Understanding treatment approaches for stimulant use disorder in Montana

JG Research & Evaluation | Bozeman, MT

REPORT INFORMATION AND ACKNOWLEDGMENTS

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STUDY SUMMARY

The role that stimulant use disorder, and specifically methamphetamine use, plays in the state of Montana's criminal justice and treatment systems seems to be growing. As many respondents in this study report, methamphetamines are by far the most common stimulant being abused across the state. Recent reports at the state level as well as by the state-approved treatment providers surveyed in this study suggest that methamphetamine has become one of the most common substances for which people are or should be seeking treatment.

The focus of this report is to provide detailed insight into the treatment approaches and modalities currently being used by state-approved treatment providers to treat stimulant use disorder. The intended outcome is to provide the Addictive and Mental Disorders Division (AMDD) with a clear understanding of the current strengths and gaps in the stimulant use disorder treatment and recovery systems, and to identify opportunities to support and expand evidence-based access to stimulant use disorder treatment across the state.

State-approved treatment providers who responded to surveys and interviews for this project stressed that an all-hands-on-deck approach to treatment modalities is necessary to try to address stimulant use disorder. Furthermore, they expressed interest in expanding their own capacity and adding tools to their toolkit through training in and support for new treatment modalities that show promise for addressing stimulant use disorder.

Specific implications and recommendations from the findings of this report include the need for the following:

1. Address gaps in withdrawal management services and inpatient treatment facilities for stimulant use disorder

2. Support the expanded use of existing evidence-based treatment approaches for stimulant use disorder by identifying and expanding funding and billing options

3. Provide support for expanding high-quality recovery housing, with a specific focus on step-down and transitional housing once clients have completed intensive outpatient (IOP) treatment modalities

BACKGROUND

A recent report for the Montana State House Interim Committee (2019–2020) on Children, Families, Health, and Human Services highlights the growth of methamphetamine use in the state of Montana[1]. Looking at the problem from several angles—the prevalence of methamphetamines as a primary factor in criminal activities, court sentencing, overdose deaths, and substance use disorder treatment—the report concludes that the burden of stimulant use disorder (STUD) has increased substantially in the state and the region over the past five to seven years. The report states that from 2012 to 2018, the number of reported drug offenses involving stimulants grew 77%, and in 2018 stimulants were second only to marijuana in the number of reported drug offenses. Further, from just 2017 to 2018 the number of Montana residents being treated for STUD increased by 20% (O'Connell, 2020). A similar report prepared by the Office of Epidemiology and Scientific Support (OESS) of the Department of Public Health and Human Services (DPHHS) in August 2020 highlights the demographics of individuals most affected by methamphetamine use and overdose. Each year from 2015 to 2018, roughly 1% of the overall adult population in Montana reported using methamphetamines sometime in the past year (OESS, 2020).

The role that stimulant use disorder, and specifically methamphetamine use, plays in the state of Montana's criminal justice and treatment systems seems to be growing. There is thus a need to understand more fully how the various systems that interact with substance use disorder in general are addressing the demand for treatment and recovery for stimulant use disorder. The focus of this report is to provide detailed insight into the treatment approaches and modalities currently being used by state-approved treatment providers to treat stimulant use disorder. The aim is to provide the Addictive and Mental Disorders Division (AMDD) with a clear understanding of the current strengths and gaps in the stimulant use disorder treatment and recovery systems, and to identify opportunities to support and expand access to evidence-based stimulant use disorder treatment across the state.

Evidence-Based Treatment for Stimulant Use Disorder

Guidelines on best practices for stimulant use disorder treatment from the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the National Institute on Drug Abuse (NIDA) support a combination of psychosocial and behavioral modification approaches to provide patients with the benefits of both treatment styles. The most recent review of evidence-based treatment for stimulant use disorder from SAMHSA focuses on motivational interviewing, contingency management, community reinforcement, and cognitive behavioral therapy as four approaches that have strong evidence of efficacy (SAMHSA, 2020). In addition, the Matrix model has been used to treat stimulant use disorder for 30 years, with some evidence of its efficacy (Obert et al., 2000).

In the state of Montana, there are currently two specific opportunities related to the State Opioid Response (SOR) grant made by SAMHSA to DPHHS to expand the use of evidence-based treatment modalities for stimulant use disorder. First, for fiscal year 2020 (FY20), SOR grant funds can be used to support "evidence-based prevention, treatment and recovery support services to address stimulant misuse and use disorders, including for cocaine and methamphetamine" (SAMHSA, 2020, p. 5). FY20 SOR funds can also be used to develop contingency management strategies, provided that each incentive is valued at no more than $15 and the total spent on contingencies for an individual client in a single year does not exceed $75. Second, the State of Montana is currently engaging some of the original developers of the Matrix model to learn from and participate in a pilot project to update the model, now called the TRUST (Treatment of Users of Stimulants) protocol, for stimulant use disorder treatment.

[1]The study was conducted by the Office of Research and Policy Analysis, Montana Legislative Services Division, for House Joint Resolution 48/49: Child Protective Services.

METHODS

Research Questions

1. Which approaches are used by state-approved treatment providers to treat stimulant use disorder?

   1a. How common is the use of contingency management, and why are providers choosing to use or not to use contingency management to treat stimulant use disorder?

   1b. How common is the use of the Matrix model, and why are providers choosing to use or not to use the Matrix model to treat stimulant use disorder?

2. What challenges and opportunities do state-approved treatment providers see to expanding access to and efficacy of stimulant use disorder treatment in Montana?

3. How do state-approved treatment providers work with other providers and parts of the continuum of care to address stimulant use disorder treatment and recovery?

Study Design

Data gathering

This was a mixed-methods study that used both key informant interviews and a web-based survey. The research team worked with staff at AMDD to identify 10 state-approved treatment providers with whom to conduct key informant interviews. These providers were chosen to represent organizational and geographic diversity and because they are known to have robust treatment programs that include demand for stimulant use disorder treatment. We conducted phone-based interviews with 7 of the 10 providers suggested by AMDD staff. Two of the remaining 3 did not respond to multiple emails and phone calls, and one provider appears to no longer be active, based on lack of phone and web presence. These interviews were audio recorded (with participant permission). Initial informal analysis of these interviews contributed to refining the web survey that was subsequently sent to all state-approved treatment providers.

In July 2020 a web survey was sent to representatives of all 65 state-approved chemical dependency treatment provider organizations (those listed as of July 1, 2020) that treat adults; providers that treat only adolescents were not included. Many of these providers have multiple locations (132 locations were listed as of July 1, 2020), and we sent the survey to the contact person listed for each location and asked that they respond for the locations for which they have responsibility. We received responses from 36 of the 65 state-approved treatment provider organizations, for an organizational response rate of 55%. We received responses that covered 70 of the 132 locations, for a location coverage rate of 53%. The web survey asked providers whether they specifically treat stimulant use disorder, and if so, how common it is among their client population and which specific treatment approaches they use. Providers that responded that they do not treat stimulant use disorder were asked how they refer clients to appropriate treatment. All providers were asked what challenges and opportunities they see for expanding access to and efficacy of stimulant use disorder treatment in Montana, as well as how they coordinate with the broader treatment and recovery system when working with clients with stimulant use disorder.

[2]For full details on allowable FY20 SOR activities, see SAMHSA Funding Opportunity Announcement (FOA) No. TI-20-012 (SAMHSA, 2020).

Data analysis

The audio recordings of key informant interviews were transcribed by a professional service, and the transcripts were then coded using NVivo qualitative analysis software (QSR International Pty Ltd., 2020). The coding approach was iterative, beginning with a structured coding schema that reflected the broad research questions. Specific themes within the structured categories were then identified and refined through an inductive secondary coding process.

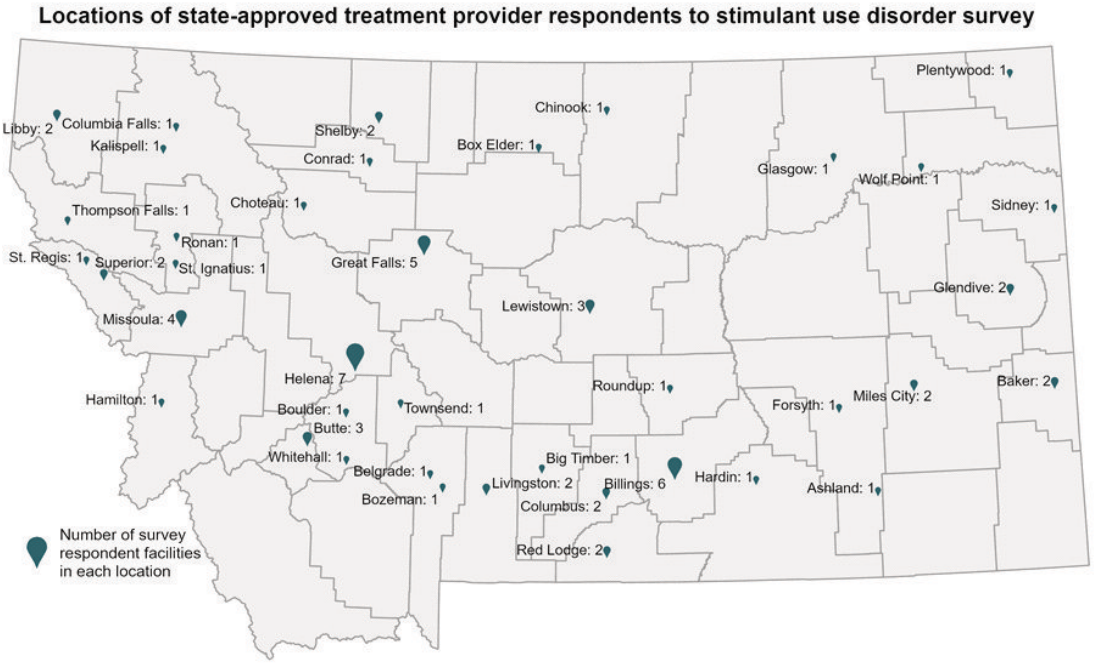
Limitations

The main limitation of this study is the lack of complete coverage in responses. Only half of the state-approved treatment providers responded to the survey, and there is underrepresentation from organizations in and for Tribal communities, as well as from a few of the major behavioral health care providers in eastern and northwest Montana.

Profile of Respondents

Figure 1 shows the state-approved treatment provider locations covered by survey respondents. Geographic coverage of survey respondents is similar to the overall coverage of state-approved treatment providers[3]. A full list of survey respondents by organization is available in Appendix A.

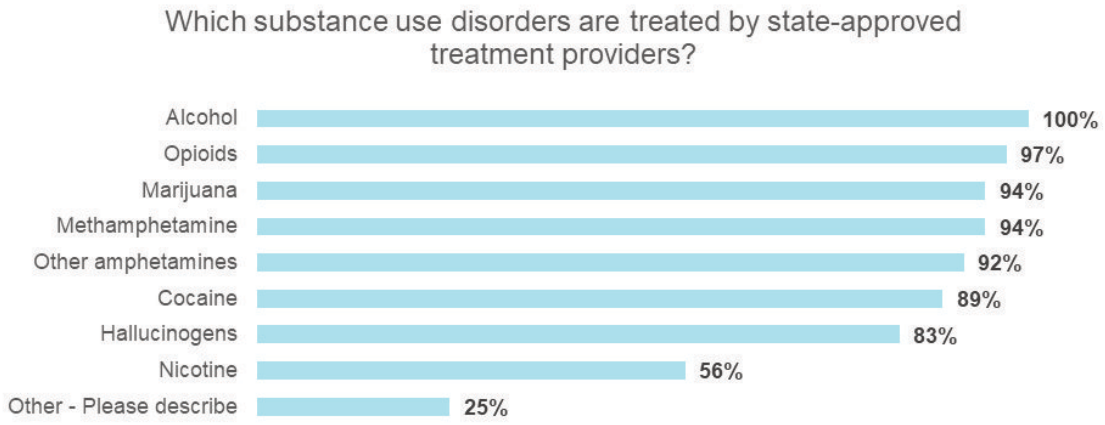
Figure 1. Survey respondents by location



Almost all respondent organizations report providing treatment for alcohol as well as the most common illegal substances (Figure 2). Notably, 94% of state-approved treatment providers reported providing treatment to individuals who use methamphetamines.

[2]For an up-to-date map of state-approved treatment provider locations, see the Substance Use Disorders Provider App from DPHHS (2020).

Figure 2. Treatment provided by substance type

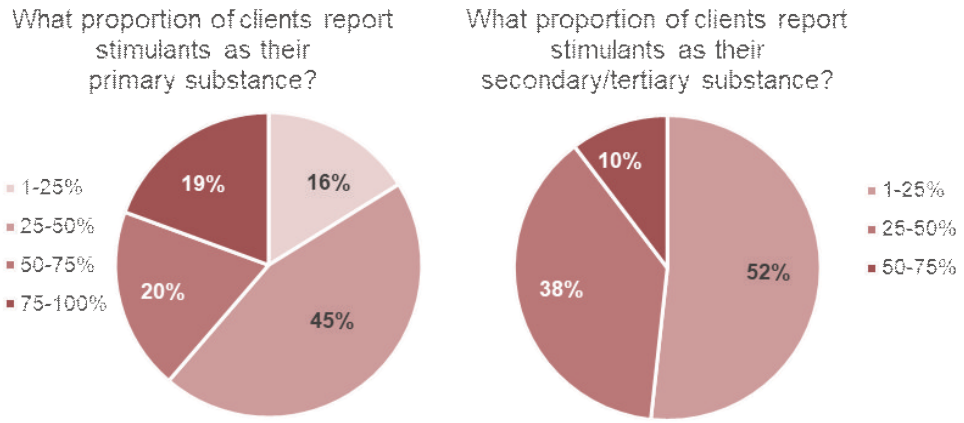


RESULTS

Prevalence of Stimulant Use Disorder

More than one-third of providers report that stimulants are the primary substance for more than 50% of their clients (Figure 3). Two-thirds (66%) of providers report that for these clients, alcohol is a common secondary or tertiary substance. Almost half (44%) of providers report that cannabis is a common secondary or tertiary substance for those clients reporting stimulants as a primary substance, and the same number (44%) of providers report that opioids are a common secondary or tertiary substance.

Figure 3. Prevalence of stimulants as primary or secondary/tertiary substance



Stimulants are less common as a secondary or tertiary substance, with only 10% of providers reporting that more than 50% of their clients use stimulants as a secondary or tertiary substance. About one-third of providers (36%) report that for these clients alcohol is the primary substance, and a similar proportion of providers (33%) report that opioids are the primary substance, for clients for whom stimulants are a secondary or tertiary substance.

Overall, interview respondents emphasized the growing dominance of stimulants in the state of Montana:

> ***Just this year, as we track diagnoses, just this year out of 1,200 clients served, meth overtook alcohol as the number one drug that we have. It's a very close race, but it's meth and alcohol, but for the first time ever, I had more diagnosis of meth than I did of alcohol. It's not a problem that's going away, it's actually growing. (Director, state-approved treatment provider).***

One SOR provider noted, "Honestly, to have someone that is purely stimulant use disorder without something else going on is pretty rare." Instead, most stimulant use disorder clients could be considered as polysubstance users. In addition, several interview respondents noted the fungibility of substances, especially opioids and stimulants. They describe clients who have "had a meth period" or who "prefer pills" [opioids], but who use methamphetamines when they don't have the money for opioids. As one SOR provider explained, "I don't necessarily think that people are happily switching substances; it's a supply and demand and a financial thing. Sometimes meth is just cheaper to get." Several providers emphasized the relative presence of methamphetamines versus opioids:

Meth has taken over again. Meth is fully, fully out in front of opiates and just sucking the life out of our communities. Opiates are still very relevant, and pills are harder to get ahold of.

So heroin is showing up more and more now. But meth is still out in front because it's cheap and it lasts long and it's easy to get (SOR counselor).

Treatment Modalities for Stimulant Use Disorder Treatment

Table 1 shows the prevalence of different treatment modalities for all substance use disorders (SUDs) nationally and in the state of Montana in 2019, as well as the prevalence of these modalities specifically for treating stimulant use disorder by state-approved treatment providers.

Table 1. Prevalence of treatment modalities for substance use disorder and stimulant use disorder nationally and in Montana

Treatment modality	National, 2019	Montana, 2019	Survey respondents
Cognitive behavioral therapy (CBT)	94%	90%	83%
Contingency management	55%	63%	19%
Matrix model	45%	55%	50%
Dialectical behavioral therapy (DBT)	59%	63%	NA[a]
Community reinforcement approach	11%	11%	50%
Relapse prevention	96%	94%	83%

Source: National and state data on SUD treatment modalities come from the N-SSAT data gathered annually by SAMHSA (SAMHSA, 2019).
Note: NA = not available.

[a]The survey asked about psycho-social approaches generally and provided both CBT and DBT as examples.

Table 1 shows that in general, stimulant use disorder treatment modalities are similar to those used for SUD treatment more generally. Two interesting points stand out: First, stimulant use disorder treatment is much more likely to include the community reinforcement approach than SUD treatment generally, and much less likely to use contingency management as a stand-alone treatment modality. Based on the key informant interviews, in which the leadership of some state-approved treatment providers did not have a precise understanding of the community reinforcement approach, we think it is possible that respondents interpreted the approach as something more colloquial or general rather than as a specific evidence-based approach. Second, stimulant use disorder treatment is as likely as SUD treatment generally to utilize the Matrix model, despite the fact that the Matrix model has not been specifically adapted for stimulant use disorder treatment.

Contingency management

Only 7 survey respondents reported that they use contingency management or motivational incentives for treating stimulant use disorder. Table 2 provides information on these providers, including the estimated cost per individual per year for contingency management and the sources of funding to pay for the approach.

Table 2. Providers who reported using contingency management for stimulant use disorder treatment

Organization	Average spent per client	How it is paid for
Alcohol and Drug Services of Gallatin County	NA	Non-monetary rewards
Billings Addiction Counseling LLC	$120	Operating budget
Boyd Andrew Community Services	$2,000	NA
Gateway Community Services	$250	Operating budget
Jeff C. Richardson LAC LLC	$1,500	NA
Prairie Hills Recovery	$120	Operating budget
YWCA Helena	NA	Grants

Note: NA = not available.

Survey respondents who use contingency management report that the approach improves motivation, increases cooperation, and extends sober time for clients. One noted the positive orientation of the approach: *"Reward versus punishment sets up a respectful, humanistic model that is empowering and not fear based."* Three of the interview respondents noted that their organizations use contingency management only with treatment courts, reporting that some of their patients have received incentives for sobriety through the court system. These incentives include both monetary rewards, which, it was implied, the courts pay paid for, and non-monetary rewards, like increased privileges associated with probation or other sentencing. One of the interview participants described the role that contingency management plays in recovery:

> ***Treatment court works off of contingency management, a range of sanctions and incentives and [. . .] what would be incentivizing for people to, staying sober. They could get a bed in a place that would protect and make sacred their recovery process, for example. In the men's recovery house, we've done, if they stayed in the house and they were sober for a certain period of time, we would get them a membership to the gym, for health and they really liked that (Director, state-approved treatment provider organization).***

One provider that claimed to regularly use contingency management in its model emphasized two components of a successful program: rewards that create opportunities for patients and clarity about what needs to be done to receive those rewards. For example, making recovery housing contingent on sobriety worked well for their organization.

All the interview and survey respondents, both those who currently use contingency management and those who do not, noted the difficulty of paying for incentives, since neither Medicaid nor private insurance can be billed for them. In addition, survey respondents noted that it is difficult to come up with new and compelling incentives over time and to cover the cost of increasingly large incentives as a treatment program progresses. Some also expressed doubts about the efficacy of incentive vouchers. According to one interview respondent with experience with the contingency management approach, *"The pat on the back, and here's your gift for showing up and not using, doesn't really work."* In addition, survey respondents highlighted that creating an external motivation for sobriety can have a negative impact.

Among providers that do not currently use contingency management to treat stimulant use disorder, 80% said they were interested in offering it. Most often, these providers noted that they are interested in learning about any new approach that could help their clients, since *"the more tools, the better the outcome."* A few survey respondents said they are aware that contingency management is an evidence-based treatment approach and that it is thus compelling to them. Those survey respondents (20%) who said that they are not interested in or are unsure about contingency management for stimulant use disorder largely noted that they already have approaches to improve attendance and participation in aspects of their treatment program as well as for pro-social behaviors. A few of these respondents said they prefer to use approaches that build intrinsic motivation rather than external rewards.

Matrix model

A full half of the survey respondents, 18 of the 36, reported that they use the Matrix model in part or in full. Table 3 provides information on these providers and the components of the Matrix model that they report using, as well as whether they use the Matrix model manuals and whether they monitor their fidelity to the model. Even among survey respondents who report that their organizations use the Matrix model, there is wide variation in terms of how many and which of the model components they use. Only 3 of the 18 report using all five of the core Matrix model components, and half (9 of 18) report using the manuals originally published by the Matrix Institute.

Survey respondents who use the Matrix model report that they appreciate the standardized and structured nature of the model, as it is easy to follow and "captures clients 'where they are' in regards to the stages of change." A few providers also mentioned that it is efficient to use the model, and the materials associated with it, because it decreases prep time for counselors. Because most state-approved treatment providers take an integrated approach to SUD treatment in general, the Matrix model, which is holistic in terms of the types of treatment approaches it includes, seems to be attractive and a good fit.

The main challenge associated with the Matrix model, as with contingency management, is the inability to bill Medicaid for the full set of approaches included in the model. Many survey and interview respondents reported that they use parts of the Matrix model, but they do not follow the manual or adhere completely to the model because not all services can be fully billed. Specifically, several respondents noted that the number of hours per week that can be billed for group therapy is fewer than what is called for by the Matrix model, and the reimbursement rates for groups are too low for providers to cover their costs.

Table 3. Providers reporting using the Matrix model for stimulant use disorder treatment

Organization	Therapy	Recovery skills	Relapse prevention	Family education	Social support groups	Manual	Fidelity
Alternatives, Inc.	Y	Y			Y	Y	Y
Aspen Assessment & Counseling Services	Y	Y	Y		Y	Y	
Cedar Creek Integrated Health	Y	Y			Y		
Choices for Change Counseling	Y	Y	Y			Y	
Eastern Montana Community Mental Health Center	Y	Y	Y	Y	Y		
Helena Valley Addiction Services	Y	Y	Y		Y	Y	
Instar Community Services	Y	Y	Y		Y		
New Directions Counseling	Y	Y	Y		Y	Y	Y
Southwest Chemical Dependency Program	Y	Y	Y	Y	Y	Y	
Western Montana Mental Health Center - Addiction Services	Y	Y	Y	Y	Y		
Alcohol and Drug Services of Gallatin County	Y	Y	Y				
Boyd Andrew Community Services	Y	Y	Y	Y		Y	Y
Gateway Community Services	Y	Y	Y	Y	Y	Y	Y
Jeff C. Richardson LAC LLC	Y	Y	Y	Y	Y	Y	Y
YWCA Helena	Y	Y	Y				
Rimrock Foundation	Y	Y	Y	Y			
Southwest Montana Addiction Recovery and Treatment	Y	Y	Y				
White Sky Hope Center	Y	Y	Y		Y		

Of the survey respondents who reported that they do not currently use the Matrix model, about 40% (7 of 18) said they are interested in doing so. Again, as with contingency management, these providers noted that they are interested in any new treatment modality that could serve their clients, and they appreciate that the Matrix model is an evidence-based practice. One survey respondent noted that the model reflects some of the beliefs of their staff, which we believe is a reference to the holistic nature of the model. Providers who are not interested in using the Matrix model said they would need more training or more capacity to implement it. One provider noted the challenge of implementing the structure of

the program in a way that meets billing requirements: "We are already stretched and having a hard time balancing the few groups and the individuals because we can't have two services on the same day. We can't even offer a true ASAM [American Society of Addiction Medicine] Level 2.1."

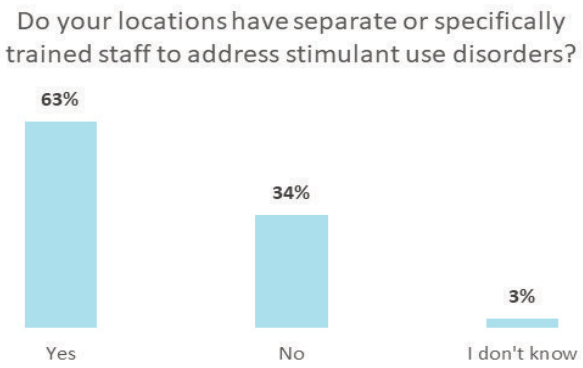
Other evidence-based treatment modalities

Both survey and interview respondents emphasized their desire to use evidence-based treatment approaches and their frustration with the lack of specific and well-documented approaches to treating stimulant use disorder. In 9 of the 10 interviews, providers mentioned a desire to incorporate more scientific evidence in their treatment strategies, but many are not sure how to do so. One SOR provider stated, *"There is some really great data on some of those treatments. I would absolutely be interested in getting more training on it, learning more about it. Like I said, I think meth is such a problem in our community that we are really unable to treat."* Another SOR provider described the lack of clear treatment plans for stimulant use disorder in their location and highlighted their desire to fully implement the evidence-based treatment approaches that do exist for treating stimulant use disorder:

> ***If a patient were to come in with meth use, really, we're at supportive care. What's out there is behavioral type interventions, or maybe more of a like contingency-based thing with the Matrix model. We don't have the official Matrix model here. Our LACs [licensed addiction counselors] use portions of it. So we're more of a stabilization and supportive care team approach at this point. [. . .] I think it's definitely a strain. No. I wish there could be more and something more formal. It's definitely not enough because I feel like [stimulant use disorder] requires more of a whole wraparound. We're at a good start because of our collaborative integrative approach, but I wouldn't say it's enough, no. I think it's a start. That would be my judgment. And if a patient had superb family support, and lots of resources, maybe it would be [enough]. But for the majority of patients, no. It's a start (SOR provider).***

One challenge to implementing evidence-based treatment approaches that are specific to stimulants is the reality that many state-approved treatment providers are small organizations. This means that both staff capacity and client profiles prevent them from tailoring their treatment approaches to specific substances. Even though, as Figure 4 shows, the majority of providers have staff who are specifically trained to address stimulant use disorder, there might not be adequate staff time to have stimulant-specific groups. As one director put it, small organizations *"do not have the luxury of tailoring treatment approaches to specific substances."* In organizations without specific staff capacity, treatment tends to focus on approaches like CBT and DBT, which are widely identified as being effective across substances. Because many clients have polysubstance use disorder to a certain extent, even when stimulants are their primary substance, there is also a tension about whether treatment approaches should focus specifically on stimulants or on substances in general.

Figure 4. Staff training for stimulant use disorder



In interviews, respondents representing a few of the larger state-approved treatment providers noted that their organizations tailor group therapy to specific client characteristics, regardless of primary substance.

> ***We don't have a stimulant-specific group, but we do have some other population-specific options. Folks with several unsuccessful treatment episodes in the past that are engaging in some criminal thinking or some anti-social thinking and behavior. We have a group that's designed for that population. We also have a women and children's program or women's program. [. . .] And that's typically women that have some pretty significant trauma history. We also have a separate group for people with significant co-occurring mental health issues. So we sort of do our population-specific pieces there. And it's less about specific substance of choice and more about some of those co-occurring treatment issues that are being addressed most often (Line manager, state-approved treatment provider).***

In addition to outpatient treatment, interview respondents highlighted the need for at least short-term inpatient treatment for stimulant use disorder, to help clients get through the initial withdrawal management process ("detox") so that they are receptive to treatment modalities.

> ***Our biggest challenge in a person using meth is the length of [inpatient] treatment is not long enough. And that is by payer. You know, they cut us off so early. We find that clarity of the meth user doesn't even start kick and toeing into their brain for 10 to 14 days. And then gosh, we might only have another 10 days with them before their payment source runs out. The studies, they do show that the longer-term treatment results in a better outcome. That's always been our challenge (Executive director, state-approved treatment provider).***

Several interview respondents highlighted the need for inpatient withdrawal management facilities and the challenges created by that gap in capacity across the state.

> ***It's hard to coordinate for detox because there are so few services. And then we have MCDC [Montana Chemical Dependency Center], the inpatient treatment center, they'll detox, but more, they don't like to detox if that's all the client's coming for. They don't want to just do a week of detox and then kick them back out to intensive outpatient or outpatient. They want them to do the whole 28 days, which, I mean, it's very understandable and beneficial, but you've got to, in my opinion as a counselor, you've got to take people where they're at and try to encourage them to get ready (Director, state-approved treatment provider).***

Survey and interview respondents also highlighted the need for long-term inpatient treatment for stimulant use disorder. One interview respondent discussed the Nexus program (which is available only to criminal justice-involved individuals) in Lewistown at length and noted that a similar program for non-offenders is needed. Other respondents noted that they have had clients turned away from the MCDC because it was determined that the clients would need long-term inpatient care; the only option for these patients is to go out of state.

Treatment for polysubstance use: Opioids and stimulants

For SOR providers, treating clients with polysubstance use that includes both stimulants and opioids generally focuses on opioids, in part because of the medication-assisted treatment option. Many survey and interview respondents noted how challenging it is to treat methamphetamine addiction, since there is not a medication option to deal with both initial withdrawal and ongoing maintenance. However, addressing opioid use disorder

through both medication and psychosocial modalities can have a positive effect on stimulant use as well:

> ***Meth does not have great medication treatments, and it's just a really tough situation for a lot of folks. So our clinic, our program, we make it very clear that Suboxone is to treat opioid use disorder. That we find a lot of people as they are able to get off opioids, that the meth use falls away naturally as their life comes back together (SOR provider).***

> ***And I think, for the most part, by the time they decide that Suboxone is what they want to do, even if they're struggling to get off the meth, it's something that they want. So that makes it a little bit easier than if they're a person who is like, well, my family wants me to come in and they want me to do this (SOR care coordinator).***

Several SOR providers report taking a harm-reduction approach to addressing polysubstance use that includes opioids and stimulants and note that they collaborate with other medication-assisted treatment (MAT) providers that do not have polysubstance use treatment capacity. As one provider explained:

> ***But it's [stimulants] never something that if we see it on a drug screen, that we are going to say, "You're out, you have to stop using this." Put any parameters around that. But it is something that we definitely talk about, try to understand it, and try to understand what their goals are. Because some people might say, "I like meth. I'm fine using it. I want to get off the heroin, but I'm fine with my meth use." And we say, "Okay" (SOR provider).***

However, other SOR providers specifically do not report taking a harm-reduction approach. As a provider from one of these programs describes, there is not a clear process for engaging individuals with polysubstance use treatment needs in this context:

> ***Historically, we're not a harm reduction agency outside of medication-assisted treatment. Folks that are enrolled in our outpatient services or inpatient services are asked to abstain, to do their best to abstain. We will work with relapses, we'll work with that stuff. But if somebody comes in and says, I want my Suboxone, but I'm also going to continue to drink potentially or smoke marijuana. What happens to those folks? Because there are people in these communities that are willing to work therapeutically on that level. We need to decide as an IMAT [integrated medication-assisted treatment] team, are we comfortable prescribing those medications to somebody that's going to be adding other substances to their system? If so, do we need to refer those people out to agencies that do more of that risk reduction work, and then just be coordinating with them? So what does that look like? (SOR provider).***

There are many anecdotal stories of providers who treat stimulant use disorder with medications meant for opioid use disorder, based on the idea that the medications take the edge off methamphetamine cravings. This is not an evidence-based practice and in fact has very little clinical guidance. None of the state-approved treatment providers use this treatment approach, but it is noted as something that other providers, especially for-profit providers, in the state do.

Systemwide Support for Stimulant Use Disorder Treatment

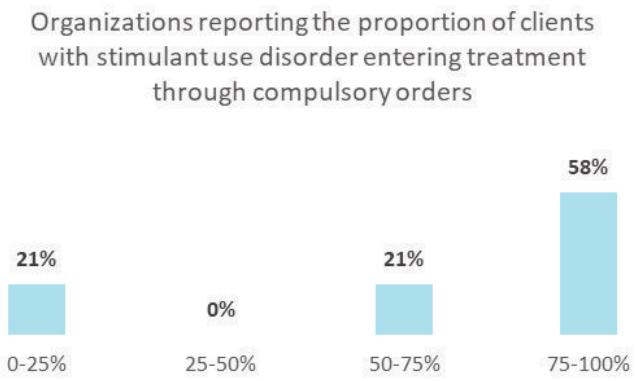
In both the survey and interviews, we asked questions about relationships and collaboration across the treatment and recovery portions of the continuum of care for stimulant use disorder. Consistently, state-approved treatment providers discussed three main types of actors with which they collaborate: courts, other medical and behavioral health providers,

and social service organizations that provide recovery support. They also noted challenges in collaborating with SUD treatment providers that take a different approach to treating SUD in general and stimulant use disorder in particular.

Courts

Almost all the survey respondents that report treating stimulant use disorder noted that they consistently collaborate with drug and treatment courts, probation officers, and Child Protective Services (CPS). In interviews, there was a consensus that for methamphetamines in particular, "so much is tied to the legal system." As one provider noted, "The bulk of people, they lose everything with meth. I mean, it gets so ugly so quick and their lives are over. And of course end up in jail a lot of the time, not everybody, some people manage to avoid jail." These observations are reflected as well in survey responses to the question about what proportion of stimulant use disorder clients enter treatment through compulsory orders (from courts or CPS). As Figure 5 shows, more than half (58%) of survey respondents reported that almost all (75% or more) of their clients with stimulant use disorder enter treatment through compulsory orders.

Figure 5. Clients entering stimulant use disorder treatment through compulsory orders



Three interviewees from state-approved treatment providers discussed their relationships with the court system and highlighted the way that treatment court programs use evidence-based approaches for stimulant use disorder treatment. Two of these organizations have experience with the contingency management model, primarily through collaboration with treatment courts. One director also mentioned that the Matrix model was most closely adhered to in treatment court–supported programs.

Interview respondents indicated that a combination of psychosocial care from state-approved treatment providers, rewards (contingency management) funded from court budgets, and oversight from parole officers assisted patients in recovering from addiction. As one director described, *"Somebody is in treatment court, and they know they're going to get in trouble, they don't want to be there, so they won't use. Because they're not using, we get a little quicker results on the counseling."* Similarly, other providers underscored that prolonged sobriety could be further reinforced through incentives. Specifically, they mentioned that less frequent urine testing and other oversight was a meaningful reward for long-term sobriety. When describing how contingency management best serves patients in the court system, one provider noted, *"They only have to come to court once a month, as opposed to the every other week sort of thing. So some of those sorts of things, enhancements to not be so closely supervised [are useful rewards]."*

Several interview respondents noted the benefits in terms of client outcomes that they see when working with the court system. These collaborations are most impactful when both parties, the criminal justice system and the treatment provider, are invested.

> ***We have [a] very good working relationship with [probation and parole], and the parole officers work very closely with the counselors, and we see great success with that. But it kind of takes both sides to make sure that that works. A little less with pre-release because they're so busy and are such a large organization, but providing counseling on the outside, whether it's probation or whether it's pre-release is extremely important (Director, state-approved treatment provider).***

Clinical referrals

Almost all the state-approved treatment providers who responded to the survey, as well as all the interview respondents, work in organizations that treat stimulant use disorder. Therefore, the referral relationships they describe with other clinical providers generally focus on specific treatment modalities or services that cannot be met by state-approved treatment providers. These relationships include referring clients to inpatient treatment at MCDC or inpatient psychiatric treatment for serious mental illness, and collaborative care relationships with medical doctors to treat comorbidities.

> ***We use a lot of Rimrock and MCDC, which is the closest for us, and so someone with methamphetamine, if they don't have a whole bunch of mental health, we can send them to MCDC just to get them, like you said, to have some recovery time and some substance-free time. If they do have more of a high needs for mental health and addiction, then we're sending them to Rimrock, just because Rimrock is able to address both of those issues, I think (SOR provider).***

At the state level, capacity to meet specific clinical needs is limited to just a few treatment providers. At the local level, only one organization described referring for stimulant use disorder treatment services as a response to reaching full capacity for treatment services. Instead, referrals for clinical care tend to be used to address mental health or medical comorbidities. For example, one interview respondent noted that for stimulant use disorder, having a referral relationship with a psychiatrist has been very helpful, since some methamphetamine users seem to be self-medicating for attention deficit hyperactivity disorder (ADHD). If they can be evaluated and engaged by a psychiatrist to treat their underlying mental health condition, they can potentially address the motivation for methamphetamine use through prescription drugs that can be managed.

Many survey respondents noted that they coordinate with primary care providers to support "whole-person care." Describing the need for such care, one interview respondent highlighted the extreme challenge associated with managing comorbidities with stimulant use disorder treatment, especially during the withdrawal management period:

> ***So now we've got diabetes and high blood pressure, and that is the standard, and people are so flipping sick. I can't believe how flipping sick they are. We're really lucky because we have a medical unit, and so a lot of their physical needs are taken care of, or we work hand in hand with their primary care provider, but we don't get a well person. We never get a well person. [. . .] It's actually gotten scary, I think, to take care of people in detox. [. . .] There's a lot of medication and a lot of monitoring when people come that sick (Executive, state-approved treatment provider).***

State-approved treatment providers noted that not all actors within the treatment and recovery continuum of care are easy or compelling as referral partners. For example, several interview respondents noted that there are certain for-profit SUD treatment providers to which they will not refer clients: *"They're like these mills, they're just running people through them. But there's also been a few that have popped up that are very respectable, and their reputations are better. But we know which ones we will not refer to."* A few interview respondents noted how difficult it is to work with the Veterans Affairs medical system. In the words of one provider, *"There's a lag time between the referral. A veteran coming into a system*

and then getting sent over to a Federally Qualified Health Center [which might partner with a state-approved treatment provider]. There's a gap, and in those gaps are where they fall between the cracks." This is both a billing issue and a coordination issue, and neither has been fully addressed by existing legislation.

One interview respondent summed up the general feeling about referrals across the whole treatment ecosystem:

> ***Really the best way to serve, not just veterans but everyone, is to have some sort of system of care, so that the left hand knows what the right hand is doing. Right now, that's really the difficulty, the client is able to jump, they're able to shop, they're able to move in and out of programs. We just need to get it so that everybody's working towards the same goal (Executive, state-approved treatment provider).***

Wraparound and recovery services

Of all the services that providers focused on, wraparound care was the most widely mentioned. There is a consensus that support beyond medical and behavioral health services is essential to long-term recovery. Different organizations approached wraparound care differently. Several interview respondents noted that they work to provide relapse prevention support through case management. One provider explained that providing patients with these services after more intensive care ends allows them to *"identify quickly when things might be getting to the point where, 'I don't want to go back to intensive patient care anymore.'"* Several survey respondents noted the need for more flexible funding sources that can address a broader set of client needs. As one provider explained,

> ***[In the past] the client really had a menu of options. That they got to choose and if they wanted help with housing, if they wanted help with job readiness, if they wanted help to get prepared for jobs, we were able to do it. I know that housing is a big issue now [. . .] so saying right, that access to recovery is access to all of these other [. . .] support for all these other parts of people's lives that aren't directly about their addiction, but are about supporting them in housing and employment (Director, state-approved treatment provider).***

By far the most discussed need within the recovery ecosystem is the need for more recovery residences of all types, from ASAM 3.1 and 3.5 facilities that provide residential treatment to community-based recovery residences, and everything in between. Recovery housing can be a site of ongoing treatment and can also provide the wraparound support needed to avoid relapse. As one provider explained, *"I think that's the number one thing that people with relapse, that they run into, is the fact that they don't always have safe places to live. They don't have safe places to go."* A few providers specifically identified the need for an intermediate type of recovery housing that has a longer time horizon than inpatient treatment:

> ***Like a 2.1 level of care, which the patient still is engaged in variable treatment modalities and have somewhat of a structured program, not nearly as intensive as what you'd see in a 3.1 or 3.5 home. We have a couple of those and that's where our long-term stuff kicks in, particularly women and children, for 12 to 18 months. (Executive, state-approved treatment provider)***

Many recovery houses are managed or actively referred to by state-approved treatment providers. In those facilities, *"they do treatment here [at the state-approved treatment provider]. They don't do it at the house, but they have to be in treatment here in order to be eligible for the house."* Other types of recovery housing do not meet any ASAM criteria but are known by providers to be reputable, and clients will be referred there. As one interview respondent explained, *"Our case managers meet with all of them and kind of keep their dossier on all of them. Of course, adding in some of the anecdotal stuff we hear from the patients."*

Several survey and interview respondents noted that there is a need for more recovery housing of all kinds, but especially the least-intensive, longer-term types of places.

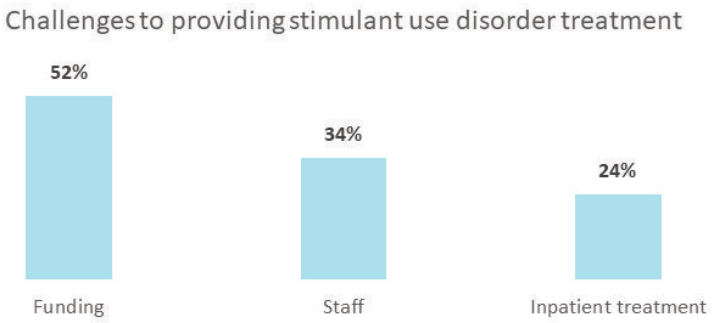
> ***Another thing that I would like to see that we've talked about a lot is a step-down facility. We have a men's recovery house, but after they leave there, they have a really hard time finding a place to live or something that they can afford or a safe, sober living environment. So a step-down facility for after they get out of there or after they get out of treatment would be really great. (Director, state-approved treatment provider)***

Several interview respondents noted specifically that there is a need for recovery housing for women and children and highlighted the fact that methamphetamine use seems to be a dominant reason for CPS involvement in families. When stimulant use disorder treatment is mandated for parents, especially mothers, there is not a clear way to reunite children with mothers in a setting that can support sobriety.

Challenges to Providing Evidence-based Stimulant Use Disorder Treatment

As shown in Figure 6, three of the most common challenges to providing evidence-based stimulant use disorder treatment noted by survey and interview respondents were limitations due to billing requirements (funding was noted as a challenge by over half of survey respondents), lack of organizational and staff capacity, and lack of inpatient treatment options. In addition, providers were asked questions about the impact of COVID-19 on their ability to treat stimulant use disorder.

Figure 6. Challenges to providing stimulant use disorder treatment



Billing options and limitations

All the interview respondents who answered in-depth questions about their financial model commonly described their clientele as being covered primarily by Medicaid. Medicaid expansion has been an important pathway to treatment access for many individuals, especially men. As one executive explained, "Before the expansion, we had little ability to have a man being on Medicaid unless they had a disability. And those funds were 100% block grant, coming from the feds to the state, and down to us. That's the only way we could provide treatment for men." Now several of the interview respondents say that 90–95% of their clients are covered by Medicaid. There are clear benefits to being able to bill for services rather than relying on timebound block grants. At the same time, Medicaid billing limitations have affected the treatment approaches that are used.

Three interview respondents noted that the withdrawal management period necessary for clients with stimulant use disorder to be able to initiate treatment is a significant barrier to adequate treatment. Withdrawal management is included in Medicaid clients' allotted days

of inpatient treatment, even though providers cannot initiate treatment from day one. One provider explained it this way: "We find that clarity of the meth user doesn't even start kicking into their brain for 10 to 14 days. And then we might only have another 10 days with them before their payment source runs out." More generally, providers note a disconnect between the observed impacts of long-term treatment and the limitations placed by insurance providers, both public and private, on the duration of treatment that is covered. One executive stated:

> ***I know if I could compile our data and pull it a little bit more efficiently, I think we would see that people that have longer treatment have a longer period of sobriety, because that's what we see people that, for one reason or another, either their insurance or their Medicaid money runs out (Executive, state-approved treatment provider).***

These limitations on billing mean that treatment services cannot be tailored to specific client needs. Instead, *"individuals are not being afforded the opportunity to treat their addiction but rather pushed through a predetermined number of sessions. Some individuals need more services than others."*

Medicaid billing requirements also shape how intensive outpatient services are provided, especially in terms of how many hours of group therapy can be offered per week. Medicaid cuts have included a decrease from three billable hours of group therapy per day to one hour per day, as well as a decreased hourly rate for groups.

> ***I use the term intensive loosely because it's more like an expanded or enhanced outpatient because technically we can't get reimbursed for how we used to run our IOP programs. That went away, what, a couple of years ago? And they restored it partially, but technically, we call it intensive outpatient, but it technically does not meet the ASAM criteria for intensive outpatient. (Director, state-approved treatment provider)***

Billing requirements for group therapy are especially limiting for providers serving smaller communities, since, as one survey respondent explained, *"most sites do not have a sufficient volume of stimulant use disorder primary clients at the recommended level of care to maintain sufficient numbers to generate enough revenue. In short, [they have] small groups that do not support their cost."* Several other providers highlighted that they consider intensive outpatient treatment the most appropriate starting point for treating stimulant use disorder, but they are unable to bill for the number of hours required for this course of treatment under current Medicaid regulations.

> ***We'd like intensive outpatient, but with the gap in funding, they've kind of done away with the old, normal intensive outpatient, because that was nine hours a week.[…] And so with Medicaid, the cuts in Medicaid and everything like that, we've gone away from the standard intensive outpatient, but we still have an enhanced patient, six hours a week (Director, state-approved treatment provider).***

There are specific challenges posed by billing requirements for vulnerable populations. One survey respondent highlighted that *"there are no agencies that accept Medicare, so our Seniors and Disabled populations are vastly under-served."* Others noted that prior to COVID-19, telehealth was not covered for stimulant use disorder treatment by public or private insurance. With the current state of emergency, telehealth treatment services are covered, and providers are seeing positive benefits for clients who are geographically remote as well as those for whom stigma about treatment might have been a barrier in the past: *"Clients are staying engaged for longer periods of time. Those who may not have sought services due to shame, or lack of transportation, are now attending on a regular basis."*

Organizational and staff capacity

Staffing concerns, especially staff credentials and the hiring of new staff, were the primary organizational challenge discussed by interview respondents. One noted that the combination of a licensed associate counselor (LAC) degree and a licensed clinical professional counselor (LCPC) or licensed clinical social worker (LCSW) degree presented *"the most valuable skillset"* because of their education in both the clinical and community-level influences on patients. For another provider, *"a Master's degree is ideal because we're dealing with the most complex organ, which is the brain [… however,] most of the people coming into the field are new counselors, are only Associate's degrees."*

Inadequate staffing levels create a challenge for providing effective treatment. As one executive explained:

> ***Especially with substance use disorders, you've got to hit them right when they're ready. Have something right there, right then to start doing something […] we just have such limited capacity for that right now, again, because of staffing […] we just don't have the staff capacity, and I know we're losing people, we're losing people along the way. (Provider, state-approved treatment provider)***

In addition to finding trained staff to hire, there are also organizational challenges associated with maximizing existing staff time to implement evidence-based practices. One interview respondent discussed the goal of expanding the use of CBT: *"Yes, we could train people in it, but how much time do we actually have to do it? Because try to work out people's schedules, both the clients and the staff, and it's almost overwhelming."*

An additional organizational point made by one state-approved treatment provider director concerns licensing, approvals, and other certifications. The overarching point is that there is a need to streamline the requirements for licensing and those for specific state-approved treatment approaches. This respondent suggests that if a provider has national certifications that are more stringent than state licensing requirements, those certifications could be used for state licensing, freeing up oversight for other facilities.

> ***One thing would be addressing discrepancies between licensing and state-approved treatment provider status. There's not enough oversight from licensing, and programs don't have to provide much evidence of certification or best practices. Because right now, we have to adhere to all the licensing requirements of the delivery of the programs, like an inpatient program or an IOP program. And then there's these licensing things for our facilities that are absolutely in conflict, with what the licensing of the program itself says. And then QA [quality assurance] comes in, and they don't talk to each other either. It's maybe a little bit more routine now, but [with a statewide hiring freeze how] can they assure that people aren't getting harmed? Because they're not checking all of the quality things. We've made some suggestions too to make it easier for them. Why don't you give a pass to those that have a national certification, like CARF [Commission on Accreditation of Rehabilitation Facilities] or The Joint Commission? I'm talking for myself right now because the rigors that we go through to have a CARF survey and get certified is unbelievable. It's far above what the state requires. Why can't we make their life easier? (Executive, state-approved treatment provider)***

IMPLICATIONS AND RECOMMENDATIONS

Stimulants have consistently been substances of concern in Montana over the past decade and continue to be one of the most challenging substances to address through treatment and recovery. As many respondents in this study report, methamphetamines are by far the most common stimulant being abused across the state. Recent reports at the state level as well as by the state-approved treatment providers surveyed in this study suggest that methamphetamines have become one of the most common substances for which people are or should be seeking treatment. Given the prevalence and the severity of stimulant use disorders in the state, one of the key messages from both survey and interview respondents in this study is the need for effective and evidence-based treatment and recovery options. State-approved treatment providers stressed that an all-hands-on-deck approach to treatment modalities is necessary to try to address stimulant use disorder. Furthermore, they expressed interest in expanding their own capacity and adding tools to their toolkit by receiving training and support to implement new treatment modalities that show promise for stimulant use disorder.

Implications

The big-picture implication of the findings presented in this study is that inpatient and residential treatment and recovery options for individuals with stimulant use disorder in the state of Montana are lacking. State-approved treatment providers consistently highlighted the large gaps in the following elements of the treatment and recovery system:

1. Withdrawal management ("detox") facilities

2. Inpatient stimulant use disorder treatment, both short term (30 days) and long term (3–9 months)

3. Recovery residences, especially step-down and community-based facilities

Survey and interview respondents consistently emphasized the physical and psychological intensity of stimulant use disorder and the need for long-term engagement with clients seeking treatment. This is especially the case early in the treatment and recovery process since withdrawal from stimulants takes time and there are no pharmacological options to ease this process. In addition, the social and community context of individuals with stimulant use disorder can easily undermine the treatment process if they do not have sober and supportive spaces to live, work, and socialize.

Recommendations

Addressing these gaps will require substantial and long-term investments in the stimulant use disorder and SUD treatment system. In the shorter term, some specific recommendations that have emerged from this study include the following:

1. Support the expanded use of existing evidence-based treatment approaches for stimulant use disorder

    1a. Provide state-approved treatment providers with guidance about ways to fund contingency management

    1b. Align Medicaid billing and covered services with the requirements of the Matrix model and other evidence-based IOP treatment modalities

    1c. Continue to use block grant opportunities to expand access to evidence-based treatment modalities

2. Provide support to expand high-quality recovery residences, with a specific focus on step-down and community-based recovery residences once clients have completed IOP treatment modalities

   2a. This support could help current community-based recovery residences to increase and improve their services to become ASAM 3.1 facilities and to learn how to bill for those services

   2b. This support could include licensing or other oversight of recovery residences and transitional housing to improve the quality and consistency of outcomes for clients

   2c. This support could include working on braided funding to develop new recovery residence options, especially in parts of the state where these services are currently lacking

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APPENDIX A: SURVEY RESPONDENTS BY ORGANIZATION AND LOCATIONS COVERED

State-approved treatment provider name	Locations covered by survey response
YWCA Helena	Helena
Alcohol and Drug Services of Gallatin County	Bozeman, Belgrade
Billings Addiction Counseling LLC	Billings
Gateway Community Services	Great Falls, Thompson Falls, Kalispell, Libby
Prairie Hills Recovery	Baker, Glendive
Boyd Andrew Community Services	Helena, Townsend, Boulder, Whitehall
Jeff C Richardson LAC LLC	Wolf Point
Center for Mental Health	Great Falls, Helena
Indian Family Health Clinic	Great Falls
Intermountain	Helena
Leo Pocha Memorial Clinic-Helena Indian Alliance	Helena
L'Esprit	Livingston
Montana Chemical Dependency Center (MCDC)	Butte
Seeking Recovery LLC	Great Falls
Journey Recovery	Billings, Red Lodge, Lewistown, Columbus, Big Timber, Roundup
Stepping Stones Counseling, PLLC	Missoula
Western Montana Mental Health Center	Missoula
Alternatives, Inc.	Billings, Columbus, Red Lodge
Aspen Assessment & Counseling Services	Lewistown
Cedar Creek Integrated Health	Ronan, St. Ignatius, Missoula, Libby, Superior, St. Regis
Choices for Change Counseling	Arlee
Eastern Montana Community Mental Health Center	Miles City, Glendive, Sidney, Plentywood, Glasgow, Forsyth, Baker
Helena Valley Addiction Services	Helena
Instar Community Services	Helena
New Directions Counseling	Billings
Southwest Chemical Dependency Program	Livingston
Western Montana Mental Health Center	Hamilton
Rimrock Foundation	Billings
Southwest Montana Addiction, Recovery and Treatment Program (SMART)	Butte
White Sky Hope Center	Box Elder
Big Horn Valley Health Center	Hardin, Miles City, Ashland, Lewistown, Chinook
Billings Urban Indian Health & Wellness Center	Billings
Blackwell Behavioral Health	Missoula
Eastern Front Counseling	Shelby, Conrad, Choteau
Glacier Hope Homes, Inc.	Columbia Falls
Misfits LLC	Great Falls, Shelby
North American Indian Alliance (NAIA)	Butte

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