more individuals experiencing behavioral health conditions and homelessness as a result of pandemic.
- Funding capacity = needs to include partnership development and maintenance

Crisis Services for Persons Living with Substance Use Disorders

Background

- 7.7 million adults have co-occurring mental and substance use disorders, recent estimates have increased that number to 9.2
- Only 9.1% of those with co-occurring conditions received both The percentage that receive the simultaneous recommended care for both is even lower.
- Low perceived need and barriers to care access for both disorders contribute to low treatment rates of co-occurring disorders.
- Intervention at the time of crisis using evidence-based practices such as motivational interviewing combined with seamless connection to treatment and effective follow up may increase the rates of treatment initiation and retention
- Presence of negative perceptions or attitudes related to SUD can manifest in prejudicial attitudes about and discriminatory practices against people with substance use disorders.
- These and other forms of stigma at the organizational and individual levels pose major challenges to the integration of SUD into crisis response systems.

Perceived Need for Substance Use Treatment among People Aged 12 or Older Who Needed but Did Not Receive Specialty Substance Use Treatment in the Past Year: 2018



18.9 Million People Needed but Did Not Receive Specialty Substance Use Treatment

<https://www.samhsa.gov/data/report/2018-nsduh-annual-national-report>

COVID-19 Issues

- Because of direct challenges to respiratory health, those with SUD may be especially susceptible to infection by the virus that causes COVID-19 and associated complications – this is especially true for individuals:
 - Who vape
 - Are opioid dependent
 - Use methamphetamine
- Individuals in recovery may be challenged by social distancing and increased stressors related to COVID-19
- Social distancing increases risk of individuals using alone and overdosing with no one nearby to administer naloxone
- Outreach workers efforts have been curtailed during the pandemic
- Emergency Departments (EDs) may no longer be as accessible to initiate Medication Assisted Treatment during COVID-19 crisis
- Socio-economic factors may decrease likelihood that individuals with SUD can access services via telehealth
- Alcohol sales up 32% - increased drinking during COVID-19 requires consideration in Crisis Response
- Access to care (especially inpatient) may be significantly reduced

24/7 Call Center Considerations and Strategies

- Substance use is a risk factor for both fatal and nonfatal overdoses, suicide attempts, and death by suicide, accident, medical complications, and other causes. Compared with the general population, people with alcohol dependence and persons who use drugs have a 10–14x greater risk of death by suicide, respectively, and approximately 22% of deaths by suicide have involved alcohol intoxication. Among the reported substances, alcohol and opioids present greatest risks of suicidal behavior.
- SAMHSA’s minimum requirements: 24/7 operation; a workforce of clinicians and trained team members overseeing triage; ability to answer all calls; ability to assess suicide and other danger risks; and ability to connect individuals to mobile crisis teams as well as facility-based care
- Training for call responders must include substance specific information in order to appropriately assess risks specific to substance use, such as acute intoxication, withdrawal requiring medical monitoring or management, or overdose to support adequate triage and determining appropriate response and referral options.
- Crisis calls for a SUD specific population focuses on connection to a specialty addiction treatment system that may be hard to understand or navigate. The caller may present with a defined desire to discontinue their use of alcohol or other drugs. Some states have created SUD specific crisis, or hotlines such as :
 - Indiana Addiction Hotline is available 24/7
 - The Tennessee “red line” offers not only a warm handoff to treatment services; it also makes a real-time connection to “lifeliners”

Mobile Crisis Response Considerations and Strategies

- Across the country, CMHCs have varying capabilities – and deficiencies – related to addressing co-occurring disorders and substance use primary diagnoses.
- MCTs are uniquely positioned to address SUD crises in the community when team members have received specific training in SUD risk assessment.
- Screening related to substance use should include type of substance(s) used, amount, and presence of withdrawal symptoms. Based on acuity, a decision can be made as to whether an MCT is appropriate or if an individual needs a more intensive response involving emergency medical services and/or law enforcement.
- In response to the opioid crisis, many co-responder programs (which are similar to, but not the same as MCTs) have been established in states, with a concerted focus on outreaching to the SUD population post-overdose. The following are examples of such programs:
 - Rhode Island Hope Initiative
 - West Virginia Quick Response Teams
 - Massachusetts Post Overdose Support Teams



Crisis Stabilization Center Considerations and Strategies

- Crisis stabilization centers vary in their approach to individuals presenting with co-occurring or primary substance use disorders.
- Many crisis stabilization providers are connected to detoxification programs which can coordinate rapid admissions for crisis center patients who require that service.
- In areas where methamphetamine use is prevalent, some crisis providers have become skilled in addressing methamphetamine induced psychosis, recognizing the need to treat the psychosis then connect individuals to the right level of care.
- In early stages of interaction with a SUD population, incorporating the transtheoretical model of behavior change to assess stage of change and guide the use of evidence-based practice such as motivational interviewing has demonstrated improvement of treatment engagement and retention rates - meeting the individual where they are is both a literal and figurative imperative.
- Crisis centers often employ peers with lived experience with substance use disorders as well as peers with lived experience with mental illness
- Crisis stabilization centers can offer induction on medications for Opioid Use Disorder (methadone, buprenorphine and vivitrol). Rapid access to MAT offered through onsite inductions can drastically increase the rates of follow-up and continuity of care and save lives
- Some Crisis Stabilization Units (short-term residential programs) also provide detoxification and medication induction services

Core Principles: Addressing Recovery Needs



- *Recovery is possible*
- Access to recovery supports is critical
- A large percentage of those admitted to SUD treatment cite legal pressure as a primary reason for seeking treatment.
- Individuals with outside influences, including risk of legal consequences tend to have higher attendance rates and in remain in treatment for longer periods, which can have a positive impact on treatment outcomes
- A “no-force-first” approach is important in SUD crisis, but must not negate the important role that the criminal justice system has had on connecting individuals to care
- How the legal pressure is formulated as part of the treatment can be a crucial difference if presented as a motivational opportunity rather than something being imposed on one who is “not ready.” The Tucson Police Department invested grant funding for comprehensive training in Motivational Interviewing and Trauma Informed Care. This training empowers officers to play a role in encouraging individuals to make recovery-oriented decisions.

Core Principles: A Significant Role for Peers



There continues to be some division amongst peers defined as having MH or SUD lived experience.

- Despite a foundation of addict helping addict through traditional 12 step programs, the SUD delivery system was slow to engage the power of peers . It was not until SAMHSA launched the Access to Recovery (ATR) discretionary grant program in 2004 that peers with SUD experience were considered essential members of the overall system of care.
- The opioid crisis has prompted states to consider new ways to leverage/employ the recovery community to share hope & resilience with individuals who are hard to engage and at risk.
- Pre-crisis programs like AnchorMore in Rhode Island deploy Peer Recovery Specialist to overdose hotspots to engage high-risk individuals.
- Many states have incorporated peer response to overdose survivors and other individuals with SUD presenting in EDs and have seen this crisis setting as a successful point of intervention and engagement for care.
- Pennsylvania integrates peers in community-based care management teams that reach out to clients in EDs post overdose, but also extends outreach to correctional facilities, primary care settings and other community- based settings

Core Principles: Essential Partnerships

EDs as a place of engagement

- Forty percent of ED visits are due to trauma, and of these, between 40% and 50% are alcohol related.
- Implementation of Screening, Brief Intervention, and Referral to Treatment (SBIRT) in ED settings (i.e. Massachusetts Project Assert) allows opportunity for identification, engagement and intervention.
- EDs are an effective site for treatment initiation, including induction on MAT for OUD
- In California, the Bridge Program supports hospitals to provide buprenorphine and embeds Recovery Support Navigator staff in EDs with the goal of improving connections to care following an SUD-related ED visit.

First Responders as Crisis Partners

- Forming partnerships with first responders also have the potential to achieve significant impact on assisting individuals experiencing SUD crisis in areas of crisis prevention, response and post crisis outreach – Safe Stations models

Law Enforcement Partnerships

- Partnerships with law enforcement also represent a promising opportunity for responding to the needs of individuals with SUD experiencing crisis. The Police Assisted Addiction & Recovery Institute is a national network of police departments spanning 32 states that offer simple, stigma-free, non-arrest pathways to treatment and recovery

Financing Strategies

- States can use traditional federal funding sources available for mental health-oriented crisis response services to achieve progress towards a more fully integrated crisis care system.
- SAMHSA has identified strong examples of states that braid funding sources to develop crisis service systems and provide crisis care, including with state general funds, federal grants, and various Medicaid authorities
- Discretionary SAMHSA grant funding opportunities can be used to pay for certain costs of crisis care systems not covered by payments from health care plans,
- States can use the annual Community Mental Health Services Block Grant and Substance Abuse Prevention and Treatment Block Grant programs to develop and enhance crisis response systems with SUD-specific capacities. FFY 2020-2020 Block Grant Application
- There are longstanding federal policy and regulatory options at states' disposal to cover crisis response services for Medicaid beneficiaries with SUD
- The 2018 guidance for the 1115 Demonstration waiver identifies improved availability of crisis response services, including crisis call centers, mobile crisis response, and crisis stabilization services, as a milestone that states must meet over the course of the demonstration

Takeaways

- The healthcare system can no longer tolerate services that are disparate for individuals with substance use disorders – this includes our crisis response systems
- Incorporating SUD meaningfully into a crisis response system requires:
 - training of staff at all levels;
 - implementation of evidence-based screening and assessment tools;
 - employment of peers with lived SUD experience;
 - access to services that can support withdrawal management and medications to treat conditions such as OUD;
 - monitoring fidelity to evidence-based practices as well as outcomes;
 - routine assessment of staff , training materials and operational procedures for presence of negative perceptions or attitudes related to SUD
- Law enforcement, EMS, health care providers, hospital systems, peer-based recovery organization and substance use specific treatment providers all have a critical role in SUD throughout the continuum
- It is no longer sufficient for the SUD treatment world to stand back and wait for individuals to show up at the door. The absence of SUD specific providers as active partners in the crisis system only perpetuates the potential for discrimination toward individuals with SUDs.

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