STIMULANT TREATMENT AND RECOVERY TEAM

CLINICAL GUIDELINES

A COLLABORATIVE CARE APPROACH

START

Stimulant Treatment and Recovery Team

TABLE OF CONTENTS

ACKNOWLEDGMENTS 3

INTRODUCTION TO THE STIMULANT TREATMENT AND RECOVERY TEAM (START) PROGRAM MODEL 4

PURPOSE **4**
TARGET AUDIENCE **4**
SCOPE **4**
INTRODUCTION TO START **4**

PROGRAM STRUCTURE: CLINICAL SPACE & CARE TEAM ESSENTIALS 6

CLINICAL SPACE **6**
NECESSARY COMPONENTS 6
ADDITIONAL SPACE CONSIDERATIONS 7
CARE TEAM COMPONENTS **7**
CLINICAL STAFF 7
NON-CLINICAL STAFF 12

START TREATMENT COMPONENTS 14

STRENGTH-BASED RECOVERY FRAMEWORK **14**
UNIVERSAL TRAUMA PRECAUTIONS **14**
OVERVIEW OF CONTINGENCY MANAGEMENT STRUCTURE **14**
PHASE 1: MONETARY REWARDS 15
PHASE 2: FISH BOWL 16
PHASE 3: MONETARY REWARDS 16
SUBSEQUENT PHASES 17
TRACKING CONTINGENCY MANAGEMENT 17
EXERCISE AS TREATMENT **17**
ENGAGEMENT **18**
TYPES OF ENGAGEMENT 19

MEDICATION CONSIDERATIONS 21

MEDICATIONS FOR COCAINE USE DISORDER **21**
MEDICATIONS FOR METHAMPHETAMINE USE DISORDER **21**
MEDICATIONS FOR OVERAMPING **22**
MEDICATIONS FOR SUPPLY CONTAMINATION **22**

SPECIAL POPULATIONS 23

CULTURALLY RESPONSIVE CARE **23**
ENGAGING BLACK, INDIGENOUS, AND PEOPLE OF COLOR (BIPOC) COMMUNITIES 23
ENGAGING GENDER AND SEXUALITY DIVERSE (GSD) PATIENT POPULATIONS 24

OVERAMPING AND HARM REDUCTION CONSIDERATIONS 26

OVERAMPING/DE-ESCALATION **26**
PREVENTION 26
INITIAL MANAGEMENT 26
NON-PHARMACOLOGIC INTERVENTIONS 27
PHARMACOTHERAPY MANAGEMENT 28
POLYSUBSTANCE USE **29**
ALCOHOL 29
OPIOIDS 29
OTHER CENTRAL NERVOUS SYSTEM DEPRESSANTS 29
CHEMSEX **30**
SCREENING 30
PATTERNS OF USE 30
HEALTH EFFECTS OF CHEMSEX 31
ADDITIONAL CHEMSEX CONSIDERATIONS 31
SEXUAL ASSAULT AND VIOLENCE 32
HARM REDUCTION **32**
LOWERING THE BARRIERS TO ENGAGEMENT 32
SAFER USE 33

REFERENCES 35

APPENDIX I: ADDITIONAL TRAINING RESOURCES 43

APPENDIX II: EXAMPLE CONTINGENCY MANAGEMENT TRACKER 45

APPENDIX III: CARE ROAD MAP 46

APPENDIX IV: GROUP DOCUMENTATION 49

APPENDIX V: MEDICATIONS FOR COCAINE USE DISORDER, TOPIRAMATE 50

APPENDIX VI: MEDICATIONS FOR METHAMPHETAMINE USE DISORDER 52

APPENDIX VII: OVERAMPING RESPONSE, MEDICAL PROTOCOL, AND PROVIDER HANDOUTS 54

APPENDIX VIII: NURSING NOTES 71

APPENDIX IX: ADDITIONAL HELPFUL POLICIES AND PROTOCOLS 82

ACKNOWLEDGMENTS

These clinical guidelines were prepared for Boston Medical Center by Justin Alves, MSN, FNP-BC, ACRN, CARN, CNE; Kristin Parent, LMHC; Logan Puleikis, BA; Rachel Xue, BA; Megan Hudson, RN, BSN; Meghan Brett, LICSW, CCTP, CAIMHP; Marielle Baldwin, MD, MPH; Alyssa Tilhou, MD, PhD; Sarah King McKeon, BSN, RN; Vanessa Loukas, MSN, NP-C, CARN-AP; Kristin Wason, MSN, NPC, CARN; Jennifer Miller, MA; and Colleen T. LaBelle, MSN, RN-BC, CARN. Professional editing services were provided by Shereen Sodder, MPH. This initiative was funded by the Massachusetts Department of Public Health, Bureau of Substance Addiction Services (BSAS) as part of the Boston Medical Center Grayken Center for Addiction Training and Technical Assistance.

Disclaimer

Boston Medical Center is pleased to share its Stimulant Treatment and Recovery Team clinical guidelines with other providers. Although Boston Medical Center has attempted to confirm the accuracy of the information contained in these documents, this information is not a substitute for informed medical decision making by an appropriate, licensed provider. Clinicians must confirm the appropriateness of all treatment that they provide to a patient and are responsible for the health care decisions they make when caring for patients. If clinicians believe that any information included in these guidelines should be revised or clarified, please contact Boston Medical Center at 617-414-7453.

The contents of these guidelines are solely the responsibility of the authors and do not necessarily represent the official views of BSAS or any other part of the Massachusetts Department of Public Health.

Alves, J.D.; Parent, K.; Puleikis, L.; Xue, R.; Hudson, M.; Brett, M.; Baldwin, M.; Tilhou, A.; King McKeon, S.; Loukas, V.L.; Wason, K.F.; Miller, J.; and LaBelle, C.T. Stimulant Treatment and Recovery Team Program Model: Clinical Guidelines. Unpublished treatment manual, Boston Medical Center, November 2023.

Sponsorship

This publication has been made possible by the grant support of the Massachusetts Department of Public Health Bureau of Substance Addiction Services to provide expansion of treatment with medication for addiction into community settings.

Originating Office
Boston Medical Center
Office Based Addiction Treatment
801 Massachusetts Avenue, 2nd floor
Boston, MA 02118
Colleen T LaBelle, MSN, RN-BC, CARN
Colleen.LaBelle@bmc.org

INTRODUCTION TO THE STIMULANT TREATMENT AND RECOVERY TEAM (START) PROGRAM MODEL

Purpose

The purpose of this document is to adapt the detailed guidelines of the Nurse Care Manager Model of Office Based Addiction Treatment (OBAT) for the care of people with stimulant use disorders (StUD) within the Stimulant Treatment and Recovery Team (START) Clinic at Boston Medical Center. The guideline emphasizes the necessary components and structure needed to implement a clinical program for the care of people with StUD using evidence-based treatments such as contingency management.

Target Audience

The target audience of the START Clinical Guideline is healthcare professionals, including prescribers, nurses, behavioral health providers, and other members of the interdisciplinary care team who are interested in implementing a multidisciplinary model of care to provide evidence-based treatment for people with StUD.

Scope

The START Clinical Guideline is a non-comprehensive guide to caring for individuals with StUD in the outpatient setting, offering an example of one effective model of StUD care that uses evidence-based treatments including behavioral health and pharmacotherapy. This document is meant to serve as a guide, detailing the key components of StUD care, and can be adapted to meet the needs of specific local treatment settings.

Introduction to START

A substance use disorder (SUD) is a chronic, treatable condition characterized by compulsive substance use that negatively affects an individual's life (Volkow, 2020). A rise in the prevalence of SUDs in the United States has contributed to a simultaneous increase in overdose deaths, with an estimated 107,622 Americans losing their lives to fatal drug overdoses in 2021 alone (CDC, 2022b). Overdose deaths involving psychostimulants have quadrupled from 2.1 deaths per 100,000 in 2016 to 9.6 per 100,000 in 2021 (Spencer et al., 2023). In the same time period, overdose deaths involving cocaine more than doubled, increasing from 3.5 deaths per 100,000 to 7.6 per 100,000. While addiction to prescription and synthetic opioids, particularly fentanyl, have claimed the national SUD spotlight, StUD prevalence has been progressively increasing; in fact, stimulants such as cocaine and methamphetamine are the second and third leading substances contributing to overdose fatality in the United States, respectively (Centers for Disease Control, 2022b).

Despite the many people adversely impacted by StUD for decades, few treatment programs have been developed and disseminated throughout the United States that support people whose primary substance use involves stimulants (Haffajee & Heins, 2021). Effective, evidence-based treatments exist for the care of people who use stimulants, yet there is a dearth of existing programs that utilize these interventions and support affected populations. For example, contingency management (CM) is an evidence-based behavioral health intervention leveraging positive reinforcement to support recovery goals for StUD, yet federal and state restrictions on the maximum amount of monetary reinforcements a person may receive per year limit CM's use

(Glass et al., 2020). Such regulatory barriers have slowed the development of CM-based StUD treatment programs and contributed to a treatment void.

In 2021, Boston Medical Center developed the Stimulant Treatment and Recovery Team (START), a pilot program that integrates multiple evidence-based interventions for StUD. At its core, START uses an adapted version of the nationally recognized Nurse Care Manager Model of OBAT to implement CM as part of a multidisciplinary approach to the care and management of patients with StUD (Alford et al., 2011). The START clinic uses evidence-based CM behavioral interventions to promote engagement in medical care, physical activity/exercise, and a reduction in stimulant use. The START Clinic also employs harm reduction strategies to promote the health and wellness of patients at various stages of substance use and recovery, acknowledging the importance of strength-based approaches to personal recovery. While there are currently no medications approved by the U.S. Food and Drug Administration (FDA) to treat stimulant use disorder, START utilizes evidence-informed pharmacotherapies to treat symptoms of StUD (SAMHSA, 2021b).

It is important to recognize that many patients with StUD also have co-occurring substance use and psychiatric disorders. Stabilizing stimulant use is enhanced by addressing these comorbid conditions. As a result, it is critical that teams caring for individuals who use stimulants are comfortable providing or connecting patients to evidence-based treatments for co-occurring psychiatric and substance use disorders (SAMHSA, 2021b).

PROGRAM STRUCTURE: CLINICAL SPACE & CARE TEAM ESSENTIALS

Clinical Space

The clinical space for a program that serves people who use stimulants is an important treatment component and should ensure that patients who have historically been disenfranchised by the healthcare system feel safe and comfortable accessing services. The space should be welcoming, supportive, and safe to both patients and visitors. The space should ideally accommodate both the needs of individuals in recovery and those experiencing acute stimulant intoxication.

Necessary Components

Clinical space for the care of people who use stimulants should be easy to access from the community. Physical barriers to the clinical space—elevators, stairs, additional security—can create access challenges or deter patients from seeking care. Additionally, providing education about StUD, associated symptoms, and available treatment for both the healthcare team and non-clinical staff (e.g., front desk, organization security) is important in creating a welcoming and stigma-free environment that promotes patient engagement and decreases barriers to care. For routine visits, it is important to have private clinical space for members of the healthcare team to meet with patients to conduct medical assessments, exams, and lab collection.

If conducting medical or psychosocial group visits, it is important to have access to clinical space that can accommodate the number of patients expected to be in each group. See additional information on groups here.

- Group space should be open, spacious, and welcoming
- Consider the availability of technology to allow for hybrid groups
- Follow organization specific and regulatory guidelines to improve safety in the setting of COVID-19 or in consideration of other potential infection control issues.

If using non-clinical space to conduct medical or psychosocial group visits, it is important to have a plan for urine or other lab specimen collection, which may be a required component of the contingency management program or necessary to screen for sexually transmitted infections or other clinical indicators.

A cool-down space is a vital component of being able to care for patients who may be experiencing stimulant intoxication or overamping (National Harm Reduction Coalition, 2020b). See additional information about overamping here.

- Effective cool-down spaces have limited stimulation (noise, movement, and lights) (Jenner et al., 2006).
- It is helpful to have snacks and water or electrolyte drinks available to address basic hunger and thirst needs of patients who are overamping.
- It is helpful to be able to dim or turn off lights in the space or to provide sunglasses to patients who are overamping.

- Fans and other cooling devices may be helpful in maintaining a therapeutic and comfortable temperature in the room. These devices may also assist in providing "white noise" for further de-stimulation (National Harm Reduction Coalition, 2020b).
- Ideally, cool-down spaces have a place for the patient to lay down (an exam table, cot, geriatric chair, etc.) and sleep briefly. This sleeping space should be in the lowest position possible with safety rails if available to avoid falls.

Additional Space Considerations

Consider displaying signs or posters indicating that people who use substances, particularly those who use stimulants, are safe to access care in your setting. It may be helpful to build trust with historically excluded patient populations by displaying materials for patients with limited English proficiency and affinity group materials (e.g., Black Lives Matter posters or signs, PRIDE flags or pins, and/or posters/signs in Spanish/Portuguese/Creole and other languages specific to a treatment site/community) (Piggott & Cariaga-Lo, 2019; Zhu et al., 2022). See additional information about special populations here.

Care Team Components

Clinical Staff

Providers

Providers for the program are those with prescriptive authority, including physicians, psychiatrists or providers with psychiatric expertise, nurse practitioners, physician assistants, or certified nurse specialists.

Training: Providers who are working in a stimulant treatment program should be familiar with common presentations of stimulant intoxication, withdrawal, and associated medical and psychiatric co-morbidities. Providers are encouraged to either be board-eligible or board-certified in Addiction Medicine through the American Board of Preventive Medicine (ABPM) or the Addiction Nursing Certification Board (ANCB). Providers may seek additional guidance from the Grayken Center for Addiction Training and Technical Assistance, the Opioid Response Network, or through Providers Clinical Support System (PCSS) if they are looking to gain more experience in providing care to people using stimulants. See Appendix I for additional contact information and resources.

Clinical Role: Providers are responsible for establishing the diagnosis of appropriate StUD, including a classification of severity, using the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). They are also responsible for overseeing prescriptions to manage StUD and associated mood disorders. This may include medical management of complex psychiatric and medical comorbidities associated with stimulant use through longitudinal visits. Specific role expectations include:

- Managing symptoms of withdrawal and acute intoxication, including symptoms of psychosis and be comfortable with behavioral de-escalation.
- Counseling around and prescribing medications for pre-exposure prophylaxis (PrEP) for HIV and non-occupational post-exposure prophylaxis for HIV (nPEP) and treating other sexual health needs including treatment and management of STIs. See more here.

- Caring for gender and sexuality diverse patients. See more here.
- Utilizing motivational interviewing techniques, specifically with regard to employing harm reduction strategies for safer use of stimulants and other substances.
- Identifying medical limitations and contraindications that impact safe physical activity/exercise and recommend specific exercise programs to fit a patient's medical presentation. More information on this can be found in the Exercise as Treatment section
- Facilitating or co-facilitating medical group visits in combination with nursing, behavioral health, or non-clinical staff (e.g., peer recovery specialist, patient navigator). See more on group visits here.

START Nurse Care Managers

Nurse care managers (NCM) are registered nurses who must, at a minimum, have passed the National Council Licensure Examination for registered nurses (NCLEX-RN©) and hold an active license in the state in which they are practicing.

Training: NCMs should complete a training curriculum that encompasses the care of patients in an office-based addiction treatment (OBAT) program as well as a comprehensive education curriculum regarding the care of people with stimulants. Ideally, NCMs will have achieved or be working toward certification in addiction nursing (Certified Addiction Registered Nurse [CARN] ©), offered through ANCB (www.ancbonline.org). To be eligible to sit for the certification examination, candidates must meet the following requirements:

- Provide evidence of a current, full, unrestricted license as a registered nurse (RN) in the United States, its territories, or Canada;
- Complete documentation verifying a minimum of 2,000 hours within the last three years of current nursing experience related to addictions as an RN in an administrative, teaching, private practice, consultation, counseling, or research capacity; and
- Acquire a total of 30 hours of continuing education related to addictions nursing within three years of application submission.

Other relevant training topics include:

- Medications for addiction treatment including buprenorphine, methadone, naltrexone, acamprosate, disulfiram, and the evidence-informed medications to treat StUD. See more here.
- De-escalation of patients who are experiencing overamping or acute stimulant intoxication, and management strategies for patients with acute/persistent psychotic symptoms. See more here.
- Co-morbid medical conditions of patients who use stimulants, specifically HIV; Hepatitis A, B, and C; tuberculosis; sexually transmitted infections; congestive heart failure; and acute coronary syndromes.
- Co-occurring psychiatric conditions. including persistent psychosis, anhedonia, depression, anxiety and panic disorders, and ADHD.
- Discussing chemsex with patients and strategies for engaging in sober sex and safer sexual practices. See more here.
- Harm reduction strategies for safer use of stimulants. See more here.

Nurse Care Managers working in the START clinic setting should have access to ongoing training to maintain skills and receive updated guidance related to treatment for SUDs (motivational interviewing, engagement in care, harm reduction, recurrent use, urine toxicology screening and interpretation, treatment and prevention). They may seek additional guidance on the care of people using stimulants from the Grayken Center for Addiction Training and Technical Assistance, the Opioid Response Network, and the Harm Reduction Coalition. See Appendix I for additional contact information and resources.

Clinical Role: Nurse Care Managers are responsible for providing patient-centered and trauma-responsive care within the nursing license scope of practice. This includes: initial patient assessment; intake and engagement; medication initiation; CM initiation and management; and the stabilization, retention, and maintenance phases of treatment. NCMs are responsible for collaborating with other clinical and non-clinical staff to coordinate care and ensure appropriate engagement with team members, including communicating with clinical staff about patients and attending scheduled appointments. Other duties include:

- Facilitating or co-facilitating medical or behavioral health groups to promote recovery support networks and increase access to clinical care. Facilitating medical groups in particular involves teaching a short educational session and seeking input and dialogue from the group to further health literacy and educational knowledge.
- Triaging medical conditions and implementing preventive care measures including routine screenings and vaccinations.
- Assisting with prescription processing and refills via coordination between providers and the pharmacy.
- Assisting the administrative coordinator with the verification and processing of CM rewards.
- Completing appropriate documentation in medical records in a timely and efficient manner.
- Administering medications as necessary to manage urgent/ongoing clinical issues including, but not limited to: antibiotics for STIs, benzodiazepines/antipsychotics for agitation/overamping, or injectable buprenorphine/naltrexone for management of SUD per clinic protocol.
- Maintaining confidentiality and obtaining appropriate releases of information.
- Collaborating with and engaging other primary care providers and medical and psychiatric care teams (e.g., inpatient healthcare teams, skilled nursing facilities, residential treatment programs).

<u>Behavioral Health Providers</u>

Behavioral health (BH) providers are a vital component in the care of people with StUD. particularly with regard to providing individual and group BH therapy for START patients. Behavioral health providers may vary greatly in their licensure, scope of practice, and experience in caring for people who use stimulants. Clinical supervision for newer BH providers with an experienced BH provider may be beneficial, particularly if the person providing supervision has experience managing the complex care of persons with StUD.

Training: Behavioral health providers should defer to their state licensing board for specific guidance on maintaining their license in good standing. In relation to the START clinic, BH

providers should complete a training curriculum that encompasses the care of patients in an OBAT as well as a comprehensive education curriculum regarding the care of people with StUD. Specific training topics include:

- De-escalation of patients who are experiencing overamping or acute stimulant intoxication, and management strategies for patients with acute/persistent psychotic symptoms. See more here.
- Using strength-based recovery principles and universal trauma precautions in the care of people who use stimulants
- For behavioral health providers working with patients who engage in chemsex, providing guidance on engaging in sober sex and training in the care of gender and sexuality diverse patients. See more here.

Additional training for BH providers may be found through the Addiction Technology Transfer Centers. A full list of training partners and contact information can be found in Appendix I.

Clinical Role: Behavioral health providers are responsible for guiding and engaging patients in behavioral health treatments. These treatments may include: cognitive behavioral therapy (CBT), dialectical behavioral therapy (DBT), trauma-informed counseling, and other pertinent therapeutic strategies. Behavioral health providers may engage patients in individual or group psychotherapy to develop insight into triggers for use, address recurrent use, discuss safe and effective coping strategies, and build the patient's sober social support network.

Counseling techniques or therapies should be strength-based and trauma-informed, which may include CBT, DBT, mindfulness, motivational interviewing (MI), eye-movement desensitization and reprocessing (EMDR), and CM. Behavioral health providers should be able to provide pscyho-education on increased mental health symptoms during the course of stimulant use and withdrawal.

Medical Assistants

Medical assistants are allied health professionals who support the work of nurses and providers. They may perform routine clinical duties (e.g., rooming patients, taking vitals, completing screening tools with patients, and collecting ordered lab specimens) under the direct supervision of licensed healthcare professionals or the organization that employs them (Taché & Chapman, 2005). Medical assistants may assist patients and providers prior to individual appointments or during group medical or behavioral health visits.

Training: Like all clinical staff, medical assistants should have a basic understanding of addiction—specifically StUD—and how to provide trauma-informed clinical care. They should receive training in de-escalation strategies for patients experiencing overamping and responding to opioid overdoses and other life-threatening situations. Medical assistants should follow their institutional guidelines regarding continuing education and ongoing training to maintain competencies in carrying out routine medical assistant duties.

Clinical Role: Medical assistants should actively support the clinical activities of NCMs and providers by performing routine clinical tasks including collecting and preparing laboratory specimens, obtaining and recording vital signs, rooming patients, performing EKGs, documenting care in the electronic medical record, and collecting verification of CM activities.

They should also assist in managing presentations of patients experiencing overamping at the discretion of the clinical staff. Additionally, medical assistants may perform routine administrative tasks such as greeting patients, scheduling appointments, filing medical charts, scribing during clinical rounds, and others. In some practices, medical assistants may also provide overdose education, conduct phone screenings, and coordinate with the pharmacy. They may also help to obtain and monitor documentation of releases of information specific to 42 CFR.

Peers and Other Recovery Support Specialists

Persons with lived experience in addiction who are in stable recovery are considered peers. Not all recovery support specialists are peers, but all should have an understanding of the best approaches to connect with people in various stages of recovery (Bassuk et al., 2016). Importantly, while there may be similarities in recovery experiences from different substances, it may be helpful to work with recovery support specialists who specifically have experience in recovery from stimulants.

Licensure and certification for recovery support specialists varies by state, and the Substance Abuse and Mental Health Services Administration (SAMHSA) has a list of core competencies for recovery support providers (SAMSHA, 2022a). There are national certifications offered for peer recovery support specialists, but typically they must obtain state certification and meet certain training requirements to be able to provide services (SAMSHA, 2022b).

Training: Like all clinical staff, peers and other recovery support specialists should complete training in the basic understanding of addiction and specifically stimulants. They should also receive training in de-escalation strategies for patients experiencing overamping. In addition, recovery support specialists should be able to provide harm reduction support for patients who continue to engage in active substance use. There are three main types of certification that may be obtained by recovery coaches: Recovery Coach Professional (RCP), Certified Corporate Recovery Coach (CCRC), and Certified Professional Recovery Coach (CPRC) (SAMSHA, 2022b).

Clinical Role: Meeting patients where they are in the various stages of recovery and walking with them through their recovery journey is the crux of the role of the recovery support specialist. They may also assist in treatment navigation and serve as supportive patient advocates in particularly stigmatizing healthcare service settings. For example, for patients who have had negative experiences in an emergency healthcare setting, recovery support specialists can accompany patients to medical evaluations or inpatient treatment programs to avoid additional negative experiences and to broker relationships with medical providers around whom the patient may be reticent from previous traumatic experiences.

Peers and other recovery support specialists should also participate in clinical rounds and meetings, offering insight to the team regarding patients and their experiences in recovery. They should actively participate in clinical supervision with a designated supervisor to ensure that they are supported in their work and in cases of secondary trauma (SAMSHA, 2022b). Refer to the SAMHSA guideline for Supervision of Peer Workers with link found in the Appendix I.

NON-CLINICAL STAFF

Case Managers

Due to the psychosocial issues that may accompany StUD, it is highly recommended to have a case manager or other care team member specifically trained to connect patients to resources that address the social determinants of health. Consider case managers with experience in housing; eviction prevention; navigation of the criminal-legal landscape; child protective services; and concrete services navigation like welfare benefits, food assistance, and vocational training. At a minimum, case managers should be familiar with core social services. Case managers should also be non-judgmental and caring members of the team.

Training: Basic training courses in addiction may be helpful so that team members have a better understanding of why patients with StUD may face many psychosocial stressors and structural barriers to care. All staff should receive training in de-escalation strategies for patients experiencing overamping. Additional training regarding access to publicly or privately funded services and how to access them if available can maximize the effectiveness of case managers in addressing the social determinants of health.

Responsibilities: Case managers may meet independently with patients—virtually, via telephone, or in person in the clinical space—to assist in determining their specific needs. Telephonic communication is best facilitated by having work cell phones that can offer protected ways to text patients or use internet-based communication technology. They may also accompany patients to a given service agency outside of the clinical space to ensure a warm hand-off. Case managers should be present and actively participate in clinical rounds, if possible, to help determine how they can most effectively support the clinic's patient panel. Other duties include:

- Assisting patients with their navigation of agencies and other benefit provider systems.
- Assisting patients with obtaining and completing forms for services, such as child, legal, and housing programs.
- Providing outreach, advocacy, and support to patients as they navigate the various levels of both clinical care and social services.

Contingency Management Coordinator

A contingency management coordinator is unique to the care of patients accessing treatment services for their StUD (see more on contingency management here). This team member ensures timely and accurate implementation of CM programming within a clinical setting. The CM coordinator should be caring, non-judgmental, and thorough in their acquisition of target behavior verifications and distribution of appropriate reinforcers. The CM coordinator should also be highly organized and diligent about documentation of CM activities. CM coordinators are responsible for helping the program adhere to appropriate federal guidelines to prevent waste, fraud, and abuse.

Training: CM coordinators should have basic training in addiction to ensure a better understanding of the complex psychosocial issues faced by many people living with StUD. This training will also support their understanding of the importance of CM practices as an evidence-based treatment for StUD. As with all staff, CM coordinators should receive training in de-escalation strategies for patients experiencing overamping.

CM Coordinators should receive extensive training on the CM tracking system utilized by your organization. Training should also include how to verify target behaviors, and how to distribute prizes. Additional training regarding how to manage difficult situations, frustrated patients, and tracking of prizes and other materials should also be provided and regularly assessed for accuracy and efficiency. An example of the START CM tracking system can be found in the Appendix II.

Responsibilities: CM coordinators are responsible for accurately verifying target behaviors from interactions with patients and through documentation review in the medical record and providing patients with the appropriate rewards for verified behaviors. They should also communicate with the patient and care team regarding any issues with the target behavior, the verification process for that behavior, or the distribution of the reward for the target behavior. Other duties include:

- Maintaining an accurate log of all verified target behaviors and distribution of rewards in a secured tracking system and the electronic medical record.
- If using prize-based contingency management, ensuring acquisition of culturally appropriate and desirable prizes in a timely manner and tracking the acquisition of the prize and its ultimate distribution to a specific patient.
- If using voucher-based contingency management, ensuring acquisition of culturally appropriate and desirable vouchers in a timely manner and tracking the acquisition of the vouchers and their ultimate distribution to the specific patient.
- Maintaining a positive attitude and being encouraging and enthusiastic about all patient rewards, regardless of their size or value.

Administrative and Non-clinical Support Staff

Administrative and non-clinical staff are imperative to the optimal function of a clinical space. Every team member, from the front desk staff to the environmental services staff, is important to the effective functioning of the stimulant treatment clinic. Ensuring that all staff are on board with the mission of the program contributes to a therapeutic space for patients. Be mindful that many staff in non-clinical roles, as well as staff in clinical roles, may be impacted by the frequent stigmatized portrayal of people who use stimulants.

Training: All staff should have basic training about the fundamentals of addiction to provide insight into factors that contribute to psychosocial problems among persons who use stimulants and how the team can address those issues. All staff should also receive training in de-escalation strategies for patients experiencing overamping.

Responsibilities: Administrative and non-clinical support staff support clinical operations by scheduling appointments; checking in patients; printing visit instructions or summaries; and maintaining the safe, clean, and healthy working environment. These front-line staff can be pivotal in initiating protocols to rapidly access clinical staff to manage patients who may present or call with evidence of intoxication, overamping, or safety concerns. It is important to consistently have someone available to answer phone calls to ensure that patients are able to reach a person rather than an answering machine. This prevents patient frustration and helps them feel valued by the team, which is especially important for patients who are already distrustful of healthcare systems.

START TREATMENT COMPONENTS

Like treatment for all SUDs, StUD treatment requires a multipronged approach. Though all of the components described in this clinical guideline may not be available to an individual practice provider, it is possible to utilize some components of the protocol to provide treatment to patients. A combination of behavioral health and medication interventions, as well as social support network building, are all vital components of StUD treatment. All of the treatment components in this guideline have two overarching themes: utilizing strength-based recovery as a framework and emphasizing the importance of universal trauma precautions in all facets of clinical work.

Strength-Based Recovery Framework

A strength-based recovery framework emphasizes the resiliency of patients with SUD and focuses on empowerment rather than punishment (McGuire et al., 2018). Such a framework also promotes long-term recovery through the development of recovery capital, an evolving concept that focuses on domains that make ongoing recovery possible (Best & Hennessy, 2022). These domains may include increased quality of life, increased self-esteem, positive social networks, and engagement with community groups and resources. Strength-based recovery frameworks recognize the chronicity of SUD, the natural trajectory of relapse and recovery, and the importance of ongoing treatment despite continued use (Gumbley, 2016). As such, returns and re-engagements in treatment are celebrated.

Universal Trauma Precautions

Given the nature of chaotic substance use, it is common for patients with SUD to have experienced trauma while using substances (Armenian et al., 2019; Ruglass et al., 2014). Additionally, adverse childhood experiences are correlated with the development and severity of substance use disorders (Tang et al., 2021). As such, some universal trauma precautions should be taken, including:

- Ensuring that all staff are prepared for patients who may experience emotional responses due to previous traumatic experiences in the past.
- Proactively making resources available for patients experiencing the residual effects of trauma so they do not need to disclose traumatic experiences to receive trauma-related support (Owens et al., 2022).
- Recognizing that many patients who use stimulants have a history of traumatic experiences within healthcare and carceral systems, including being restrained (chemically and physically), denied care, or treated poorly by staff with stigma against people who use stimulants (O'Brien et al., 2019).

Overview of Contingency Management Structure

Contingency management is an evidence-based treatment for StUD (SAMHSA, 2021b). CM employs the basic principles of behavioral analysis to change neurobiological responses to stimuli, ultimately changing behavior through the use of motivational reinforcers. While the research supporting abstinence-based CM programs indicates the need for high frequency and increasing magnitude of reinforcers to elicit lasting behavior change, federal restrictions on motivational reinforcer amounts limit START from providing an evidence-based level of CM. It is important to note that START uses a limited number of motivational reinforcers in the spirit of

CM to promote the other major components of treatment, which include engagement with treatment providers, exercise, and urine drug screens that are negative for non-prescribed stimulants.

PHASE 1: MONETARY REWARDS

During Phase 1, accrued points will be given to patients via gift cards or ClinCards of the same value for achieving the targeted behaviors listed below (i.e., 10 points = $10 gift card). ClinCards are re-loadable debit cards that can be provided to patients. Some agencies will choose to use other forms of gift cards. It is important that these can be tracked and easily provided to patients with additional funds for additional point accruals in real time.

Patients may earn up to $75 before they transition into Phase 2. The length of Phase 1 depends on the number of points patients earn, with patients spending a minimum of four weeks in Phase 1. Below is an example strategy of how the BMC START clinic utilizes motivational incentives in the spirit of CM given current government restrictions:

Targeted Behavior	Verification	Incentive
Initial engagement in treatment	Completes RN and administrative intakes	15 points

Targeted Behavior	Verification of Completion	Incentive per Week
Engagement in meaningful physical activity at least once per week	Can include: attendance at sober gym class (e.g., Phoenix Gym); photographic proof of attendance at another athletic facility; or completion of other physical activity (physical therapy, home exercise, individual exercise tracker (Fit Bit), etc.)	5 points
Engagement in weekly check-ins with nurse or other care provider or via group session	Attendance recorded by RN or group provider	5 points
Abstinence from stimulant substances	Urine toxicology screen negative for non-prescribed stimulant substances	5 points

PHASE 2: FISH BOWL

After earning 75 points in successful voucher-based CM, patients continue to accrue points. If permissible with non-government funds, programs could consider a fish bowl method of CM. In this method, patients would have one opportunity to win patient supplies that are used as a motivational incentive for every 25 points they earn. Patient supplies may range in monetary value but should abide by regulations related to both anti-kickback statutes and the restrictions of the private funder (Office of the Inspector General, 2021). An example of how this phase of treatment could look is provided below:

Targeted Behavior	Verification of Completion	Incentive per Week
Engagement in meaningful physical activity at least once per week	Can include: attendance at a sober gym class (e.g., Phoenix Gym); photographic proof of attendance at another athletic facility; or completion of other physical activity (physical therapy, home exercise, etc.)	5 points
Engagement in weekly check-ins with nurse or via group session	Attendance recorded by RN or group provider	5 points
Abstinence from stimulant substances	Urine toxicology screen negative for stimulant substances.	5 points

PHASE 3: MONETARY REWARDS

Patients are eligible to receive monetary reinforcers up to $75 once one year has passed since their enrollment date, in accordance with anti-kickback statues and funder limitations. A patient does not need to be continuously enrolled in the program for this entire period; entering Phase 3 is not contingent on point values but solely on abiding by federal regulations and funder guidelines. This is not an evidence-based strategy for CM but rather what is currently permissible with federal statutes. Some states may have different laws allowing evidence-based magnitude of CM; in those cases, we highly encourage using an evidence-based magnitude level for best efficacy. If CM is being funded by private foundations, the limiting factors related to magnitude and frequency of CM are bound by the regulations put forth by the funder.

As in Phase 1, accrued points will be given to patients via gift cards or ClinCards of the same value (i.e., 10 points = $10 gift card). See the table below for an example of motivational reinforcers in Phase 3.

Targeted Behavior	Verification of Completion	Incentive per Week
Engagement in meaningful physical activity at least once per week	Can include: attendance at a sober gym class (e.g., Phoenix Gym); photographic proof of attendance at another athletic facility; or completion of other physical activity (physical therapy, home exercise, etc.)	5 points
Engagement in weekly check-ins with nurse or via group session	Attendance recorded by RN or group provider	5 points
Abstinence from stimulant substances	Urine toxicology screen negative for stimulant substances	5 points

Subsequent Phases

Additional phases can be added to the above schema depending on how much time has passed since the patient's initial enrollment date. To maximize the efficacy of CM provided, utilizing voucher-based CM in subsequent phases is prioritized when available.

Tracking Contingency Management

Accurate, precise, and timely recording of CM is crucial to ensure disbursement of reinforcers and documentation for auditing and credentialing purposes. The Contingency Management Tracker (Appendix II) is a Microsoft Excel-based application created to help programs record the points accrued, weeks of CM, phase, and other pertinent information. It is imperative in tracking CM to have established self-auditing processes to avoid waste, fraud, and abuse. All systems should be audited regularly. In the START model of care, CM is audited monthly by a program manager who is not part of the CM management and data tracking team. Additional information can be found in the CM Supplement also located on our website.

Exercise as Treatment

There is a growing body of evidence regarding the effectiveness of physical exercise in improving longitudinal outcomes for patients with StUD (Huang et al., 2020; Killeen et al., 2020; Li et al., 2022; Liu & Wang, 2021; Marrero-Cristobal et al., 2022; Ruglass et al., 2014). This research suggests that regular aerobic and anaerobic exercise can improve longitudinal recovery responses and improve secondary symptoms, including anhedonia/depression and stimulant cravings. For this reason, exercise is one of the pillars of treatment used in the START clinic model to promote long-term recovery for StUD patients.

In addition to its potential benefits for StUD outcomes, exercise may also be used as a way to build community. Many cities have established recovery exercise groups or sober gyms (see here for one such organization). Forming relationships with these groups may be helpful for connecting patients to exercise opportunities and obtaining verification of exercise.

Patients with StUD may have multiple medical comorbidities including cardiovascular disease, pulmonary disease, movement disorders, and other conditions that affect their ability to participate in regular exercise. Exercise plans should be discussed with patients during their initial visit with clinical staff, ideally either the nurse or the provider. Clinicians should educate patients about the importance of exercise for longitudinal recovery from StUD.

Levels of Exercise: Three levels of exercise programs have been developed in collaboration with physical therapy colleagues at the START clinic for patients to complete exercises at home:

- **Low intensity** exercise program offers chair-based exercises that can be completed by all patients, including patients with significant functional and ambulatory limitations.
- **Moderate intensity** exercise program offers exercises that be completed at home by patients with minor/moderate medical comorbidities and those with minor or no functional limitations.
- **High intensity** exercise program offers more vigorous resistance-based exercises for patients without significant medical comorbidities or functional limitations.

Patients may transition from one exercise program to another depending on their level of medical acuity and comorbidity. Examples of exercise programming can be found here.

Verifying Exercise: The START clinical program encourages exercise through the use of CM, which is both a powerful reinforcer for abstinence and, potentially, for engaging in regular physical activity (Alessi et al., 2020). For CM to be effective in this setting, it is important to establish and monitor how the START team will be able to verify completion of exercise multiple times a week. Establishing strategies for exercise verification during the initial visit with a patient may be important; these may include self-recorded videos, confirmation by gym or physical therapy staff, or the use of pedometers or phone- or web-based applications that track physical activity.

Creative Exercise Solutions: Allow for patients to engage in creative forms of robust physical activity including dance classes, provider-led physical activity (physical therapy, cardiac rehab), walking a pet, and labor-intensive jobs (Zhou et al., 2021). For example, counting steps and equating them to robust physical activity may be one of the most accessible forms of physical activity for patients (del Pozo Cruz et al., 2022).

Engagement

Treatment engagement may vary based upon several patient-specific factors. Engagement in treatment should consider the patient's current level of substance use; amount of recovery time; social support; other roles and responsibilities; and, ultimately, patient preference. Ideally, patients are seen more frequently in early stages of recovery and active use. This concept is further outlined within the Care Road Map (Appendix III).

TYPES OF ENGAGEMENT

Nurse Visits

Nurse visits may occur in person or via telemedicine, with visit frequency determined at the discretion of the NCM with input from the clinical team; these visits may be more frequent than provider or group visits for patients. Initial nurse visit frequency may vary from multiple times per week to every other week.

Nurse visits should be documented in the electronic medical record, and documentation of targeted CM behaviors should include details verifying CM targets. These visits may be more frequent for patients with active use than that they are for those in long-term recovery, but they remain important regardless of recovery stage to manage the critical components of maintaining long-term recovery. Depending on a patient's current presentation (less stable vs. stable), nursing visits may range in time for 15 to 60 minutes or longer.

Group Visits

Group visits may be an integral part of treating patients with StUD and provide patients with education and social supports specific to stimulant use. They can have a medical or behavioral health focus. Three curricula exist for group visits in the START clinic:

- 12 Week Behavioral Health Groups
- 12 Week Medical Groups
- 12 Week Art Groups

See here for these group curricula.

Group visits may be facilitated by nursing, behavioral health, or provider staff. Visits are traditionally 45-50 minutes in length, though this will vary based on therapeutic modality and space/time constraints of staff and setting. Participants should help create an established set of rules and boundaries for all patients engaging in group treatment. See group curricula linked above for an example of patient-directed rules and boundaries for BMC START's behavioral health group. Visits should be documented in the EMR, and each patient should have an individual assessment and note for the group visit. The documentation will vary based on the type of provider running the group and their billing requirements. See Appendix IV for an example of group documentation.

Other considerations for group visits include:

- Make provider or nursing support available during behavioral health and non-medical led group sessions if patients have acute medical needs that require more intensive follow-up.
- If possible, create opportunities to celebrate recovery during group. For example, this celebration may involve announcing the group's cumulative CM points at the end of each session.
- Consider whether a given patient may be appropriate for a particular group setting and provide low-barrier alternatives (see Appendix III for examples).
- Affinity groups may be another valuable way to create safe spaces for specific populations who use stimulants.

Provider Visits

Visits with medical providers focus on medical and/or pharmacological interventions for recovery, motivational interviewing around behavior change, use prevention, and harm reduction techniques for patients with active use and sexualized drug use. Provider visits should also identify and manage comorbid health conditions associated with acute and chronic stimulant use, including: cardiovascular (MI, CAD, CVA, aneurysm/dissection, CHF); pulmonary; hepatic (cirrhosis); renal (CKD, ESRD); neurologic (memory impairment, parkinsonism); psychiatric (psychosis); and infectious complications (skin, soft tissue and deep tissue infections, HIV/AIDS, syphilis, HCV, HBV, STIs). Providers should additionally screen for secondary health conditions related to stimulant use and employ strategies for their prevention.

Collaboration with the patient's primary care provider, if different from their START provider, is critical in maximizing patient health outcomes. Given the nature of StUD, patients may have been without medical care for a significant period of time before START engagement, falling behind on routine preventive health care and developing more advanced presentations of chronic health conditions. Providers and nursing teams should work collaboratively to ensure patients are brought up to date with vaccinations, cancer screenings, oral healthcare, and other health maintenance goals**.** Provider visits should be documented in the EMR and billed appropriately through traditional billing codes.

Behavioral Health Visits

Visits with BH providers may occur individually or in a group setting. Ideally, BH providers should have experience in caring for patients with StUD and topics related to StUD, including chemsex, sexual assault, and trauma. BH visits should be strength-based and should provide basic containment/coping skill building. These visits may be conducted by a variety of behavioral health professionals, including LICSW, LCSW, PsyD, PhD, LMHC, etc. Visits may range in time from 30-60 minutes and may be in-person or telephonic/virtual. Behavioral health visits should be documented in the EMR, so that they are recorded as "care engagement" for patients seeking CM points.

MEDICATION CONSIDERATIONS

There are currently no FDA-approved medications for the treatment of StUD (SAMHSA, 2021b). However, there are pharmacotherapy options with a growing evidence base to support their use in StUD treatment. **The information provided in this section is an example of how evidence informs prescribing practices used in the START Clinic for patients with StUD.** It is important to note that the medication regimens should be assessed by an individual provider for appropriateness in each patient based on symptomatology, risk, and comorbid medical conditions.

Given the significant differences in neurobiology between cocaine and methamphetamines, it is important to not assume that medications that have shown evidence of efficacy for cocaine use disorder are effective for methamphetamine use disorder, and vice versa.

Medications for Cocaine Use Disorder

When considering pharmacologic treatment of cocaine use disorder, providers must also be able to assess the patient for co-occurring attention-deficit/hyperactivity disorder (ADHD). For patients **without** co-occurring ADHD, existing research supports the use of topiramate (Johnson et al., 2013). Topiramate should not be discontinued abruptly, particularly if patient has a history of seizures or epilepsy. The use of topiramate is contraindicated in people who are pregnant or trying to conceive because it is teratogenic and can lead to oral clefts. Special consideration should be given to the use of contraception in this population (Veroniki et al., 2017). Topiramate may worsen memory, so caution is advised in using this medication for patients with advanced age, cognitive dysfunction, or brain injuries. Additionally, topiramate can cause weight loss, so caution is advised in patients with eating disorders and low body mass index. Topiramate should be renally dosed in patients with CKD and CrCl less than 70 mL/min.

For patients with cocaine use disorder **and co-occurring ADHD**, the combination of topiramate and extended-released mixed amphetamine salts may be an appropriate regimen (Levin et al., 2015, 2020). Mixed amphetamine salts should be used cautiously in patients with significant cardiovascular risk factors. Additional information regarding initiation, titration, and monitoring considerations for using medications in the treatment of cocaine use disorder can found in Appendix V.

Medications for Methamphetamine Use Disorder

The most important patient-specific factor that should guide medication selection for people with methamphetamine disorder is whether or not the person also has a co-occurring opioid use disorder (OUD). For patients **without** co-occurring OUD, the preferential combination for treatment of methamphetamine use disorder is injectable naltrexone every 21 days and oral bupropion (Trivedi et al., 2021).

For patients **with** co-occurring OUD, FDA-approved opioid agonist treatment (e.g., methadone or buprenorphine) is indicated to prevent overdose death. Bupropion alone can still be offered without naltrexone for methamphetamine use disorder in people on medication for opioid use disorder (MOUD), but in this case mirtazapine is another option with evidence for reducing methamphetamine use (Naji et al., 2022). Bupropion is contraindicated in patients with seizure disorders, and, at high doses, should be used with caution in patients with severe anxiety or panic

disorders. Additional information regarding initiation, titration, and monitoring considerations for using medications in the treatment of methamphetamine use disorder can be found in Appendix VI.

Medications for Overamping

Overamping is the common term used to describe a psychostimulant overdose (Harding et al., 2022). It is possible for patients experiencing overamping to present to the clinical setting while acutely impaired (Gicas et al., 2022).

Behavioral health interventions, described in the overamping section of this guideline, are the mainstay of treatment for overamping. However, when behavioral interventions alone do not control symptoms, medications may be useful if allowed based on organization-specific policies and associated licensing. The first-line medications used to treat the psychiatric symptoms associated with overamping are benzodiazepines, and the second-line option is to use antipsychotics (Braunwarth et al., 2016). A sample protocol for recognition and response to overamping, including medication dosing strategy, can be found in Appendix VII.

In the event that the patient is having profound physiologic dysfunction secondary to overamping, refer this patient to emergency medical services for a more comprehensive evaluation and treatment plan.

Medications for Supply Contamination

The stimulant drug supply in the United States is increasingly contaminated with fentanyl (CDC, 2023a). As such, every patient who uses illicit or illicitly obtained substances should be provided with naloxone (SAMHSA, 2018a).These patients should also be educated on appropriate opioid overdose response, including how to use naloxone, the recovery position, and the importance of rescue breaths. In addition, some patients who use stimulants with evidence of fentanyl contamination in their urine may be appropriate candidates for opioid antagonist therapy with naltrexone or opioid agonist therapy with buprenorphine-naloxone or methadone. Evidence in this area is limited, but the BMC START clinic observes the risk-benefit balance to be in favor of providing this life-saving treatment for patients at high risk of fentanyl overdose. Providing fentanyl test strips is another sensible harm reduction technique for patients experiencing or at risk of experiencing fentanyl contamination and subsequent overdose (Goldman et al., 2019). For more information about harm reduction, see additional information here.

Other contaminating agents commonly found in the stimulant supply are levamisole, baking soda, and, occasionally, xylazine (Solomon & Hayes, 2017). Though no data exist yet regarding strategies for management of these types of contamination, providers should be prepared to educate patients about these potential risks and strategies to maintain safety while ongoing use occurs. Awareness about the possible vascular effects of levamisole contamination and the sedative and dermatologic manifestations of xylazine contamination should be part of basic training for START staff so they can offer education and prevention information to patients.

SPECIAL POPULATIONS

Culturally Responsive Care

It is important that staff in a culturally responsive treatment program represent the communities that they serve. Consideration of race, ethnicity, gender, sexual orientation, and other important cultural identities should be included when staffing clinics that are designed to serve minoritized communities.

Engaging Black, Indigenous, and People of Color (BIPOC) Communities

Epidemiological data from various sources have demonstrated the disproportionate number of Black and Indigenous People of Color (BIPOC) who have been affected by StUD (Kariisa et al., 2021). In creating a StUD treatment program, it is imperative to create safe and equitable spaces for BIPOC patients to engage. Active outreach and recruitment to BIPOC communities is an important component of building a program to meet the needs of minoritized patients. (SAMHSA, 2020). When creating a treatment program, consider focus groups or communication with key stakeholders among BIPOC communities to create culturally responsive strategies for engagement, treatment, and retention.

Special attention should be given to collaboration with American Indian and Alaska Native (AI/AN) communities. Outreach to understand the specific AI/AN communities in the catchment area of your program can help identify cultural liaisons who can provide vital information about local indigenous communities (SAMHSA, 2018b). Working with groups and organizations like White Bison may be a good way to begin creating a culturally responsive environment. See additional information in Appendix I.

Individualized patient-centered care is vital for patients engaging in treatment for StUD, and this begins with clinical history gathering during an intake visit. Being respectful, genuinely curious, and willing to collaborate with patients to best meet their needs will help broker relationships with patients across racial, ethnic, and cultural lines.

The intersectional nature of identities is important to many patients. Clinical data collection should specifically consider this and ask information about patients who may identify with multiple races or ethnicities. Programmatic data collection with limited response options related to race and ethnicity may not accurately represent patients (e.g., not being able to select multiple races/ethnicities, using response options that may exclude some racial identities, etc.) (Abuelezam, 2022). Providing more options for patients to select multiple racial and ethnic identities creates opportunities to better characterize and therefore represent the patient populations being served.

There are many resources available for training or technical assistance related to providing culturally responsive care:

- The Opioid Response Network provides TTA on this topic and includes a Black Communities and a Native American/Indigenous work group to address TTA needs

specific to developing culturally responsive treatment practices. https://opioidresponsenetwork.org/
- SAMHSA has a Tribal Training and Technical Assistance Center that can be contacted for additional support if building or working with a tribal community or community of AI/AN patients. https://www.samhsa.gov/tribal-ttac/tribal-training-technical-assistance
- See additional information in Appendix I

Active outreach strategies to engage local BIPOC communities include:

- Identifying key stakeholders who can provide vital information about local communities and help build trust between communities and the START program.
- Creating focus groups to examine the current practices involved in the treatment program and identify areas where improvements are needed to better serve BIPOC individuals.

Consider using the *Native American Cultural Assessment Survey* to identify opportunities to improve the cultural sensitivity of non-Native staff towards patients identifying as Native American (SAMHSA, 2018b). Additionally, use the **RESPECT** mnemonic when communicating with AI/AN patients:

- **R**espect cultural values and communication styles
- **E**xplanatory model aims to understand how patients perceive their problem.
- **S**ociocultural context recognizes how the person's sociocultural identities may affect treatment.
- **P**articipation from the patient's perspective may have a different expectation from the provider and this should be discussed early in treatment.
- **E**mpathy should be expressed verbally and nonverbally to demonstrate genuine concern for the outcomes of the patient.
- **C**oncerns and fears should be elicited from the patient so that they can be addressed in real time before and while in treatment.
- **T**herapeutic alliance/**T**rust occurs in care settings where providers can commit to behaviors that strengthen their relationships with patients and build trust. For many historically underserved communities, trust in the medical system must be earned.

Engaging Gender and Sexuality Diverse (GSD) Patient Populations

Gender and sexuality diverse (GSD) patient populations are disproportionately affected by stimulant use. In particular, men-who-have-sex-with-men (MSM) have high rates of methamphetamine use disorder (Kidd et al., 2021). As such, it is important to actively engage GSD populations to ensure those who need StUD care are able to access it. Active outreach strategies to GSD communities may include online outreach and information dissemination through geosocial networking applications. Creating safe spaces for GSD patients is imperative in engaging them in treatment for stimulants.

Appropriately collecting and protecting sexual orientation and gender identity information data is important to ensure patient-centered care in GSD populations (Suen et al., 2022). Demographic collection forms should allow for open responses, when at all possible, to accommodate the myriad of sexual orientations and gender identities that patients may hold (Suen et al., 2022).

Training and technical assistance to ensure culturally responsive care for GSD patient populations is available from:

- Opioid Response Network: Gender and Sexuality Working Group
- National LGBTQIA+ Health Education Center
- The *Joint Commission* has a Field Guide with a safety and inclusion checklist which may be helpful in evaluating your clinical space for appropriateness for the care of patients who are GSD (The Joint Commission, 2011).

Additional resources may be found in Appendix I.

OVERAMPING AND HARM REDUCTION CONSIDERATIONS

Overamping/De-escalation

Overamping refers to the constellation of physiological and psychiatric symptoms that occur in the setting of excessive stimulant use, indicating a psychostimulant overdose. Overamping may occur among patients who use methamphetamines, cocaine, or other amphetamines. Acute overamping incidents are generally related directly to the amount of stimulant the patient has been using, the potency of the stimulant, the route of use of the stimulant, how long they have been using it, and the amount of sleep that they have had in the last several days (SAMHSA, 2021b).

PREVENTION

Education to prevent overamping events is vital for the patient's safety and wellbeing. Patients should be educated on safer use strategies, including:

- Switching to a different route of use (e.g., insufflating rather than injecting)
- Limiting use/taking breaks between use events
- Maintaining adequate hydration while using
- Maintaining adequate nutrition (e.g., consumption of nutrient dense snacks while using)
- Adhering to medications for both psychiatric and non-psychiatric treatments to reduce flares of conditions that may increase risk of overamping
- Identifying safe places to go should an overamping event occur

INITIAL MANAGEMENT

Symptom Recognition

It is important to recognize the signs and symptoms of overamping. The somatic symptoms of overamping include:

- Uncontrolled hypertension
- Arrhythmias or angina
- Stroke
- Seizures
- Depressed respiration
- Loss of consciousness or altered mental status
- Diaphoresis
- Syncope

The psychological symptoms of overamping are:

- Protective behaviors (e.g., hypervigilance, anxiety, mood lability)
- Agitation
- Repetitive behavior
- Hallucinations and/or delusions
- Paranoia

Ideally, patients should be managed in the ambulatory clinical space where they know the staff members and feel safe to prevent further distress and avoid potentially escalating and unsafe situations in the emergency room. However, if patients exhibit the following signs or symptoms, emergency management is needed immediately:

- Inability to protect airway
- Hypertension that persists despite pharmacologic measures and is accompanied by emergent symptoms (chest pain, headaches, vision changes)
- Hyperthermia of over 40 °C (104°F)
- Seizures

NON-PHARMACOLOGIC INTERVENTIONS

Non-pharmacologic methods are preferred as first-line management of patients experiencing psychosis related to stimulant use. These include:

1. Utilizing the mnemonic AGRO+ to address the behavioral escalation:
    - **A**ssess what is driving the patient's agitation.
    - **G**auge your response to the patient's escalating behavior and remain calm to avoid further escalation of the patient.
    - **R**espond to the patient's source of agitation and concern with direct questions that can be easily answered verbally or non-verbally with one or two words.
    - **O**bserve that the patient can respond to the question you posed either verbally or non-verbally.
    - \+ Immediately positively reinforce the patient's engagement with you through available resources in the clinic, including snacks, a glass of water, and/or a place to sit/rest. (SAMHSA, 2021b)

2. Verbal de-escalation:
    - Actively listen to the affected patient
    - Convey empathy and acceptance
    - Create an alliance with and sense of safety for the patient

3. Using a cool down space, as previously discussed. See Appendix X for pictures of the START Clinic cool down space. Key components to reducing stimulation in the cool down space include:
    - Darkening the room
    - Speaking to the patient in quiet voice tones and in short, simple sentences
    - Decreasing outside stimuli (with white noise, face mask, ear plugs)

Do not leave a patient alone if clinical judgment indicates that they are an immediate threat to themselves or others. If possible, keep a consistent "reference person" in contact with the patient at all times, usually a staff person who can act as the main point person while the patient is experiencing the altered perception of reality. Avoid physically restraining patients, as this can

lead to an increase in agitation or development of rhabdomyolysis and hyperthermia. To maintain the safety of clinic personnel, keep escape routes open for the patient to prevent them from feeling cornered, and avoid abrupt movements that could be misinterpreted by patients with hypervigilance.

PHARMACOTHERAPY MANAGEMENT

Oral or intramuscular medications should only be administered to consenting patients. If patients do not consent to oral or intramuscular medication administration and the non-pharmacologic approaches described above are not effective in managing protective behaviors, providers should weigh the benefits and harms of escalating care to the emergency room. Permissibility regarding the administration of these pharmacological agents may vary based on organization policies and state regulations.

Pharmacotherapy is appropriate for patients with **persistent hyperactive vital signs, protective behaviors, excessive paranoia, and overt psychotic symptoms**. The goal of pharmacotherapy is to produce a calming effect that will ultimately reduce protective behaviors.

Pharmacotherapy options include:

- Benzodiazepines: oral lorazepam
    - Exercise caution with patients using stimulants in combination with central nervous system depressants such as: alcohol, gamma hydroxybutyrate (GHB) or "liquid ecstasy", opioids, and/or psilocybin due to concerns for additive respiratory depression and altered consciousness
    - Monitoring:
        - Monitor vital signs, including the degree of sedation, of patients treated with lorazepam every 30 minutes, for at least 90 minutes
        - After 90 minutes, vital signs may continue to be monitored every 60 minutes while the patient remains in the clinic
        - Monitoring for excessive sedation and respiratory depression is especially important for lorazepam-treated patients who have also been exposed to other sedatives, such as opioids or alcohol (Braunwarth et al., 2016)
- Antipsychotics: oral or intramuscular olanzapine
    - Particularly helpful for patients exhibiting protective behaviors and experiencing hallucinations or delusions
    - Antipsychotics can lower seizure threshold and may increase the risk for QT prolongation and neuroleptic malignant syndrome
    - Monitoring:
        - Monitor vital signs, including degree of sedation, every 30 minutes for at least 90 minutes
        - After 90 minutes, vital signs may continue to be monitored every 60 minutes while the patient remains in the clinic
        - Olanzapine may cause orthostatic hypotension associated with brachycardia, especially in patients with concomitant alcohol intoxication

- Where possible, and when the patient is calm and able to remain still, it is appropriate to monitor the patient's electrocardiogram (EKG) due to the risk for QT prolongation and cardiac arrhythmia (Braunwarth et al., 2016)

Polysubstance Use

Alcohol

Addressing co-occurring alcohol use disorder (AUD) should include assessment of physical dependence, history of withdrawal, and treatment goals. Patients interested in alcohol cessation can consider behavioral and pharmacologic strategies to support their goals. In patients pursuing abstinence from alcohol, it is important to assess their history of complicated withdrawal. Patients with a history of alcohol withdrawal complicated by seizures or delirium tremens, among other complications, should be advised to seek supervised detoxification if pursuing abstinence-based treatment for their AUD.

Pharmacotherapies for alcohol use disorder include naltrexone, acamprosate and disulfiram (SAMHSA, 2009). Naltrexone, which is a potent mu opioid receptor antagonist, may be particularly beneficial in the treatment of AUD when urine toxicology demonstrates evidence of opioid use, such as in the case of adulterated stimulants. See Appendix I for more information and resources on AUD treatment.

Alcohol and concurrent cocaine use presents specific challenges because of the metabolic creation of cocaethylene, which increases risk for adverse cardiovascular events more than alcohol or cocaine alone (Pergolizzi et al., 2022). Patients who use both alcohol and cocaine should be counseled about the cardiotoxic and neurotoxic risks and the increased risk of death specific to concurrent use. They should be educated on harm reduction strategies, including avoiding concurrent use when possible, to minimize their risk of adverse events.

Opioids

Patients known to take opioids and cocaine simultaneously (often referred to as a speedball) or opioids and methamphetamines simultaneously (often referred to as a goofball) are at an increased risk for fatal overdose. Patients with a concurrent OUD should be offered FDA-approved MOUD such as buprenorphine, naltrexone, or methadone with first line treatment being opioid agonist therapy (SAMHSA, 2021a).

The use of CM in combination with MOUD may produce the most effective outcomes for patients with co-occurring StUD and OUD. Caution should be exercised when considering injectable buprenorphine for patients with tactile disturbances related to stimulant use because of the risks associated with skin picking. See Appendix I for more information and resources on the treatment of OUD.

Other Central Nervous System Depressants

As described above, **benzodiazepines** may be used in the setting of overamping to minimize risk of adverse events related to stimulant intoxication. Assessing patients for benzodiazepine

dependence is important to determine if a benzodiazepine taper or inpatient withdrawal management may be necessary.

Gamma Hydroxybutyrate (GHB), also known as "liquid ecstasy," is a sedative hypnotic agent that causes smooth muscle dilatation and may be used in combination with methamphetamine in a chemsex setting. GHB poses a particular risk for overdose that similarly causes respiratory depression but does not respond to naloxone due to a different mechanism of action (Tay et al., 2022). When patients are using GHB, it is important to determine if dependence has occurred and if monitoring withdrawal from GHB is necessary. Autonomic dysfunction—particularly hypertension, tremulousness, and headache—in the setting of discontinued GHB use is a sign of dependence and would require medical monitoring and treatment (Dyer et al., 2001). No FDA approved medications exist specifically for the treatment of GHB use disorder or withdrawal

Chemsex

Chemsex is the phenomenon of using illicit substances, often stimulants, in a sexual setting, more frequently occurring in the MSM community (Giorgetti et al., 2017). Unhealthy chemsex—chemsex with negative, undesired, or unhealthy consequences—may occur with even limited exposure to or engagement in chemsex behaviors. Treatment of patients with StUD who engage in chemsex requires special considerations to achieve the best outcomes (Lyons et al., 2010). For patients engaging in chemsex, addressing sexual practices is a critical part of both promoting recovery from stimulant use and maintaining health. This is also a key part of achieving recovery from stimulants in the context of chemsex, as sex is intimately involved in the patient's relationship with substance use. Leveraging a harm reduction framework is a useful vehicle for empowering patient engagement and also is critical in maintaining patient health. Strategies such as pre-exposure prophylaxis (PrEP) for HIV and safe sex counseling and education are critical. In addition, there is some evidence for the role of mirtazapine in both reducing stimulant use and sexual HIV risk behaviors. Supporting patients in developing sexual relationships outside the setting of substance use can be an important, though sometimes challenging, part of recovery.

Screening

Asking direct questions about a person's sexualized drug use is the clearest way to identify patients engaging in chemsex. A sex-positive, HIV-neutral approach should be utilized when assessing patients who engage in chemsex. Asking indirect questions about the last time a person had sober sex may also help to reduce the stigma around disclosure of sexualized drug use. GSD patients and patients who have been diagnosed with an STI in the setting of stimulant use should be screened for chemsex behaviors (Torres et al., 2020).

Patterns of Use

It is common for patients engaging in chemsex to start with binge use of stimulants (Chahine et al., 2021). Patients engaged in weekend binge use may report a "Blue Monday," an episode of profound depression associated with the crash of not using stimulants (Flameling et al., 2022; Terrins Higgins Trust, 2018). It can be helpful to counsel patients about this pattern both as a tool to motivate reduced binging and to help patients manage post-binge symptoms.

Health Effects of Chemsex

Regardless of frequency, chemsex carries risk of negative consequences, like STIs and sexual trauma, particularly in the setting of condomless sex with new and/or unknown partners. Support of patients who engage in chemsex must attend to these particular risks in addition to the risks imposed by substance use.

HIV prevention and treatment is a core component of treatment for patients who use stimulants and engage in chemsex. An HIV neutral approach to caring for people engaging in chemsex can help to prevent HIV transmission (CDC, 2022a). HIV-neutral programs offer the same comprehensive sexual health services to people living with and at risk for acquiring HIV and do not create a hierarchy of treatment based on someone's HIV serostatus. Patients may be recommended for pre-exposure prophylaxis (PrEP), including oral and injectable formulations; non-occupational post-exposure prophylaxis (nPEP); and/or antiretroviral therapy with the goal of achieving viral suppression.

Patients who engage in chemsex should be regularly screened for sexually transmitted infections including gonorrhea, chlamydia, trichomonas, syphilis, HIV, HCV, and HBV; they should be treated for known exposures. Patients' sexual practices should guide screening. For example, oral, anal, and/or urogenital samples should be collected for chlamydia and gonorrhea screening when indicated based on sexual practices. When possible, expedited partner therapy should be made available.

Therapeutic interventions related to the phenomenon of chemsex are also vital. Patients may benefit from group and/or individual therapy to discuss triggers for use, strategies for management, and cognitive behavioral therapy to address the issues underscoring sex while using substances (Braunwarth et al., 2016).

Additional Chemsex Considerations

Identification of the primary stimulant used should drive the decision for medication management in patients who engage in chemsex. Consider the polysubstance use that may occur in the setting of chemsex with non-stimulants:

- Gamma-hydroxybutyrate (GHB):
    - Produces smooth muscle relaxation to promote anal or vaginal relaxation (Dryer et al, 2001)
    - Educate patients about the risk of GHB overdose (G-Hole)
        - A GHB overdose is characterized by profound sedation and respiratory depression.
        - It is vital to protect a person's airway and seek emergency medical attention if there are concerns for overdose
        - Patients should be educated about safer use strategies for GHB ("start low and go slow")
    - GHB use can lead to dependence and may require managed or monitored withdrawal
    - Baclofen can be used to treat longitudinal GHB use disorder (Kamal et al., 2015)
- Amyl nitrates (Poppers):

    - Commonly used intranasally and huffed for the fumes (Le et al., 2020)
    - Cause a temporary "rush" that enhances sexual experiences
    - Patients should be educated about the health risks associated with popper use, including methemoglobinemia, skin discoloration, and perinasal dermatitis (Barrangou-Poueys-Darlas et al., 2021)
    - Patients should be educated on the risk of combining poppers and medications for erectile dysfunction
        - See Appendix I for resources for patients
- Ketamine (K) (Sewell et al., 2018)
    - Educate patients about the risk of K overdose ("K-hole")
    - Educate patients on safer use strategies (safer snorting, "start low and go slow")
    - K is commonly used in combination with other substances and should be monitored for frequency of use
    - See Appendix XI for resources for patients on ketamine

Sexual Assault and Violence

Disinhibition in the setting of sexualized drug use such as chemsex is common (Gong et al., 2019). Universal trauma precautions are recommended; offer all patients information on survivor and post-sexual assault care. Drug Facilitated Sexual Assault can be particularly traumatic and difficult to cope with and manage longitudinally (Thompson, 2021). Patients with a history of complex sexual trauma may be best supported by clinicians with specialized training. Patients may be both victims and perpetrators of sexual assault/violence, and it is important to avoid characterizations of perpetrators or victims of violence and focus on actions instead.

Harm Reduction

Treating psychostimulant use inherently embodies the principles of harm reduction by creating a more equitable treatment landscape for people who use drugs. START employs a harm reduction framework when working with patients who use stimulants by supporting patients in optimizing their health according to their goals and preferences; this creates a treatment environment that accepts and validates patients, promoting longitudinal treatment engagement and improved health outcomes. Harm reduction principles and safer use strategies are considered best practices in the care of people who use stimulants and can often be the first envoy into treatment for many patients (National Harm Reduction Coalition, 2020a). In this way, START clinical teams should work with their agencies to create protocols and policies to distribute and provide access to the harm reduction supplies listed below.

Lowering the Barriers to Engagement

Many patients come to substance use care with a history of trauma and having experienced stigma related to their substance use. Facilitating engagement is the first step in developing longitudinal relationships that enable increased access to services. This can be particularly true for patients who use stimulants, who often experience psychotic symptoms including hallucinations and paranoia. Having walk-in hours or offering low barrier ways of seeing patients outside of scheduled visits. Quick and ready access to CM can promote the regular, frequent, and ongoing engagement of patients with clinical staff.

SAFER USE

Safer Injection

Provide supplies for safe injection including needles, cookers, cottons, tourniquets, sterile water, alcohol pads, and antibacterial ointment (National Harm Reduction Coalition, 2020a). Patients should be educated on safer injection practices, including strategies for vein care/preservation and post-injection care. Remind patients who may be injecting crack cocaine that it is necessary to use a weak acid (like ascorbic acid) to neutralize the base in crack in order to make it injectable. Communicate with the local syringe exchange to ensure that patients have regular check-ins with harm reduction service providers and others who are able to facilitate access to safer injection supplies.

Safer Snorting

Provide patients with supplies for safer snorting including hard non-porous surfaces, paper straws, safety blades, sterile water, and alcohol pads (National Harm Reduction Coalition, 2020c). Patients should be educated on safer insufflation strategies, including strategies for rinsing the nares and alternating nares for insufflation. Remind patients that the finer the powder, the less likely the substance will cause mechanical damage to the nose.

Safer Smoking

Provide patients with supplies for safer smoking, including straight stem or bubble pipes, mouth pieces, sterile water, a heat source (lighter), alcohol pads, and lip balm (Imtiaz et al., 2020). Patients should be educated on safer smoking strategies to protect the lips and lungs, namely to avoid touching the pipe directly with your mouth and hold shallower breaths of inhaled drug smoke. Remind patients that there is a risk for barotrauma with regular smoking of stimulant substances (SAMHSA, 2021b). The purchase of safer smoking supplies is currently restricted with federal funds, but working with local harm reduction agencies to create systems to better provide patients with needed resources is pivotal to embedding harm reduction practice in clinical spaces.

Safer Intrarectal Use (Booty Bumping)

Providing supplies for safer intrarectal use including needleless syringes, water-based lubricants, sterile water, moistened body wipes, and safety blades can help patients pursue safer intrarectal use practices (Prillwitz, 2018). Educate patients on using drugs totally dissolved in water prior to administration to the rectum. Remind patients that HIV risk from intrarectal use comes from behaviors that usually occur after intrarectal use. For example, being an anal receptive sex partner after intrarectal use of a stimulant may result in increased risk for rectal tissue tearing and HIV acquisition.

Overdose Prevention

Traditional opioid overdose prevention strategies still apply for stimulant use (SAMHSA, 2018a). These include:

- Never use alone
- Test your shot (Taste your shot)
- Carry naloxone
- Prescribe medications for opioid use disorder

Consider the risk of opioid overdose due to accidental opioid consumption in the setting of a contaminated stimulant supply (CDC, 2023a). Strategies to prevent such overdoses include providing fentanyl test strips, acquiring one's drug supply from consistent dealers, utilizing overdose prevention centers, and using prescribed naltrexone in a prescribe-to-protect strategy.

Overamping Prevention

Strategies to prevent overamping should address modifiable risk factors for overamping events (Rigoni et al., 2018). These include taking a break from use, remaining hydrated while using, consuming a high-calorie meal in the setting of ongoing use, getting adequate sleep, taking prescribed medications that may help manage the psychiatric symptoms of overamping, and changing the route of use to smoking or insufflation to avoid direct assault from injection use.

Vaccines

Vaccine administration should consider the medical vulnerability and risk groups of the patients using stimulants (CDC, 2023b). Some vaccines to provide to StUD patients include: influenza, COVID-19, HPV, HAV, HBV, Meningitis, MPox, and TDAP.

REFERENCES

Abuelezam, N. N. (2022). Collecting and Reporting Accurate Data on Race and Ethnicity Are Necessary to Achieve Health Equity. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, *51*(6), 562–565. https://doi.org/10.1016/j.jogn.2022.09.001

Alessi, S. M., Rash, C. J., & Pescatello, L. S. (2020). Reinforcing exercise to improve drug abuse treatment outcomes: A randomized controlled study in a substance use disorder outpatient treatment setting. *Psychology of Addictive Behaviors : Journal of the Society of Psychologists in Addictive Behaviors*, *34*(1), 52–64. https://doi.org/10.1037/adb0000517

Alford, D. P., LaBelle, C. T., Kretsch, N., Bergeron, A., Winter, M., Botticelli, M., & Samet, J. H. (2011). Five Year Experience with Collaborative Care of Opioid Addicted Patients using Buprenorphine in Primary Care. *Archives of Internal Medicine*, *171*(5), 425–431. https://doi.org/10.1001/archinternmed.2010.541

Armenian, P., Effron, Z., Garbi, N., Dirks, R., Benowitz, N. L., & Gerona, R. R. (2019). Stimulant drugs are associated with violent and penetrating trauma. *The American Journal of Emergency Medicine*, *37*(4), 645–650. https://doi.org/10.1016/j.ajem.2018.06.071

Barrangou-Poueys-Darlas, M., Gerardin, M., Deheul, S., Istvan, M., Guerlais, M., Jolliet, P., Dejoie, T., & Victorri-Vigneau, C. (2021). Poppers Use and High Methaemoglobinaemia: 'Dangerous Liaisons.' *Pharmaceuticals*, *14*(10), 1061. https://doi.org/10.3390/ph14101061

Bassuk, E. L., Hanson, J., Greene, R. N., Richard, M., & Laudet, A. (2016). Peer-Delivered Recovery Support Services for Addictions in the United States: A Systematic Review. *Journal of Substance Abuse Treatment*, *63*, 1–9. https://doi.org/10.1016/j.jsat.2016.01.003

Best, D., & Hennessy, E. A. (2022). The science of recovery capital: Where do we go from here? *Addiction*, *117*(4), 1139–1145. https://doi.org/10.1111/add.15732

Braunwarth, W.-D., Christ, M., Dirks, H., Dyba, J., Hartel-Petri, R., Harfst, T., Fleischmann, H., Gouzoulis-Mayfrank, E., & Hamdorf, W. (2016). *S3 Practice Guideline Methamphetamine-related Disorders* (p. 219). Drug Commissioner of the German Federal Government. https://www.aezq.de/mdb/edocs/pdf/literatur/s3-gl-methamphetamine-related-disorders-long.pdf

CDC. (2022a, November 29). *Issue Brief: Status Neutral HIV Care and Service Delivery | Policy and Law | HIV/AIDS | CDC*. https://www.cdc.gov/hiv/policies/data/status-neutral-issue-brief.html

CDC. (2022b, May 11). *U.S. Overdose Deaths In 2021 Increased Half as Much as in 2020—But Are Still Up 15%*. National Center for Health Statistics Pressroom. https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/202205.htm

CDC. (2023a, May 12). *Other Drugs*. Centers for Disease Control and Prevention. https://www.cdc.gov/drugoverdose/deaths/other-drugs.html

CDC. (2023b, August 2). *ACIP Vaccine Recommendations | CDC*. https://www.cdc.gov/vaccines/hcp/acip-recs/index.html

Chahine, A., Koru-Sengul, T., Feaster, D. J., Dilworth, S. E., Antoni, M. H., Klatt, N., Roach, M. E., Pallikkuth, S., Sharkey, M., Salinas, J., Stevenson, M., Pahwa, S., Fuchs, D., & Carrico, A. W. (2021). Blue Monday: Co-occurring Stimulant Use and HIV Persistence Predict Dysregulated Catecholamine Synthesis. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, *86*(3), 353–360. https://doi.org/10.1097/QAI.0000000000002560

del Pozo Cruz, B., Ahmadi, M. N., Lee, I.-M., & Stamatakis, E. (2022). Prospective Associations of Daily Step Counts and Intensity With Cancer and Cardiovascular Disease Incidence and Mortality and All-Cause Mortality. *JAMA Internal Medicine*, *182*(11), 1139. https://doi.org/10.1001/jamainternmed.2022.4000

Dyer, J. E., Roth, B., & Hyma, B. A. (2001). Gamma-hydroxybutyrate withdrawal syndrome. *Annals of Emergency Medicine*, *37*(2), 147–153. https://doi.org/10.1067/mem.2001.112985

Flameling, J., van der Does, F., van Veelen, N., & Vermetten, E. (2022). Not too quick on "Debunking the myth of 'Blue Mondays.'" *Journal of Psychopharmacology (Oxford, England)*, *36*(8), 1001–1004. https://doi.org/10.1177/02698811221100713

Gicas, K. M., Parmar, P. K., Fabiano, G. F., & Mashhadi, F. (2022). Substance-induced psychosis and cognitive functioning: A systematic review. *Psychiatry Research*, *308*, 114361. https://doi.org/10.1016/j.psychres.2021.114361

Giorgetti, R., Tagliabracci, A., Schifano, F., Zaami, S., Marinelli, E., & Busardò, F. P. (2017). When "Chems" Meet Sex: A Rising Phenomenon Called "ChemSex." *Current Neuropharmacology*, *15*(5). https://doi.org/10.2174/1570159X15666161117151148

Glass, J. E., Nunes, E. V., & Bradley, K. A. (2020). Contingency Management: A Highly Effective Treatment For Substance Use Disorders And The Legal Barriers That Stand In Its Way. *Health Affairs Forefront*. https://doi.org/10.1377/forefront.20200305.965186

Goldman, J. E., Waye, K. M., Periera, K. A., Krieger, M. S., Yedinak, J. L., & Marshall, B. D. L. (2019). Perspectives on rapid fentanyl test strips as a harm reduction practice among young adults who use drugs: A qualitative study. *Harm Reduction Journal*, *16*(1), 3. https://doi.org/10.1186/s12954-018-0276-0

Gong, A. T., Kamboj, S. K., & Curran, H. V. (2019). Post-traumatic Stress Disorder in Victims of Sexual Assault With Pre-assault Substance Consumption: A Systematic Review. *Frontiers in Psychiatry*, *10*. https://doi.org/10.3389/fpsyt.2019.00092

Gumbley, S. J. (2016). Recovery in the 21st Century: From Shame to Strength. *Journal of Addictions Nursing*, *27*(2), 143–147. https://doi.org/10.1097/JAN.0000000000000125

Haffajee, R. L., & Heins, S. (2021). *State and Community Efforts to Address Stimulant Use*. https://aspe.hhs.gov/reports/state-community-efforts-address-stimulant-use

Harding, R. W., Wagner, K. T., Fiuty, P., Smith, K. P., Page, K., & Wagner, K. D. (2022). "It's called overamping": Experiences of overdose among people who use methamphetamine. *Harm Reduction Journal*, *19*, 4. https://doi.org/10.1186/s12954-022-00588-7

Huang, J., Zheng, Y., Gao, D., Hu, M., & Yuan, T. (2020). Effects of Exercise on Depression, Anxiety, Cognitive Control, Craving, Physical Fitness and Quality of Life in Methamphetamine-Dependent Patients. *Frontiers in Psychiatry*, *10*. https://doi.org/10.3389/fpsyt.2019.00999

Imtiaz, S., Strike, C., Elton‐Marshall, T., & Rehm, J. (2020). Safer smoking kits for methamphetamine consumption. *Addiction*, *115*(6), 1189–1190. https://doi.org/10.1111/add.14914

Jenner, L., Spain, D., Whyte, I., Baker, A., Carr, V., & Crilly, J. (2006). *Management of patients with psychostimulant toxicity: Guidelines for emergency departments*. Australian Government Department of Health and Ageing. https://cracksintheice.org.au/guidelines/guidelines-for-emergency-departments

Johnson, B. A., Ait-Daoud, N., Wang, X.-Q., Penberthy, J. K., Javors, M. A., Seneviratne, C., & Liu, L. (2013). Topiramate for the Treatment of Cocaine Addiction: A Randomized Clinical Trial. *JAMA Psychiatry*, *70*(12), 1338. https://doi.org/10.1001/jamapsychiatry.2013.2295

Kamal, R. M., Loonen, A. J. M., Dijkstra, B. A. G., & De Jong, C. A. J. (2015). Baclofen as Relapse Prevention in the Treatment of Gamma-Hydroxybutyrate Dependence: A Case Series. *Journal of Clinical Psychopharmacology*, *35*(3), 313–318. https://doi.org/10.1097/JCP.0000000000000315

Kariisa, M., Seth, P., Scholl, L., Wilson, N., & Davis, N. L. (2021). Drug overdose deaths involving cocaine and psychostimulants with abuse potential among racial and ethnic groups – United States, 2004–2019. *Drug and Alcohol Dependence*, *227*, 109001. https://doi.org/10.1016/j.drugalcdep.2021.109001

Kidd, J. D., Paschen-Wolff, M. M., Mericle, A. A., Caceres, B. A., Drabble, L. A., & Hughes, T. L. (2021). A scoping review of alcohol, tobacco, and other drug use treatment interventions for sexual and gender minority populations. *Journal of Substance Abuse Treatment*, 108539. https://doi.org/10.1016/j.jsat.2021.108539

Killeen, T. K., Wolf, B., Greer, T. L., Carmody, T., Rethorst, C. D., & Trivedi, M. H. (2020). Gender and racial/ethnic differences in physiologic responses in the Stimulant Reduction Intervention using Dosed Exercise Study. *Addictive Behaviors*, *110*, 106546. https://doi.org/10.1016/j.addbeh.2020.106546

Le, A., Yockey, A., & Palamar, J. J. (2020). Use of "Poppers" among Adults in the United States, 2015-2017. *Journal of Psychoactive Drugs*, *52*(5), 433–439. https://doi.org/10.1080/02791072.2020.1791373

Levin, F. R., Mariani, J. J., Pavlicova, M., Choi, C. J., Mahony, A. L., Brooks, D. J., Bisaga, A., Dakwar, E., Carpenter, K. M., Naqvi, N., Nunes, E. V., & Kampman, K. (2020). Extended release mixed amphetamine salts and topiramate for cocaine dependence: A randomized clinical replication trial with frequent users. *Drug and Alcohol Dependence*, *206*, 107700. https://doi.org/10.1016/j.drugalcdep.2019.107700

Levin, F. R., Mariani, J. J., Specker, S., Mooney, M., Mahony, A., Brooks, D. J., Babb, D., Bai, Y., Eberly, L. E., Nunes, E. V., & Grabowski, J. (2015). Extended-Release Mixed Amphetamine Salts vs Placebo for Comorbid Adult Attention-Deficit/Hyperactivity Disorder and Cocaine Use Disorder: A Randomized Clinical Trial. *JAMA Psychiatry*, *72*(6), 593. https://doi.org/10.1001/jamapsychiatry.2015.41

Li, Y., Re, G.-F., Zhao, Y., Wu, X.-C., Zhou, R.-Y., Kuang, Y.-Q., & Wang, K.-H. (2022). Long-term exercise at different intensities can reduce the inflammatory response in the brains of methamphetamine-treated mice. *Biochemical and Biophysical Research Communications*, *613*, 201–206. https://doi.org/10.1016/j.bbrc.2022.05.042

Liu, X., & Wang, S. (2021). Effect of aerobic exercise on executive function in individuals with methamphetamine use disorder: Modulation by the autonomic nervous system. *Psychiatry Research*, *306*, 114241. https://doi.org/10.1016/j.psychres.2021.114241

Lyons, T., Chandra, G., Goldstein, J., & Ostrow, D. G. (2010). Breaking the Bond Between Stimulant Use and Risky Sex: A Qualitative Study. *Substance Abuse*, *31*(4), 224–230. https://doi.org/10.1080/08897077.2010.514240

Marrero‐Cristobal, G., Gelpi‐Dominguez, U., Morales‐Silva, R., Alvarado‐Torres, J., Perez‐Torres, J., Perez‐Perez, Y., & Sepulveda‐Orengo, M. (2022). Aerobic exercise as a promising nonpharmacological therapy for the treatment of substance use disorders. *Journal of Neuroscience Research*, *100*(8), 1602–1642. https://doi.org/10.1002/jnr.24990

McGuire, A. P., Mota, N. P., Sippel, L. M., Connolly, K. M., & Lyons, J. A. (2018). Increased Resilience is Associated with Positive Treatment Outcomes for Veterans with Comorbid PTSD and Substance Use Disorders. *Journal of Dual Diagnosis*, *14*(3), 181–186. https://doi.org/10.1080/15504263.2018.1464237

Naji, L., Dennis, B., Rosic, T., Wiercioch, W., Paul, J., Worster, A., Thabane, L., & Samaan, Z. (2022). Mirtazapine for the treatment of amphetamine and methamphetamine use disorder: A systematic review and meta-analysis. *Drug and Alcohol Dependence*, *232*, 109295. https://doi.org/10.1016/j.drugalcdep.2022.109295

National Harm Reduction Coalition. (2020a). *Getting Off Right: A Safety Manual for Injection Drug Users* (p. 89). National Harm Reduction Coalition. https://harmreduction.org/wp-content/uploads/2020/08/Resource-SaferDruguse-GettingOffRightASafetyManualforInjectionDrugUsers.pdf

National Harm Reduction Coalition. (2020b, August 31). *Recognizing Stimulant Overamping*. National Harm Reduction Coalition. https://harmreduction.org/issues/overdose-prevention/overview/stimulant-overamping-basics/recognizing-stimulant-overamping/

National Harm Reduction Coalition. (2020c, October 5). *Safe(r) Drug Use 101*. Harm Reduction Coalition. https://harmreduction.org/issues/safer-drug-use/facts/

O'Brien, P., Crable, E., Fullerton, C., & Hughey, L. (2019, March). *Best Practices and Barriers to Engaging People with Substance Use Disorders in Treatment*. ASPE. https://aspe.hhs.gov/reports/best-practices-barriers-engaging-people-substance-use-disorders-treatment-0

Office of the Inspector General. (2021, September 1). *Fraud & Abuse Laws*. Office of Inspector General | Government Oversight | U.S. Department of Health and Human Services. https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/

Owens, L., Terrell, S., Low, L. K., Loder, C., Rhizal, D., Scheiman, L., & Seng, J. (2022). Universal precautions: The case for consistently trauma-informed reproductive healthcare. *American Journal of Obstetrics and Gynecology*, *226*(5), 671–677. https://doi.org/10.1016/j.ajog.2021.08.012

Pergolizzi, J., Breve, F., Magnusson, P., LeQuang, J. A. K., & Varrassi, G. (n.d.). Cocaethylene: When Cocaine and Alcohol Are Taken Together. *Cureus*, *14*(2), e22498. https://doi.org/10.7759/cureus.22498

Piggott, D. A., & Cariaga-Lo, L. (2019). Promoting Inclusion, Diversity, Access, and Equity Through Enhanced Institutional Culture and Climate. *The Journal of Infectious Diseases*, *220*(Supplement_2), S74–S81. https://doi.org/10.1093/infdis/jiz186

Prillwitz, J. (2018, July 19). *How to Booty Bump Better*. San Francisco AIDS Foundation. https://www.sfaf.org/collections/beta/how-to-booty-bump-better/

Rigoni, R., Breeksema, J., & Woods, S. (2018). *Speed Limits: Harm Reduction for People Who Use Stimulants* (p. 16). MAINline. http://mainline.blogbird.nl/uploads/mainline/2018_Mainline_%E2%80%93_Harm_Reduction_for_People_Who_Use_Stimulants_%E2%80%93_Executive_Summary.pdf

Ruglass, L. M., Hien, D. A., Hu, M.-C., & Campbell, A. N. C. (2014). Associations between Posttraumatic Stress Symptoms, Stimulant Use, and Treatment Outcomes: A Secondary Analysis of NIDA's Women and Trauma Study. *The American Journal on Addictions / American Academy of Psychiatrists in Alcoholism and Addictions*, *23*(1), 10.1111/j.1521-0391.2013.12068.x. https://doi.org/10.1111/j.1521-0391.2013.12068.x

SAMHSA. (2009). *Incorporating Alcohol Pharmacotherapies Into Medical Practice* (49; Treatment Improvement Protocol (TIP) Series, p. 126). SAMHSA. https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4380.pdf

SAMHSA. (2018a). *SAMHSA Opioid Overdose Prevention Toolkit* (18–4742; p. 24). SAMHSA. https://store.samhsa.gov/sites/default/files/d7/priv/sma18-4742.pdf

SAMHSA (2018b). *TIP 61 Behavioral Health Services for American Indians and Alaska Natives* (Treatment Improvement Protocol (TIP) Series, p. 240). SAMHSA. https://store.samhsa.gov/sites/default/files/d7/priv/tip_61_aian_full_document_020419_0.pdf

SAMHSA. (2020). *THE OPIOID CRISIS AND THE BLACK/AFRICAN AMERICANPOPULATION: AN URGENT ISSUE* (p. 30). SAMHSA. https://store.samhsa.gov/sites/default/files/pep20-05-02-001.pdf

SAMHSA. (2021a). *TIP 63: Medications for Opioid Use Disorder* (Treatment Improvement Protocol (TIP) Series, p. 332). SAMHSA. https://store.samhsa.gov/sites/default/files/pep21-02-01-002.pdf

SAMHSA. (2021b). *Treatment for Stimulant Use Disorders. Treatment Improvement Protocol (TIP) Series 33* (SAMHSA Publication No. PEP21-02-01-004).

SAMSHA. (2022a, April 14). *Core Competencies for Peer Workers*. Substance Abuse Mental Health Services Administration. https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers/core-competencies-peer-workers

SAMSHA. (2022b, September 27). *Peer Support Workers for those in Recovery*. Substance Abuse Mental Health Services Administration. https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers

Sewell, J., Cambiano, V., Miltz, A., Speakman, A., Lampe, F. C., Phillips, A., Stuart, D., Gilson, R., Asboe, D., Nwokolo, N., Clarke, A., Hart, G., & Rodger, A. (2018). Changes in recreational drug use, drug use associated with chemsex, and HIV-related behaviours, among HIV-negative men who have sex with men in London and Brighton, 2013–2016. *Sexually Transmitted Infections*, *94*(7), 494–501. https://doi.org/10.1136/sextrans-2017-053439

Solomon, N., & Hayes, J. (2017). Levamisole: A High Performance Cutting Agent. *Academic Forensic Pathology*, *7*(3), 469–476. https://doi.org/10.23907/2017.039

Spencer, M., Miniño, A., & Garnett, M. (2023). *Co-involvement of Opioids in Drug Overdose Deaths Involving Cocaine and Psychostimulants, 2011–2021*. National Center for Health Statistics (U.S.). https://doi.org/10.15620/cdc:129733

Suen, L. W., Lunn, M. R., Sevelius, J. M., Flentje, A., Capriotti, M. R., Lubensky, M. E., Hunt, C., Weber, S., Bahati, M., Rescate, A., Dastur, Z., & Obedin-Maliver, J. (2022). Do Ask, Tell, and Show: Contextual Factors Affecting Sexual Orientation and Gender Identity Disclosure for Sexual and Gender Minority People. *LGBT Health*, *9*(2), 73–80. https://doi.org/10.1089/lgbt.2021.0159

Taché, S., & Chapman, S. (2005). *What a Medical Assistant Can Do for Your Practice*. American Academy of Family Physicians. https://www.aafp.org/pubs/fpm/issues/2005/0400/p51.html

Tang, S., Jones, C. M., Wisdom, A., Lin, H.-C., Bacon, S., & Houry, D. (2021). Adverse childhood experiences and stimulant use disorders among adults in the United States. *Psychiatry Research*, *299*, 113870. https://doi.org/10.1016/j.psychres.2021.113870

Tay, E., Lo, W. K. W., & Murnion, B. (2022). Current Insights on the Impact of Gamma-Hydroxybutyrate (GHB) Abuse. *Substance Abuse and Rehabilitation*, *13*, 13–23. https://doi.org/10.2147/SAR.S315720

Terrins Higgins Trust. (2018, August 31). *Comedowns*. Friday/Monday. https://www.fridaymonday.org.uk/morning-after/comedowns/

The Joint Commission. (2011). *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community: A Field Guide*. https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/health-equity/lgbtfieldguide_web_linked_verpdf.pdf?db=web&hash=FD725DC02CFE6E4F21A35EBD839BBE97

Thompson, K. M. (2021). Beyond roofies: Drug- and alcohol-facilitated sexual assault. *Journal of the American Academy of Physician Assistants*, *34*(1), 45–49. https://doi.org/10.1097/01.JAA.0000723940.92815.0b

Torres, T. S., Bastos, L. S., Kamel, L., Bezerra, D. R. B., Fernandes, N. M., Moreira, R. I., Garner, A., Veloso, V. G., Grinsztejn, B., & De Boni, R. B. (2020). Do men who have sex with men who report alcohol and illicit drug use before/during sex (chemsex) present moderate/high risk for substance use disorders? *Drug and Alcohol Dependence*, *209*, 107908. https://doi.org/10.1016/j.drugalcdep.2020.107908

Trivedi, M. H., Walker, R., Ling, W., Wahle, A., Kim, M., Shores-Wilson, K., Sparenborg, S., Coffin, P., Schmitz, J., Wiest, K., Bart, G., Sonne, S. C., Wakhlu, S., Rush, A. J., Nunes, E. V., & Shoptaw, S. (2021). Bupropion and Naltrexone in Methamphetamine Use Disorder. *N Engl J Med*, 14.

Veroniki, A. A., Cogo, E., Rios, P., Straus, S. E., Finkelstein, Y., Kealey, R., Reynen, E., Soobiah, C., Thavorn, K., Hutton, B., Hemmelgarn, B. R., Yazdi, F., D'Souza, J., MacDonald, H., & Tricco, A. C. (2017). Comparative safety of anti-epileptic drugs during pregnancy: A systematic review and network meta-analysis of congenital malformations and prenatal outcomes. *BMC Medicine*, *15*, 95. https://doi.org/10.1186/s12916-017-0845-1

Volkow, N. D. (2020). *Drugs, Brains, and Behavior: The Science of Addiction*. NIDA. https://nida.nih.gov/sites/default/files/soa.pdf

Zhou, Y., Finlayson, G., Liu, X., Zhou, Q., Liu, T., & Zhou, C. (2021). Effects of Acute Dance and Aerobic Exercise on Drug Craving and Food Reward in Women with Methamphetamine Dependence. *Medicine & Science in Sports & Exercise*, *Publish Ahead of Print*. https://doi.org/10.1249/MSS.0000000000002723

Zhu, X., Gray, D., & Brennan, C. S. (2022). Impact of Implementing Welcoming Clinic Space Indicators on Sexual and Gender Minority Patients' Health Care Experience. *AIDS Patient Care and STDs*, *36*(S2), 127–142. https://doi.org/10.1089/apc.2022.0098

APPENDIX I: ADDITIONAL TRAINING RESOURCES

- Grayken Center for Addiction Training and Technical Assistance: https://www.addictiontraining.org
- Opioid Response Network: https://opioidresponsenetwork.org/
- Providers Clinical Support System (PCSS): https://pcssnow.org/
- Harm Reduction Coalition: https://harmreduction.org/
- Addiction Technology Transfer Centers: https://attcnetwork.org
- SAMHSA guideline for Supervision of Peer Workers: https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers
- Opioid Response Network Gender and Sexuality Working Group: https://opioidresponsenetwork.org
- National LGBTQAI+ Health Education Center: https://www.lgbtqiahealtheducation.org/
- Joint Commission Field Guide: Advancing Effective Communication, Cultural Competence, and Family-Centered Care for Lesbian, Gay, Bisexual, and Transgender (LGBT) Community: https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/health-equity/lgbtfieldguide_web_linked_verpdf.pdf?db=web&hash=FD725DC02CFE6E4F21A35EBD839BBE97&hash=FD725DC02CFE6E4F21A35EBD839BBE97
- Picture of START Clinic cool down space:

- Resources for the Treatment of Alcohol Use Disorder:
    - Clinician Research Summary: Pharmacotherapy for Adults with Alcohol Use Disorder (AUD) in Outpatient Settings: https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/alcohol-misuse-drug-therapy_clinician.pdf
    - National Institute on Alcohol Abuse and Alcoholism: https://www.niaaa.nih.gov/
    - NIAAA Core Resource on Alcohol: https://www.niaaa.nih.gov/health-professionals-communities/core-resource-on-alcohol
- SAMHSA TIP 63: Medications for Opioid Use Disorder for Healthcare and Addiction Professionals, Policymakers, Patients, and Families: https://store.samhsa.gov/sites/default/files/pep21-02-01-002.pdf
- Chemsex resources:
    - https://www.addictiontraining.org/resources/?category=15#Safer+Sex%2FChemSex+%2 6+Sexual+Health
    - https://www.fridaymonday.org.uk/
    - https://www.dean.st/chems/

APPENDIX II: EXAMPLE CONTINGENCY MANAGEMENT TRACKER

Contingency Management Reporting

1 *Please Select your Patient Name*

2 *Please Select Week of Treatment*

3 *Which has the patient participated in?*

- ☐ Meaningful Activity
- ☐ Nurse Check-In or Group
- ☐ Abstinence from Substances

Submit Reset

New Patient Form

1 *First name:*

2 Last name

3 *Client ID:*

4 *Admission Date:*

5 *Phone Number:*

6 *Email:*

Submit Reset

Patient Discharge Form

1 *Full name*

2 *Discharge Date*

3 *Admin discharge completed?*

4 *BSAS disenrollment Completed?*

Submit Reset

START Clinic Treatment Plan

Patient care through the Stimulant Treatment and Recovery Team (START) includes four stages of treatment: Engagement, Initiation, Stabilization, and Maintenance.

ENGAGEMENT

Prior to initiating treatment for a patient with stimulant use disorder (StUD), it is imperative to engage patients in a safe and caring environment. Patients may be reticent to initiate treatment for their StUD during their initial interaction with staff. Building trust and increasing willingness for treatment may take weeks or months of engagement with harm reduction staff. Engagement with harm reduction staff should be coupled with low threshold introductions to RN or admin/coordinator staff.

***Goals of Engagement**:*

1) Patients will identify START as a safe place with caring providers.
2) Patients will identify where they are able to seek harm reduction services, including STI/HIV testing during active use.
3) Patients will complete a screener for the START treatment program.

Documentation: Tracking of harm reduction services and/or screening tests completed. Any interaction, even minimal contact with RN or admin/coordinator, should be documented to identify the strategies used to increase trust with staff.

Staff Involved During Engagement Phase: Outreach/case manager, admin/coordinator, RN, referring provider

INITIATION

During initiation, clinicians should address management of withdrawal symptoms, improve the personal safety of the individual in stimulant withdrawal, and complete an initial medical and psychological assessment. Their focus should not only include recovery from stimulants but should equally address the patient's overall physical health, including chronic health needs and unmet medical/psychological needs that may require intervention and assistance throughout treatment. Goal setting and early support network building should also occur during this phase of treatment.

Initiation of treatment in the START Clinic can occur after intake completion with clinic staff and enrollment in the contingency management treatment program. Initiation is characterized by the first 4 weeks of treatment or participation in the contingency management program with up to $75 of incentives. Treatment will include weekly (or more frequent) RN visits, engagement with an exercise program, and the outpatient management of stimulant withdrawal. Some patients may not be stable enough to engage with group counseling in their first few weeks of treatment, but will be encouraged to participate once clinical staff determines them to be stable.

***Goals of Treatment**:*

1) Patients will complete all intake assessments and intake laboratory/diagnostic testing.
2) Patients will start the contingency management program.
3) Patients will safely undergo withdrawal from stimulant dependence.
4) Patients will develop a safety plan for stimulant withdrawal and increased depressive symptoms.
5) Patients will safely undergo withdrawal from other substances and initiate medications for addiction treatment as appropriate.
6) Patients will discuss and identify goals of treatment with the START Clinic staff.
7) Patients will initiate a program of exercise.
8) Patients will join at least one group visit.

Documentation: Completion of all intake documentation. Signed patient treatment agreement, anchor contract, contingency management and verification plan, release of information for treatment providers, and GPRA/EIM, Goals of treatment.

***Staff Involved During Initiation Phase**:* Outreach/Case Manager, Admin/Coordinator, RN, Primary Care Provider or Referring Provider, Behavioral Health Clinicians, Exercise Support Staff.

STABILIZATION

Stabilization in patient treatment should focus on the post-acute withdrawal phase of stimulant use. In this phase (often referred to as "early recovery"), START Clinic staff will assist patients in achieving their functional goals of recovery. It is common for patients to struggle with continued substance use during the stabilization phase. **Building recovery capital, developing sober social support networks, and reassessing the initial treatment plan for a patient's substance use disorder are critical.** As patients stabilize in treatment, behavioral health interventions can more effectively address the concurrent mental health and trauma needs of patients. Additionally, continued clinical assessment of physical health conditions and physical or cognitive deficits (to include brain injury, parkinsonian symptoms, and psychotic symptoms) that patients may have neglected during active use is critical.

All relevant providers should meet weekly to determine the continued course of treatment for patients in START. Patients who are meeting goals and responding appropriately to treatment interventions will transition from weekly RN visits to visits every other week. This transition to biweekly behavioral health and medical visits is dependent on the provider team's assessment. During the stabilization phase, contingency management will transition to a point-based system where points can be exchanged for privileges or patient supplies. Patients should continue to participate in exercise regularly to help with the re-regulation of dopamine.

Goals of treatment:

1) Patients will achieve a profound reduction or elimination of illicit substance use.
2) Patients will develop the framework for a recovery support network.

3) Patients will build recovery capital to support continued cessation of substance use and strategies for prevention of recurrent substance use.
4) Further evaluation and management of chronic health conditions.

Documentation: The team review should be documented in the patient chart. Additionally, the patient should reassess their goals for treatment. Documentation of the patient's plan for building recovery capital and success in recovery should be completed.

Staff Involved During Stabilization Phase: Outreach/case manager, admin/coordinator, RN, primary care provider or referring provider, behavioral health staff

MAINTENANCE

The maintenance phase of treatment is characterized by a patient who is stable in their recovery and has built strong recovery support networks. Achieving recovery is less central in this phase; rather, protecting the patient's sobriety and encouraging the prevention of recurrent substance use is key. A patient in the maintenance phase of treatment may require increased support services at specific times throughout the year (e.g., holidays) or if particularly stressful situations occur. Overall, however, patients in the maintenance phase should require less intensive intervention and support when compared to patients in early recovery.

Patients should continue to attend monthly medical or behavioral health groups, incorporate exercise and healthy living habits into their lives, and see the nurse or other medical provider as needed. Most patients will engage with the nurse every 2-4 weeks. Patients in the maintenance phase will no longer be eligible for any contingency management services. Some patients may show interest in continuing frequent involvement in behavioral health or medical groups in order to set a hopeful example for other patients in early recovery, although this is not a requirement or expectation. The needs of a patient in the maintenance phase will vary greatly depending on their own medical history and patient-centered individualized recovery plan.

Goals of Treatment:

1) Continued growth in recovery
2) Achievement of personal goals for recovery
3) The ability to identify triggers and develop strategies to prevent recurrent use
4) Improved management of other chronic health conditions

Documentation*:* Additional team review should occur and be documented before patients are moved into the maintenance phase of treatment. Regular reassessment of patient recovery goals should be assessed and documented. GPRA data should be collected and reported as appropriate.

Staff Involved During the Maintenance Phase*:* Admin/coordinator, RN, primary care provider or referring provider, behavioral health staff

START Medical Group Note

Patient presented for medical group with START clinic staff. There were *** patients present for today's group session.
Today's group topic was ***
Group session was approximately 60 minutes in length.

Additional pertinent information from group session today: ***

Provider name

APPENDIX V: MEDICATIONS FOR COCAINE USE DISORDER, TOPIRAMATE

START
Stimulant Treatment and Recovery Team

Pharmacotherapy for Cocaine Use Disorder

Medication or Combination Medication Name	Indications for Use	Contraindications for use	Baseline Evaluation	Dosage/ Administration	Adverse Effects	Drug Interactions	Monitoring	Patient Education
Topiramate	**CUD**	Renal impairment, glaucoma, Category D in pregnancy	BUN/Cr	50 mg PO BID titrating weekly by 50mg to reach a max tolerated dose or 150 mg PO BID	Acute myopia, suicidal ideation, skin reactions, renal calculi, encephalopathy	CNS depressants, oral contraceptives(decreases effectiveness), lithium, amitriptyline	BUN/Cr, monitor for increased depressive symptoms	Do not stop the medication abruptly (taper). If a dose is missed it should be taken as soon as possible unless within 6 hours of the next scheduled dose.
Extended Release-Mixed Amphetamine Salts	**CUD+ ADHD**	**MUD** Uncontrolled hypertension Cardiovascular disease Hyperthyroidism	Vital signs Diagnosis of ADHD	60-80 mg PO daily	Weight loss, dry mouth, headache, jitteriness, anxiety, cardiac event	Serotonergic agents, cobicistat, TCAs	Monitoring BP and HR, worsening psychiatric side effects (anxiety, psychosis), PDMP checking.	Patients should be educated on the risks of serotonin syndrome and signs of cardiac overstimulation.

START
Stimulant Treatment and Recovery Team

Topiramate Ramp Up for Cocaine Use Disorder

Week	Morning Dose	Afternoon Dose	Total Dose
0-1	25mg Cap	25mg Cap	50mg Daily
1-2	25mg Cap + 25mg Cap	25mg Cap + 25mg Cap	100mg Daily
2-3	25mg Cap + 50mg Cap	25mg Cap + 50mg Cap	150mg Daily
3-4	100mg Cap	100mg Cap	200mg Daily
4-5	100mg Cap + 25mg Cap	100mg Cap + 25mg Cap	250mg Daily
5-6	100mg Cap + 50mg Cap	100mg Cap + 50mg Cap	300mg Daily

APPENDIX VI: MEDICATIONS FOR METHAMPHETAMINE USE DISORDER

START
Stimulant Treatment and Recovery Team

Pharmacotherapy for Methamphetamine Use Disorder

Medication or Combination Medication Name	Indications	Contraindications	Baseline	Dosage	Adverse Effects	Drug Interactions	Monitoring	Patient Education
Mirtazapine	**MUD**	Concurrent MAOI therapy, renal failure, severe hepatic impairment	LFTs, BUN/Cr (CrCl> 40mL),	15mg for 1 week and increase to 30mg PO daily	Drowsiness, weight gain, dry mouth, akathisia	Risk for serotonin syndrome and QTc prolongation in combination with other agents.	QTc risk consider an EKG, renal/ hepatic function if changes in metabolic status.	Do not stop the medication abruptly (taper)
Injectable Naltrexone+ Bupropion	**MUD**	Concurrent OUD, severe hepatic impairment.	LFTs, urine toxicology (opioid free),	380 mg IM naltrexone q 3 weeks + 450 mg PO bupropion	Injection site reaction, increased depression, weight loss, serotonin syndrome	Opioid antagonist,	Regular LFTs,	Risks for injection site reaction and pain management control.

APPENDIX VII: OVERAMPING RESPONSE, MEDICAL PROTOCOL, AND PROVIDER HANDOUTS

START (Stimulant Treatment and Recovery Team) Acute Psychosis Management Protocol

I. Background:

Psychostimulants, such as cocaine and methamphetamines, are powerful central nervous stimulants that produce feelings of wellbeing, increased confidence, energy, appetite suppression, and improved concentration. Psychostimulant overdose can cause acute experiences of hyperactivity, agitation, uncontrollable or choreiform movements, reduction in logical thinking, hypertension, and/or palpitations usually within the first 4 hours of use; this is sometimes referred to as overamping. When people experience overamping, elevated moods can become paranoid/persecutory perceptions of the world; tactile/auditory/visual hallucinations; and protective behaviors such as hypervigilance, anxiety, and labile mood. Risk factors for psychostimulant use-associated psychosis are the amount of psychostimulants used over time, amount used on one occasion, use of other drugs, duration of current binge (sleep deprivation), underlying psychiatric or medical diagnoses, and the purity of the substance used. The goal of managing patients with non-pharmacologic and pharmacologic measures in the outpatient setting is to prevent emergency room visits that may result in further escalation for the patient and unnecessary care costs to the health system.

II. Initial management

- Recognize signs and symptoms of psychostimulant overdose:
  - Somatic symptoms
    - Uncontrolled hypertension
    - Arrhythmias or angina
    - Seizures
    - Decreased respirations
    - Stroke
    - Loss or impairment of consciousness
    - Diaphoresis
    - Syncope
  - Psychological symptoms
    - Protective behaviors (hypervigilance, anxiety, mood lability)
    - Agitation
    - Repetitive behavior
    - Hallucinations, delusions
- Recognize need for emergency management
  - Patient inability to protect airway
  - Hypertension that persists despite pharmacologic measures and is accompanied by emergent symptoms (chest pain, headaches, vision changes)
  - Hyperthermia of more than 40°C
  - Seizures
  - Non-pharmacologic methods are preferred for first-line management of patients experiencing psychosis related to

stimulant use. These include:

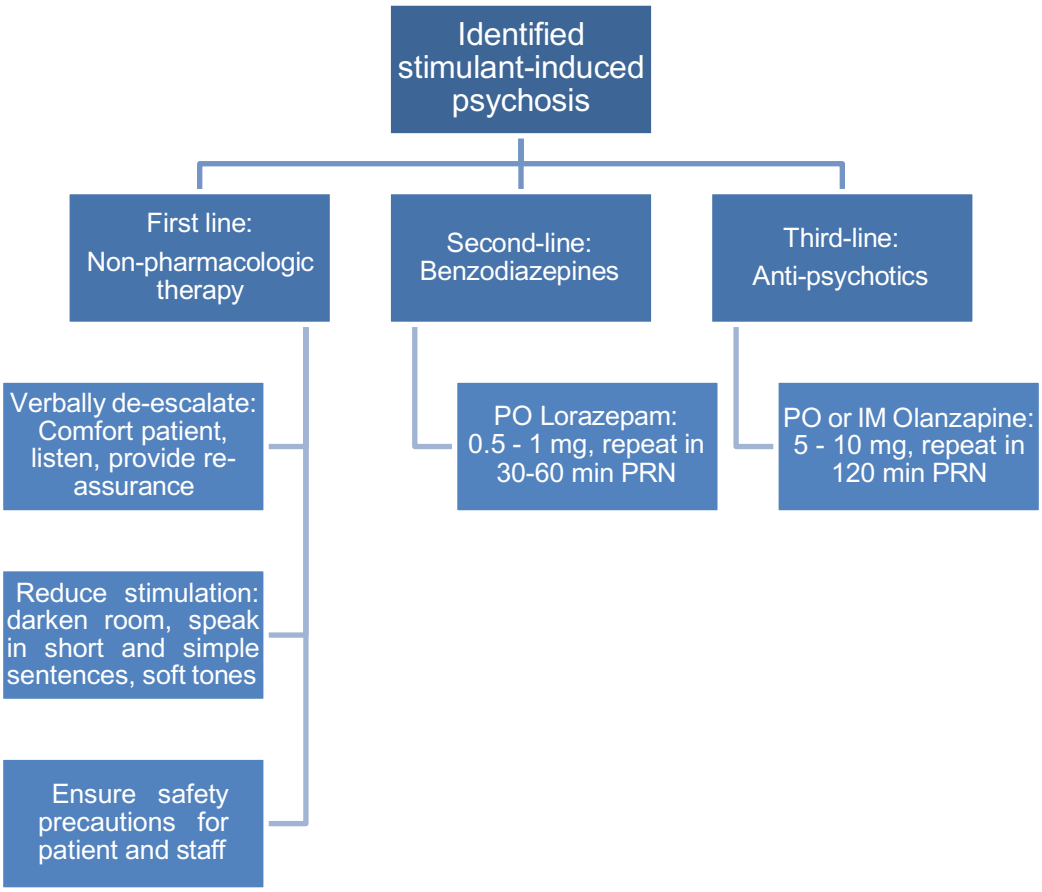
- Verbal de-escalation using comforting words
  - Listen to the affected patient
  - Convey empathy and acceptance
  - Create an alliance and sense of safety with the patient
- Reduction in environmental stimulation
  - Darken room
  - Speak in quiet tones
  - Speak in short, simple sentences
  - Decrease outside stimuli
- Do not leave the patient alone if clinical judgement indicates that they are an immediate threat to themselves or others
  - If possible, keep consistent "reference person" in contact with patient at all times
- Avoid physical restraint
  - Can lead to increase in agitation
  - Can lead to development of rhabdomyolysis, hyperthermia

- Maintain safety of clinic personnel
  - Keep escape routes open
  - Avoid abrupt movements

III. Beyond initial management: pharmacotherapy

- Oral or intramuscular medications should only be administered to <u>consenting patients</u>. If patients do not consent to oral or intramuscular medication administration and the non-pharmacologic approaches described above are not effective in managing protective behaviors, then providers should weigh the benefits and harms of escalating care to the emergency room.
- Pharmacotherapy is appropriate for patients with <u>persistent protective behaviors, excessive paranoia, and overt psychotic symptoms</u>
  - Goals of treatment are to produce a calming effect that will ultimately reduce protective behaviors
- Pharmacotherapy options
  - Benzodiazepines: PO lorazepam
    - In patients that have also used alcohol, liquid ecstasy, opiates, and/or psychedelic mushrooms in addition to psychostimulants, exercise caution due to respiratory depression and altered consciousness
      - Consider avoiding entirely if patient is known to have opiates or alcohol in their system
  - Antipsychotics: PO or IM olanzapine
    - Preferred in cases of accidental or intentional concomitant use of opiates or other depressants in addition to psychostimulants
    - Particularly helpful for patients exhibiting protective behaviors and experiencing hallucinations or delusions
    - Consider that antipsychotics can lower seizure threshold

IV. Flow diagram for management of acute psychosis related to stimulant intoxication for consenting patients



V. Monitoring

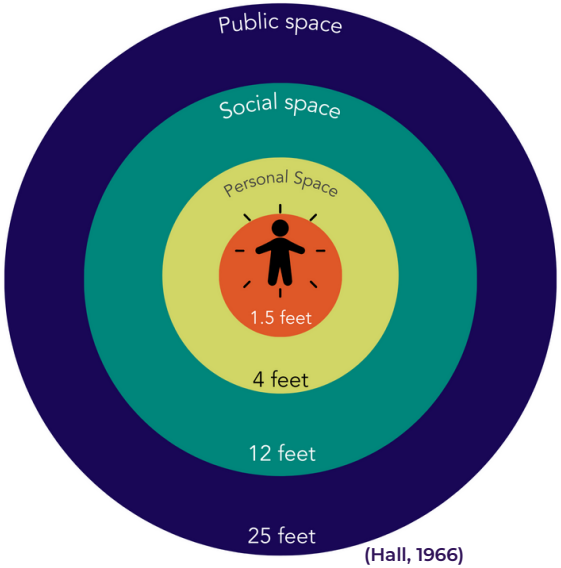
- PO Lorazepam
  - Monitor vital signs, including degree of sedation, every 30 minutes for at least 90 minutes; may continue to monitor vital signs every 60 minutes while patient remains in clinic
  - Monitor for excessive sedation and respiratory depression especially when lorazepam is administered in patients that have been exposed to other sedatives, such as opiates or alcohol
- PO Olanzapine, IM Olanzapine
  - Monitor vital signs, including degree of sedation, every 30 minutes for at least 90 minutes; may continue to monitor vital signs every 60 minutes while patient remains in clinic
  - Olanzapine may cause orthostatic hypotension associated with bradycardia especially in patients with concomitant alcohol intoxication
  - If possible, appropriate to monitor electrocardiogram (EKG) when patient is calm and willing to remain still during EKG

VI. References

1. S3 Practice Guideline Methamphetamine-related Disorders. Drug Commissioner of the German Federal Government. Available at: https://www.aezq.de/mdb/edocs/pdf/literatur/s3-gl-methamphetamine-related-disorders-long.pdf. Accessed 14 March 2022.
2. Drug and Alcohol Services South Australia (DASSA). Management of patients presenting with acute methamphetamine-related problems: evidence summary. Available at: https://www.sahealth.sa.gov.au/wps/wcm/connect/915c4c60-a766-414c-8606-94d1702d052f/Management+of+meth+presentations+-+evidence+summary+2017+final.pdf?MOD=AJPERES. Accessed 14 March 2022.
3. Xue X, Song Y, Yu X, et al. Olanzapine and haloperidol for the treatment of acute symptoms of mental disorders induced by amphetamine-type stimulants: A randomized controlled trial. *Medicine (Baltimore)*. 2018;97(8):e9786. doi:10.1097/MD.0000000000009786
4. Wilson MP, Pepper D, Currier GW, Holloman GH, Feifel D. The psychopharmacology of agitation: consensus statement of the American Association for Emergency Psychiatry project BETA psychopharmacology workgroup. *West J Emerg Med*. 2012;13(1):26-34.
5. Douglas N, Carew J, Johnson D, et al. Safety and Efficacy of an On-Site Intensive Treatment Protocol for Mild and Moderate Sympathomimetic Toxicity at Australian Music Festivals. *Prehosp Disaster Med*. 2020;35(1):41-45. doi:10.1017/S1049023X19005089

Created by: Courtney Cameron, PharmD; Justin Alves, RN, MSN, ACRN, CARN, CNE; Marielle Baldwin, MD, MPH; Michael Angelini, BA, BS, MA, PharmD, BCPP;

BEHAVIORAL INTERVENTION



(Hall, 1966)

De-escalation

Do NOT:

- Approach a patient with a weapon.
- Stare directly at patients, or request eye contact
- Corner or stand over the patient.
- Make sudden gestures that could be interpreted as threatening.
- Validate the delusion/hallucination the person is experiencing.

Do:

- Be aware of your own safety.
- Minimize stimulation and distractions.
- Have an exit point/discrete way to signal for assistance.
- Use open-ended questions focus on the patient's well-being.
- Validate the emotional experience the person is having.

Scan QR code for AGRO+ De-escalation strategy in clinical practice

PHARMACOLOGICAL INTERVENTION

Pharmacological protocol:
1st line-Benzodiazepines
2nd line-Antipsychotics

Goals:

1. Resolution of most distressing symptoms of psychiatric overamping.
2. Avoid emergency room and public safety/criminal legal involvement.
3. Promote engagement with outpatient providers.

Scan QR code for Ambulatory Medication Protocol Psychostimulant Overamping.

START Clinic
617-414-7490
START@BMC.ORG
11 Melnea Cass Blvd, Boston, MA, 02119

START
Stimulant Treatment and Recovery Team
Grayken Center for Addiction Training & Technical Assistance
Boston Medical Center

BSAS
Prevent • Treat • Recover • For Life

BOSTON UNIVERSITY

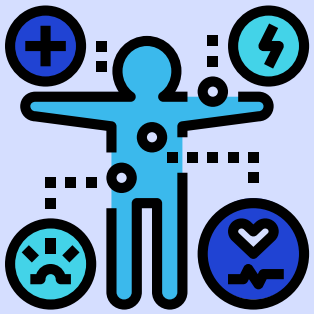
PROVIDER'S GUIDE TO OVERAMPING

IDENTIFICATION

Recognize the impact that providing non-judgmental care and fostering a safe and supportive environment has on the quality of care and outcomes for individuals using stimulants.

(SAMHSA, TIP 33)

SYMPTOMS OF OVERAMPING



Psychiatric Symptoms

- Paranoia
- Altered perception of reality
- Persecutory perceptions of the world
- Restlessness
- Visual, Auditory, or Tactile Hallucinations
- Trauma-response
- Psychosis
- Protective behaviors: hypervigilance, anxiety, agitation, defensive posturing

Physical Symptoms

- Headache
- Nausea/Vomiting
- Jaw grinding
- Spastic movement
- Choreiform movements
- Dry mouth
- Hypertension
- Hyperthermia
- Tachycardia
- Chest pain
- Insomnia
- Seizure
- Cardiac dysrrhythmia

RESPONDING TO OVERAMPING

1. RECOGNIZING OVERAMPING

Overamping occurs on a spectrum. It may initially present with mild symptoms and progress to more severe and life-threatening symptoms with prolonged use or lack of sleep.

2. BEHAVIORAL HEALTH INTERVENTION

- Actively listen and convey empathy.
- Validate patient emotional response without endorsing delusions.
- Assist patient in developing a short-term safety plan for return to community.

3. PHARMACOLOGICAL INTERVENTION

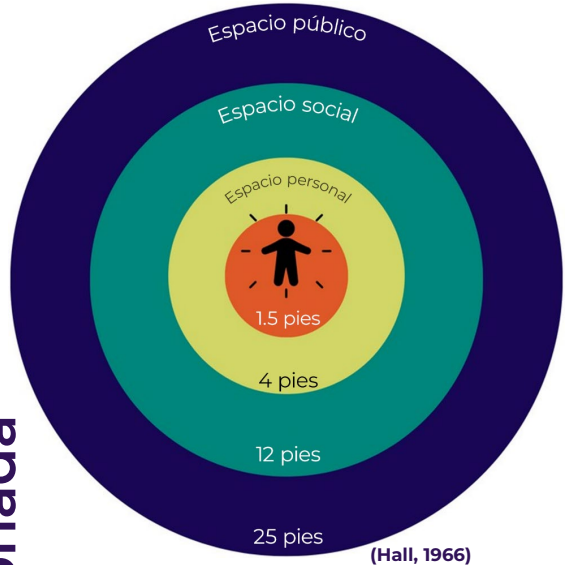
In some cases the use of psychotropic medications may be indicated to prevent worsening overamping symptoms or to resolve and episode of overamping.

POST ACUTE MANAGEMENT & CARE

Develop a post-acute care plan and safety plan for individuals who have experienced overamping, including incorporation of overamping prevention strategies.

- **Harm reduction strategies**
- **Developing a safety plan**
- **Acknowledgement of safe space/people**
- **Connect/referrals to resources/communities to build support network**
- **Safer use kits (smoking, sniffing, booty-bumping)**

INTERVENCIÓN CONDUCTUAL



(Hall, 1966)

Disminución escalonada

NO haga lo siguiente:

- Acercarse a un paciente que tiene un arma. Mirar directamente a los pacientes o solicitar contacto visual.
- Acorralar o ponerse enfrente del paciente.
- Hacer gestos repentinos que puedan interpretarse como amenazantes.
- Validar el delirio/alucinación que la persona está experimentando.

Haga los siguiente:

- Ser consciente de su propia seguridad. Minimizar los estímulos y las distracciones.
- Contar con un punto de salida/una forma discreta de solicitar asistencia.
- Formular preguntas abiertas centradas en el bienestar del paciente.
- Validar la experiencia emocional que la persona está sintiendo.

Escanee el código QR para obtener la estrategia de disminución escalonada de AGRO+ en la práctica clínica

INTERVENCIÓN FARMACOLÓGICA

Protocolo farmacológico:
1ª línea: Benzodiazepines
2ª línea: Antipsicóticos

Objetivos:

1. Determinar los síntomas más angustiantes de la sobredosis desde una perspectiva psiquiátrica.
2. Evitar acudir a la sala de emergencias y participar en actos legales de seguridad pública/penal.
3. Promover la participación de los proveedores de atención ambulatoria.

Escanee el código QR para obtener el Protocolo de medicamentos ambulatorios para sobredosis de psicoestimulantes.

Clínica START
617-414-7490
START@BMC.ORG
11 Melnea Cass Blvd, Boston, MA, 02119

START
Stimulant Treatment and Recovery Team
Grayken Center for Addiction Training & Technical Assistance
Boston Medical Center

BSAS
Prevent • Treat • Recover • For Life

BOSTON UNIVERSITY

GUÍA DEL PROVEEDOR PARA UNA SOBREDOSIS

IDENTIFICACIÓN

Reconocer el impacto que tiene proporcionar atención sin prejuicios y fomentar un entorno seguro y de apoyo en la calidad de la atención y los resultados de las personas que consumen estimulantes.

(SAMHSA, CONSEJO 33)

SÍNTOMAS DE UNA SOBREDOSIS

Síntomas psiquiátricos

- Paranoia.
- Percepción alterada de la realidad.
- Ideas persecutorias del mundo.
- Inquietud.
- Alucinaciones visuales, auditivas o táctiles.
- Respuesta ante el trauma.
- Psicosis
- Comportamientos de protección: hipervigilancia, ansiedad, agitación, postura defensiva.

Síntomas físicos

- Dolor de cabeza.
- Náuseas/vómitos.
- Apretar la mandíbula.
- Movimientos espásticos.
- Movimientos coreiformes.
- Boca seca.
- Hipertensión.
- Hipertermia.
- Taquicardia.
- Dolor de pecho.
- Insomnio.
- Convulsiones.
- Trastornos del ritmo cardíaco

CÓMO RESPONDER ANTE UNA SOBREDOSIS

1. CÓMO RECONOCER LA SOBREDOSIS

La sobredosis se produce en un espectro. Inicialmente puede presentarse con síntomas leves y progresar a síntomas más intensos y potencialmente mortales que conlleva un sueño prolongado o la falta de este.

2. INTERVENCIÓN DE SALUD CONDUCTUAL

- Escuchar activamente y transmitir empatía.
- Validar la respuesta emocional del paciente sin respaldar sus delirios.
- Ayudar al paciente a desarrollar un plan de seguridad a corto plazo para que se reincorpore a la comunidad.

3. INTERVENCIÓN FARMACOLÓGICA

En algunos casos, se puede indicar el uso de medicamentos psicotrópicos a fin de prevenir el agravamiento de los síntomas de sobredosis o superar un episodio de esta.

CONTROL Y ATENCIÓN DE AGUDOS POSTERIORES

Desarrollar un plan de atención aguda posterior y un plan de seguridad para personas que han experimentado una sobredosis, incluida la incorporación de estrategias de prevención de sobredosis.

- **Estrategias de reducción de daños.**
- **Desarrollar un plan de seguridad.**
- **Reconocimiento de un espacio y personas seguras.**
- **Poner en contacto/derivar a recursos/comunidades para crear una red de apoyo.**
- **Kits de consumo más seguro (para fumar, aspirar, jeringa sin aguja con drogas diluidas en agua)**

AMBULATORY MEDICATION PROTOCOL PSYCHOSTIMULANT OVERAMPING

	Drug	Dose	Route	Monitoring
First Line Benzodiazepines	Lorazepam	0.5mg-1mg, repeat in 30-60min	PO	Monitor vital signs and for decreased agitation. If sleeping check q60min.
Second Line Antipsychotics	Olanzapine	5-10mg repeat in 120min	PO or IM	Monitor for vital signs and for decreased agitation. Assess for extrapyramidal symptoms.

START Clinic
617-414-7490
START@BMC.ORG
11 Melnea Cass Blvd, Boston, MA, 02119

(SAMHSA, TIP 33)

POST OVERAMPING EDUCATION

You have just been through feeling too uncomfortable or weird (not in a nice way) after taking stimulants. You were experiencing overamping,

1 EAT, STAY HYDRATED

We recommend trying to eat and drink more in the next 24 to 48 hours to make up for possible missed food and lack of water.

2 AVOID

We recommend avoiding ongoing use until symptoms of overamping clears up.

- When avoiding expect a crash (being fatigued, sleepy, groggy).
- Moving around and getting outside may be helpful to improve mood and energy levels.

3 STAY AWAY

Stay away from stimulating situations with bright lights, loud noises, and chaotic environments.

4 SELF CHECK IN

Reality testing is important. If you aren't sure if something is real using skills to confirm the feeling or experience is important.

5 FIND HELP

If you have gotten medications for overamping, it is possible that some of the symptoms you were having before (hearing voices, seeing shadow people, meth mites) may return. We want you to come back for re-evaluation with any persistent symptoms.

- Find a safe person who you can reach out to if the symptoms get worse or return.
- Plan to come back to clinic for re-evaluation
- If you have feelings of self-harm or suicide we recommend getting emergency medical care to keep you safe.

Clínica START
617-414-7490
START@BMC.ORG
11 Melnea Cass Blvd, Boston, MA, 02119

(SAMHSA, CONSEJO 33)

INFORMACIÓN POSTERIOR A UNA SOBREDOSIS

EDUCACIÓN

Justo después de consumir estimulantes se sintió demasiado incómodo o extraño (no de una manera agradable). Estabas experimentando un episodio de sobredosis.

1 COMA Y MANTÉNGASE HIDRATADO

Recomendamos que intente comer y beber más durante las próximas 24 a 48 horas para compensar los posibles casos en los que no comió ni bebió nada.

2 EVITE

Recomendamos que evite el consumo continuo hasta que los síntomas de sobredosis hayan desaparecido.

- Al evitarlo, espere sentir un colapso, es decir, sentirse fatigado, somnoliento, aturdido.
- Estar en movimiento y salir al aire libre pueden ser útiles para mejorar los niveles de energía y el estado de ánimo.

3 MANTÉNGASE ALEJADO

Manténgase alejado de situaciones estimulantes que incluyan luces brillantes, ruidos fuertes y entornos caóticos.

4 AUTOCONTROL

La prueba de la realidad es importante. Si no está seguro de si algo es real, es importante que utilice sus habilidades para confirmar si el sentimiento o la experiencia es real.

5 BUSQUE AYUDA

Si ha recibido medicamentos para la sobredosis, es posible que algunos de los síntomas que presentó anteriormente regresen, por ejemplo, escuchar voces, ver personas en las sombras y alucinaciones de insectos. Si presenta algún síntoma persistente, queremos que regrese para realizarle una nueva evaluación.

- Busque a una persona con la que se sienta segura y con quien pueda comunicarse si los síntomas empeoran o regresan.
- Planifique regresar a la clínica para que le realicemos una nueva evaluación.
- Si tiene sentimientos de autolesión o suicidio, le recomendamos que busque atención médica de emergencia para que esté a salvo.

RED FLAGS

Reasons to get further medical care in the Emergency Department

HEART ATTACK
(CRUSHING CHEST PAIN, WORSE PAIN WITH MOVING AROUND, INTENSE SWEATING)

STROKE
(NUMBNESS OR NOT ABLE TO MOVE ONE PART OF BODY, FACIAL DROOP, CAN'T SPEAK)

OVERHEATING
BODY TEMPERATURE OVER 104 DEGREES

CHEST PAIN

SHORTNESS OF BREATH

SEIZURE

Call 9-1-1
During A Medical Emergency

Calling 9-1-1
During A Medical Emergency

How to call 9-1-1:

State the actual negative effect, not overamping/overdosing. You can say "my friend is having multiple seizures and they need help". Tell paramedics what drug they took when they arrive.

Good Samaritan Policies:

These policies protect the person who called for help from being arrested. It can be different state to state so it's important to be aware of the Good Samaritan policies in your area. You can check some out here: **nextdistro.org/policies**

START Clinic
617-414-7490
START@BMC.ORG
11 Melnea Cass Blvd, Boston, MA, 02119

START Stimulant Treatment and Recovery Team

BSAS Prevent • Treat • Recover • For Life

Grayken Center for Addiction Training & Technical Assistance
Boston Medical Center

BOSTON UNIVERSITY

OVERAMPING GUIDE

Have you ever felt too uncomfortable or weird (not in a nice way) after taking stimulants?

You could have been "overamping."

Stimulants like crack/cocaine and meth can lead to side effects that are unwanted and uncomfortable or potentially dangerous.
Knowing what it is and what to do can help you be prepared if it happens.

(SAMHSA, TIP 33)

Psychological Symptoms Of Overamping

Listen to your body. It's okay if you start feeling any of these effects. Noticing can be the first step to helping you get the help and support.

- Paranoid
- Distrustful
- Afraid
- Seeing things that others are not
- Hearing people talking about you
- Feeling bugs on your skin or in your body

Prevention Tips

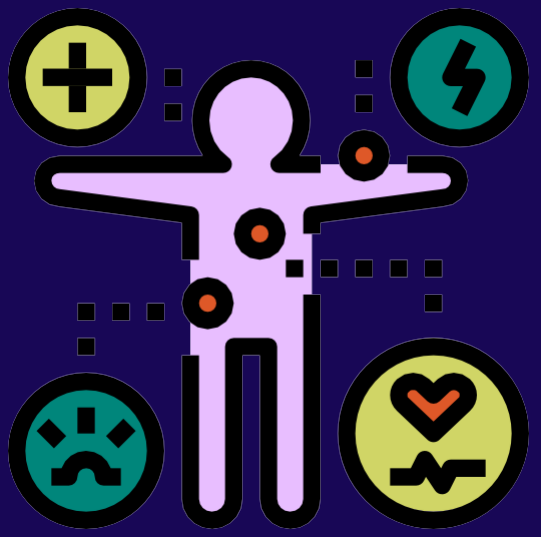
Some tips that may help symptoms of overamping stop or prevent them from starting include:

- Taking breaks from use
- Sleeping
- Drink water
- Eat food
- Change your environment
- Walking, walking, walking!
- Avoid using many substances at once.
- Take smaller doses of your drug.

Physical Signs of Overamping

Listen to your body. It's okay if you start feeling any of these effects. Noticing can be the first step to helping you get the help and support.

- Fast heart beat
- Bad headache
- Upset stomach
- Jerky movements that you can't control
- Chest pain
- Dry mouth
- Passing out but still breathing



SEÑALES DE ADVERTENCIA

Motivos para recibir atención médica adicional en el Departamento de Emergencias

ATAQUE CARDÍACO
(DOLOR OPRESIVO EN EL PECHO, EL DOLOR EMPEORA AL MOVERSE, SUDORACIÓN INTENSA)

DERRAME CEREBRAL
(ENTUMECIMIENTO O NO PODER MOVER UNA PARTE DEL CUERPO, CAÍDA FACIAL, NO PODER HABLAR)

TEMPERATURA ELEVADA
LA TEMPERATURA CORPORAL SUPERA LOS 104 GRADOS

DOLOR DE PECHO

DIFICULTAD PARA RESPIRAR

CONVULSIONES

Llamar al 9-1-1
Si se presenta una emergencia médica

Llame al 9-1-1
Si se presenta una emergencia médica

Cómo llamar al 9-1-1:

Indique el efecto negativo real, no diga que es una sobredosis. Puede decir "mi amigo presenta múltiples convulsiones y necesita ayuda". Cuando los paramédicos lleguen, coméntele qué droga consumió.

Políticas del buen samaritano:

Estas políticas protegen de ser arrestada a la persona que solicitó ayuda. Estas suelen diferir dependiendo del estado, por ello, es importante que esté al tanto de las políticas del buen samaritano en su área. Puede consultar las políticas de algunos estados aquí:
nextdistro.org/policies

Clínica START
617-414-7490
START@BMC.ORG
11 Melnea Cass Blvd, Boston, MA, 02119

START
Stimulant Treatment and Recovery Team

BSAS
Prevent • Treat • Recover • For Life

Grayken Center for Addiction Training & Technical Assistance
Boston Medical Center

BOSTON UNIVERSITY

GUÍA DE SOBREDOSIS

¿Alguna vez se ha sentido demasiado incómodo o extraño (no de una manera agradable) después de tomar estimulantes?

Podría haber tenido una sobredosis.

Los estimulantes como el crack, la cocaína y la metanfetamina pueden provocar efectos secundarios no deseados, incómodos o potencialmente peligrosos. Saber qué significa y qué debe hacer puede ayudarle a estar preparado en caso de que esto suceda.

(SAMHSA, CONSEJO 33)

Síntomas psicológicos de una sobredosis

Escuche a su cuerpo. Es normal que comience a sentir alguno de los siguientes efectos. Reconocerlos puede ser el primer paso para ayudarle a recibir ayuda y apoyo.

- Paranoia.
- Desconfianza.
- Miedo.
- Ve cosas que otras personas no ven.
- Escucha a personas hablando de usted.
- Siente que hay insectos caminando sobre su piel o cuerpo.

Consejos para la prevención

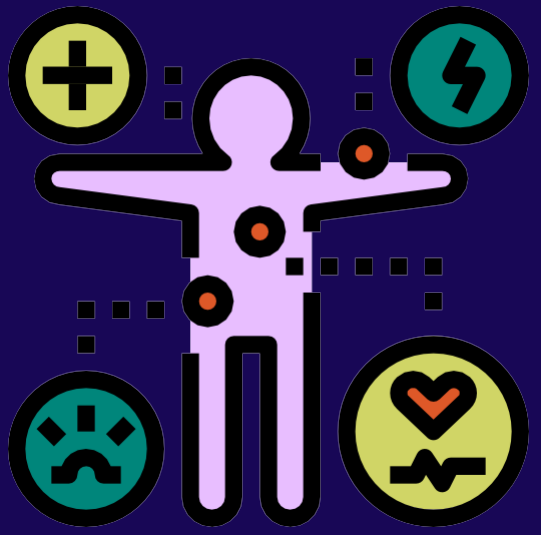
Algunos consejos que pueden ayudar a detener o prevenir que los síntomas de una sobredosis comiencen incluyen los siguientes:

- Tomar descansos después de cada consumo.
- Dormir.
- Beber agua.
- Ingerir alimentos.
- Cambiar de entorno.
- Caminar, caminar y seguir caminando.
- Evitar el consumo de muchas sustancias a la vez.
- Consumir dosis más pequeñas de la droga.

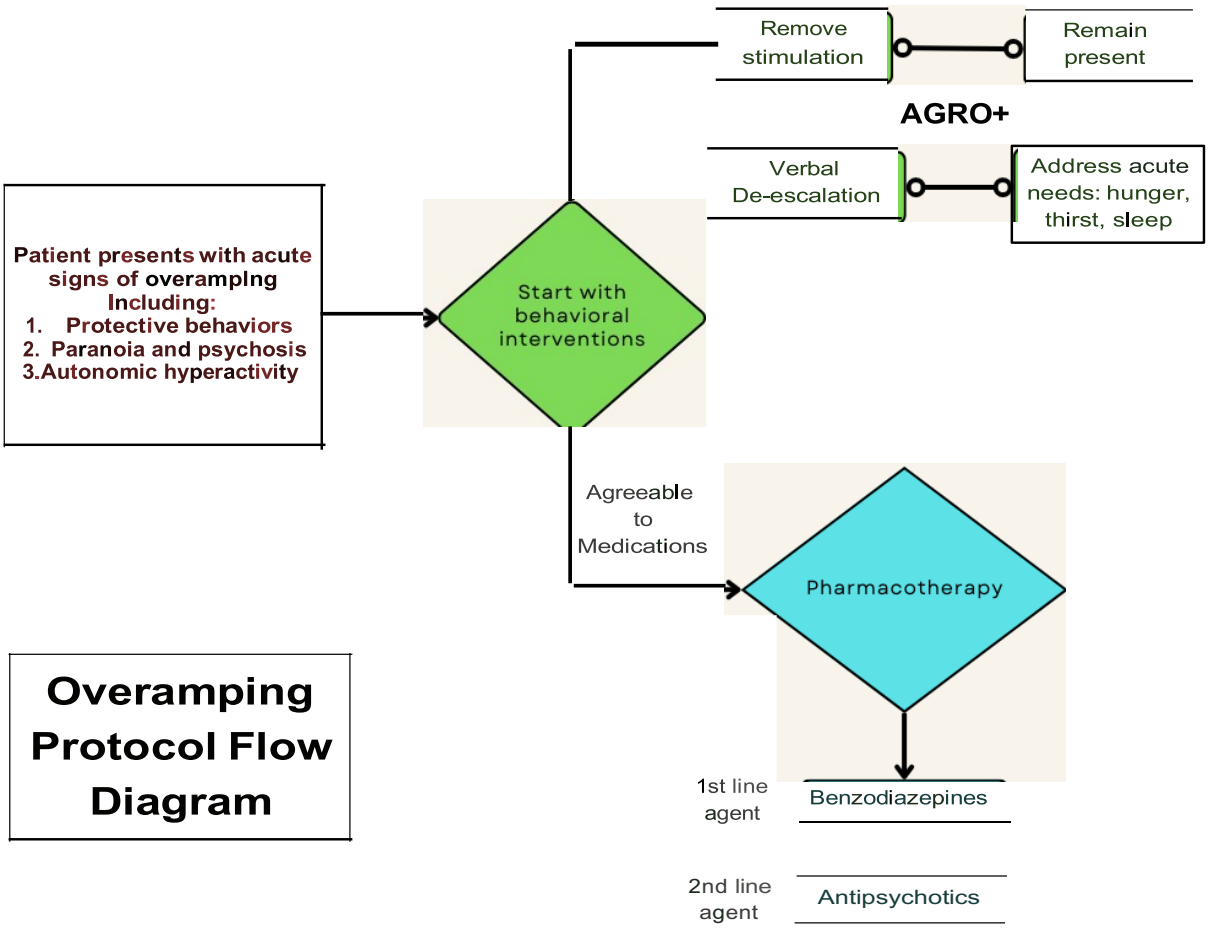
Señales físicas de una sobredosis

Escuche a su cuerpo. Es normal que comience a sentir alguno de los siguientes efectos. Reconocerlos puede ser el primer paso para ayudarle a recibir ayuda y apoyo.

- Ritmo cardíaco acelerado.
- Dolor de cabeza intenso.
- Malestar estomacal.
- Movimientos bruscos que no puede controlar.
- Dolor en el pecho.
- Boca seca.
- Desmayarse, pero sigue respirando.



Overamping Protocol Flow Diagram



A — ASSESS

Using a patient-centered focus, asses the cause of the patient's agitation. CALMLY engage the patient in conversation.

G — GAUGE

How are you feeling? Be mindful of the feelings that you may be projecting that may escalate or de-escalate the patient.

R — RESPOND

Be calm yet firm in your interactions. Use open ended questions and empathetic listening to respond to the patient's concerns.

O — OBSERVE

Observe verbal and non-verbal cues. Is this working?

+ — POSITIVE REINFORCEMENT

As the patient starts to de-escalate offer them something. A place to sit, a glass of water, a snack.

APPENDIX VIII: NURSING NOTES

START Initial Nursing Intake

Patient name:
Date of birth:
Medical Record Number:
Insurance
Primary care provider:

Vitals filed for this visit:

Problem list on file for this patient:

Social History
  Substance and Sexual Activity
    Alcohol use: Not on file

Social History
  Substance and Sexual Activity
    Drug use: Not on file

Social History
  Tobacco Use
    Smoking status: Not on file
    Smokeless tobacco: Not on file

The patient is completing triage for the START clinic

The pt reports that their primary stimulant of choice is ***.
The patient reports that their last use of stimulants was ***.
The patient reports that they first used stimulants at age ***.
The pt reports using the following additional substances: ***.
Additional DX:***
The pt reports the following negative consequences from their stimulant use: ***.
The pt reports that their longest period of abstinence from stimulants was *** in the setting of ***.
Pt supports:***
PT strengths:***
Pt living:***
PCP:***

The patient endorses the following perceptual disturbances in the setting of stimulant use: ***

Discussed contingency management to patient which involves 3 components physical activity, engagement, and stimulant free urine. Reward and recovery was also discussed with patient.

Exercise/ PA: Engagement: Stimulant free Urine
Verify: Verify: Verify:

DSM 5 Criteria:
Date assessed:
In the past year, have you:
1. __ had times when you ended up using more or longer than intended?
2. __ more than once wanted to cut down or stop using, or tried to, but couldn't?
3. __ spent a lot of time using? Or being sick or getting over other after effects?
4. __ wanted to use so badly you couldn't think of anything else?

5. __ found that using or being sick from using often interfered with taking care of your home or family? Or caused job troubles? Or school problems?
6. __continued to use even though it was causing trouble with your family or friends?
7. __ given up or cut back on activities that were important or interesting to you, or gave you pleasure, in order to use?

8. __ more than once gotten into situations while or after using that increased your chances of getting hurt?
9. __ continued to use even though it was making you feel depressed or anxious or adding to another health problem? Or after having had a memory blackout?

10. __ had to use much more than you once did to get the effect you want? Or found that your usual use had much less effect than before?
11. __found that when the effects were wearing off, you had withdrawal symptoms?

Severity of substance use disorder is mild (2-3 symptoms), moderate (4-5 symptoms), or severe (6 or more symptoms).
Note that tolerance and withdrawal (the last two criteria) in the absence of other criteria do not indicate substance use disorders and should not be diagnosed as such.

Assessment: ***
Problem List Items Addressed This Visit
None

Plan of care:
Quit date: ***
Harm reduction:***
RTC:***
Engagement:***

@RESULTRCNT[1W]@

Gender: adult
DOB: There is no date of birth on file.
ID: **

History Substance Mis-use, Nicotine/Tobacco Use & Gambling
For pharmaceutical drugs prescribed for the client, only code misuse (more than the recommended dosage) or non-medical use. (Example - If the client was prescribed a benzodiazepine for a mental health disorder and used per instruction, do not list on History Table.) Note: For the safety of the client all drugs used must be recorded in the client record.(See Manual for commercial names.)

START NURSING FOLLOW-UP NOTE TEMPLATE

Visit type:

☐ Scheduled
☐ Call back
☐ Walk-in
☐ Random call back

Reason for visit: _____

Medication for Addiction Treatment:

☐ Transmucosal buprenorphine/naloxone ☐ Transmucosal buprenorphine
☐ Injectable buprenorphine ☐ Oral naltrexone
☐ Injectable naltrexone ☐ Other: _____

Current dose of transmucosal buprenorphine product:

☐ 1 = 2 mg ☐ 4 = 8 mg ☐ 7 = 16 mg ☐ 10 = 28 mg
☐ 2 = 4 mg ☐ 5 = 10 mg ☐ 8 = 20 mg ☐ 11 = 32 mg
☐ 3 = 6 mg ☐ 6 = 12 mg ☐ 9 = 24 mg ☐ 12 = Other _____

Current dose of injectable buprenorphine:

Sublocade: ☐ 100 mg ☐ 300 mg

Brixadi: ☐ 8 mg ☐ 16 mg ☐ 24 mg ☐ 32 mg
☐ 64 mg ☐ 96 mg ☐ 128 mg

Current dose of naltrexone:

☐ 25 mg (oral) ☐ 50 mg (oral) ☐380 mg (injectable)

Is patient taking medication for addiction treatment as directed (dose, administration, etc.)?

☐ 1 = Yes ☐ 2 = No

The patient's dose is:

☐ Stable
☐ Titrating up
☐ Tapering down

Is patient experiencing any of the following?

☐ Cravings
☐ Withdrawal symptoms
☐ Side effects
☐ Other: _____
☐ Patient denies cravings/withdrawal symptoms

Comments: Discussed contingency management to patient which involves 3 components pjysical activity, engagement, and stimulant-free urine. Reward and recovery was also discussed with patient.

Exercise/PA:	**Engagement:**	**Stimulant free urine:**
Verify:* **	**Verify:*** **	**Verify:*** **

Has patient used any substances? (**Check all that apply)**

□ Fentanyl
□ Heroin
□ Oxycodone
□ Morphine
□ Illicit buprenorphine
□ Other opioid
□ Cocaine
□ Alcohol
□ Barbiturate
□ Benzodiazepines
□ Amphetamines
□ Methamphetamines
□ Cannabinoid
□ Patient endorses no substance use
□ Other: _____

Route of substance use:

□ Oral
□ Smoke/inhalation
□ Intranasal
□ Intrarectal
□ Injection
□ Other: _____

Does patient have access to nasal naloxone?

□ 1 = Yes □ 2 = No

If no access to naloxone:

□ Patient was provided with a prescription for nasal naloxone today
□ Patient was dispensed a nasal naloxone rescue kit at time of clinic visit
□ Patient was provided with information about how to access naloxone
□ Patient declined naloxone at time of encounter
□ Comment: _____

Is patient engaged in counseling or psychotherapy? □ 1 = Yes □ 2 = No

Details of psychotherapy (e.g., 1:1 counseling or group, psychiatry, name of provider, location, frequency of visits, etc.):

_____

Is there a release of information on file to collaborate? □ 1 = Yes □ 2 = No

Is patient engaged in peer support services? □ 1 = Yes □ 2 = No
Details of peer support:

_____

Is the patient currently engaged with any of the following agencies?

□ Department of Children and Families
□ Criminal-Legal System
□ Vocational Training
□ School
□ Other/Comment: _____

Is there a release of information on file to collaborate? □ 1 = Yes □ 2 = No

Details of release of information: _____

Where is the patient currently staying?

□ Own house or apartment
□ House or apartment belonging to a friend or family member
□ Residential treatment program
□ Shelter
□ Street
□ Sober House
□ Other/Comment: _____

Sexually active: □ 1 = Yes □ 2 = No

Gender identity of sexual partner(s):

□ Man
□ Woman
□ Non-binary
□ Gender nonconforming
□ Genderfluid
□ Intersex
□ Other/Comment: _____

Does sexual partner identify as transgender: □ 1 = Yes □ 2 = No

What contraception is the patient using? (check all that apply)
□ Male condoms
□ Oral contraceptives
□ Injection (e.g., Depo-Provera)
□ Hormonal implant
□ Intrauterine device/contraception (IUD or IUC)
□ Vaginal ring
□ Patch
□ Rhythm/fertility awareness methods/withdrawal
□ Female barrier method (e.g., diaphragm, female condom)
□ Permanent medical reason (e.g., menopause, bilateral tubal ligation, hysterectomy)
□ Abstinence
□ None
□ Trying to conceive
□ Other/Comment: _____

****For people with female sex organs [Delete if not applicable]: LMP:****

_____

If menses was more than one month ago, would you like a pregnancy test today?

□ 1 = Yes □ 2 = No

If positive result:

□ Patient desires prenatal care: offered prenatal vitamins and facilitated warm-handoff to Obstetrics and Gynecology team to begin prenatal care
□ Patient does not wish to continue pregnancy: connected to appropriate Obstetrics and Gynecology team
□ Patient unsure: offered prenatal vitamins and connected to appropriate Obstetrics and Gynecology team
□ Comment: _____

Are there any medical concerns today? □ 1 = Yes □ 2 = No

If yes, details: _____

PCP Name: _____

Was the last OBAT provider visit within 4 months? □ 1 = Yes □ 2 = No

When were the patient's last labs drawn? _____

Toxicology Screen collected? □ 1 = Yes □ 2 = No

Was recovery support and education provided today? □ 1 = Yes □ 2 = No

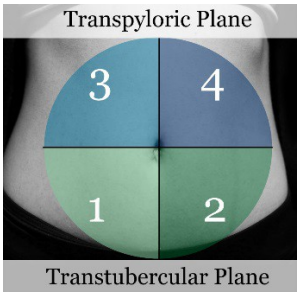
Was a form of injectable medication administered during the visit?

□ No
□ Yes: Injectable naltrexone
□ Yes: Injectable buprenorphine
□ Other/Comment: _____

Dose of injectable medication administered today: _____

Injection location:

□ Right upper quadrant of gluteal muscle
□ Left upper quadrant of gluteal muscle
□ Transpyloric plane 1
□ Transpyloric plane 2
□ Transpyloric plane 3
□ Transpyloric plane 4
□ Other/Comment: _____



Lot: _____

Expiration: _____

Appearance of most recent injection site: _____

Prescription Drug Monitoring Program checked? □ 1 = Yes □ 2 = No

Refill sent? □ 1 = Yes □ 2 = No

Visit summary and Plan:

_____

_____

_____

START RN FOLLOW-UP INJECTION NOTE

Visit Type: {OBAT Visit Type:25594}

History of Present Illness/Reason for Visit:
No patient name on file. is a No DOB on File. adult patient presenting for scheduled subcutaneous injection of buprenorphine ER and ongoing SUD treatment.

Medication for Addiction Treatment: {Medication for Addiction Treatment:25595}

Discussed contingency management to patient which involves 3 components physical activity, engagement, and stimulant free urine. Reward and recovery were also discussed with patient.

Exercise/ PA:	Engagement:	Stimulant free Urine:
Verify:***	Verify:***	Verify:***

Patient used the following substances: {OBAT substance list:25597}
Route of substance use: {OBAT substance route:25598}

Does patient have ready access to naloxone? {YES No:23203}, If no, then {OBAT Naloxone:25599}

Physical exam:

Previous injection site: ***

Benefit has been identified as {Medical/Pharmacy Benefit:25431} under *** insurance plan.

History of buprenorphine ER injection treatment (in chronological order):

Date, {Dose, Buprenorphine ER injectable:25430} buprenorphine ER, location of injection {BUPE ER, ANATOMY ABDOMEN:25429:::1}
Date, {Dose, Buprenorphine ER injectable:25430} buprenorphine ER, location of injection {BUPE ER, ANATOMY ABDOMEN:25429:::1}

Today's dose of buprenorphine ER: {Dose, Buprenorphine ER injectable:25430}

Today's injection location: {BUPE ER, ANATOMY ABDOMEN:25429:::1}

Lot Number: ***
Expiration Date: ***
Serial Number: ***

Patient tolerated medication and injection without complications during visit.

VISIT SUMMARY AND TREATMENT PLAN
Details: ***

Reviewed care plan, relapse prevention and harm reduction strategies.

Supplemental buprenorphine plan (if applicable):

{dose; buprenorphine:21659} buprenorphine/naloxone SL daily/BID for *** days

Next follow-up visit in *** {Time; days - weeks:18646}.

Patient {IS/IS NOT:24599} engaged in psychiatry with ***. Presenting to clinic with {Exam; psychiatric mood:30298} mood and {thought content:31889::"appropriate","logical"}.

Patient {IS/IS NOT:24599} engaged in counseling with

Patient {IS/IS NOT:24599} attending mutual support groups:

Patient {IS/IS NOT:24599} engaged with peer support services:

Is there a release of information on file to collaborate with other providers or agencies? {YES/NO:23543}

Is the patient engaged in the following: {OBAT agencies:25600}

Patient is currently sleeping in {OBAT currently sleeping:25601}

Sexually active? {YES No:23203} Partner(s): {OBAT SEXUAL PARTNERS:25602}
Contraception type: {OBAT contraception:25603}
Patient {IS/IS NOT:24599} interested in PrEP.

**FOR PEOPLE WITH FEMALE SEX ORGANS [DELETE if not applicable]
LMP: ***
Last pregnancy test result and date:

If last pregnancy test was > 6 months ago, would you like to take a pregnancy test today? {YES/NO:23543}

If patient is positive, then {OBAT pregnant:25604}

Any medical concerns today?
Details: ***

Any psychiatric concerns today ?
Details:***

Toxicology screen collected today: {YES/No:23203}

The last PCP/OBAT provider visit was within 4 months: {Yes/If No,comment:23583}

I spent *** minutes interviewing the patient, collecting data, formulating/reviewing an assessment and plan with OBAT/START provider and OBAT/START team, communicating with patient and coordinating with other providers. I spent *** minutes administering the injection.

START RN FOLLOW-UP NOTE

Visit Type: {OBAT Visit Type:25594}

History of Present Illness/Reason for Visit
No patient name on file. is a No DOB on File. adult patient presenting for scheduled follow-up of ongoing SUD treatment.

Medication for Addiction Treatment: {Medication for Addiction Treatment:25595}

Discussed contingency management to patient which involves 3 components physical activity, engagement, and stimulant free urine. Reward and recovery was also discussed with patient.

Exercise/ PA: Engagement: Stimulant free Urine:
Verify:*** Verify:*** Verify:***

Patient used the following substances: {OBAT substance list:25597}
Route of substance use: {OBAT substance route:25598}

Does patient have ready access to naloxone? {YES No:23203}, If no, then {OBAT Naloxone:25599}

Physical exam:

Last BM:***

VISIT SUMMARY AND TREATMENT PLAN
Details: ***

Reviewed care plan, relapse prevention and harm reduction strategies.

Next follow-up visit in *** {Time; days - weeks:18646}.

Patient {IS/IS NOT:24599} engaged in psychiatry with ***. Presenting to clinic with {Exam; psychiatric mood:30298} mood and {thought content:31889}.

Patient {IS/IS NOT:24599} engaged in counseling with

Patient {IS/IS NOT:24599} attending mutual support groups:

Patient {IS/IS NOT:24599} engaged with peer support services:

Is there a release of information on file to collaborate with other providers or agencies? {YES/NO:23543}

Is the patient engaged in the following: {OBAT agencies:25600}

Patient is currently sleeping in {OBAT currently sleeping:25601}

Sexually active? {YES/NO:23203} Partner(s): {OBAT SEXUAL PARTNERS:25602}

Contraception type: {OBAT contraception:25603}
Patient {IS/IS NOT:24599} interested in PrEP.

**FOR PEOPLE WITH FEMALE SEX ORGANS [DELETE if not applicable]
LMP: ***
Last pregnancy test result and date:

If last pregnancy test was > 6 months ago, would you like to take a pregnancy test today? {YES/NO:23543}

If patient is positive, then {OBAT pregnant:25604}

No patient ID available.

Any Medical Concerns Today?
Details: ***

Any psychiatric concerns today ?
Details:***

Recent Relevant Results

Toxicology screen collected today: {YES No:23203}

The last PCP/OBAT provider visit was within 4 months: {Yes/If No,comment:23583}

Plan of care:

Quit date: ***
Harm reduction:***
RTC:***
Engagement:***

I spent *** minutes interviewing the patient, collecting data, formulating/reviewing an assessment and plan with OBAT provider and team, communicating with patient and coordinating with other providers.

BOSTON MEDICAL CENTER | START
Stimulant Treatment and Recovery Team
T: 617-414-7490
F: 617-414-7491

Patient Acknowledgment

Please sign your initials next to the following agreements. If you have any questions or have not received this material, please feel free to ask your clinician.

1. I agree that I have received a copy of the Program Guidelines and have reviewed them with the START Program. _____

2. I agree that I have received a handout on the Phoenix gym, including information about the weekly exercise groups. _____

3. I agree that I have received a handout on the Recovery Rewards system, which details how to track my point balance, earn points, and describes the rewards for which I am eligible. _____

As a patient in the Stimulant Treatment and Recovery Team (START) program, I acknowledge that the START Clinic, including the providers, nurses, care coordinators, medical assistants, counselors, outreach workers, and administrative personnel are working with me in recovery. The START program and its staff are safe, and I can seek their assistance if I am ever feeling unsafe.

_____
(Name of Patient)

_____ _____
(Signature of Patient) (Date Signed)

_____ _____
(Signature of Witness) (Date Signed)

BOSTON MEDICAL CENTER | START Stimulant Treatment and Recovery Team
T: 617-414-7490
F: 617-414-7491

START Referral Form

Thank you for your interest in the Stimulant Treatment and Recovery Team. Please answer the following questions and fax this form to (617) 414-7491. We will contact the patient typically within seven (7) business days. We will attempt to contact the patient three (3) times. Please see the second page to see if additional steps are needed based on the patient's insurance.

1) Patient Full Name:

2) Date of Birth:

3) Insurance Company:

4) Insurance ID:

5) Name of provider:

6) Program of provider:

7) Provider phone number:

8) Provider email:

9) What are the best ways to reach the patient?

☐ Phone call — Home number:
☐ Text message — Cell number:
☐ Email — Email:

10) Is patient diagnosed with a…

a) Cocaine Use Disorder? ☐Yes ☐No ☐Primary ☐Secondary ☐Mild ☐Moderate ☐Severe

b) Other stimulant use disorder? ☐Yes ☐No ☐Primary ☐Secondary ☐Mild ☐Moderate ☐Severe
If yes, which substance(s)?

c) If none of the above, please describe patient's patterns of use and why they would be a good fit for the START Clinic.

11) Is patient aware they will receive correspondence from START in regards to starting treatment? If no, please inform patient. ☐ Yes ☐ No

BOSTON MEDICAL CENTER | START Stimulant Treatment and Recovery Team
T: 617-414-7490
F: 617-414-7491

Stimulant Treatment and Recovery Team

Admission and Discharge Criteria

ADMISSION

Patients who meet the criteria for admission to the START Clinic must have:

- A primary or secondary stimulant use disorder
    - Patients with polysubstance use may be referred to a different treatment setting if withdrawal management or stabilization is warranted prior to care initiation in the START clinic.
    - Unhealthy stimulant use may include patients using methamphetamines, cocaine, MDMA, or illicitly obtained prescription stimulants.
- Willingness to receive primary care through duration of treatment.
    - Patients may continue to see their current primary care provider at any health center.
    - Patients who are without a primary care provider will be assigned a provider within Family Medicine.

DISCHARGE

Patients enrolled in the START Clinic will be discharged from services if:

- They have not engaged in any way (telephonically, electronically, or in-person) with program staff in over 60 days.
    - Discharge from the START Clinic for disengagement with providers does NOT preclude patients from re-enrolling.
    - Patients who are lost-to-follow-up will be welcomed back warmly when they represent for care and every effort should be made to mitigate future loss-of-follow-up events.
- Administrative discharge of patients from the program is reserved for patients who are violent, cause injury to staff, or are unable to respect the safety of other patients in the treatment program.
    - Any staff member may request team review of patient for administrative discharge or alternative engagement strategy

START

Stimulant Treatment and Recovery Team

COMMUNITY AGREEMENTS

- Sharing is caring!
- Lift each other up
- Be kind/ Respectful
- Confidentiality
- Do not speak over each other
- No glorifying substance use
- Keep cellphone on silent or vibrate
- Stay in the moment
- Stay on topic
- Be mindful of language
- 30 minute grace period (Art Group does not have a grace period)
- Enter group quietly, please do not interrupt
- No disrespecting staff
- No threatening of any kind
- Only speak when holding the stop sign
- If you see something, say something

BOSTON MEDICAL CENTER | START Stimulant Treatment and Recovery Team
T: 617-414-7490
F: 617-414-7491

Stimulant Treatment and Recovery Team (START)

Program Guidelines

Thank you for joining us at the Stimulant Treatment and Recovery Team (START). We want to help you meet your personal goals for your stimulant use and overall health. The following guidelines are used for patients and providers of the START Program.

1) Each patient will complete an intake with the program coordinator and a treatment plan with the nurse.

- The program coordinator will complete state-required intake questions.
  - This process should take no more than one (1) hour.
  - The questions may be personal in nature. Please respond to the best of your ability and comfort level, and you can always refuse or defer answering the question.
  - You may ask to take a break at any time or complete the intake at a later date.
- You will be scheduled to meet with the nurse to create your treatment plan.
  - Your treatment plan is designed to help you meet your goals and will be reevaluated as your needs or desires change. Your input is the most important piece of creating a plan for your treatment.

2) Patients will meet with providers per their treatment plan, in-person or telephonically, unless otherwise discussed and agreed upon by the patient and their provider. Engaging with providers may include attending group counseling, meeting with a counselor, or having a visit with the START nurse or other medical provider.

- Your individualized treatment plan will specify the best way(s) to talk with you and will detail the kind of meetings you prefer (groups or individual).
- The frequency of your meetings with the START Program may change depending on your needs. If you are struggling to attend visits or arrive on time, we will work with you by reviewing your treatment plan and making changes with your input.
- Changing your treatment plan does not mean you have done anything wrong. It simply means that your original treatment plan isn't meeting your current needs. We want you to be successful, so if something isn't working, let us know and we can work together to help you.

3) All patients are part of the Recovery Rewards Program, which provides rewards for participating in recovery activities.

- Points are awarded weekly for completing three recovery activities - engaging with the START, exercising, and screening negative for stimulants in a urine test.
- You will be awarded five (5) points for completing a recovery activity. These points are earned on a weekly basis. Please see handout for more information.

T: 617-414-7490
F: 617-414-7491

4) Patients and providers of the START program should emphasize safety and respect.

- Illegal, threatening, or disruptive activities are not allowed in the clinic or on BMC campus.
- However, START recognizes that behaviors often *perceived* as disruptive and threatening may be a direct result of feeling unsafe. Feeling unsafe may be a result of side effects from high doses of stimulant drugs.
- When you feel unsafe or are in crisis, please ask to speak with staff members of the START Program to receive assistance.

BOSTON MEDICAL CENTER | START Stimulant Treatment and Recovery Team

Teléfono: 617-414-7490
Fax: 617-414-7491

Pautas del Programa para el Equipo de Tratamiento y Recuperación de Estimulantes (START)

Gracias por unirse a nuestro Equipo de Tratamiento y Recuperación de Estimulantes (START, por sus siglas en inglés). Queremos ayudarle a cumplir sus metas personales con respecto al uso de los estimulantes y a su salud en general. Las siguientes pautas se utilizan para los pacientes y proveedores del Programa START.

1) Cada paciente completará una admisión con el coordinador del programa y un plan de tratamiento con la enfermera.

- El coordinador del programa se comunicará con usted para completar las preguntas de admisión.
  - Este proceso no debe tomar más de una (1) hora.
  - Las preguntas pueden ser de naturaleza personal. Por favor responda de la mejor manera posible y según su nivel de comodidad.
  - Usted puede solicitar tomar un descanso en cualquier momento o completar la admisión en una fecha posterior.
- Se le programará una cita para reunirse con el miembro del personal de enfermería para elaborar su plan de tratamiento.
  - Su plan de tratamiento está diseñado para ayudarle a alcanzar sus metas y se reevaluará a medida que cambien sus necesidades o deseos. **Sus comentarios** son la parte más importante para la elaboración de un plan para su tratamiento.

2) Los pacientes se reunirán con los proveedores según su plan de tratamiento, en persona o por teléfono, a menos que el paciente y su proveedor acuerden otra cosa. Interactuar con los proveedores puede incluir asistir a asesoría grupal, reunirse con un consejero o tener una visita con la enfermera de START u otro proveedor médico.

- Su plan de tratamiento individualizado especificará la mejor manera de hablar con usted y detallará el tipo de reuniones que prefiere, ya sean grupales o individuales.
- La frecuencia de sus reuniones con el Programa START puede cambiar dependiendo de sus necesidades. Si tiene dificultades para asistir a las visitas o llegar a tiempo, trabajaremos con usted al revisar su plan de tratamiento y realizar cambios a partir de sus comentarios.
- Cambiar su plan de tratamiento no significa que usted haya hecho algo malo. Simplemente significa que su plan de tratamiento original no satisface sus necesidades actuales. Queremos que usted tenga éxito, por lo que si algo no funciona, háganoslo saber y trabajaremos juntos para ayudarle.

3) Todos los pacientes forman parte del Programa de Recompensas de Recuperación, que proporciona recompensas por participar en actividades de recuperación.

- Los puntos se otorgan una vez a la semana por completar tres actividades de recuperación: participar con el Programa START, hacer ejercicio y tener un resultado negativo en un examen de orina para estimulantes.
- Se le otorgarán cinco (5) puntos por completar una actividad de recuperación. Estos puntos se obtienen semanalmente. Consulte el folleto del Programa de Recompensas de Recuperación para obtener más información.

4) Los pacientes y proveedores del programa START deben enfatizar la seguridad y el respeto.

- No se permiten actividades ilegales, amenazantes o perjudiciales en la clínica ni en las instalaciones de BMC.
- Sin embargo, START reconoce que los comportamientos con frecuencia percibidos como perjudiciales y amenazantes pueden ser un resultado directo de sentirse inseguros. Sentirse inseguro puede ser el resultado de los efectos secundarios de altas dosis de medicamentos estimulantes.
- Cuando se sienta inseguro o esté en crisis, pida hablar con el personal del Programa START para recibir asistencia.

BOSTON MEDICAL CENTER | START Stimulant Treatment and Recovery Team
T: 617-414-7490
F: 617-414-7491

Recovery Rewards Program Acknowledgment

Please sign your initials next to the following agreements. If you have any questions or have not received this material, please feel free to ask your clinician.

1. I acknowledge that I can receive credit for exercising outside of the group, if I provide proof of exercise. I acknowledge that proof of exercise can include _____
    a. Exercising at a different time at the Phoenix and having a staff member sign my rewards sign-off sheet.
    b. Going to physical therapy and having your physical therapist sign rewards sign-off sheet.
    c. Completing physical exercise and showing START staff my Health app.
    d. A modified exercise plan created by my clinician to account for physical limitations.

2. I acknowledge that I am responsible for keeping track of my ClinCard. I understand that if I lose my card, I can contact the program coordinator to have it replaced. I understand the funds will transfer over to the new card. _____

3. I acknowledge that I will be automatically entered into the weekly raffle when I am in phase 2 and have 25 points. If I want to save my points for a different raffle, it is my responsibility to opt out of the raffle by texting the phone number listed in the reminder. _____

As a patient in the Stimulant Treatment and Recovery Team (START) program, I acknowledge that I am automatically enrolled in the Recovery Rewards Program. I understand the Recovery Rewards Program is separate from the treatment I receive from the clinical team, thus my treatment does not vary based upon my points balance.

_____

(Name of Patient)

BOSTON MEDICAL CENTER | START Stimulant Treatment and Recovery Team

T: 617-414-7490
F: 617-414-7491

_____ _____

(Signature of Patient) (Date Signed)

_____ _____

(Signature of Witness) (Date Signed)

BOSTON MEDICAL CENTER
START
Stimulant Treatment and Recovery Team
T: 617-414-7490
F: 617-414-7491

Patient Acknowledgement

Please sign your initials next to the following agreements. If you have any questions or have not received this material, please feel free to ask your clinician.

1. I agree that I have received a copy of the Program Guidelines and have reviewed them with the START Program. _____

2. I agree that I have received a handout on the Phoenix gym, including information about the weekly exercise groups. _____

3. I agree that I have received a handout on the Recovery Rewards system, which details how to track my point balance, earn points, and describes the rewards for which I am eligible. _____

As a patient in the Stimulant Treatment and Recovery Team (START) program, I acknowledge that the START Clinic, including the providers, nurses, care coordinators, medical assistants, counselors, outreach workers, and administrative personnel are working with me in recovery. The START program and its staff are safe, and I can seek their assistance if I am ever feeling unsafe.

_____
(Name of Patient)

_____ _____
(Signature of Patient) (Date Signed)

_____ _____
(Signature of Witness) (Date Signed)

Oral Health Assessment Flowsheet

1. Does patient have natural teeth?
    a. Yes
        i. 0 – NO decayed or broken teeth or roots
        ii. 1 – 1-3 decayed or broken teeth or roots or very worn down teeth
        iii. 2 – 4+ decayed or broken teeth or root, or very worn down teeth, or less than 4 teeth
    b. No
2. Does patient wear dentures?
    a. Yes
        i. 0 – No broken areas or teeth, dentures regularly worn, and named
        ii. 1 - 1 broken area or tooth or dentures only worn for 1-2 hours daily or dentures not harmed or loose.
        iii. 2 – More than 1 broken area or tooth, denture missing or not worn, loose and needs denture adhesive, or not named
    b. No
3. Is patient experiencing dental pain?
    a. 0 – No behavioral, verbal, or physical signs of dental pain
    b. 1 – There are verbal and/or behavioral signs of pain such as pulling at face, chewing lips, not eating, and aggression
    c. 2 – There are physical pain sign s(swelling of cheek or gum, broken teeth, ulcers), as well as verbal and/or behavioral signs (pulling at face, not eating, aggression)
4. Oral cleanliness
    a. 0 – Clean and no food particles or tartar in mouth or dentures
    b. 1 – Food particles, tartar or plaque in 1-2 areas of the mouth or on small area of dentures or halitosis (bad breath)
    c. 2 – Food particles, tartar, or plaque in most areas of the mouth or on most of dentures or server halitosis (bad breath)
5. Lips:
    a. 0 – Smooth, pink, moist
    b. 1 – Dry, chapped, or red at corners
    c. 2 – Swelling or lump, white, red, or ulcerated patch; bleeding or ulcerated at corners
6. Saliva
    a. 0 – Moist tissues, watery, and free flowing saliva
    b. 1 – Dry, sticky tissues with little saliva present, clinician thinks they have a dry mouth
    c. Tissues parched and red, little or no saliva present, saliva is thick, clinician thinks they have a dry mouth
7. Tongue
    a. 0 – Normal, most roughness, pink
    b. 1 – Patchy, fissured, red, coated
    c. 2 – Patch that is red and/or white, ulcerated, swollen
8. Gums and tissues
    a. 0 – Pink, moist, smooth, no bleeding
    b. 1 – Dry, shiny, rough, red, swollen, 1 ulcer, or sore spot under dentures

c. 2 – Swollen, bleeding, ulcers, white/red patches, generalized redness under dentures

Create row at bottom that sums up the total points out of 16. Flag that patient needs dentist referral if score is above _____.

THE 16-ITEM VERSION OF THE PRODROMAL QUESTIONNAIRE (PQ-16)

				If TRUE: how much distress did you experience?			
				None	Mild	Moderate	Severe
1.	I feel uninterested in the things I used to enjoy.	❑ True	❑ False	❑ 0	❑ 1	❑ 2	❑ 3
2.	I often seem to live through events exactly as they happened before (déjà vu).	❑ True	❑ False	❑ 0	❑ 1	❑ 2	❑ 3
3.	I sometimes smell or taste things that other people can't smell or taste.	❑ True	❑ False	❑ 0	❑ 1	❑ 2	❑ 3
4.	I often hear unusual sounds like banging, clicking, hissing, clapping or ringing in my ears.	❑ True	❑ False	❑ 0	❑ 1	❑ 2	❑ 3
5.	I have been confused at times whether something I experienced was real or imaginary.	❑ True	❑ False	❑ 0	❑ 1	❑ 2	❑ 3
6.	When I look at a person, or look at myself in a mirror, I have seen the face change right before my eyes.	❑ True	❑ False	❑ 0	❑ 1	❑ 2	❑ 3
7.	I get extremely anxious when meeting people for the first time.	❑ True	❑ False	❑ 0	❑ 1	❑ 2	❑ 3
8.	I have seen things that other people apparently can't see.	❑ True	❑ False	❑ 0	❑ 1	❑ 2	❑ 3
9.	My thoughts are sometimes so strong that I can almost hear them.	❑ True	❑ False	❑ 0	❑ 1	❑ 2	❑ 3
10.	I sometimes see special meanings in advertisements, shop windows, or in the way things are arranged around me.	❑ True	❑ False	❑ 0	❑ 1	❑ 2	❑ 3
11.	Sometimes I have felt that I'm not in control of my own ideas or thoughts.	❑ True	❑ False	❑ 0	❑ 1	❑ 2	❑ 3
12.	Sometimes I feel suddenly distracted by distant sounds that I am not normally aware of.	❑ True	❑ False	❑ 0	❑ 1	❑ 2	❑ 3
13.	I have heard things other people can't hear like voices of people whispering or talking.	❑ True	❑ False	❑ 0	❑ 1	❑ 2	❑ 3
14.	I often feel that others have it in for me.	❑ True	❑ False	❑ 0	❑ 1	❑ 2	❑ 3
15.	I have had the sense that some person or force is around me, even though I could not see anyone.	❑ True	❑ False	❑ 0	❑ 1	❑ 2	❑ 3
16.	I feel that parts of my body have changed in some way, or that parts of my body are working differently than before.	❑ True	❑ False	❑ 0	❑ 1	❑ 2	❑ 3

PREP Screener

1. Are you sexually active?
    a. Yes
        i. Do you have a serodiscordant sex partner (i.e., in a sexual relationship with a partner living with HIV?
            1. 0 – No
            2. 1 – Yes
        ii. Have you been diagnosed or suspected of having an STI within the past 6 months such as syphilis, gonorrhea, or chlamydia?
            1. 0 – No
            2. 1 – Yes
        iii. Are you sexually active with people of the opposite sex?
            1. Yes
                a. Do you have an inconsistent use of condoms during sex with a partner whose HIV status is unknown and who is at high risk (e.g., a person who injects drugs who has sex with men and women)?
                b. 0 – No
                c. 1 - Yes
            2. No
        iv. Are you a man who has sex with men?
            1. Yes
                a. Do you have inconsistent use of condoms during receptive or insertive anal sex?
                    i. 0 – No
                    ii. 1 – Yes
            2. No

    b. No
2. Do you inject drugs intravenously?
    a. Yes
        i. Do you share drug-injection equipment with others or use shared drug-injection equipment?
            1. 0 – No
            2. 1 - Yes
    b. No

Create a row summing scores of questionnaire. Flag patient as a good candidate for PREP if they receive a score of 1 or higher.

START
Stimulant Treatment and Recovery Team

START Phone Screen

Do you use cocaine, meth, or other amphetamines? Which one(s)?	
How often?	
How much?	
When you are using (cocaine/meth/amphetamines), do you ever hear, see, or feel things that other people don't? **If yes, does this continue when you are not using?**	
Are you currently hearing, seeing, or feeling things that other people aren't?	
Do you use any other substances?	
Are you currently having any thoughts about hurting yourself or others including thoughts about suicide or homicide?	
Do you have any concerns relating to your physical health at the moment?	
Do you need help with transportation to the appointment? **If yes, use the smartphrase PT1REQUEST to gather information to set-up their PT-1.**	
The patient is agreeable to engaging in treatment and has provided the following method for communication for completion of an intake with the nurse and admin:	

BOSTON MEDICAL CENTER | START Stimulant Treatment and Recovery Team
T: 617-414-7490
F: 617-414-7491

Columbia Suicide Severity Risk Scale (CSSRS):

Record both participants Yes/No response and any specific report for each

START clinicians and staff will complete the Columbia Suicide Risk Assessment for all patients who report suicidal thoughts, a recent suicide attempt, or a recent overdose. This assessment may be found as a flowsheet in EPIC.

	YES	NO
1. During the past week, have you wished you were dead or wished you could go to sleep and not wake up?	☐	☐
2. During the past week, have you actually had any thoughts of killing yourself? ***If "no" to Question #2, skip to Question #7***	☐	☐
3. During the past week, have you been thinking about how you might kill yourself?	☐	☐
4. During the past week, have you had some intention of acting on those suicidal thoughts?	☐	☐
5. During the past week, have you worked out some or all of the details of how to kill yourself?	☐	☐
6. ***If YES to #5***: Do you intend to carry out this plan?	☐	☐
7. Have you ever done anything, started to do anything, or prepared to do anything to end your life? *Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.*	☐	☐

8. ***If YES to #7:*** How long ago did you do any of these?

☐ Within the last week? ☐ Over a year ago? ☐ Between three months and a year ago?

☐ 1-3 months ago? ☐ Within the last month? ☐ Within the last week?

BOSTON MEDICAL CENTER | START Stimulant Treatment and Recovery Team
T: 617-414-7490
F: 617-414-7491

The patient's score is equal to the Question # of the highest YES given for Questions #1-6 (range of score is 0-6). Questions # 7 and 8 are not scored.

SCORE:

BOSTON MEDICAL CENTER | START Stimulant Treatment and Recovery Team
T: 617-414-7490
F: 617-414-7491

Columbia score 0-2 (no immediate risk): Provide support

1. **Empathetically discuss results with patient, provide support:**
    - Be respectful, acknowledge/validate patients' feelings, thank them for sharing (see "General guidance for talking with patients about suicidality" at the beginning of this protocol for other tips about talking to patients about suicidal thoughts and behaviors)
    - Identify and discuss patient specific protective factors (distractors/pleasant activities, social support; "it sounds like things have been really hard, what are some of the things you do to make you feel better when you are feeling this way?" "Who are people who [or places that] help you feel better to be around?" "Is there anyone you feel comfortable confiding in and getting help from?" Encourage patient to use.)
    - Offer reassurance that things can get better (reassure the person that with appropriate treatment, he or she can develop other ways to cope and can feel better about life again; "I really appreciate that you shared with me today, and that you're taking steps working with me and your clinicians to change things for the better in your life and identify things you can do when feeling this way")
    - Encourage the person to avoid alcohol and drug use or at least decrease use if they do not feel they cannot use ("although it can seem at the time that drinking or taking drugs can ease or block painful feelings, it often makes such feelings worse and makes someone more likely to act on suicidal feelings impulsively so really encourage you to especially avoid alcohol or drug use when you're feeling this way")
    - Encourage securing lethal means (many suicide attempts are impulsive; as such, encouraging restricting access to highly lethal means like firearms is an important preventive step; "finally, let's talk about ways we can make your home environment as safe as it can be. If you have any firearms in the home, the safest plan is removing them from your home. If you do keep guns in the home, the next best thing is to keep guns unloaded and stored in a secure location using a firearm safe, lock box, trigger, or cable lock. Ammunition should be stored in a separate secure and locked location.")
2. **Encourage patient to discuss any suicidal thoughts or behaviors with other relevant health care providers with whom they're working** (refer to specific upcoming visit(s) if chart review showed relevant scheduled appointments, encourage patient to keep the appointment if relevant)

3. **Ensure patient has ready access to 24/7 hotlines** (and encourage them to put the relevant information in their telephone contact list) and provide information about other resources available for the patient should symptoms worsen:

External resources

- **National Suicide Prevention Lifeline: 1-800-TALK (1-800-8255), text line: Text "HEAL" to 741741.**

Offering other resource information below is at nurse discretion. National Suicide Prevention Lifeline above networked with local/regional resources across the state and country so most broadly relevant external resource.

- Call2Talk: 508-532-2255 or text C2T to 741741
- Samaritans Text Line: 877-870-HOPE
- Riverside Trauma Center: To help after a traumatic event, call 888-851-2451. Ask to speak to Riverside Trauma Center manager.
- Crisischat.org
- Veterans Crisis Line: (800) 273 – 8255 – press 1

Other resources

- DV Hotline: 1-800-799-7233 or TYY 1800-787-3224 thehotline.org
- Boston Area Rape Crisis Center (BARC): 800-841-8371

Columbia score 3-6: High Risk, assess if immediate risk

If call is being conducted by a non-clinical staff member, urgently contact the nurse on duty to transfer the call. The following steps are to be completed by clinical staff:

1. Document where patient is and confirm the home address on file is correct. Ask: "Where are you currently?"
    a. If they say they are at home, "Do you still live at (address on file)?" <confirm address or update new home address>
    b. If elsewhere, "Can you tell me the address of where you are please? <document>

2. Empathetically discuss results with patient (see below on tips to talk to patients with suicidal ideation) and assess immediate and near-term risk for suicidal behavior, as clinically appropriate
    a. "Can you tell me a little more about what's going on for you today?"

b. **Method**: "How are you thinking you may act on these thoughts?"
c. **Lethal means**: "Do you have access to ____ (lethal means described by patient in #2 above)? Have you taken any steps toward preparing? What were they? How recently"
d. **Plan/Intent**: "Do you have plans to carry this out in the next 24 hours?"
e. Risk factors: when was the last time you drank or used drugs? Are you drinking alcohol or using drugs right now?
f. **Coping behaviors and supports**: "What and who helps you with those thoughts? How important are these things in keeping you from harming or killing yourself?"

Immediate risk is if any yes to:

- Item c: access to lethal means or have taken any steps towards preparing
- Item d: plans/intent in next 24 hours

Immediate risk/immediate danger: Patient is making threats to take their life and has the means:

2. "Do you have anyone with you right now?"
    a. If yes, "Are they supportive? Can we talk to them together about what is going on?"
        i. If patient allows and puts the support person on the phone, seek confirmation that the support person will accompany the patient to the closest ER unless: (1) the support person agrees to secure lethal means available to the person immediately and (2) the patient has an active safety care plan with which the support person is familiar and he or she agrees to talk with patient along with the nurse on the phone about implementing care plan components (e.g., self-care activities to counteract and social outreach steps the patient has agreed to take)
    b. If not already asked above, ask how recently the patient has taken drugs or drank and if drunk or high currently?
3. If no, to above, urge patient to secure means, to avoid drug and/or alcohol use as can cloud judgement and lower threshold for risky behavior, and call for a ride (Uber, Lyft) and go immediately to the closet emergency room. Tell the patient you will stay on the phone with them as they reach out to secure a rideshare and travel to the ER and will call them back if lose the call. Discourage patient driving themselves and instead plan with them other means of transportation. ***If patient is intoxicated, possibly losing***

T: 617-414-7490
F: 617-414-7491

consciousness/suicide attempt in progress, and/or nurse has any concern patient not willing or able to carry out these steps, go on to step 4.

4. Keep the caller on the phone while trying to call 9-1-1. Message a colleague/supervisor for assistance if you need it.

Tips for calling 9-1-1

- To participant: "I'm concerned about you and your safety and would like to get help right away for you. I am going to contact 9-1-1 so we can have someone come out to you to do a wellness check."
- To 9-1-1: "I'm calling because I'm concerned about active suicidal ideation and would like a wellness check done for ----------. Ask if they could send members from the BEST team.

5. Open a telephone encounter (if outreach call) or document in phone visit in Epic to:
   a. Indicate that the Columbia was done {as a follow up to a positive PHQ9 i9 or when the patient disclosed suicidal ideation during a collaborative care nurse visit}.
   b. Document the Columbia Suicide Risk Assessment score, that patient was imminently suicidal, and that 9-1-1 was called.

      Draft text for documentation:

      I completed the Columbia Suicide Risk Assessment with this patient because the patient disclosed suicidal ideation.

      - *Columbia score:*
      - *Patient was at <<HOME or ADDRESS>>The patient was at immediate risk for self-harm, stating "<<what patient said with quotes, if possible>>"*
      - *9-1-1 was called*
      - *Other relevant information from assessment or 9-1-1 call*

      Plan:

      As part of our collaborative care protocol, developed with IMH Social Workers, MHW, and primary care, we are routing telephone encounters to patients' primary care teams as an FYI.
   c. Close out encounter.
   d. Route to appropriate providers.

BOSTON MEDICAL CENTER | START
Stimulant Treatment and Recovery Team
T: 617-414-7490
F: 617-414-7491

Not immediate risk: Complete crisis response plan, offer resources, and schedule follow up visit

In Epic:

1. Review existing care plan (in problem list) and update if needed / start new crisis response with patient
    - Update in problem list
2. Document in telephone encounter or phone visit:
    - Indicate that the Columbia was done {as a follow up to a positive PHQ9 Q9 or when the patient disclosed suicidal ideation during a collaborative care nurse visit}.
    - Document the Columbia Suicide Risk Assessment score
3. Route the telephone encounter to the appropriate providers.
4. Schedule follow-up with behavioral health provider.

BOSTON MEDICAL CENTER | START Stimulant Treatment and Recovery Team
T: 617-414-7490
F: 617-414-7491

START Clinic Telephonic Suicidality Protocol

(Adapted from the MI-CARE Safety Protocol)

The clinician or staff member is not with the patient in a clinic but interacting with them virtually/remotely (i.e. phone or video visit). This protocol is for situations where a patient spontaneously reports suicidal thoughts, a recent suicide attempt, or a recent overdose during a virtual visit. Any time the safety protocol is used, it must also be documented routed to the clinical team after the patient call has ended, or sooner if an immediate risk is identified.

General Guidance for Talking with patients about suicidality:

- Listen attentively to everything the caller says, learn as much background as possible about what the caller is going through.
    - Don't try to talk the person out of his or her feelings or express shock. Even though someone who's suicidal may not be thinking logically, the emotions are real. Not respecting how the person feels can shut down communication.
- Allow the caller to cry, scream or become emotional, this can help the pt. express what they are going through.
- Stay calm, be supportive and kind!
- Do not judge or invalidate the person's feelings. Do not provide negative feedback.
    - Ask questions such as "what's causing you to feel so bad?" "What would make you feel better?" or "How can I help?" rather than saying things like "things could be worse" or "you have everything to live for")
- After getting an understanding of what the pt. is going through, summarize the problems back to them. This shows you are being attentive.
- Never promise to keep someone's suicidal feelings a secret. Be understanding but explain that it is important that the patients' healthcare providers are aware of the situation so as to best be able to help the patient get the help they need, especially if their life might be in danger.
- What people want from those they share their suicidal thoughts/behaviors with: Don't panic, be present, offer hope

T: 617-414-7490
F: 617-414-7491

- It is not easy to be on the receiving end of these conversations. Be aware of the emotions this might bring up for you and take the steps you need to stay present with the patient.