Helping People Who Use Opioids and Stimulants

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Introduction

In recent years, people serving those with an opioid use disorder (OUD) have noticed the uptick in stimulant use in their clients. Individuals who use opioids and stimulants may be more likely to seek out treatment or services for opioid use rather than for stimulant use, making opioid treatment a possible touchpoint to talk about and work on stimulant use. What are the best ways to work with people who use both opioids and stimulants? Medications are the gold standard for treating opioid use and psychosocial supports are invaluable for many. People who work with individuals who are being treated for OUD can address stimulants in important ways: 1) integrate evidence-based interventions that target stimulant use into current care provision services; and 2) identify and address goals that may not be directly related to stimulant use, but may improve quality of life or increase retention in other services and indirectly affect stimulant use.

Objectives

1. Describe research documenting the added challenges stimulant use contributes to those who use opioids.
2. Discuss the importance of continuing to provide medications for OUD when people are using stimulants.
3. Review the psychosocial approaches targeting stimulant use that can be integrated into OUD treatment.
4. Discuss patient-centered approaches to goal setting for people who use opioids and stimulants.

For clinicians trained and prepared to treat opioid use disorder, the addition of stimulant use may feel like a new challenge. Indeed, adding any substance use on top of an opioid use disorder can complicate the clinical picture. Compared to people who just use opioids, people who use stimulants and opioids tend to have:

- Lower treatment retention (Tsui et al., 2020; Banta-Green et al., 2009)
- More physical and mental health conditions (Timko et al., 2017; Shearer et al., 2020)
- Riskier drug use patterns and consequences (e.g., fentanyl v heroin, injection v smoking, self-reported overdose; Daniulaityte et al., 2020; Glick et al., 2018)
- Higher rates of houselessness and unemployment (Chawarski et al., 2020)

We discuss ways of working with people who use stimulants that are enrolled in medication treatment for opioid use disorder (MOUD), and the first step to this process is ensuring that these patients and clients are started and maintained in treatment. This step is key because:

- Keeping people enrolled in MOUD increases the likelihood that they will live (Fugelstad et al., 2007; Pierce et al., 2016; Sordo et al., 2017).

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- Keeping people in treatment keeps them connected, and opens up the possibilities for both behavior change, as well as connection to other helpful services. Discharging people for stimulant use cuts off these possibilities.
- Treatment staff may feel obligated to "keep people accountable" (i.e., discharge for ongoing stimulant use) with the hopes that doing so will help the person initiate change. However, this approach may only work for some small proportion of individuals. Those for whom this approach does not work are likely among the most vulnerable.
- MOUD patients and clients discharged for stimulants may seek re-admission shortly thereafter. Instead of having a "revolving door", why not reduce the work of readmitting individuals and keep the door open? Readmissions can be time consuming for clients and staff as well as send a signal of failure.

Evidenced-based Psychosocial Treatments Targeting Stimulant Use

Whilst treatment programs are treating and maintaining patients and clients with opioid use disorder, stimulant use can be addressed in a number of ways. Summarized here are evidence-based interventions that target stimulant use; a more thorough review can be found in SAMHSA's resource guide.

Contingency Management

Contingency Management (CM) is an intervention that uses incentives to positively reinforce specific behaviors. For example, CM targeting the behavior of stimulant use (as measured by drug screening results) would involve providing participants with incentives by demonstrating reductions in stimulant use. Other behaviors to incentivize with a CM program could be clinic attendance or goals identified by the client. According to research, CM is the most reliable and effective behavioral intervention we have to target stimulant use (Ronsley et al., 2020). The intervention sounds simple: "Just give people an incentive when there is a negative drug screening." However, setting up successful CM programs can involve extensive planning and preparation.

An effective CM program will adhere to CM principles, account for important details like incentive storage and distribution, and involve clinician and other staff training to carry out the intervention consistently and effectively. Successful CM programs are a whole team effort, whereby staff in many parts of an organization buy in and contribute to CM efforts. Resources to help your agency start a CM program include ATTC materials on CM/CM Implementation a free, online course on CM in healthcare settings.

Motivational Interviewing

According to its originators, Motivational Interviewing (MI) "…is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion." (Miller & Rollnick, 2012, p. 29). MI targets ambivalence around change, making it a good fit for many people who use stimulants, as motivation to change stimulant use may itself be multi-faceted. The great thing about MI is that you can implement this intervention at every single encounter with MOUD patients and clients who use stimulants. Even if you see a person one time, MI can be effective in engaging them, or even having them think about their substance use in a new way (DiClemente et al., 2017).

Another strength of MI is that there are plenty of training opportunities and resources to learn about and improve MI skills. However, we know from research that one workshop or even tailored MI trainings does not predict a person's adherence to MI (Baer et al., 2009). In other words, a person does not develop MI skills by simply attending MI trainings. MI trainings are a great start, but the way people get better at MI is both by

practicing and getting feedback about their skills, either through role plays or observed practice (e.g., recorded sessions or direct observation). If you are interested in using MI to help people reduce stimulant use, seeking out MI trainings is the best first step.

Ideas for Ongoing MI Practice

- Record yourself doing MI with a friend to see how you sound.
- With explicit consent from the person you work with, record your encounters with the people you serve. Ask them how they think the encounter went from their perspective.
- Partner with a colleague who is interested in improving MI skills for regular role play, practice, and discussion of MI implementation with the people you serve.
- Explore resources that help people practice MI techniques.

Cognitive Behavioral Therapy

Cognitive Behavioral Therapy (CBT) is an intervention that supports people to purposefully think about their thoughts and emotions, and how these aspects of inner life relate to behaviors like substance use. Through CBT, people can heighten their awareness around thoughts, feelings, and circumstances that precede stimulant use, and result from stimulant use. People learn skills that can be employed when they have cravings to use stimulants, or are in a "high risk" situation for using stimulants. A strength of CBT is that, once acquired, people will always have access to the skills and concepts they learn in CBT; they can take the skills and knowledge with them. This learning process may explain the "sleeper effect" seen in some CBT studies targeting substance use (Rawson et al., 2006), whereby the effect of the intervention appears to show up later, once the person develops some mastery over the concepts and skills.

The fact that CBT seems to be more successful after ongoing exposure to the therapy is also a downside. Some people may not want to, or be able to, dedicate time and effort to absorb CBT, and therefore it may not be a good fit for some MOUD patients and clients who use stimulants. To find out whether the person is interested in hearing more about CBT, all you have to do is ask! If you have this conversation, be prepared to serve as a CBT therapist yourself, or with an appropriate referral to a CBT therapist.

Sample language to use when asking whether a person might be interested in learning more about CBT

"What do you know about 'cognitive behavioral therapy' or CBT? Have you heard of this before? It's a therapy that focuses on our thoughts, feelings, and behaviors. In CBT the idea is that these things are related. It's been shown to be helpful for people who want to change stimulant use. It works best for people who feel at least a little ready to change, and want to participate in multiple sessions. It's even better if people are willing to practice the skills they learn between sessions. Is this something you want to hear more about?"

Community Reinforcement Approach

Community Reinforcement Approach (CRA) is another behavioral intervention that has been shown to be effective at reducing stimulant use. The CRA approach focuses on increasing activities that will compete with

substance use and achieve the desired benefit (e.g., avoid depression; feel safe). In CRA, the patient and clinician collaboratively look at environmental and other factors that maintain substance use behaviors. In other words, what are the factors that continue to reinforce ongoing substance use in the short term? Why does the behavior persist? With stimulant use, the function of the behavior might be to avoid feeling very depressed or to feel safe by staying vigilant in high risk living environments.

CRA includes skill building in problem solving, coping, and relationships. Job hunting may be a part of CRA, and sometimes the person's family members are invited to participate as well. Like CBT, CRA takes effort on the part of the patient and for this reason may not be a good fit for some depending on their circumstances.

Other Ways to Help MOUD Patients and Clients Who Use Stimulants

The abovementioned interventions can work directly to affect stimulant (and other substance) use. However, there are other ways of helping MOUD patients and clients who use stimulants.

Engage in Shared Decision-making

- Shared decision making is a patient-centered approach whereby clients and professionals work together to identify and address goals. This approach allows the person receiving the care to be in charge of what's important in their treatment and care, as opposed to goals prescribed to them by a professional helper. For example, MOUD patients and clients may not be interested in changing stimulant use; however, they may be interested in pursuing other goals, some of which may indirectly have an effect on stimulant use.

    - ✓ Ask: Asking is the first step in understanding what is important to the person sitting in front of you.
    - ✓ Explore: Exploring the person's goals that are not stimulant related requires you to better understand what the person is interested in working on, what they have tried, and their previous experiences with treatment and other services.
    - ✓ Plan: Patient-centered planning involves further discussion of how the person might arrive at their end goal. What steps will the person need to make? What might the barriers be? Who is on the person's team to encourage and help?
    - ✓ Support: You are part of the person's team. Ask the person what support they will need.

Asking About Goals in a Client-centered Way

- Query the person with an open question: "What would you want to be different in your life?" "What do you want to work on?"
- Ask about specific areas to start the conversation. When faced with an open question about how they want their lives to be different, some people may not know where to start. Asking about specific categories can get a person thinking broadly and people can start considering areas they want to focus in on.
- A measure like the Happiness Scale could be used to explore potential goals, or based on your setting and experiences, you could generate your own list of areas. Categories may include: physical health, mental health, basic needs (e.g., housing), relationships, work/school, other substance use, or reducing harms related to substance use.

Talk with Patients and Clients About Safer Use

Talk with patients and clients about safer using strategies, including education around opioid and methamphetamine health risks, safer use supplies including syringes and smoking equipment, and offering naloxone.

Focus on Non-use

During encounters with MOUD patients and clients who use stimulants, it might be automatic to ask about how often the person has been using, or to review urine drug screen results. This type of conversation puts the emphasis on drug use. Try flipping the discussion.

"What do your days/times look like when you are not using?"

"What are you doing at that time?"

Take Care of Yourself

- Consider your hours: How often do you work late or outside of your scheduled hours?
- Self-care: What do you do to maintain your own mental health, physical health, and/or spirituality?

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