Contingency Management for Methamphetamine Use: Qualitative Interviews at Harm Reduction Programs

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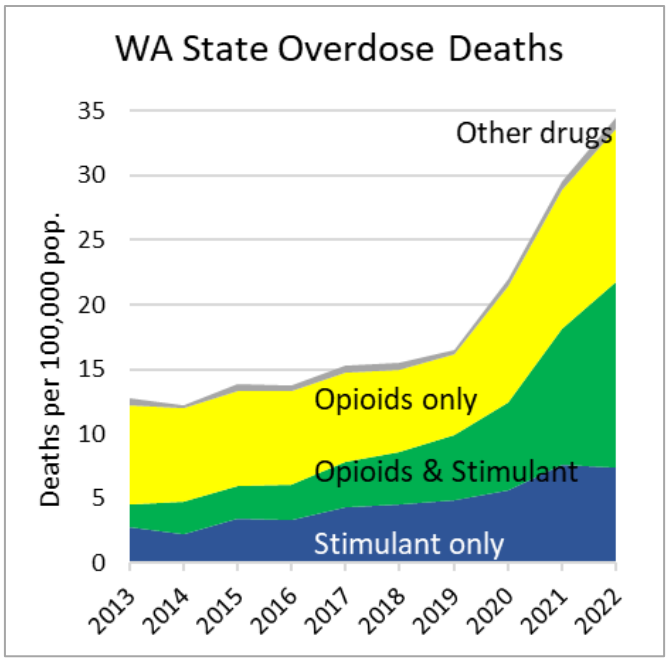
Background

Dramatic increases in methamphetamine-involved overdose deaths necessitate community-involved and innovative public health, harm reduction, and health care responses. The "Community-Based Medications First" model ("Meds First") was started in 2019 as a first step toward building one such innovation: low-barrier, same-day access to buprenorphine access within syringe services programs (SSPs). The Meds First model brings together prescribers, nurse care managers and care navigators into a care team that provides clinical and practical supports to help individuals initiate and stabilize on medications for opioid use disorder (OUD). Meds First clients can maintain care on OUD medications either onsite or by transferring successfully to other outside health care providers.



Building this new care model within existing SSPs conveyed significant strategic advantages, in large part because trusting relationships with participants were already established in that environment. In addition, the low-barrier model offers these additional care and treatment services on a drop-in basis, with no appointments required, and prioritizes engagement and retention. Central to this model is a philosophy of care which views ongoing drug use as an opportunity for further engagement rather than a reason to discontinue services. Services were expanded in 2021 due to the need to address methamphetamine use among those using SSP and/or Meds First services. Two program components were added to the model of care: Contingency Management (CM), an evidence-based practice to reduce stimulant use, and low-barrier mental health support and linkage with mental health treatment.

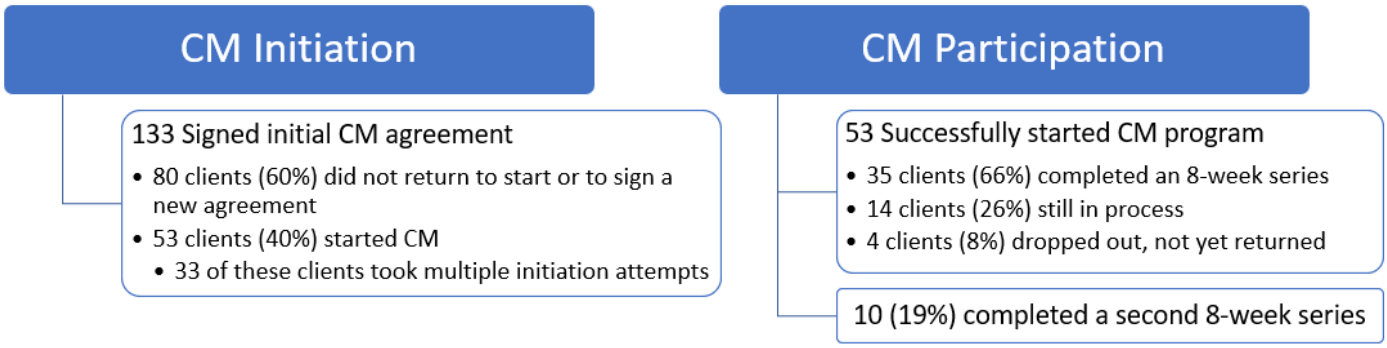
Objective

To better understand the impact of this model and the interventions to reduce stimulant use, staff at the University of Washington Addictions, Drug & Alcohol Institute (ADAI) conducted an evaluation of this approach. The evaluation specifically focused on the facilitators and barriers of a low-barrier, extended model of care for clients using these services and for staff providing them. This work builds on previous work between ADAI and Meds First sites that involved outgoing implementation support and outcomes research.

Study Design

We conducted qualitative, semi-structured interviews at organizations implementing the Meds First model of care with both staff in a variety of roles (n=15) and clients eligible for enrollment in Contingency Management (n=27). Inductive and deductive coding was conducted on all transcripts. Human subjects approval was obtained.

Results



Staff included site leads, care navigators, prescribers, nurse care managers, and mental health counselors. Clients averaged 40 years of age, were mostly white (85%), unemployed (56%), men (70%), and living in stable housing (63%). Preliminary CM program data showed that 133 clients signed an initial agreement to begin the 8-week CM series. At the time of interviews, of the 53 clients who started CM, 35 completed an 8-week series, 14 were still in the program and 4 individuals had discontinued. These data show that a substantial minority of people who indicate an interest in CM actually begin, and most of them actually complete a full CM series.

Participants outlined a number of facilitators and barriers of the low-barrier model of care, including CM. The facilitators focused on the positives of the harm-reduction based and non-judgmental approach of staff and surrounding services, as well as appreciation for the reward incentive. The barriers included challenges relating to the abstinence-based approach of CM and logistical challenges of participating in CM.

Facilitators

Positive addition to harm reduction services: Respondents shared enthusiasm and support of CM. They felt that CM fit well in the short- and long-term with other harm reduction services to improve engagement, retention and program success.

"I love it. It works. I mean, the science is behind it. Behavioral modification is fantastic. It works for anybody at any age. You just find that person's currency which literally is cash. Everybody likes it." – Staff

Rewards and accountability work: Respondents agreed CM is a powerful program for people using stimulants, due to its ability to foster individual accountability and client-driven stimulant reduction goals.

"There's the motivation side. They kind of push you and help you and talk, and they're so positive and they're open to talking to you anytime. That really helps, just knowing that someone is there, and someone actually cares. That's huge." – Client

Meeting people where they're at: Crucial to the model are its low-barrier and non-judgmental approach. Clients and staff agreed that CM helps people who use stimulants to engage and stay in care, especially where easy rapport, compassion, and respect can foster a respectful relationship.

Barriers

Need stimulants to function: Respondents agreed that stimulants often serve important roles in client's lives, especially when clients lack basic needs such as housing, transportation, or personal safety. These basic needs should ideally be met before CM involvement can have potential benefits.

"We work with a lot of people who are chronically homeless, who live in rural areas, and it's been really difficult to keep people engaged in wanting to come to receive stimulant services twice a week, every week, when some of them are driving an hour or 90 minutes to get here, or a lot of them are staying outside and stimulants help them feel safe." – Staff

Scheduling and transportation difficulties: Respondents identified the clear need for help with scheduling and transportation. They suggested that more flexible scheduling and transportation support to and from the clinic could improve engagement and CM success.

"Thinking about other people being in active addiction, the start-up first couple gift cards are kind of low. For me it was enough, because $10 twice a week was my gas money to achieve my goals. But to bring someone out of the world that has no goals…other than just getting high, it seems like kind of a low incentive for someone in that frame of mind." – Client

Program too short, compensation not enough: Respondents had ideas for how program engagement, retention, and success could be improved. These included: offering a series longer than just 8 weeks, allowing clients to repeat the series, increasing incentive amounts, and offering client-led incentives.

References

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