Stimulant Webinar Series FAQ

July 18, 2019 | Stimulant Webinar Series Part 2
Provider Perspectives on Effective Strategies for Treating People with Stimulant Use Disorders

Frequently Asked Questions

Questions below were collected from audience members who attended Stimulant Webinar Series Part 2: Provider Perspectives on Effective Strategies for Treating People with Stimulant Use Disorders, presented by the Great Lakes ATTC and Northwest ATTC.

Michelle Peavy, PhD

1. **Why shouldn't providers take patients out of opioid treatment if they continue to use stimulants?**

   Providers should maintain individuals in opioid treatment – even if they continue to use stimulants – because 1) discharging people out of opioid treatment increases their likelihood of dying;* 2) individuals have different "clocks for change," and discharging patients from opioid treatment disables providers from continuing to work on stimulant use with evidence-based interventions (e.g., MI, CM); 3) in terms of behavioral principles, we know that punishment (i.e., threatening discharge, discharge as punishment for ongoing stimulant use) is far less effective at effecting change than positive reinforcement; and 4) most people have a number of compelling reasons to change their stimulant use besides "my provider will take me out of treatment if I don't stop using." Our job as providers is to draw out those reasons from our patients. Doing so will support internal motivation, providing patients with ownership over their recovery.

   Stimulant use by itself should not constitute the reason for discharge; however, certain associated behaviors may be considered to ensure preservation of the treatment milieu (i.e., when behavior threatens patients'/others' health and safety). Examples include using drugs on-site, violence on campus, selling drugs on campus, and drug impairment. While not an exhaustive list, providers may decide to take patients out of opioid treatment because of these or other clinic inappropriate behaviors.

   *Numerous studies have highlighted the importance of treatment retention in opioid treatment to reduce mortality. A selection of readings here:

   - Fugelstad, A., Stenbacka, M., Leifman, A., Nylander, M., & Thiblin, I. (2007). Methadone maintenance treatment: the balance between life-saving treatment and fatal poisonings. *Addiction*, *102*(3), 406–412.
   - Pierce, M., Bird, S. M., Hickman, M., Marsden, J., Dunn, G., Jones, A., & Millar, T. (2016). Impact of treatment for opioid dependence on fatal drug-related poisoning: a national cohort study in England. *Addiction*, *111*(2), 298–308.
   - Sordo, L., Barrio, G., Bravo, M. J., Indave, B. I., Degenhardt, L., Wiessing, L., ... & Pastor-Barriuso, R. (2017). Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. *bmj*, *357*, j1550.

2. **How long should you maintain a client in a certain level of care if they are continuing to use stimulants?**

The decision to toggle between levels of care is informed by the following criteria: 1) patient expresses a preference for and willingness to pursue a different level of care; 2) results from an ASAM-based assessment indicate that patient meets criteria for a different level of care; 3) there is availability in a different level of care; and 4) patients have the ability to pay for a different level of care. If a treatment-enrolled individual is continuing to use stimulants and meets the above criteria, a transfer to a different level of care may be in order. If the stimulant using patient does not meet the above criteria, we should maintain them at the current level of care, lest we miss an opportunity to reach them and discharge them prematurely.

See question #1 for rationale. Exactly "how long" is a difficult question to answer. In terms of duration of treatment, research does not point us to a magic number. Ideally, we have a collaborative relationship between client and counselor to help determine the best treatment plan, keeping in mind the chronic nature of substance use disorders.

Dominick DePhilippis, PhD

3. **Is change sustainable for patients once they're done with treatment? Are there any contraindications for individuals with gambling disorders?**

As is the case with just about any treatment of a chronic disorder, when the treatment is discontinued, the symptoms of the disorder do sometimes return. This is true of patients with chronic medical disorders like hypertension and diabetes, as well as chronic mental health disorders like substance use disorder (SUD). However, Contingency Management (CM) is among the most effective SUD treatments for producing lengthy durations of abstinence (LDA) during treatment. The duration of abstinence during treatment is prognostic of resistance to relapse. CM works like a behavioral scaffold that helps the patient establish healthy behavior patterns (read: practice living sober) that can secure reinforcement (e.g., sober interpersonal relationships, employment, sober recreational activities) once the CM is withdrawn. Moreover, lengthier durations of abstinence during treatment give the brains of SUD patients time to heal. Although the evidence of enduring benefits of CM is mixed, Nancy Petry and colleagues (2017, Psychology of Addictive Behaviors, 31(8),897-906) noted the following: "Thus, decades of research clearly indicate excellent short term benefits of CM, and no or possibly some long term improvements with this treatment (p. 899)."

There is no evidence that CM exacerbates or triggers gambling behavior. On the contrary, given the common co-morbidity (and functional relationship) of SUD and problem gambling, CM's effect on arresting the SUD can have ancillary benefits for problem gambling. That is, arresting the SUD can mitigate setting events and cues for gambling behavior. Furthermore, the treatment retention benefit observed among CM patients can create an ongoing venue for discussing/treating problem gambling. All that said, ongoing monitoring of gambling behavior among CM patients with problem gambling is warranted. Please note that while Prize (aka Fishbowl) CM and gambling both involve chance, Prize CM is NOT a form of gambling. It involves no risk or wagering by the patient.

4. **Why shouldn't one use contingency management with individuals who have opioid use disorder?**

Theoretically, CM can be used to promote any operant behavior. The challenge is in the need for frequent, objective monitoring of the behavior. Even then, the magnitude of reinforcement available in CM must be sufficient to displace the targeted problem behavior (which, in the case of opioid misuse, is powerfully and immediately reinforced). Because of the pronounced physical and psychological dependence that comes with OUD, the MATs (methadone, buprenorphine, and NTX-XR) are the optimal treatments for OUD. CM reinforcing abstinence from opioids isn't contraindicated for OUD per se, it's just not as effective as MAT. That is, the magnitude of reinforcement in CM doesn't compete as effectively with, for example, the negative reinforcement the patient experiences when he/she uses opioids to quell withdrawal symptoms. Therefore, CM for OUD should only be used as an (albeit less effective) alternative treatment for OUD when MAT is either unavailable or unacceptable to patients with OUD.

CM for OUD is complicated because the toxicology surveillance must include the entire spectrum of opioids (including methadone, buprenorphine, oxycontin, and fentanyl) because whichever opioid escapes surveillance creates a perverse incentive for the patient to use that opioid. Similarly, CM for OUD would be challenging to implement when patients are on methadone or buprenorphine because the testing likely would be unable to distinguish illicit versus medical use of these substances. However, CM for OUD can be used in combination with NTX-XR because that medication is not an opioid replacement.

All that said, CM can be very effective for treating other SUDs among patients with OUD. For example, CM reinforcing stimulant abstinence can be very beneficial to OUD patients on MAT who misuse stimulants. CM also can be used to reinforce attendance in treatment and completion of treatment plan objectives (among SUD patients with and without OUD).

Regina Fox, BS, CSAC

5. **Is Ready for Change a separate curriculum [from the Matrix Program]?**

Ready for Change is a group that we added to our IOP (Intense Outpatient Program) to help the clients to become motivated and to create a routine before they enter the Matrix program. Ready for Change is on the same days as our Matrix groups just an hour earlier. The client is recommended to attend a minimum of three consecutive groups to ensure that they are able to attend groups. This is also helpful to identify any barriers that may arise and become a barrier to treatment. This gives the client and their therapist time to work out the barriers before entering Matrix. We are finding that we have more success with the addiction of Ready for Change group. It does have a separate curriculum it uses the Matrix idea of routine, schedules, and creating the structure.

6. **Are these clients/patients mandatory or voluntary?**

All clients/patients are here voluntarily. They make the decision every day to come to treatment or not. Most of the clients do have outside motivation such as probation/parole or Treatment Court. We find that the client may start with the external motivation and eventually, the longer they stay in treatment they gain internal motivation. We have a few that are attending groups voluntarily, that also struggle with their internal motivation. Regardless of whether they are here due to external motivation or not, we still follow our protocol by calling the client to see how we can help to ensure that they are successful.