



## Greater Southern California Node Quarterly Digest Ask an Expert – Interview with Rick Rawson, Ph.D.



**Rick Rawson, Ph.D.**, is an Emeritus Professor in the Department of Psychiatry and Biobehavioral Sciences at the University of California, Los Angeles. He is also a Research Professor at the Vermont Center for Behavior and Health, part of the Department of Psychiatry at the University of Vermont.

**Question** You've been providing treatment services to patients with stimulant use disorders since the 1980s, what makes this reemerging trend in stimulant use different this time around?

**Answer** From 1983-2005, I worked on a wide variety of issues related to stimulants (cocaine/methamphetamine). One issue I did not work on was stimulant-related overdose deaths. Then, rates of overdose deaths from stimulant overdose were not a major concern. Of course, they happened from strokes, heart attacks and seizures, but they were relatively rare. As the opioid overdose crisis accelerated during the early 2000s, the attention of the U.S. health system appropriately shifted to a major effort to reduce opioid deaths. In many parts of the U.S., cocaine and methamphetamine were still a major problem but overdose death from these drugs was much less of a problem. In 2021, two things are different; fentanyl and more potent/deadly methamphetamine.

In 2021, the cocaine supply into the U.S. almost all contains fentanyl. Cocaine-related overdose deaths are almost all from a combination of cocaine and fentanyl. In some parts of the U.S., where fentanyl test strips are given to cocaine users at harm reduction facilities, virtually all the samples of cocaine are positive for fentanyl. The extent of the presence of fentanyl in the methamphetamine supply is less than with cocaine but increasing. And, with methamphetamine, the drug itself (without fentanyl) is much more deadly. In the "breaking bad" era of domestic methamphetamine production, up until 2005, the purity of methamphetamine ranged from 30-60%, and often was further diluted to below 30%. Now sample from DEA seizures reflect 98%+ purity. And because the supply is so widely available at a lower price, there is less dilution by street dealers, so the user is getting a much more powerful and lethal drug. Rates of strokes, heart attacks, deaths from hypothermia are all dramatically increased due to the more potent methamphetamine. And, when combined with fentanyl, as is increasingly happening, this becomes a very deadly drug.

**Question** In the past decade, we have seen treatment (and/or treatment initiation) in settings other than specialty Substance Use Disorder (SUD) care. Ideally, how do we identify patients using stimulants that need support and intervention? Where should we be providing care?

**Answer** In my opinion, policy makers and SUD service development leaders have to shift the focus of efforts with stimulant users from an exclusive focus on recovery-oriented treatment, to a focus that starts with overdose prevention/harm reduction and treatment engagement. We never really worried about our stimulant using patients dying, but now that has to be our first priority. Dead people don't recover.

**Question We have some robust medications that help treat opioid, alcohol, and tobacco use disorders. Where is the science on treating stimulant use disorder? Are there any biomedical interventions on the horizon for stimulants?**

**Answer** For over 30 years, NIDA has been very aggressively searching for/trying to develop medication(s) to help people with Stimulant use Disorder (StimUD). There is a tremendous need and provider demand for effective medications. However, despite this major effort, currently there are no medications approved by the FDA for the treatment of cocaine or methamphetamine use disorder. There are a number of medications that appear to have promise for the treatment of methamphetamine use disorder (MUD) and have some published positive research support, including mirtazapine and bupropion/naltrexone, but more supportive data is needed before these medications could be approved by the FDA.

**Question Generally, we have had the same set of behavioral/psych-social tools in our toolbox for the past two decades. Where is the research/science in terms of determining what works best?**

**Answer** Evidence-based behavioral treatments are currently the foundation of treatment for people with Stimulant Use Disorder (stimUD). There have been numerous, excellent recent reviews of the literature on this topic. All of the meta-analyses and systematic reviews uniformly agree that contingency management (CM) has by far the best evidence of helping people reduce their use of cocaine and methamphetamine and improve their functioning. There are some studies providing positive, but less robust support for cognitive behavioral therapy, community reinforcement approach, motivational interviewing, and physical exercise.

Contingency management (CM) is used routinely in the Veterans Affairs for the treatment of individuals with StimUD. However, in the broader health care system it has minimal use. At present, many SUD treatment providers are not familiar with how CM is used, and there are no established funding mechanisms for the incentives used in CM. A major obstacle for use of CM with patients whose health insurance is provided via Medicaid, is a Medicaid regulation that requires some very rigorous rules for the use of incentives over \$75 in total. The research supporting CM used amounts from \$100-\$200 per month and above. This \$75 ceiling on the incentive value makes use of evidence-based CM very difficult at this time. However, because the need for effective treatment for StimUD is rapidly increasing, pilot projects using CM (with adequate incentive values) are occurring and efforts are underway to make federal regulations much clearer and supportive of the use of CM.