PRI
POLICY RESEARCH, INC.

Guide to Methamphetamine Use, Treatment, and Housing Considerations for People Experiencing Homelessness

APRIL 2022

HOMELESS & HOUSING RESOURCE CENTER

SAMHSA
Substance Abuse and Mental Health Services Administration

Contents

Introduction 1

Methamphetamine Basics 1

- Methamphetamine Use in the United States 2
- How Methamphetamine Is Used 2

Drivers of Methamphetamine Use 3

- Adverse Childhood Experiences 3
- Depression 4
- Survival Needs. 4
- The Impact of Methamphetamine on the Body, the Brain, and Behavior 4

Housing Considerations for People Who Use Methamphetamine 6

- Setting Expectations and Promoting Boundaries 7

Treatment and Management Approaches for People Using Methamphetamine 11

- Addressing Acute Symptoms of Methamphetamine Use 11
- Treatment for Methamphetamine Use Disorder 13

Conclusion 15

Endnotes 16

Disclaimer and Acknowledgments

This resource was supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services (HHS) under grant 1H79SM083003-01. The contents are those of the authors and do not necessarily represent the official views of, nor an endorsement by, SAMHSA/HHS, or the U.S. Government. The Homeless and Housing Resource Center (HHRC) would like to thank the National Health Care for the Homeless Council (NHCHC) for the contribution of their expertise to the development of this resource. The lead writers were Kate Gleason-Bachman, MPH, RN, and Courtney Pladsen, DNP, FNP-BC, RN.

Recommended Citation

Homeless and Housing Resource Center, *Guide to Methamphetamine Use, Treatment, and Housing Considerations for People Experiencing Homelessness*, 2022, https://hhrctraining.org/knowledge-resources.

Introduction

The transition into permanent supportive housing following homelessness or housing instability can be particularly challenging for individuals who use methamphetamine or other stimulants. However, there are interventions and supports that can help improve safety, independence, and recovery in housing. This guide will explore how service providers can better support people who use methamphetamine in the process of transitioning into and maintaining housing.

This issue brief covers the following:

- Basic information on methamphetamine
- Strategies to reduce harm
- The impact of methamphetamine on physical and mental health
- Drivers of methamphetamine use
- Supports for those who are transitioning into or living in housing
- Current treatment modalities and management strategies

Methamphetamine Basics

Methamphetamine (MA) is a powerful central nervous system stimulant that people use to induce many different effects. MA increases the release of dopamine in the brain and, as such, acts as a potent antidepressant and causes high levels of euphoria, which can be a driver of addiction to this substance. In addition to euphoria, MA use causes the following:

- increased wakefulness and physical activity
- insomnia
- talkativeness
- decreased appetite
- racing heart
- sweating
- increased blood pressure and body temperature[1]

It can also cause other symptoms, including anxiety, paranoia, hallucinations, and psychosis.[2] It is a synthetic, easily dissolved, odorless, crystalline powder or crystal "rock" that can be ingested orally, smoked, inhaled/snorted, or injected.[3]

Methamphetamine Use in the United States

MA has been called "America's next substance use crisis."[4,5] There was a 43 percent increase in reported MA use between 2015 and 2019, with 2 million Americans reporting MA use in 2019.[6] Rates of methamphetamine use disorder (MAUD) also increased, as did polysubstance use with cocaine and opioids, reports of daily MA use, and reports of injecting MA (over other methods of use).[7,8]

The increase in MA use is impacting individuals and communities in multiple ways, affecting quality of life, health status, housing stability, emergency room visits, and overdoses. In 2020 there were 23,352 overdose deaths involving non-cocaine stimulants (mostly MA), up from 5,526 in 2015, a more than 300 percent increase.[9] Many are using MA along with opiates, increasing the risk of overdose.

METHAMPHETAMINE USE AMONG PEOPLE EXPERIENCING HOMELESSNESS

As with other public health crises, the increase in MA use is disproportionately impacting marginalized communities, including people experiencing homelessness and those in permanent supportive housing (PSH). Overdose is already a leading cause of death among people experiencing homelessness,[10,11] and MA use can increase that risk, which, in turn, impacts health, functional status, safety, and housing stability.

How Methamphetamine Is Used

The table below provides information on the different formulations of MA, how they are used, time to onset of effects, risks, and basic harm-reduction interventions.

Table 1. Methamphetamine Use[i]

Method of Use	Formulation	Time to Onset	Risks and *Harm Reduction (HR)*
Oral Ingestion	MA is dissolved in a beverage, put into an empty pill capsule, or swallowed wrapped in paper.	20-30 minutes	• MA may irritate the digestive system. • *HR: People can better control the amount they are ingesting by mixing the drink or preparing the pill themselves.*
Smoking	MA crystals are smoked out of a glass pipe or stem.	7-10 seconds	• MA can irritate the lungs and can worsen conditions like asthma. • The pipe can get hot and cause burns in or around the mouth; a mouthpiece will reduce the risk of burns. • *HR: Reduce the risk of communicable disease by not sharing pipes or mouthpieces.*
Snorting	MA crystals are chopped into a fine powder and inhaled through a straw or rolled paper.	3-5 minutes	• MA, and in particular any crystals that aren't reduced to powder, can irritate or damage the nasal passages and cause nose bleeds. • *HR: Reduce the risk of communicable disease by not sharing straws.*

i Information for table adapted from the San Francisco AIDS Foundation's project www.tweaker.org.

Method of Use	Formulation	Time to Onset	Risks and *Harm Reduction (HR)*
Booty Bumping	MA is dissolved in water and injected into the rectum using a syringe with no needle.	3-5 minutes	• MA can irritate the lining of the rectum; undissolved or larger pieces of crystal can cause abrasions. • *HR: People should use clean water to mix and should not share syringes to prevent spread of hepatitis A, parasites, and other communicable diseases.*
Injection	MA is dissolved in water and injected directly into the bloodstream using a syringe.	15-30 seconds	• Injecting can introduce bacteria and foreign particles into the bloodstream and can cause skin and soft tissue infections, like abscesses, as well as life-threatening infections, like endocarditis and spinal abscess. • MA cannot be absorbed through muscle or skin, so people should not skin pop (inject directly under the skin). • *HR: Use clean hands, sterile water, new works or rig, a sterile cotton filter, and clean the skin with alcohol before injecting.* • *HR: People can reduce the risk of communicable disease transmission (HIV, Hepatitis C) by not sharing syringes or works.*

Note: All methamphetamine products can contain fentanyl.

People who use MA should be aware of this risk, know the signs of opioid overdose, be trained on the use of naloxone (often known by the name brand Narcan), and have naloxone available when they use.

Drivers of Methamphetamine Use

Like other health behaviors, the circumstances around MA use initiation and continuation are complex and multifaceted. However, some key factors may influence behaviors and experiences around MA. Understanding potential drivers of MA use can help clinicians and service providers better support peoples' goals around use, health, safety, and housing.

Adverse Childhood Experiences

Adverse childhood experiences (ACEs) are preventable and traumatic experiences during childhood that can have a lifelong impact on health, health behaviors, educational attainment, and work. ACEs include events such as experiencing or witnessing violence, abuse, or neglect at home, a suicide death or suicide attempt by a family member, incarceration of family members, parental divorce, or experiences of substance use or mental health challenges in the home.[12]

ACEs can impact brain development, immune responses, coping skills, and decision-making both short- and long-term. ACEs have been associated with the development of chronic diseases, greater likelihood of engaging in higher-risk behaviors around sex and substance use, and educational and work outcomes below potential.[13] It is very important for providers to understand that although ACEs may impact health and life outcomes, people who have experienced trauma *can and do* heal, show remarkable resilience, educate and lift up others, and accomplish their goals. Support systems of all kinds can mediate both the initial and ongoing impacts of early trauma.

With regard to the relationship between ACEs and MA use, ACEs are associated with increased incidence of MA use and MAUD.[14] Large-scale studies demonstrate a positive relationship between ACEs and stimulant use disorders: as the number of reported ACEs increases, so does the prevalence of reported stimulant use.[15] This relationship highlights the importance of a trauma-informed approach in health care and housing support, one that acknowledges and addresses the impact of past traumatic experiences and fosters healing. By recognizing the role of trauma in substance use behaviors, service providers and clinicians can better support people who want to decrease or stop their MA use by planning for potential mental health challenges and the need for additional supports with cessation of use.

Depression

Individuals who use MA have high rates of depression, which is often reported as a symptom of early MA withdrawal.[16] For those who have experienced past trauma and are living with ongoing stress and traumatization related to homelessness, MA can act as a potent and fast-acting anti-depressant. While other means to address depression exist, they are often not easily accessed by those experiencing homelessness and are longer-term solutions, including medications, therapy, mindfulness, exercise, or dietary changes. The mood-elevating effects of MA can literally be life-saving, and because MA is accessible and very fast-acting, it can become an individual's first-line method of mood management and coping. Interventions to reduce MA use must assess whether MA is being used for mood elevation and address underlying depression.

Survival Needs

MA is also used by people experiencing homelessness as a survival tool due to its ability to promote wakefulness, provide feelings of increased energy, and suppress appetite. Staying awake can be crucial to protect oneself from the dangers of sleeping on the streets. Moreover, people experiencing homelessness often must walk to different meal locations and sometimes are only able to eat once a day, which is time- and energy-consuming. MA can be helpful, then, to suppress appetite. MA can also be used for energy or as a coping mechanism by people doing difficult or potentially traumatic work, such as scrapping metal or sex work.

The Impact of Methamphetamine on the Body, the Brain, and Behavior

Methamphetamine use has a wide-reaching impact on multiple body systems and on behavior. Service providers and clinicians are called on to support people's health and safety around MA use in multiple ways, mitigating both acute and long-term impacts for individuals and communities. Below are some of the ways MA can have an impact on the body, the brain, and behavior.

Table 2. Impact of Methamphetamine Use on the Body, the Brain, and Behavior

Body System	Impacts	Information for Clinicians and Service Providers
Behavior	• Behavior changes are a major outward manifestation of MA use. • MA can cause agitation, irritability, irrational behavior, anxiety, hallucinations, and psychotic symptoms. • Symptoms can last from hours to days, depending on use frequency, quantity used, and individual response.	• People may need immediate support for acute symptoms. • Safety concerns may extend to other program participants and staff. • Interventions include decreasing sensory input, moving to a space in which the person feels safer, and a 1:1 meeting with a behavioral health professional. • Plan for the future with program participants: what helped them cope with unpleasant symptoms and what would help if this arises again?
Cardiovascular (CV)	• CV events are the second leading cause of death among MA users after accidental overdose.[17] • MA use causes increased heart rate, vasoconstriction, and vasospasm. • MA use can lead to formation of arterial plaques and stroke, myocardial infarction (heart attack), arrythmias, pulmonary hypertension, and cardiomyopathy.[18,19]	• Clinicians and service providers should notify patients of the need to seek care for chest pain, stroke symptoms, new or increased shortness of breath, and new or increased edema (swelling in lower extremities).
Neurologic	• MA use causes significant inflammation, neurodegeneration, and neurotoxicity in the brain.[20] • People who use MA may present with cognitive and memory impairments, psychotic symptoms, and emotional dysregulation.[21]	• Many of the central nervous system changes related to MA are reversible with cessation of use, though some changes, including neurodegeneration and psychosis, may persist or return. • Chronic MA use can cause permanent neurological remodeling that leads to lifelong deficits in cognition, decision-making, and memory.
Immune System	• MA use can cause immune dysregulation and has been demonstrated to hasten the clinical progression of HIV, even among individuals who are taking anti-retrovirals.[22] • Injection of MA can introduce foreign particles and bacteria, leading to abscesses and potential for endocarditis/spinal abscess.	• Clinicians should consider closer monitoring of labs for people who are HIV+ and using MA. • People who use MA need access to safer sex and injection supplies to decrease the risk of disease transmission related to MA use.

Body System	Impacts	Information for Clinicians and Service Providers
Dental and Nutrition	• MA use is associated with increased dental and periodontal disease.[23] • Dental disease and the appetite-suppressing effects of MA, along with poverty, can lead to nutritional deficits among MA users.	• Clinicians and service providers should monitor dental health, weight, and nutrition status of people who use MA. • People who use MA may need support with access to dental care and food resources and/or nutritional supplements.
Skin and Soft Tissue	• MA use via injection can cause abscesses. • Because MA can cause "skin crawling" sensations, skin picking can be an issue and cause related cellulitis.	• A skin assessment should be a routine part of care for people who use MA. • Access to safe-use supplies—like clean syringes, alcohol prep pads, and clean "works" (injection equipment, such as cookers)—helps decrease skin infections.
Mental Health	• People experiencing homelessness who use MA are at high risk for social isolation, stigmatization, depression, and suicidality. • MA use can cause psychotic symptoms that are very distressing and can impact individual and community safety. • MA-related insomnia can profoundly impact mental health.	• People using MA should be routinely screened for suicidality and thoughts of self-harm, during periods of both active use and decreased use or abstinence. • Clinicians and service providers should work with people experiencing psychotic symptoms around safety and future management strategies.
Overdose	• MA overdose, or "overamping," occurs along a continuum of psychological and physical symptoms, ranging from anxiety and paranoia, memory loss/ blackout, involuntary physical movements, cardiac pain/events, and hyperthermia/death related to overheating.[24,25] • Fatal MA overdose often occurs in the context of other substance use, including opioids.	• MA overdose can be difficult to recognize for individuals and clinicians/service providers because it occurs along a continuum. • People who use MA need education on the symptoms of overdose and how to seek help.

Housing Considerations for People Who Use Methamphetamine

For people who recently experienced homelessness and are newly transitioning to housing, the strategies that once kept them alert on the street or provided a critical coping mechanism can pose a challenge to maintaining housing. Homeless service providers and permanent supportive housing programs across the country have reported unique challenges around supporting the housing needs of people who use MA. Behaviors and symptoms related to use can impact tenants and neighbors and make maintaining housing difficult. These behaviors and symptoms include paranoia and hallucinations, in addition to activity around

drug sales and other money-generating activities that move from the street or community into housing. There are various strategies that can support people who use MA in maintaining housing, including promoting boundary-setting and planning around use and potential issues in housing.

Setting Expectations and Promoting Boundaries

People who are newly housed may not have experience in independent housing as an adult or any time in the recent past. In addition to education on housekeeping and navigating one's new neighborhood, education that supports people's ability to maintain boundaries is essential to becoming a successful member of a community. Program participants can benefit from specific knowledge about expectations for housing and what constitutes a lease violation. Providers should share information about boundaries and expectations at all phases of the housing process, from the initial housing application to move-in, and then routinely during ongoing interactions.

- Provide clear information on lease restrictions regarding roommates who are not on the lease, subleasing a property, or using the unit to generate income.
- Provide education and support around setting boundaries for the way they use their unit. Important details to communicate might include the risks of allowing others to use the unit for selling drugs, the risks of "abandoning" or not using the unit, and the potential impact of having frequent traffic in and out of their apartment or building.
- Develop a clear policy on use of drugs and/or the use of the property for drug sales; include in the policy any restrictions related to federal or state regulations or funding sources, as well as the potential consequences of these behaviors/activities.
- Help people plan for what their substance use will look like now that they are housed:
    - Do they plan to use substances in their unit or in the community with peers, or both?
    - How can they control who comes into their unit to use?
    - How do they plan to reduce overdose risk when using at home?
    - Create a safety plan for if they begin to feel unsafe, paranoid, or "over-amped." The safety plan might specify who they could go to for help, where they could go to feel safe, and what measures they could take at home to prevent worsening of paranoia (e.g., locking their door, closing their curtains, asking guests to leave, or temporarily leaving the apartment themselves to seek other supports).

LANDLORD RELATIONS

Landlords participating in Housing First, Section 8, or other supportive housing programs are partners in efforts to end homelessness, though some may not view themselves this way at first. Programs should provide education to landlords and maintain open communication to foster partnership and buy-in around the goals of permanent supportive housing.

- Programs should educate landlords on the permanent supportive housing model, the supports available to program participants, and the importance of housing to overall health and the community.
- While not every program model engages landlords in the same way, individuals who will have direct interactions with the landlord should be educated on the role of the landlord, problems that warrant involving the landlord or property manager, tenants' rights, and how to get the support of housing staff if needed.

The table below reviews specific challenges related to MA use in permanent supportive housing and provides support strategies for each scenario.

Table 3: Housing Challenges and Strategies

Housing Challenge	Support Strategies	
	Prior to Move-In	Ongoing
General preparation and support before and after move-in: Moving into housing is a major milestone and dramatic change. Preparation and ongoing support are vital to success in housing.	• Foster open dialogue about housing goals and potential challenges after move-in. • Utilize peers and/or community health workers to share their experiences and support. • Identify community partners that can provide multidisciplinary support.	• Frequent check-ins, even daily in the first 1-2 weeks after moving in, are essential. • Leverage relationships with community partners, such as other harm-reduction organizations, primary and behavioral health care, or vocational programs to provide wrap-around support.
Increased use or difficulty decreasing use: Many people intend to decrease or stop their use once housed. Planning and support are often needed to achieve these goals.	• Talk through goals around use and what steps would be needed to move forward. • Planning beyond just becoming housed is essential. • Suggest that the individual consider moving away from where they were living while experiencing homelessness and using MA more heavily. • Plan for what community supports will be available in a new neighborhood.	• Connect new tenants with primary and behavioral health care and/or make sure they know how to access their providers from their new location. • Maintain ongoing dialogue about goals around drug use and how to take steps to achieve them. • Support higher levels of care if needed, including inpatient mental health and substance use treatment.
Decline in daily functioning/ health concerns: Daily functioning (functional status) or health may decline with ongoing MA use. For those who have not been connected to medical care, moving into housing can coincide with restarting care and/or uncovering health concerns that had gone untreated.	• Consider current functional/mobility status and potential needs around climbing stairs, instrumental activities of daily living/activities of daily living specifically in a new environment. • Plan for how to access needed medical care or how the individual will address existing health issues once housed.	• Provide ongoing support on engaging in physical and behavioral health care. • Consider assessing functional status and need for additional support after hospitalizations, falls in the home or community, new use of an assistive device, or new significant diagnoses that could impact functioning, such as wounds, fractures, cerebrovascular accident, etc.

Housing Challenge	Support Strategies	
	Prior to Move-In	Ongoing
Neighborhood/Community Integration: Becoming part of one's surrounding community is an important part of the housing process.	• People who plan to live close to their pre-existing community will need education and support on boundaries and planning for what they want their substance use to look like once housed. • People who plan to move to a new neighborhood will need support to identify resources and integrate into their new community, such as AA/NA meetings, supermarket, libraries, and community centers.	• Provide specific check-ins about community integration: relations with neighbors, feelings of belonging or isolation, social interactions and supports, daily activities, use of community resources, etc. • Provide strategies to improve community integration and leverage peers and community health workers to support the use of new resources and new social connections.
Overdose Risk: Overdose risk can increase due to changes in peer supports and shifts in drug use patterns that come with new housing.	• Talk explicitly about overdose risk and prevention. People are often shifting from using with peers in the community to using alone or with a few people in their apartment. • Provide education on the signs of stimulant toxicity and of opioid overdose, ensure access to naloxone, and help people plan for how to prevent and address an overdose.	• Inquire about overdose events or near misses at regular check-ins. • Ensure that naloxone is available in the unit and provide ongoing teaching on naloxone use. • Ensure people have access to a phone to call emergency services in the event of an MA or opioid overdose.
Apartment take-over/loss of control of apartment: Those who are actively using MA and other drugs are at risk for apartment take-over, especially immediately after move-in.	• Prepare new tenants for the possibility of being approached by friends or other community members about using the unit for drug sales, often in exchange for a free drug supply. These relationships frequently result in loss of control of the unit, loss of privacy and safety for the tenant, and significant risk to tenancy.	• Frequent check-ins, especially early in the tenancy, are very important. • Talk explicitly and provide ongoing education about boundaries. • Provide direct feedback about lease violations and threats to maintaining tenancy. • If an apartment has been taken over, the renting individual may need to consider changing the locks or even moving to a new apartment.

Housing Challenge	Support Strategies	
	Prior to Move-In	Ongoing
Harm reduction in housing: Applying harm reduction in housing can look different from what people may have been doing in the community.	• Prepare people for how they plan to use substances in their unit and how they will safeguard against overdose, e.g., by using with another person, testing their drug supply, maintaining access to clean syringes, etc.	• Prepare people for how they can avoid issues with property management or the landlord around their use. • Consider using a shoe box to store all supplies related to drug use so that syringes and paraphernalia are not lying out in the unit. • Ensure people have access to sharps containers/are properly using sharps containers at each check-in. A sharps container is a rigid, puncture-resistant container that can be obtained from medical suppliers. • A laundry detergent bottle is an appropriate and inconspicuous sharps container for personal use. • Check local regulations on biohazardous waste disposal regulations; in many cases, properly sealed, personal-use sharps containers can be disposed of in the regular trash.
Frequent loss of keys/lockouts: For people who are using MA and other substances, loss of keys and lockouts are a frequent issue that can quickly impact relationships with neighbors and the landlord.	• For people at high risk for loss of keys/lockouts, consider selecting an apartment with a separate and direct entrance rather than a shared door in a multi-unit building. This will prevent neighbors from frequently being called on to let the person in or the person needing to sleep in the hallway, etc.	• For people who lose keys frequently, consider a real-estate-style lockbox outside the unit with a tethered key inside that will reach the lock but that cannot be removed. The code can be their birthday or year of birth.
High traffic in unit: While it is important to foster community connections and support, people's desire to help others who are experiencing homelessness and behaviors related to MA use can sometimes lead to excessive visitations.	• People may have high traffic in their units if they have heavy or chaotic use patterns or have a large community in the neighborhood where they lived when experiencing homelessness. Such tenants may also benefit from a separate and direct entrance rather than a shared door/multi-unit building.	• People may not always feel they have control over traffic in and out of their unit. Support people in setting boundaries and strategies for limiting traffic. • Provide direct feedback about issues with traffic and potential threats to maintaining tenancy.

Housing Challenge	Support Strategies	
	Prior to Move-In	Ongoing
Property damage: While property damage and repairs/ maintenance are common to all rental properties, people who are actively using MA are at greater risk of incurring damage.	• Provide pre-move-in education about how to live in an apartment, use appliances, and deal with issues that come up in rental units. • Talk explicitly about how MA use may impact an apartment, such as the impacts of paranoia and hallucinations or high traffic in and out of the unit. • Educate tenants about how to contact their housing team or property manager/ landlord about any issues in the unit or damage.	• Inspect units for damage or issues at each check-in. • Provide education on reporting issues to the housing team immediately. • Foster a partnership-based approach to identifying what led to the damage and make a plan to avoid future incidents.
Unit abandonment: Paranoia related to MA use can sometimes prompt people to leave their apartments and not use them for extended periods. People can be fearful of returning due to paranoia around being watched in the unit, people entering the unit without permission, or fear of an insect infestation (related to MA-induced skin-crawling sensations).	• Discuss the potential for paranoia related to MA use and plan for how a tenant can communicate with program staff if fears related to the unit arise. • Educate tenants on any requirements for home visits and the potential consequences for not utilizing an apartment for a month or more.	• Use regular home visits to check in with tenants about how they are feeling in their unit or any experiences of fear or paranoia while in their apartment. • Stay engaged with tenants who are not using their units and work with them on strategies that would make them feel safe using their unit again (e.g., an extermination or a lock change).

Treatment and Management Approaches for People Using Methamphetamine

Reducing harm related to MA use and improving health and housing outcomes takes a multidisciplinary approach that is led by the program participant's goals. Strategies must include partners in primary care, outpatient treatment, inpatient substance use and mental health treatment, harm-reduction organizations, community organizations, peers, and other community members.

Addressing Acute Symptoms of Methamphetamine Use

Acute symptoms around MA use—including agitation, paranoia, hallucinations, emotional distress, and suicidality—are some of the most difficult to address across all settings. Below are strategies for addressing acute symptoms with considerations for both the individual experiencing symptoms and for staff.

Table 4: Management of Acute Symptoms of MA Use in Permanent Supportive Housing Settings

	Prevention	Acute Symptom Management	Multidisciplinary Approach
For the Individual Experiencing Symptoms	• Create a safety plan at move-in that addresses substance use, including goals and self-management strategies, as well as potential supports in times of crisis. • Explicitly name potential challenges related to MA use and housing; keep an open dialogue, especially if use and/or external stressors are increasing. • Following any incident related to MA use (e.g., agitation, emergency room visit, or damage to the apartment), debrief with the tenant and plan for prevention/management should symptoms recur.	• Bring up the individual's safety plan and prompt them to use self-management strategies and offer to communicate/link them with pre-identified supports. • Support nutrition and hydration needs: people using MA over several days and in crisis have often not eaten or consumed liquids.15 • Assess for sleep: help the person problem-solve how they might pause use and attempt to sleep. • Facilitate reasonable measures to increase a sense of safety, e.g., closing curtains, supporting the tenant in asking guests to leave, decreasing external stimuli (traffic in and out of unit, TV/radio), or demonstrating that their door lock functions.	• Make sure the person has access to a telephone and knows how to contact the housing team and seek help in the event of an emergency. • Encourage the tenant to seek supports/a supportive setting; this may mean leaving the apartment to be with peers or in a safe community space. • Work with other staff and multidisciplinary team members to meet tenant's immediate needs for medical, behavioral health, and substance treatment. • If emergency services are needed, be sure the tenant and responding/admitting personnel know how to contact housing program staff; if possible, provide their primary care physician's contact information. • Follow up on any referrals that were made and pursue active care coordination with the emergency department, hospital, primary care/behavioral health or inpatient/outpatient substance use treatment. • Make a specific plan for follow-up that includes time, location, and manner of check-in; this could happen at the apartment, primary care physician's office, treatment setting, emergency department, etc.

	Prevention	Acute Symptom Management	Multidisciplinary Approach
For Staff Members	• Work to build rapport and trust with tenants and identify staff as a support in times of crisis. • Plan for home visits and conduct a two-staff visit to increase safety. • Notify supervisors/ team of planned visits and locations for the day. • Address safety plans and goals with tenants at non-crisis encounters so they are up to date if needed.	• Prioritize personal safety and do not remain in a situation that is unsafe; maintain a mode of egress from the apartment/situation. • Use clear, calm language and provide an objective assessment of the tenant's concerns and their medical and safety needs. • Assess for higher level-of-care needs and support the person as appropriate, e.g., linking to a mental health professional via telehealth, linking to crisis response, or 911. • In the event of a threat to the tenant's safety (e.g., interpersonal violence), identify options and make a plan to take agreed-upon actions. • Assess the apartment for damage or safety concerns and address them immediately per program policies.	• See this column on the previous page.

Treatment for Methamphetamine Use Disorder

When an individual would like to decrease the amount of MA they are using or stop altogether, consider a multipronged approach. The most effective treatment options for reducing MA use are psychosocial-based interventions: contingency management and the Community Reinforcement Approach.[26] These interventions incentivize lifestyle modifications and harm reduction, but used on their own, they do not address some of the root causes of use, such as mental health concerns and trauma. Therefore, it is important to work as a multidisciplinary team and support access to psychiatric care and therapy and help address social needs like housing.

Medications have demonstrated some positive results in reducing cravings, but the observed treatment effects have not been large, and no FDA-approved medications for the treatment of MAUD currently exist. That said, the National Institute of Health is conducting a clinical trial evaluating the efficacy of the combination of bupropion and naltrexone, and results have been promising.[27] Medication management is beyond the scope of this guide.

2X

Co-occurring use of opioids and methamphetamine in the United States is estimated to have doubled from 2011 to 2017.

CO-OCCURRING OPIOID USE AND METHAMPHETAMINE USE DISORDER

It is increasingly common for people to use both opioids and MA concurrently, which complicates treatment,

education, and harm reduction related to overdose prevention.[28,29] Between 2011 and 2017, research estimates that co-occurring use of opioids and MA in the United States doubled, largely due to the high produced by using the two substances together, and the potential to counteract both sedation and over-amping by using the substance with the opposite effect.[30]

People who co-use MA and opioids, and are engaged in opioid treatment, are often under-treated for their MA use.[31] In addition to the need for ongoing education on overdose risk for both substances, the interventions explained below could also help to close this treatment gap for MA users.

CONTINGENCY MANAGEMENT

Contingency management (CM) is a behavioral therapy based on an operant conditioning principle that provides positive reinforcement for evidence of behavioral change.[32] MA use can highjack the brain's reward system during prolonged periods of use.[33] Through monetary rewards for positive behavior changes, contingency management provides a competing incentive for the reward center. In the case of treating MAUD, this positive reinforcement of behavioral change can entail earning gift cards or cash prizes for kept appointments, no MA in a urine drug screen, or completing a housing application. CM can be applied to any setting and alongside other forms of substance use treatment. Compared to all other psychosocial treatments, CM has the greatest impact at improving outcomes for people with MAUD.[34]

COMMUNITY REINFORCEMENT APPROACH

The Community Reinforcement Approach (CRA) is a behavioral strategy that is effective and commonly used in combination with CM.[35] This strategy focuses on supporting individuals to meet their substance use treatment goals and reduce harm by adapting to meet their social and emotional needs in ways other than using substances. CRA works with the individual to evaluate the function that the substance is serving in their life (functional analysis) and helps develop skillsets to create positive change.[36]

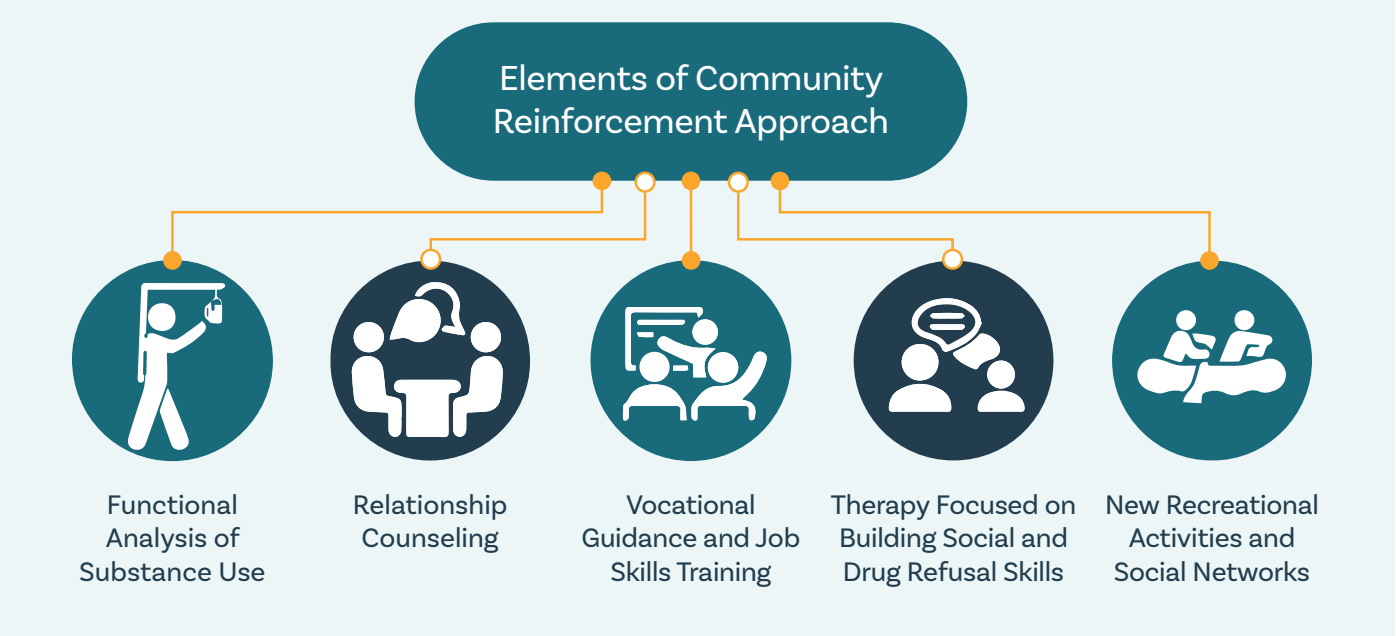

Figure 1: Elements of Community Reinforcement Approach[37] (adapted from SAMHSA's Treatment of Stimulant Use Disorders [PDF])

CRA is customized to every individual to allow for collaborative goal-setting between the program participant and support team. During the treatment, participants learn practical skills in areas such as communication, interpersonal effectiveness, problem-solving, employment, and recreation. Each of these skills helps the person discover new substance-free activities and supports a person-directed recovery journey.

Explore this SAMHSA-funded online course for more information on how to design and implement these two behavioral interventions in your organization.

Learn More

SAMHSA Treatment of Stimulant Use Disorders [PDF]

SAMHSA Tip 33: Treatment for Stimulant Use Disorders

SAMHSA Advisory: Prescription Stimulant Misuse and Prevention among Youth and Young Adults

Conclusion

People who use drugs deserve housing as much as anyone else, and securing and maintaining housing is also an important step in reducing harm from drug use and can be a catalyst for one's recovery journey. It is very difficult to make progress in recovery goals while experiencing homelessness. Housing provides a stabilizing force in someone's life that can greatly improve quality of life and safety, allowing people to begin to tackle their goals around substance use, physical health, and mental health. While the benefits of housing are clear, it can be challenging to support people using MA in the move from homelessness to housing.

This guide highlights the importance of a participant-driven, multipronged approach. Methamphetamine use can be a challenge to maintaining housing, but there are interventions that support autonomy and safety. People who have experienced homelessness and substance use are incredibly resilient individuals and can thrive in housing with the right support system.

Endnotes

1 Seminerio, Michael J., Matthew J. Robson, Christopher R. McCurdy, and Rae R. Matsumoto. "Sigma Receptor Antagonists Attenuate Acute Methamphetamine-Induced Hyperthermia by a Mechanism Independent of Il-1β Mrna Expression in the Hypothalamus." *European Journal of Pharmacology* 691, no. 1-3 (2012): 103–9. https://doi.org/10.1016/j.ejphar.2012.07.029.

2 Paulus, Martin P., and Jennifer L. Stewart. "Neurobiology, Clinical Presentation, and Treatment of Methamphetamine Use Disorder." *JAMA Psychiatry* 77, no. 9 (2020): 959. https://doi.org/10.1001/jamapsychiatry.2020.0246.

3 National Institutes of Health, U.S. Department of Health and Human Services. "Methamphetamine Research Report: What Is Methamphetamine?" Last modified October 2019. https://nida.nih.gov/publications/research-reports/methamphetamine/what-methamphetamine.

4 Seminerio, Michael J., Matthew J. Robson, Christopher R. McCurdy, and Rae R. Matsumoto. "Sigma Receptor Antagonists Attenuate Acute Methamphetamine-Induced Hyperthermia by a Mechanism Independent of Il-1β Mrna Expression in the Hypothalamus." *European Journal of Pharmacology* 691, no. 1-3 (2012): 103–9. https://doi.org/10.1016/j.ejphar.2012.07.029.

5 Kevil, Christopher G., Nicholas E. Goeders, Matthew D. Woolard, Md. Shenuarin Bhuiyan, Paari Dominic, Gopi K. Kolluru, Connie L. Arnold, James G. Traylor, and A. Wayne Orr. "Methamphetamine Use and Cardiovascular Disease." *Arteriosclerosis, Thrombosis, and Vascular Biology* 39, no. 9 (2019): 1739–46. https://doi.org/10.1161/atvbaha.119.312461.

6 Han, Beth, Wilson M. Compton, Christopher M. Jones, Emily B. Einstein, and Nora D. Volkow. "Methamphetamine Use, Methamphetamine Use Disorder, and Associated Overdose Deaths among US Adults." *JAMA Psychiatry* 78, no. 12 (2021): 1329. https://doi.org/10.1001/jamapsychiatry.2021.2588.

7 Ibid.

8 Ellis, Matthew S., Zachary A. Kasper, and Theodore J. Cicero. "Twin Epidemics: The Surging Rise of Methamphetamine Use in Chronic Opioid Users." *Drug and Alcohol Dependence* 193 (2018): 14–20. https://doi.org/10.1016/j.drugalcdep.2018.08.029.

9 Han, Beth, Wilson M. Compton, Christopher M. Jones, Emily B. Einstein, and Nora D. Volkow. "Methamphetamine Use, Methamphetamine Use Disorder, and Associated Overdose Deaths among US Adults." *JAMA Psychiatry* 78, no. 12 (2021): 1329. https://doi.org/10.1001/jamapsychiatry.2021.2588.

10 Nicholas, Will, Lisa Greenwell, Benjamin F. Henwood, and Paul Simon. "Using Point-in-Time Homeless Counts to Monitor Mortality Trends among People Experiencing Homelessness in Los Angeles County, California, 2015–2019." *American Journal of Public Health* 111, no. 12 (2021): 2212–22. https://doi.org/10.2105/ajph.2021.306502.

11 Baggett, Travis P., Stephen W. Hwang, James J. O'Connell, Bianca C. Porneala, Erin J. Stringfellow, E. John Orav, Daniel E. Singer, and Nancy A. Rigotti. "Mortality among Homeless Adults in Boston." *JAMA Internal Medicine* 173, no. 3 (2013): 189. https://doi.org/10.1001/jamainternmed.2013.1604.

12 Centers for Disease Control and Prevention. *Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence.* Atlanta: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2019.

13 Ibid

14 Tang, Shichao, Christopher M. Jones, April Wisdom, Hsien-Chang Lin, Sarah Bacon, and Debra Houry. "Adverse Childhood Experiences and Stimulant Use Disorders among Adults in the United States." *Psychiatry Research* 299 (2021): 113870. https://doi.org/10.1016/j.psychres.2021.113870.

15 Ibid.

16 Ren, Wenwei, Xiaoqian Luan, Jie Zhang, Priyanka Gutteea, Yan Cai, Jiyun Zhao, Yingying Gu, Chaowen Wu, Hang Su, Jingyan Tao, et al. "Brain-Derived Neurotrophic Factor Levels and Depression during Methamphetamine Withdrawal." *Journal of Affective Disorders* 221 (2017): 165–71. https://doi.org/10.1016/j.jad.2017.06.017.

17 Kevil, Christopher G., Nicholas E. Goeders, Matthew D. Woolard, Md. Shenuarin Bhuiyan, Paari Dominic, Gopi K. Kolluru, Connie L. Arnold, James G. Traylor, and A. Wayne Orr. "Methamphetamine Use and Cardiovascular Disease." *Arteriosclerosis, Thrombosis, and Vascular Biology* 39, no. 9 (2019): 1739–46. https://doi.org/10.1161/atvbaha.119.312461.

18 National Institutes of Health, U.S. Department of Health and Human Services. "Methamphetamine Research Report: What Is Methamphetamine?" Last modified October 2019. https://nida.nih.gov/publications/research-reports/methamphetamine/what-methamphetamine.

19 Reddy, Pavan KV, Edward Chau, Sagar V Patel, Katharine Yang, Tien MH Ng, and Uri Elkayam. "Characteristics of Methamphetamine-Associated Cardiomyopathy and the Impact of Methamphetamine Use on Cardiac Dysfunction." *The American Journal of Cardiology* 154 (2021): 86–91. https://doi.org/10.1016/j.amjcard.2021.06.001.

20 National Institutes of Health, U.S. Department of Health and Human Services. "Methamphetamine Research Report: What Is Methamphetamine?" Last modified October 2019. https://nida.nih.gov/publications/research-reports/methamphetamine/what-methamphetamine.

21 Ibid.

22 Miller, Michelle, Ji-Young Lee, Jennifer A. Fulcher, Margaret E. Roach, Samantha E. Dilworth, Antonio Chahine, Suresh Pallikkuth, Dietmar Fuchs, Savita Pahwa, and Adam W. Carrico. "Getting to the Point: Methamphetamine Injection Is Associated with Biomarkers Relevant to HIV Pathogenesis." *Drug and Alcohol Dependence* 213 (2020): 108133. https://doi.org/10.1016/j.drugalcdep.2020.108133.

23 Shetty, Vivek, Lauren Harrell, Debra A. Murphy, Steven Vitero, Alexis Gutierrez, Thomas R. Belin, Bruce A. Dye, and Vladimir W. Spolsky. "Dental Disease Patterns in Methamphetamine Users." *The Journal of the American Dental Association* 146, no. 12 (2015): 875–85. https://doi.org/10.1016/j.adaj.2015.09.012.

24 Harding, Robert W., Katherine T. Wagner, Phillip Fiuty, Krysti P. Smith, Kimberly Page, and Karla D. Wagner. "'It's Called Overamping': Experiences of Overdose among People Who Use Methamphetamine." *Harm Reduction Journal* 19, no. 1 (2022). https://doi.org/10.1186/s12954-022-00588-7.

25 Seminerio, Michael J., Matthew J. Robson, Christopher R. McCurdy, and Rae R. Matsumoto. "Sigma Receptor Antagonists Attenuate Acute Methamphetamine-Induced Hyperthermia by a Mechanism Independent of Il-1β Mrna Expression in the Hypothalamus." *European Journal of Pharmacology* 691, no. 1-3 (2012): 103–9. https://doi.org/10.1016/j.ejphar.2012.07.029.

26 De Crescenzo, Franco, Marco Ciabattini, Gian Loreto D'Alò, Riccardo De Giorgi, Cinzia Del Giovane, Carolina Cassar, Luigi Janiri, Nicolas Clark, Michael Joshua Ostacher, and Andrea Cipriani. "Comparative Efficacy and Acceptability of Psychosocial Interventions for Individuals with Cocaine and Amphetamine Addiction: A Systematic Review and Network Meta-Analysis." *PLOS Medicine* 15, no. 12 (2018). https://doi.org/10.1371/journal.pmed.1002715.

27 Trivedi, Madhukar H., Robrina Walker, Walter Ling, Adriane dela Cruz, Gaurav Sharma, Thomas Carmody, Udi E. Ghitza, et al. "Bupropion and Naltrexone in Methamphetamine Use Disorder." *New England Journal of Medicine* 384, no. 2 (2021): 140–53. https://doi.org/10.1056/nejmoa2020214.

28 Ellis, Matthew S., Zachary A. Kasper, and Theodore J. Cicero. "Twin Epidemics: The Surging Rise of Methamphetamine Use in Chronic Opioid Users." *Drug and Alcohol Dependence* 193 (2018): 14–20. https://doi.org/10.1016/j.drugalcdep.2018.08.029.

29 Daniulaityte, Raminta, Sydney M. Silverstein, Timothy N. Crawford, Silvia S. Martins, William Zule, Angela J. Zaragoza, and Robert G. Carlson. "Methamphetamine Use and Its Correlates among Individuals with Opioid Use Disorder in a Midwestern U.S. City." *Substance Use & Misuse* 55, no. 11 (2020): 1781–89. https://doi.org/10.1080/10826084.2020.1765805.

30 Ellis, Matthew S., Zachary A. Kasper, and Theodore J. Cicero. "Twin Epidemics: The Surging Rise of Methamphetamine Use in Chronic Opioid Users." *Drug and Alcohol Dependence* 193 (2018): 14–20. https://doi.org/10.1016/j.drugalcdep.2018.08.029.

31 Yen Li, Mimi, George A. Alba, Julian Mitton, and Benjamin Bearnot. "Care-Engaged Individuals with Polysubstance Use in Northeastern US Are Undertreated for Methamphetamine Use Disorder: A Retrospective Cohort Study." *Addiction Science & Clinical Practice* 16, no. 1 (2021). https://doi.org/10.1186/s13722-021-00267-1.

32 Petry, Nancy M., Sheila M. Alessi, Todd A. Olmstead, Carla J. Rash, and Kristyn Zajac. "Contingency Management Treatment for Substance Use Disorders: How Far Has It Come, and Where Does It Need to Go?" *Psychology of Addictive Behaviors* 31, no. 8 (2017): 897–906. https://doi.org/10.1037/adb0000287.

33 Bischoff-Grethe, Amanda, Colm G Connolly, Stephan J Jordan, Gregory G Brown, Martin P Paulus, Susan F Tapert, Robert K Heaton, Steven P Woods, and Igor Grant. "Altered Reward Expectancy in Individuals with Recent Methamphetamine Dependence." *Journal of Psychopharmacology* 31, no. 1 (2016): 17–30. https://doi.org/10.1177/0269881116668590.

34 Daniulaityte, Raminta, Sydney M. Silverstein, Timothy N. Crawford, Silvia S. Martins, William Zule, Angela J. Zaragoza, and Robert G. Carlson. "Methamphetamine Use and Its Correlates among Individuals with Opioid Use Disorder in a Midwestern U.S. City." *Substance Use & Misuse* 55, no. 11 (2020): 1781–89. https://doi.org/10.1080/10826084.2020.1765805.

35 Ronsley, Claire, Seonaid Nolan, Rod Knight, Kanna Hayashi, Jano Klimas, Alex Walley, Evan Wood, and Nadia Fairbairn. "Treatment of Stimulant Use Disorder: A Systematic Review of Reviews." *PLOS ONE* 15, no. 6 (2020). https://doi.org/10.1371/journal.pone.0234809.

36 Meyers, Robert, and Daniel D. Squires. *The Community Reinforcement Approach: A Guideline Developed for the Behavioral Health Recovery Management Project.* Albuquerque: University of New Mexico Center on Alcoholism, Substance Abuse and Addictions, 2001. Available at www.bhrm.org/media/pdf/guidelines/CRAmanual.pdf.

37 Substance Abuse and Mental Health Services Administration, Department of Health and Human Services. *Treatment of Stimulant Use Disorders*. SAMHSA Publication No. PEP20-06-01-001. Rockville: National Mental Health and Substance Use Policy Laboratory, 2020.