2020 Psychostimulant Symposium
Questions from Sessions Answered After-the-Fact

There was not enough time to answer questions during the Symposium, so some questions were taken back for responses after-the-fact. To follow are those questions and answers.

Plenary 1 – Stimulant Use Disorders: Epidemiology, Clinical Challenges, and Review of Treatments
(Responses provided by the presenter, Dr. Richard Rawson)

1. *Is there evidence that OUD patients on MAT are using psychostimulants?*

   Yes. In many parts of the US, there is significant cocaine (Eastern/Midwestern Urban areas) and meth amphetamine use (West/Midwest/South Rural and Suburban areas). In some parts of the US, 50%+ of patients on buprenorphine are using stimulants.

2. *What is "smurfing?"*

   Going to multiple pharmacies and buying the maximum allowed amounts of pseudoephedrine products. This is used to manufacture methamphetamine.

3. *I have heard several injection meth users say they would use bath salts if they could not find meth because it's a similar high, are bath salts currently classified as a stimulant?*

   Bath salts do have stimulant properties. Bath salts are a variety of substances.

4. *I'm curious if the previous use of methamphetamine impacts pregnancy or the child or women who abstain during their pregnancy*.

   I am not aware of any evidence that use of methamphetamine in the past impacts pregnancy when the woman is abstinent.

5. *Please provide link/resource for article referenced in presentation relating to stimulant use/pregnancy.*

   Smid, M., Metz and Gorden. (2019). Stimulant Use in Pregnancy: An Under-Recognized Epidemic Among Pregnant Women, Clin Obstet Gynecol. *62*(1), 168–184

6. *Are there any findings that there is a correlation between psychotic behaviors and the high temps that Methamphetamine users experience?*

   I am not aware of data on this relationship. However, high temperatures induced by methamphetamine would be the results of high amounts of methamphetamine in the blood stream. High amounts of methamphetamine in the blood stream are frequently associated with psychosis. Very high temperatures are often associated with overdose and loss of consciousness.

7. *Have read that contingency management programs offering less than $400.00-$500.00 per pt, are not necessarily effective. Generally as no funds are available to support such, what can you recommend as an alternative?*

   I am not sure on what the cut off number is for incentive values. I'm sure it is dependent upon the population being treated. And over what period of time. The studies that have established the efficacy of CM have ranged from $200 to $1200 over a 12 to 16 week period.

   Values below these are likely to have much less impact on changing behavior. One possible strategy might be to combine lower levels of incentives with other EBP, including MI, CBT and CRA. That is what we are attempting to do with our TRUST model. But we don't have data to support this approach.

8. *Given the success of contingency management in the treatment setting, and the sometimes limited access to the appropriate length of treatment based on insurance, etc. could CM also be used, perhaps in a modified way, in the family setting after formal treatment is over?*

   Yes. I think the use of incentives should be applied in many settings in different ways.

9. *Was there a distinction made between types of exercise effectiveness - e.g. aerobic vs. anaerobic? High- vs. low intensity?*

   Don't know. No evidence on this.

10. *With exercise having such a positive response and safe exercise spaces are a challenge for members of our community, is there a space for state/fed funding for vouchers/ memberships for exercise programs or community centers with exercise program capacity?*

    I think this is a good idea. I don't know if this can currently be done with federal funds.

11. *Please provide info. as how to obtain the TRUST manual.*

    Send me an email rrawson@mednet.ucla.edu.

12. *I was curious on any samples or recommendations on protocols for any client exhibiting psychosis or violent behaviors?*

    I am in the process of collecting these for a project in California. Should have some of these in 3-6 months. I know they exist, but I don't have them currently in hand.

Breakout Session 2C – Harm Reduction: Meet Me and Walk with Me

1. *How do we expand access to funding for harm reduction efforts across PA? This is a vital service that is provided to a very vulnerable population. Funding is needed to do this important work.*

   - Education and Awareness. A main goal of the presentation was to share the **breadth of strategies** and highlight who plays a role. *Harm Reduction offers a compassionate approach to reduce the consequences of substance abuse with a pathway into treatment when the*

person is ready. In this light, SCAs can educate and foster dialogue to broaden the definition and further strategies such as Naloxone distribution; MAT; support for testing for Hepatitis and HIV; training for families and caregivers on substance abuse and how to support a loved one; and training doctors, nurses, and EMTs to educate patients in areas of self-care such as veins vs. arteries, wound care, Hep C, and sexual health while building trusting relationships and remaining an open door and path to resources.

- Advocacy Work. As of now, traditional "harm reduction services" (safe injection, test strips) are still not permitted in PA and so funding is limited (although there are current efforts to change that legislation which professionals can stay abreast of and contribute to the conversation).
- Capacity building. SCAs can investigate grant or other funding sources to promote recovery and reduce harm. Sources to review are: PA Commission on Crime and Delinquency (PCCD) The PCCD Funding and Grants Process Home (pa.gov); Substance Abuse and Mental Health Services Administration (SAMHSA) Grants | SAMHSA; and the Harm Reduction Coalition link on SAMHSA's page https://harmreduction.org/our-work/training-capacity-building/. SCAs who oversee a Health Choices program may also have access to reinvestment dollars that could be utilized for this purpose.

2. *How can Recovery Community Organizations help the Pennsylvania Department of Health to expand access to Naloxone during a time of great need (pandemic)?*

   You can contact your local Single County Authority (SCA) at the following link Find your county office (pa.gov.) The SCA will be able to assist Recovery Community Organizations obtain Naloxone for distribution to individuals. In addition, the PA Commission on Crime and Delinquency (PCCD) has a Naloxone distribution program for first responders that could include Recovery Community Organizations. More information on PCCD's program can be found at Naloxone for First Responders (pa.gov).