Primary Care/Harm Reduction for People Who Use Stimulants

Key "Take-Aways":

1. **If you are a primary care provider who treats chronic diseases, you already have the skill set you need.**
2. **Stigma kills; you should be comfortable asking questions and giving practical advice.**

Presentation Transcript:

Hi, my name is Candy Stockton, and I've spent the last 20 years working in primary care in rural Northern California. This presentation is part of a video series UCLA's Integrated Substance Abuse Programs is doing in partnership with the California Department of Healthcare Services. The goal of the series is to provide tips and tools to busy clinicians to help them better address the use of stimulants among their patients. The title of my talk is "Addressing Stimulant Use in Primary Care Settings." And I hope this content's useful to you as you care for patients who use substances in your practice.

(00:31) The first thing I want to cover today is that:

- You already have, as primary care providers, the **understanding of how to treat a patient with stimulant use disorder in the same way that you treat other patients** with other chronic diseases.

  One of the most frustrating things I think in primary care for me is when you feel powerless to help somebody who keeps coming in. They have a problem. You don't know what to do. And when I first started treating people who use stimulants, this was really something I struggled with. It felt like there was nothing I had to offer them. There are no treatments. You know, buprenorphine doesn't work for stimulant use disorder. There is no medicine I can give them to stabilize their cravings for drugs. And so, I just really felt kind of powerless, and I really felt like these patients were difficult because they just kept coming back with the same problems over and over. And there was a small part of me that wanted to just say, "*If you just quit using the drug, this would all be better*," but you already have the skills you need to effectively treat patients with stimulant use disorder. You just need to shift your thinking to look at them the same way you treat other chronic diseases.
- The second takeaway tip today is that **stigma kills**. You should be comfortable asking questions about your patient's substance use, asking questions about the complications and the impact that has on their life, and giving practical advice to help offset the harm associated with that disease.

Take a Thorough History:

(01:56) The first thing I want to go over is **take a thorough history**, and I'm going to run through some terms with you today that you may not be familiar with. We get quite a bit of education about, you know, the ins and outs of diabetes and diabetes complications, of hypertension, coronary artery disease, but I didn't get much education about how people use drugs on a practical basis and what that means.

Routes and frequency of people's use: do they inject? If they inject, is it IV or skin popping? Is it IM? Do they smoke it? Do they snort it? Do they swallow it? Do they do something called booty bump, which is when you dissolve the drug in water and inject it rectally? There's a lot of different ways people use substances and their risk of complications, injury, and how you address harm reduction in that person really depends on what substance or what route that person is using the substance with and recognizing that it's also a first step towards really destigmatizing this use. If you know nothing about how people use drugs and it's just kind of this blur to you, then you're going to do a bad job taking a history. You're going to be uncomfortable

with the information that you're receiving. You're not going to be able to ask questions that can help you fine tune what the risks are. So. this is important.

The next thing you want to ask about is **common complications of substance use**, particularly the substance that your patient is using. With methamphetamines and other stimulants, are they experiencing weight loss? Are they having skin problems? Are they having dental problems? Are they experiencing chest pain or palpitations, arrhythmias, shortness of breath, abnormal movements, mood disorders, anxiety, paranoia, difficulty with sleeping, feeling overly sleepy? This can tell you a lot about where somebody is in the process of their drug dependence and their substance use disorder.

It's also important to ask about **sexual practices**. There are a lot of women who use stimulants and particularly methamphetamines. There's also a lot of use among men who have sex with men. And so you're looking at different risk factors in terms of co-occurring sexual infections and, you know, particularly in patients who have a uterus, the risk of pregnancy or unplanned pregnancy associated with this. So understanding patients' sexual practices can go a long way towards helping you mitigate harm from the use disorder that they have.

Then, ask patients: ***"do you have any concerns about your substance use?"*** You know*, "How do you feel about it?" "Are you worried that you're using more than you want to or seeing complications from your use?"* ***"Are you interested in trying to cut back or trying to quit your substance use?"*** Both of those questions are key to understanding your patient's motivation, where they are in the, cycle of willingness to change and how motivated they might be to work with you on different things.

"If you are interested in cutting back or quitting, ***what have you done that's worked for you before?****"* Most people who use substances for any prolonged period of time, you know, have cycles of use. They've had times where they've been successful at cutting back or quitting, and they've had times where they've used more.

And then the next question is, ***"are there times or situations you find yourself using more than you intended to use?"*** And that's really kind of a guiding question to trigger people to start thinking about, you know, what are the things that trigger your substance use? What are the situations that you use that can help people recognize when they're using substances to self-medicate or to cope with relationship problems, job problems, physical pain, or mood disorders in ways that they may not have made that connection previously. That can be a valuable tool in helping move people towards readiness to change.

Key Points in Taking A Thorough History:

(05:45) There are two key points here. **Do not assume that people who use drugs don't care about their health or aren't willing or able to make any changes at all**. They may not be interested in making the changes that you are most interested in right that minute, but most of them do care about their health and will make some changes or do some things to self-care already, and that's a foundation that you can use to build, work together around more change.

And **do not use stigmatizing language with people**. Try to get used to using the term people who use drugs instead of addicts or people with substance use disorders if they meet those criteria. When you're talking about urine drug screens, it's better to use the terms "expected or unexpected urine drug screen results" or "positive" for or "negative" for substances. "Clean" and "dirty" is really stigmatizing language and it sort of

misses the point. The point about caring for somebody with substance use disorder is helping to improve the trajectory of their life, helping to minimize the complications from their disease. It's not all about whether they're clean or dirty that day; whether they have drugs in their system, or whether they don't have drugs in their system that day.

Offer Real, Practical Advice:

(06:59) Being able to offer real practical advice. If your patient is somebody who is injecting drugs, talk to them about what to do to make that less risky. **Use an alcohol swab** to clean the site. **Rotate sites**, so that you're not scarring up the skin so much. Some valuable reasons for that is that you decrease the risk of skin trauma and infections a little bit when you're rotating sites. But also, from a practical standpoint, when you're rotating sites and not scarring the tissue as much or not injecting into scarred tissue as much, the drug remains more effective for them. When the skin gets too scarred up. It starts not injecting or not absorbing drugs through that area very well. That can **lead to unpredictability** about how much you absorb and increasing doses, which if you inject that someplace else can increase your risk of overdosing. Take an area where you're only absorbing about 50% of what you're injecting quickly, and then you start upping your dose to compensate for that. And then you inject in another location where you don't have that scarring and suddenly you've got a much higher dose getting into your system and increasing the risk of overdose and complications from that.

About 30% of people who use injection drugs will **lick the needle** sometimes. There's a variety of different reasons for that, but it's something that you want to be able to talk with patients about because obviously that increases the risk of an infection at the injection site.

You as a provider should know where in your community somebody can get **syringe exchange services or syringe services and have printed handouts** to give to people who are in that situation if they want them.

Make sure you're talking to people about **using clean water** when injecting. This is particularly important for patients who may not have access to easy clean water supplies.

And then you want to talk about the needle, the syringe, the cooker, the device that they heat the drugs in, the cotton or filter that they use to draw up the drugs. You want to talk to them about **only using those things once**. Reusing them increases the risk of bacterial and fungal infections from injecting and you don't want to share them with others because it is possible to transmit bloodborne infections through that equipment.

And then the other thing is, when you're heating and dissolving your drug in the cooker, when you draw that up, people typically draw that up through a filter of some sort. The safest thing to use with that is the cotton-off or either like a clean Q-tip or cotton ball. Just use it one time, clean one every time. Some people when they don't have access to that will use **pieces of tampons or pieces of cigarette filters**, and both of those have other chemicals in them that can be harmful when they're injected. So when you're talking to people about clean supplies for injecting, if you're not familiar with this process and you don't understand this, you're going to miss an opportunity to educate them. If you're doing a syringe exchange program or syringe services out of your site, then you want to consider, should we be offering cotton with this as well? Clean cotton balls can be almost as important as clean tampons. You also want to understand that because there's a little bit of the drug that's absorbed into that filter material, when it's used, a lot of times particular people

with lower income levels, who are maybe out of money at the end of the month to buy drugs, will have a tendency to try to soak those and get any remaining drug out of those. And that can be very risky as well because those are cottons that have been contaminated and sitting around for days or weeks on end and have a really high risk of fungal or bacterial infections associated with using them again. You want to talk to people about those things.

"Safer Use" Is Possible:

(10:33) It is possible to use more safely. I think in our culture we tend to talk about using or being abstinent, and we have abstinent-based approaches to substance use, but there are things we can do to help people, or education we can give to help people who are not ready to stop be safer while they're using. If you have somebody who's in a phase of use where they're able to **refrain from use for a week or two at a time periodically**, that can help reset your tolerance levels. You're not needing to take as high of doses to get the same effect.

You can talk to people about **setting limits before use**. If you have somebody who is, say, a parent who's using, can they set limits, so they don't use after a certain time of day; so, the system has a chance to clear most of the drug before their kids get home at the end of the day, and they're responsible for caring for them? Or for somebody who works, can they limit their use to periods where they're not going to be under the influence working in a situation that could end up with them losing their job or being more at risk of making dangerous decisions? We tend to think of people who uses stimulants, particularly methamphetamines, as at the end of the course. And so, we tend to think of them as people who are heavily, heavily dependent, have completely burnt out, you know, their brain chemistry and are unhoused and non-working, but you'll see people who are using stimulants for 5, 10, 15, 20 years in your practice who are not at that level. And so, we tend to think, "*oh, nobody who uses stimulants, so people use meth, they're not going to listen to this, they're too paranoid*", but if you're asking the questions about patients who are using methamphetamines and stimulants in your practice, you're going to actually become aware that there are a lot more patients, a lot more people than you think there are. And many of them are at a stage in their substance use where they can benefit from advice like this.

Are there **safer routes of administration**? If you're injecting, is it possible to move to swallowing, to smoking, to snorting that at least decreases the risk of skin infections? Are there ways that you can change, or can you inject less frequently? Or if you can't, if the person doesn't feel like they can't inject less frequently, are there ways that you can pre-stock with the supplies you need to make sure that you're changing out all of your injection kit every time, so you're at less risk of infection and secondary infections from that.

And then the other thing is, at this point in California pretty much every drug supply we have is **cross-contaminated** with fentanyl. So do not assume that your patients, who tell you they're only using stimulants, are not at risk for overdose deaths from fentanyl. They absolutely are. And that's not even considering that very few people who have high-level drug dependence use only ever a single substance. A lot of people will alternate to their non-preferred substances if their preferred substance isn't available. A lot of people will knowingly use an opioid if they can't get a hold of their stimulant or another drug at that time. Do talk to people about the **possibility of fentanyl**, either accidental or intentional ingestion. Talk to them about **fentanyl test strips** to help them figure out how to get them in your area, so they can test their meth supply before they're using it, and make sure that you've given them a **prescription for naloxone** and explain how to use it. This is critically important.

Practical Advice for Everybody:

Onto the practical advice for everybody. Maybe they're not interested in talking about reducing their drug use at all. Maybe they're not interested in talking about safer routes. We can still talk to them about **drinking water and eating before and during their drug use periods**. It helps prevent the dehydration and the weight loss that occurs. Being well-hydrated helps slow the dental problems that develop with methamphetamine use, as well as helping with some of the skin problems that develop with methamphetamine use.

Encourage patients to **brush their teeth and floss daily,** and if it's appropriate in your site, even provide them with brushes and dental floss to help send that message home.

Talk to them about **skincare**, about keeping their skin moisturized, not dried out. They can do a couple different things. If they're housed individuals with easy access to care, something as simple as applying like a baby oil gel while they're in the shower, or using moisturizer several times a day can really help keep their skin from drying out as much, which can decrease some of the picking that occurs and the secondary skin infections.

And then talk to them about **what skin infections look like**. Ask if you can check any areas on their skin that they're concerned about even if they're covered by their clothing right now because they are at high risk for chronic abscesses to develop in sites where they inject.

Make sure that they're up to date on their **vaccinations**, and so this is both hep A, hep B, HPV, your common things that you might think of in this age and population depending on who they are, but it's also their pneumonia vax and tetanus vaccines. They're at higher risk for infection with pneumonia because they are somewhat immunosuppressed, and they're at higher risk for infection with tetanus, particularly if they're injecting regularly and their supplies are not always clean. These are important.

Also, all these things are a way to say *"**I care about you and you're still important and I'm still providing care to you** whether you are using or whether you're not using. You are a valuable human being and we care about your wellbeing."* These are practical ways that you can express that to a patient and help them mitigate the harms from their substance use even in somebody who's not interested in talking about quitting or reducing.

The other thing that's important here is **write down any important advice or instructions**. We know in people with stimulant use disorder that their auditory memory is often much more impaired than their visual memory. There is a good chance that they may not remember those instructions that you give them, especially ones that are a little more detailed or a little bit more complicated.

Sexual and Reproductive Healthcare:

(16:25) Sexual and reproductive healthcare is critically important. I am going to break this out in terms of two populations. Where this is most concerning is in **men who have sex with men** and in **women of childbearing age**. It is, of course, important for everybody, but the focus is a little bit different on those two populations.

So first, for everybody, **condoms**. Provide them. Educate about the importance. Talk to people who qualify about **prep or post-exposure prophylaxis** if it seems like they could be compliant with those things or at least educate them about the possibility. Talk to them about, particularly for men who have sex with men and for women who might be exchanging sex for drugs or for transactional sex for survival, that that when possible, choosing more partners who are known to you than unknown reduces your risk of sexually transmitted infections. And then something called **serosorting and seropositioning**. If you have somebody who's not maybe willing to use condoms all the time, talk to them about using condoms or protective measures collectively in situations where they know the partner has been tested or has a lower risk of having HIV or hepatitis, and seropositioning has to do with choosing sex positions. If you are a person who does not have HIV or hepatitis and you're having intercourse with somebody whose status is unknown or who you think might have in those situations, you always want to be in the top position. You only want to be in the bottom position with partners that you know are free of infection or where you're using appropriate protection condoms.

These are things that I was ever actually raised talking about, so they weren't part of my normal language, but being able to actually understand these concepts, these are the things that many of our patients are talking about, are facing in their lives. And being able to understand that and talk about that is just as important as being able to talk about, you know, how to appropriately finger stick yourself to check your blood sugar if you have diabetes or understanding the complications that can happen when you're injecting yourself with insulin and being able to coach a patient through those. These topics are just important.

Discuss sexual practices for your patients and **offer regular STI screening if it's indicated for them** in their practices.

And then getting back to people who are at risk of pregnancy. We know **that stimulant use increases the risk of unplanned pregnancy**, and that's a variety of reasons. For one, it lowers inhibitions, you know, and, therefore, leads to more risky sexual practices in many people Also. if you have somebody who has a use disorder, it puts someone in a position where they may be at the mercy of somebody in their lives who is expecting sex in exchange for a place to sleep at night, drugs, or protection. So, they just are at an increased risk of pregnancy. You really want to talk with those women about what their desires around pregnancy are. **I did not say demand that they take birth control because we don't really have the right to make those decisions for other people**, number one, and number two, from a practical standpoint, we don't get anywhere when we're trying to impose our viewpoints on somebody else instead of actually engaging them around their desires.

For women who are not wanting pregnancy, it's important to encourage **LARCs**, help them connect with long-acting reversible contraception, get an IUD in, get an implant in, get injectables in if that's something that they're interested in doing, as well as educating them about **morning-after treatments** and helping to reduce barriers to accessing those for patients who are not wanting pregnancy.

For those patients who think they do want to be pregnant or undecided about what they would want if a possible pregnancy were to occur, you do want to talk to them about **treatment programs for stimulant use disorder in your area**. You do want to talk to them about the fact that every bit that they reduce stimulant use during pregnancy does help improve outcomes for their baby. So, even if they're not able to quit entirely, if they're willing to talk about cutting back, that can still be beneficial, and have a plan in place so you know what to do to assist this patient if an unplanned pregnancy does occur. Don't leave it or don't wait to figure

out what you're going to do until the pregnancy happens. Talk about it, think about it with a patient. Have a plan in place for what those steps would be if a pregnancy does occur.

Summary:

(20:57) In summary, you know how to take care of patients with chronic diseases. These are the same skills that we use to take care of somebody with complicated diabetes or congestive heart failure, to take care of somebody with resistant depression. We need compassion. We need enough knowledge to be able to understand the issues our patients are facing, and we need to collaborate to develop a treatment plan using the patient's goals that helps improve their quality of life and mitigates the complications associated with their chronic disease.

Thank you so much for spending this time with me today. I hope it's been helpful, and we'll see you again. Bye.