The Future of Addiction Medicine

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Brian Hurley, M.D., M.B.A., FAPA, DFASAM
President, American Society of Addiction Medicine

Brian Hurley, M.D., M.B.A., FAPA, DFASAM

No financial conflicts of interests

Brian is the President of the American Society of Addiction Medicine, so comments on topics involving ASAM may be biased towards ASAM

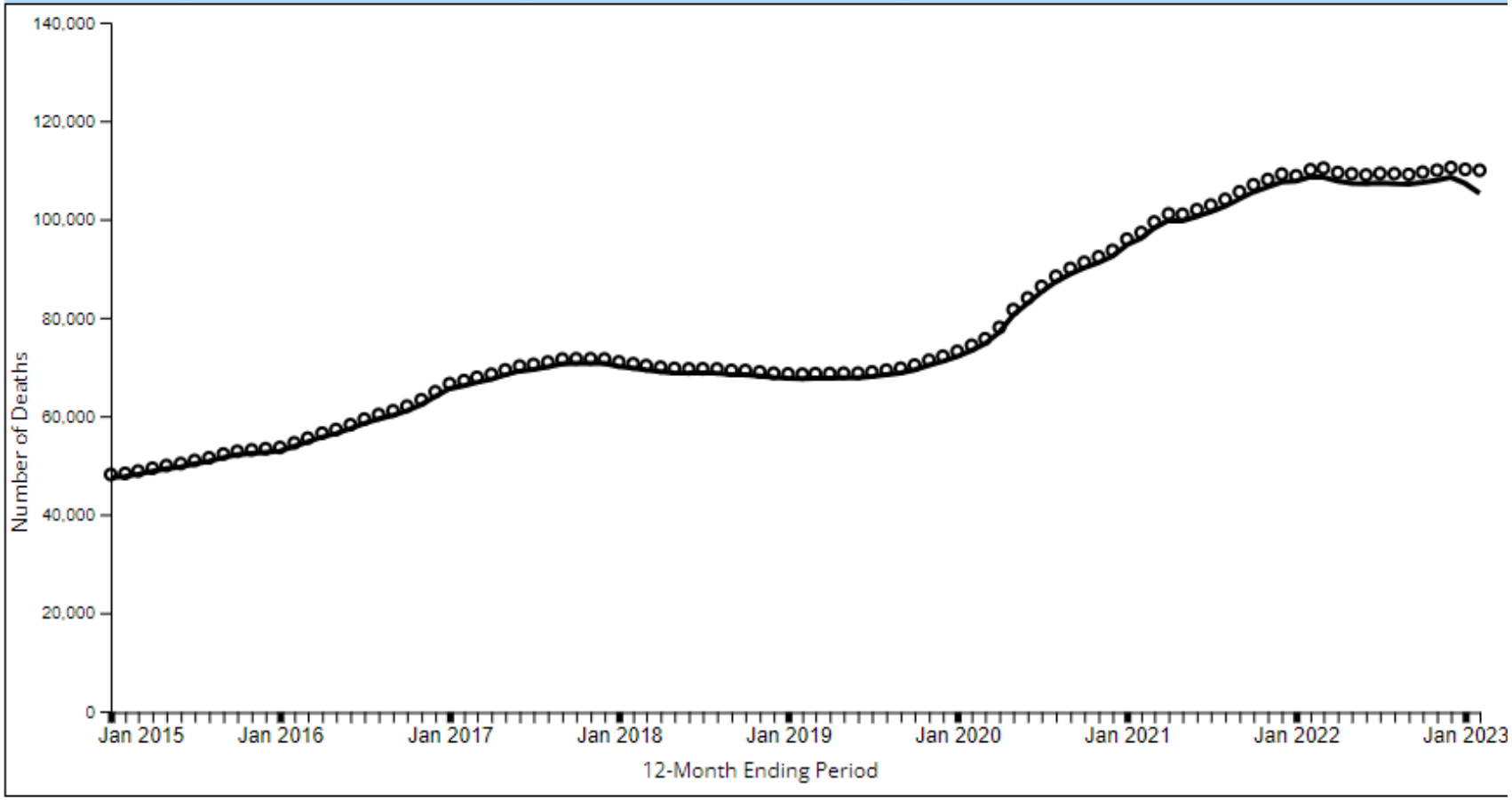
None of the medications discussed
in this presentation are FDA approved for
Cannabis or Stimulant Use Disorders

Key Take Home Points

- Everyone gets naloxone
- Language matters
- Lack of demand > Lack of supply of formal specialty substance use treatment
  - 95% of people don't get specialty SUD treatment (*because they are not interested in treatment as usual*)
- Don't assume the goal of abstinence initially
  - The 95%!
- Offer Medications for Addiction Treatment
  - Particularly for Opioid Use Disorder
  - As quickly as possible
  - Without unnecessary contingencies

Rising Overdose Rates

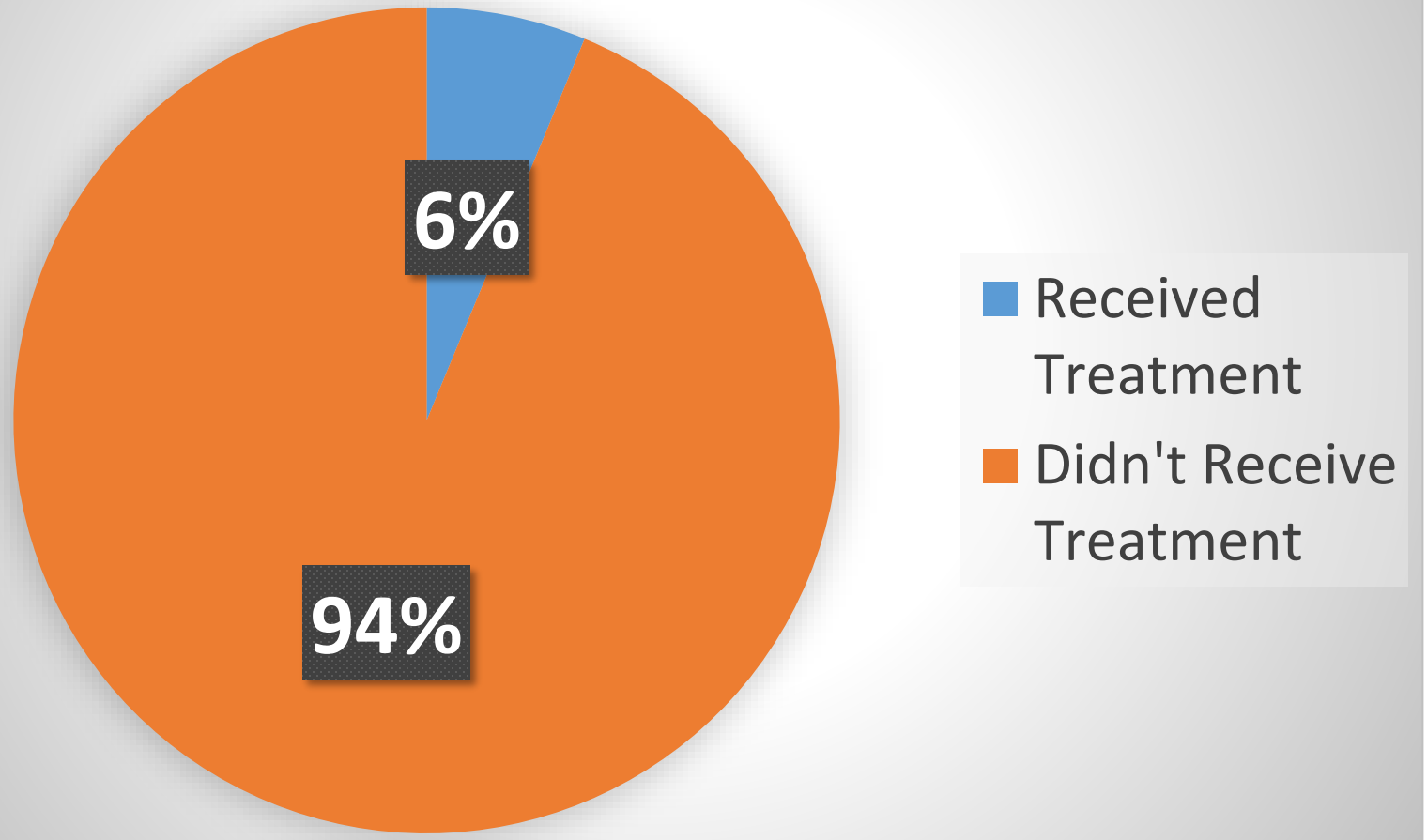
Figure 1a. 12 Month-ending Provisional Counts of Drug Overdose Deaths: United States



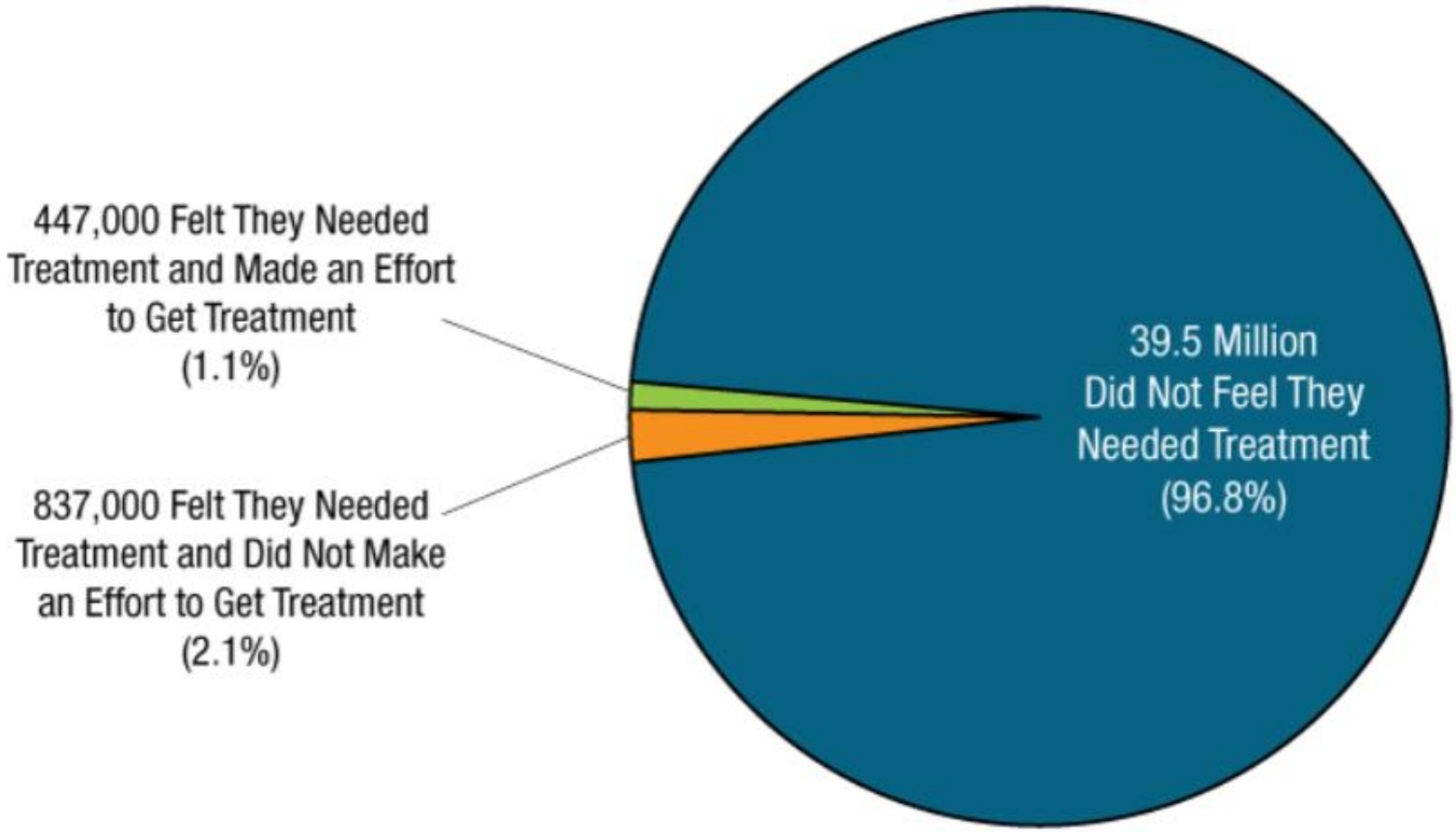
https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm


HEROIN
FENTANYL
CARFENTANIL

Receipt of Any Substance Use Treatment among People with a Past Year SUD



Substance Abuse and Mental Health Services Administration. (2022). *Key substance use and mental health indicators in the United States: Results from the 2021 National Survey on Drug Use and Health* (HHS Publication No. PEP22-07-01-005, NSDUH Series H-57). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report



40.7 Million People with an Illicit Drug or Alcohol Use Disorder Who Did Not Receive Substance Use Treatment at a Specialty Facility

Substance Abuse and Mental Health Services Administration. (2022). *Key substance use and mental health indicators in the United States: Results from the 2021 National Survey on Drug Use and Health* (HHS Publication No. PEP22-07-01-005, NSDUH Series H-57). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report

Biology of Motivation

Positive reinforcement

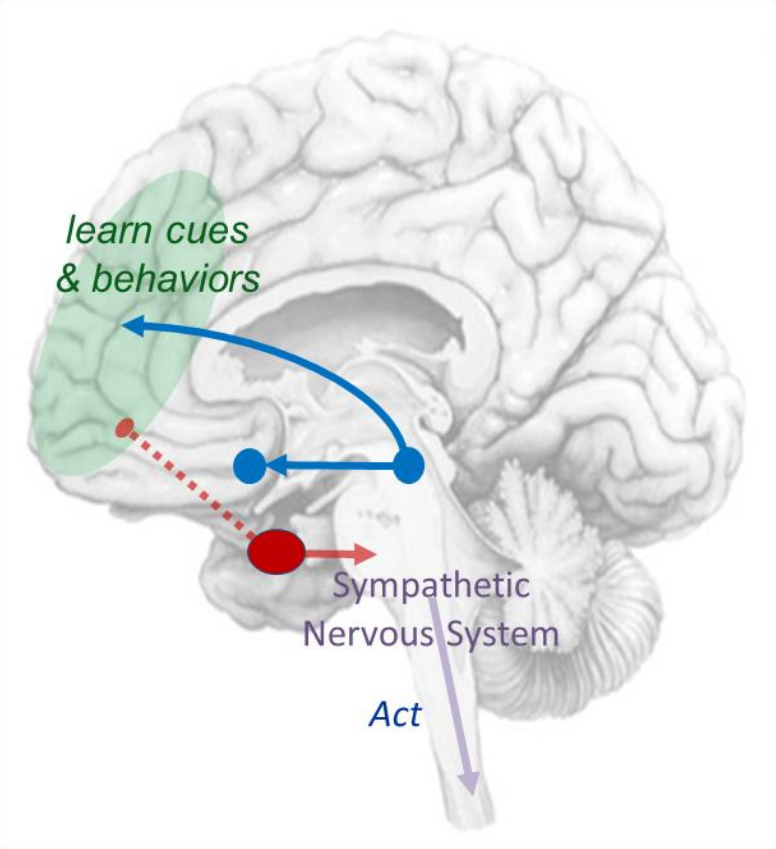
cells in the brainstem release **dopamine** in the **nucleus accumbens**

↓

liking and wanting

↓

seek out and do more



Negative reinforcement

cells in the **amygdala** are stimulated

↓

anxiety, fear, distress

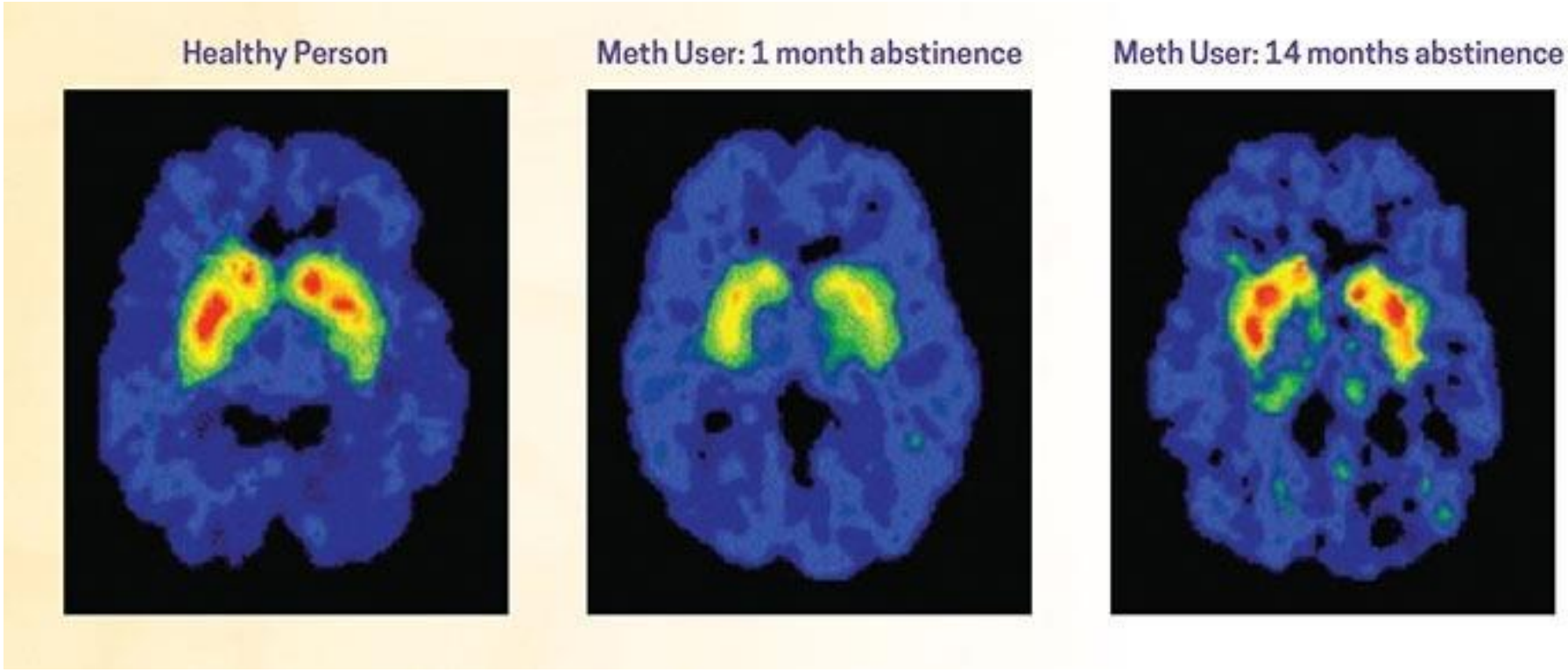
↓

avoid things that cause, do things that relieve fear

Volkow et al., 2016
Wise and Koob, 2014

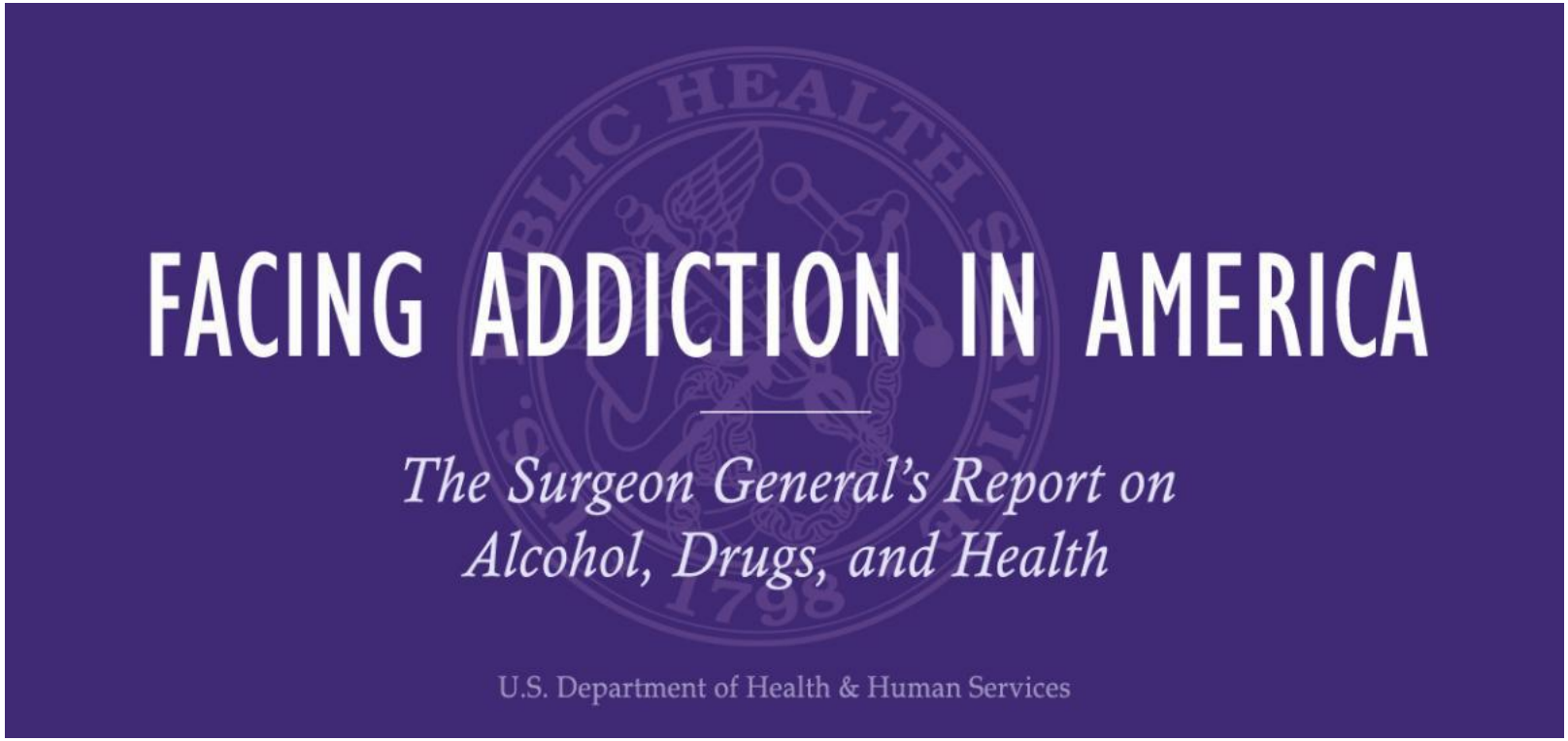
Attention, thinking, and judgment use the **prefrontal cortex**

It takes time for the brain to recover



http://www.drugabuse.gov/publications/research-reports/methamphetamine/what-are-long-term-effects-methamphetamine-misuse

Surgeon General's Report

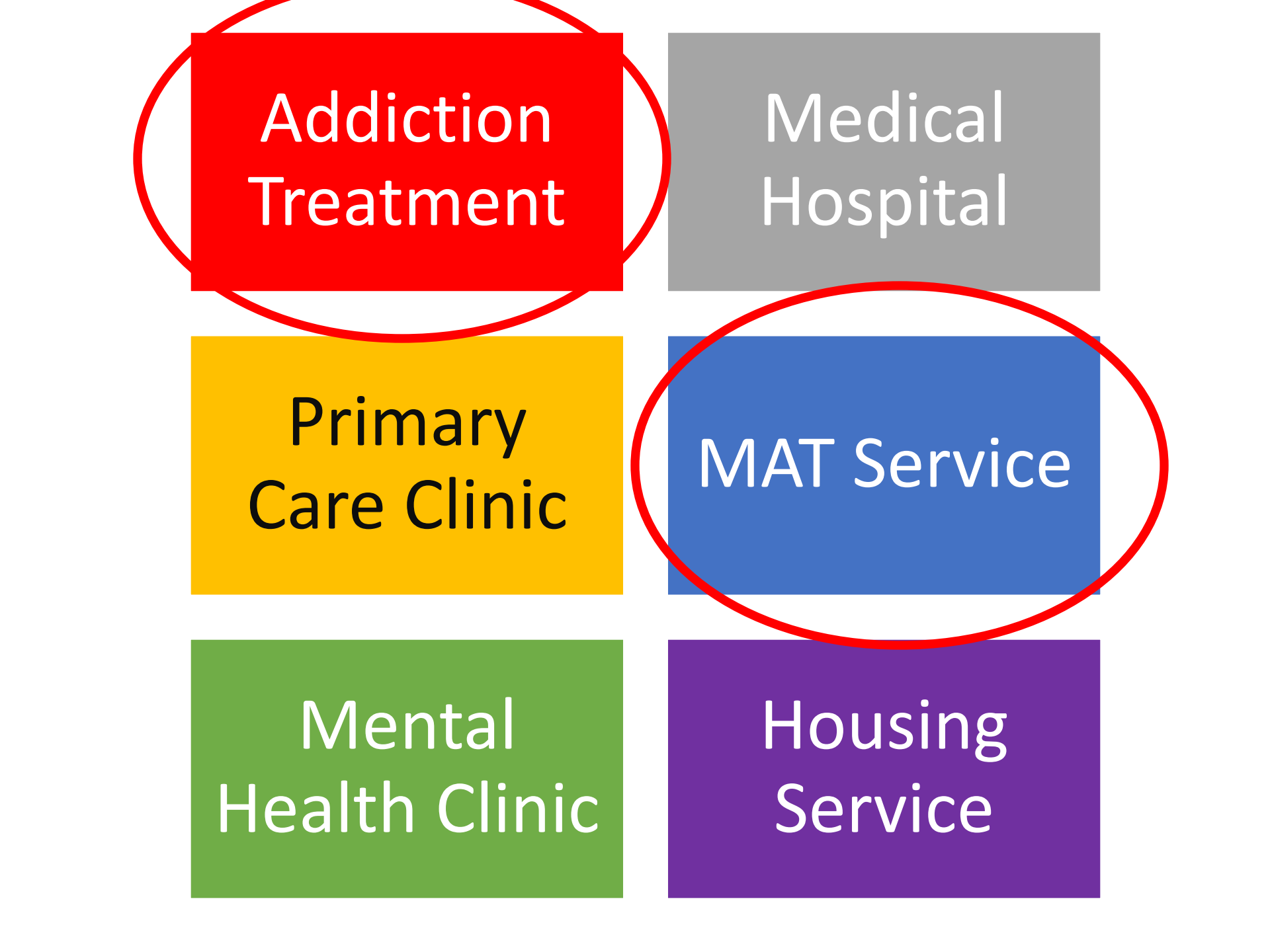


https://addiction.surgeongeneral.gov/

Surgeon General's Report

Integrating substance use services results in better outcomes

https://addiction.surgeongeneral.gov/


Addiction Treatment
Medical Hospital
Primary Care Clinic
MAT Service
Mental Health Clinic
Housing Service

Addiction Treatment

including MAT

Medical Hospital

offering Addiction Tx

Primary Care Clinic

providing Addiction Tx

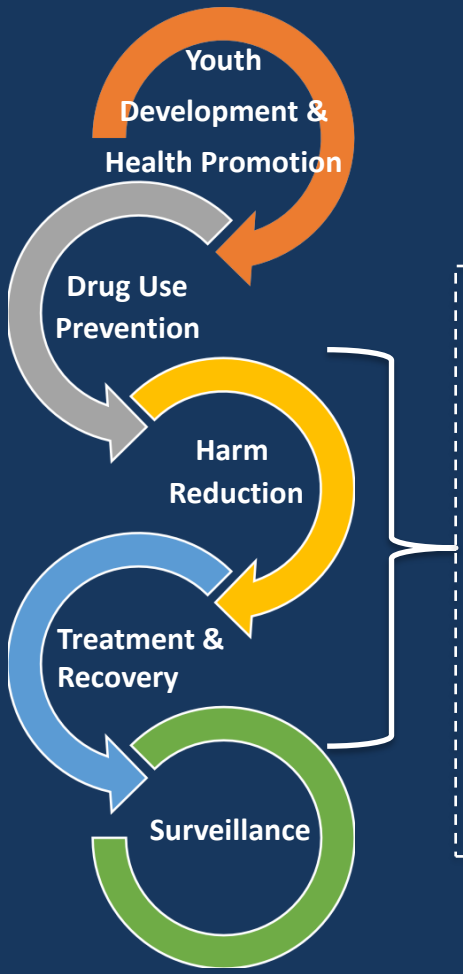
Mental Health Clinic

providing Addiction Tx

Housing / Social Service

linking people to Addiction Tx

A Continuum of Substance Use Interventions



Youth Development & Health Promotion

- Programs at school- and community-level

Drug Use Prevention

- Universal, selected, and indicated prevention

Harm Reduction → Currently largely serves people who are using drugs and not yet interested in SUD treatment

- Low threshold services proven to reduce morbidity and mortality, including outreach, overdose prevention (naloxone and fentanyl test strip distribution, etc), syringe exchange, peer services, linkages to SUD treatment and other needed services, etc.

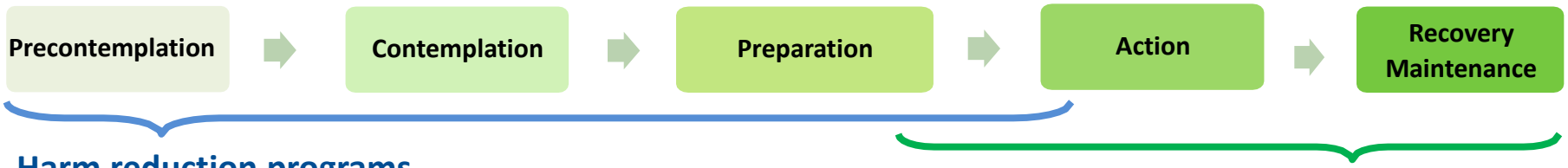
SUD Treatment & Recovery → Currently largely serves people who are ready for abstinence

- Involves a spectrum of settings: opioid treatment programs, outpatient, intensive outpatient, residential, inpatient, withdrawal management, Recovery Services, Recovery Bridge Housing, field-based services, care coordination and navigation, etc.

Surveillance of drug use and its community impact

Slide Credit: Adapted from Agència de Salut Pública de Barcelona

Stages of Change



Harm reduction programs

- Initial engagement
- Harm reduction supplies
- Skills development to reduce risks
- Linkage to health care and social services
- Outreach: street teams
- Low-threshold medications for addiction treatment

Recovery is Possible!

- Of those in the U.S. with a history of substance use disorder, 75% are in recovery.

Harm Reduction is Essential

- Harm reduction is practiced all across health care (diabetes example, lollipops in dental offices, etc)
- In the context of the worst overdose crisis in history, harm reduction reduces mortality risks, increases treatment access and access to other health and social services, and supports recovery.

Treatment programs

- Biopsychosocial treatment for substance use (including medication services, individual and group therapy)
- Linkage to other medical and social services
- Crisis care

Aligning Services with Readiness is Essential

- Addiction is chronic and recurrent, and not all people are at the same stage of readiness to change.
- Only focusing on individuals in some stages of change as opposed to ALL stages of change limits service reach and impact → We need the widest service net possible

Slide Credit: Adapted from Agència de Salut Pública de Barcelona

Evidence-Based Practices (EBPs) and Personal Beliefs

- We are ethically bound to provide the services that give the patient the best chance of success.
- For both MH and SUD, this means using EBPs whenever they exist
- This is another place where personal belief and practice may come into conflict. (E.g., “I don’t believe in using medicines in addiction treatment.”)
- Engaging patients with empirically-based choices is essential

Slide Credit: UCLA ISAP (Freese, Hasson, Hovik, Kurtz, Peck, Rutkowski)

Recommendations

- Avoid labeling
- Receive training
- Use person first language (avoid stigmatizing language)
- Supportive atmosphere with zero tolerance for discrimination
- Acknowledge patients' significant others and encourage their support and participation in prevention and treatment p

Slide Credit: UCLA ISAP (Freese, Hasson, Hovik, Kurtz, Peck, Rutkowski)

The use of affirming language inspires hope and advances recovery.

LANGUAGE MATTERS.

Words have power.

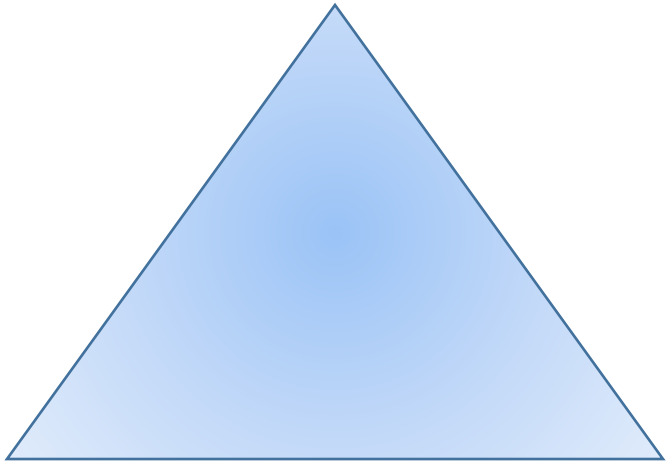
PEOPLE FIRST.

The ATTC Network uses affirming language to promote the promises of recovery by advancing evidence-based and culturally informed practices.

http://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction

Core Components of Addiction Treatment

*Medications

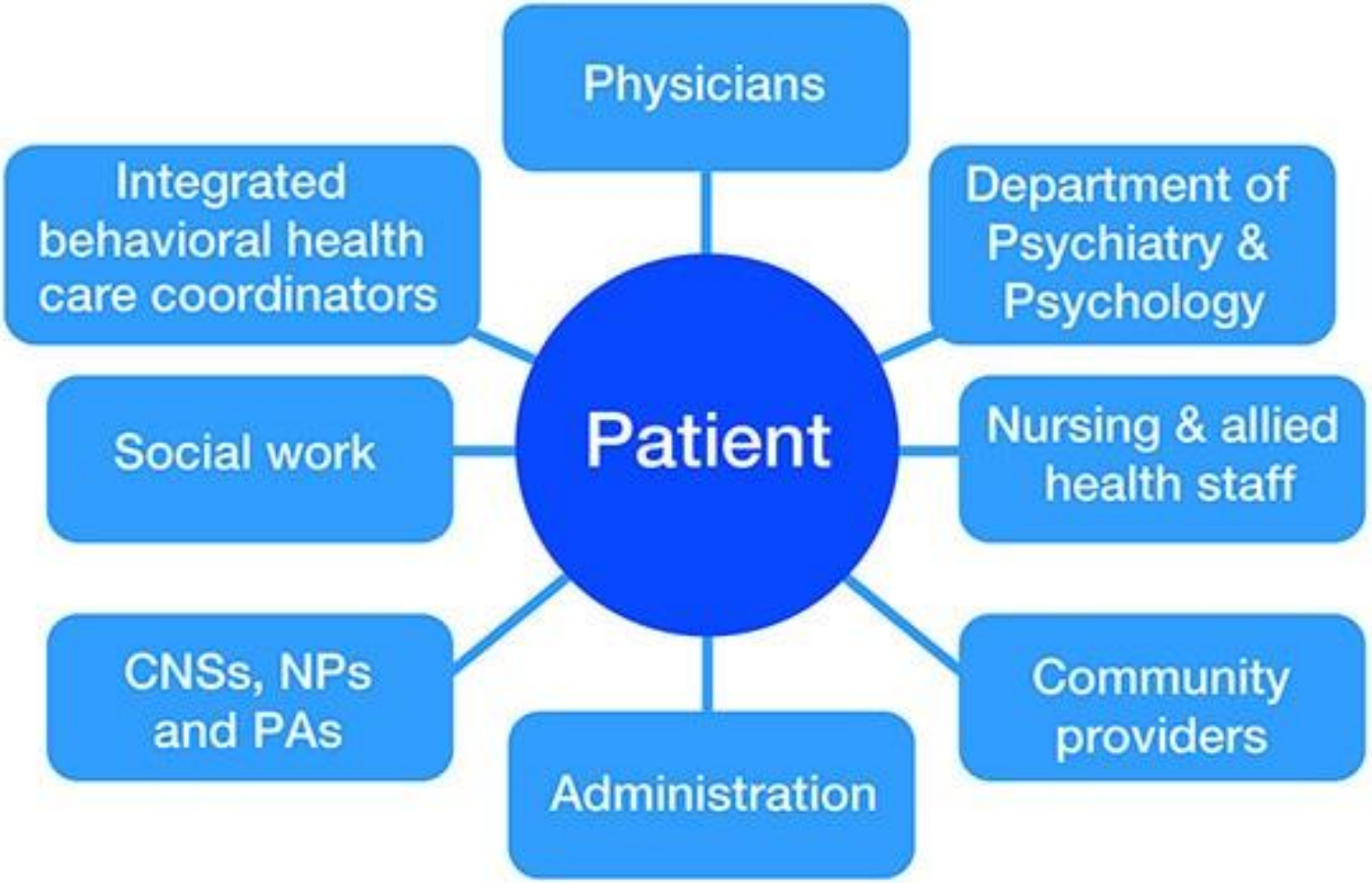


*Counseling

*Support

*When appropriate

Source: http://www.samhsa.gov/treatment


Physicians
Integrated behavioral health care coordinators
Department of Psychiatry & Psychology
Social work
Patient
Nursing & allied health staff
CNSs, NPs and PAs
Community providers
Administration

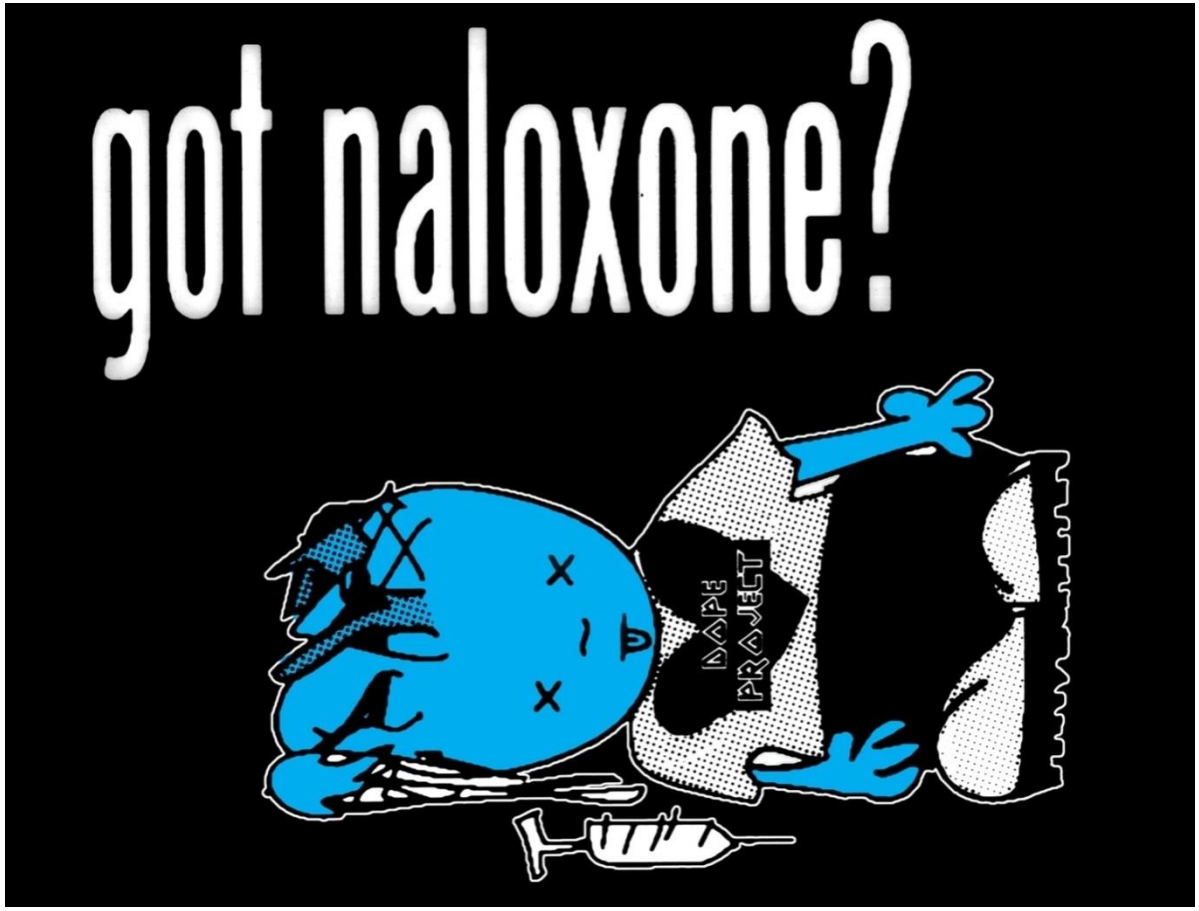
Psychosocial Treatments

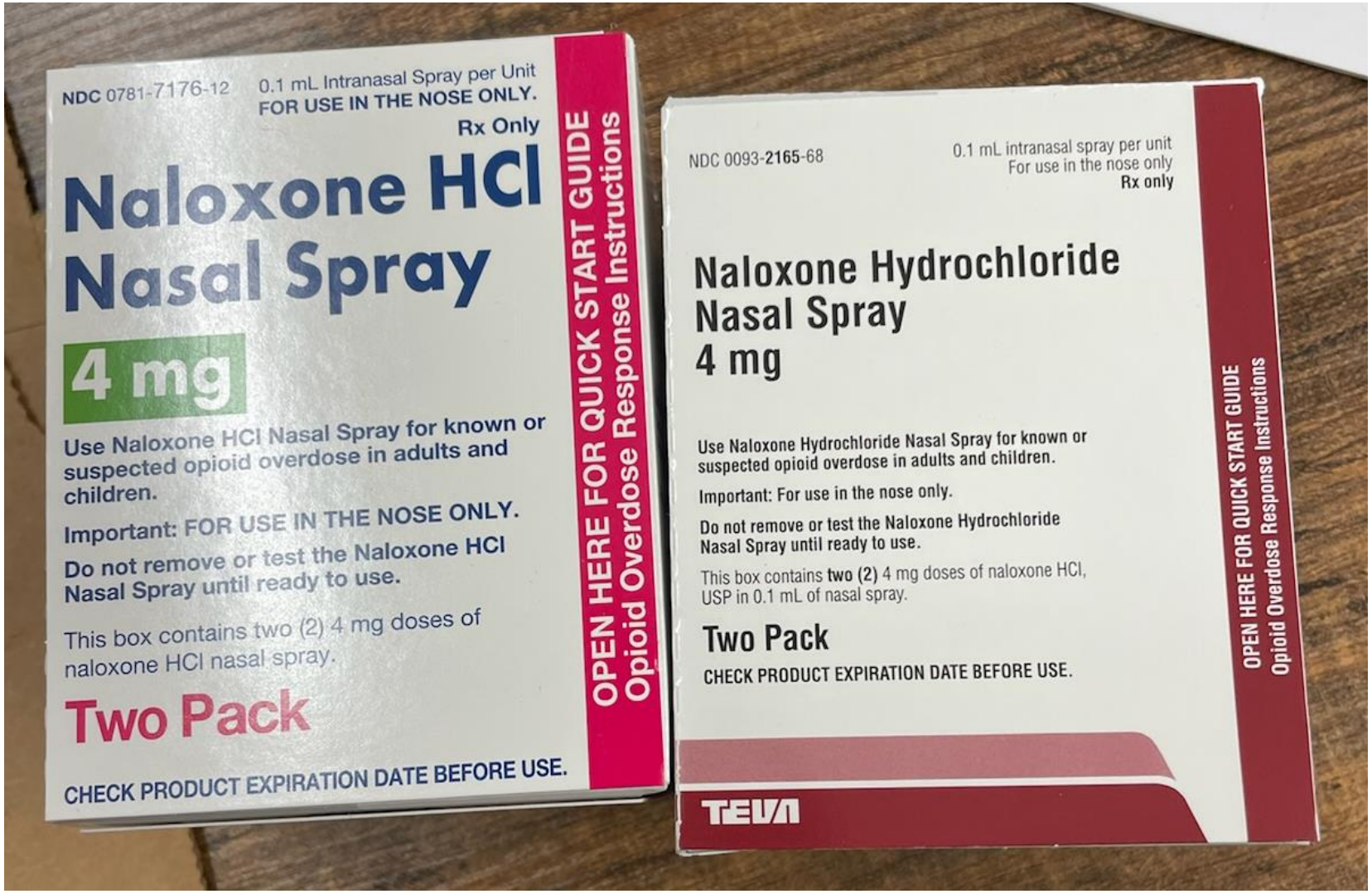
- 12-step
- Cognitive and/or Behavioral Psychotherapies
- Motivational Enhancement Therapy
- Community Reinforcement
- Contingency Management
- Multisystemic Therapy
- Multidimensional Family Therapy

Contingency Management (CM)

- Basic Assumptions of CM
  - Substance use can be reduced using operant conditioning
  - Useful in promoting treatment retention and adherence
  - Incentives for negative urine tests useful in decreasing drug use

Naloxone




NDC 0781-7176-12
0.1 mL Intranasal Spray per Unit
FOR USE IN THE NOSE ONLY.
Rx Only
Naloxone HCl
Nasal Spray
4 mg
Use Naloxone HCl Nasal Spray for known or suspected opioid overdose in adults and children.
Important: FOR USE IN THE NOSE ONLY.
Do not remove or test the Naloxone HCl Nasal Spray until ready to use.
This box contains two (2) 4 mg doses of naloxone HCl nasal spray.
Two Pack
CHECK PRODUCT EXPIRATION DATE BEFORE USE.
OPEN HERE FOR QUICK START GUIDE
Opioid Overdose Response Instructions
NDC 0093-2165-68
0.1 mL intranasal spray per unit
For use in the nose only
Rx only
Naloxone Hydrochloride
Nasal Spray
4 mg
Use Naloxone Hydrochloride Nasal Spray for known or suspected opioid overdose in adults and children.
Important: For use in the nose only.
Do not remove or test the Naloxone Hydrochloride Nasal Spray until ready to use.
This box contains two (2) 4 mg doses of naloxone HCl, USP in 0.1 mL of nasal spray.
Two Pack
CHECK PRODUCT EXPIRATION DATE BEFORE USE.
TEVA
OPEN HERE FOR QUICK START GUIDE
Opioid Overdose Response Instructions

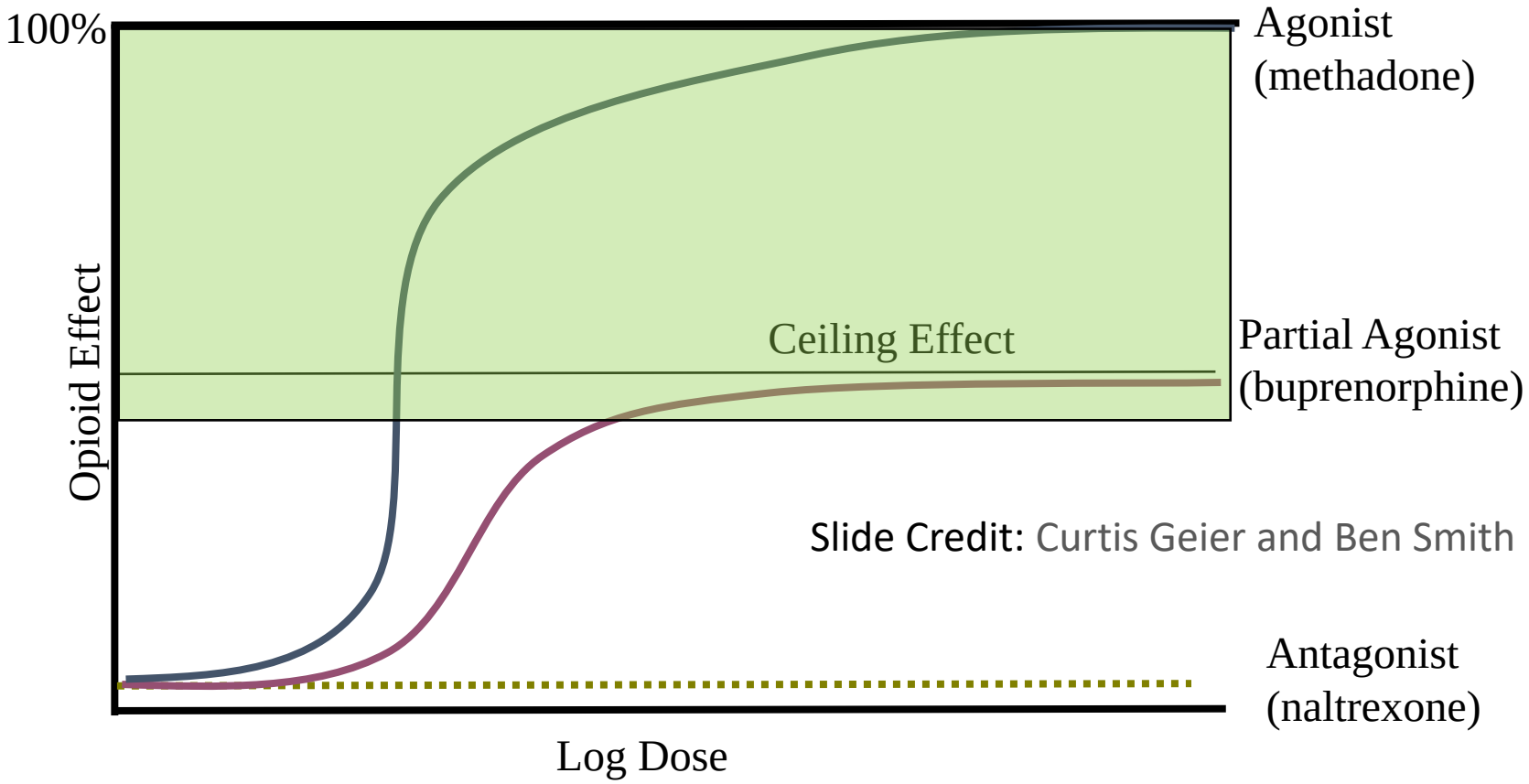
Bottom Line

Nobody needs to die from an opioid overdose

Medications for Addiction Treatment (MAT)

- Opioids
  - Methadone
  - Buprenorphine
  - Naltrexone
  - Naloxone* (not a maintenance medication)
- Alcohol
  - Disulfiram
  - Naltrexone
  - Acamprosate
- Tobacco
  - Nicotine
  - Bupropion
  - Varenicline
- Others
  - No FDA-approved medications (yet)

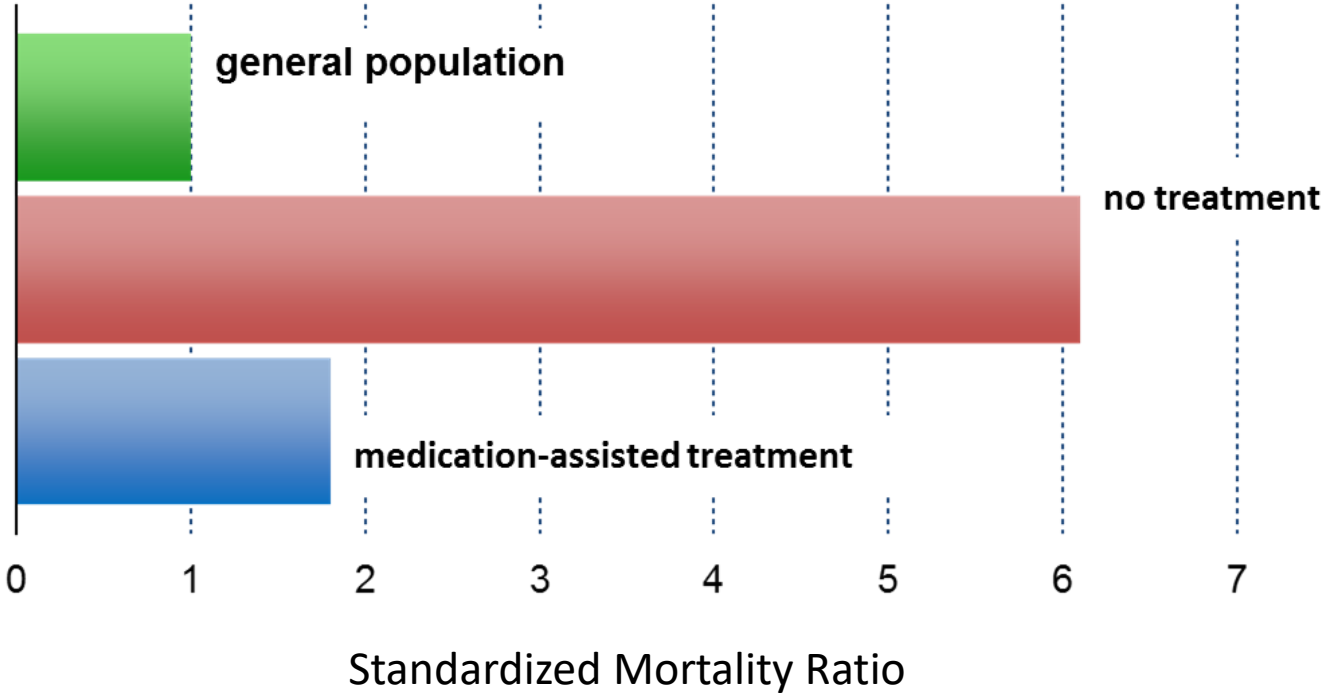
Buprenorphine & Methadone Pharmacokinetics



Slide Credit: Curtis Geier and Ben Smith

Benefits of MAT: Decreased Mortality

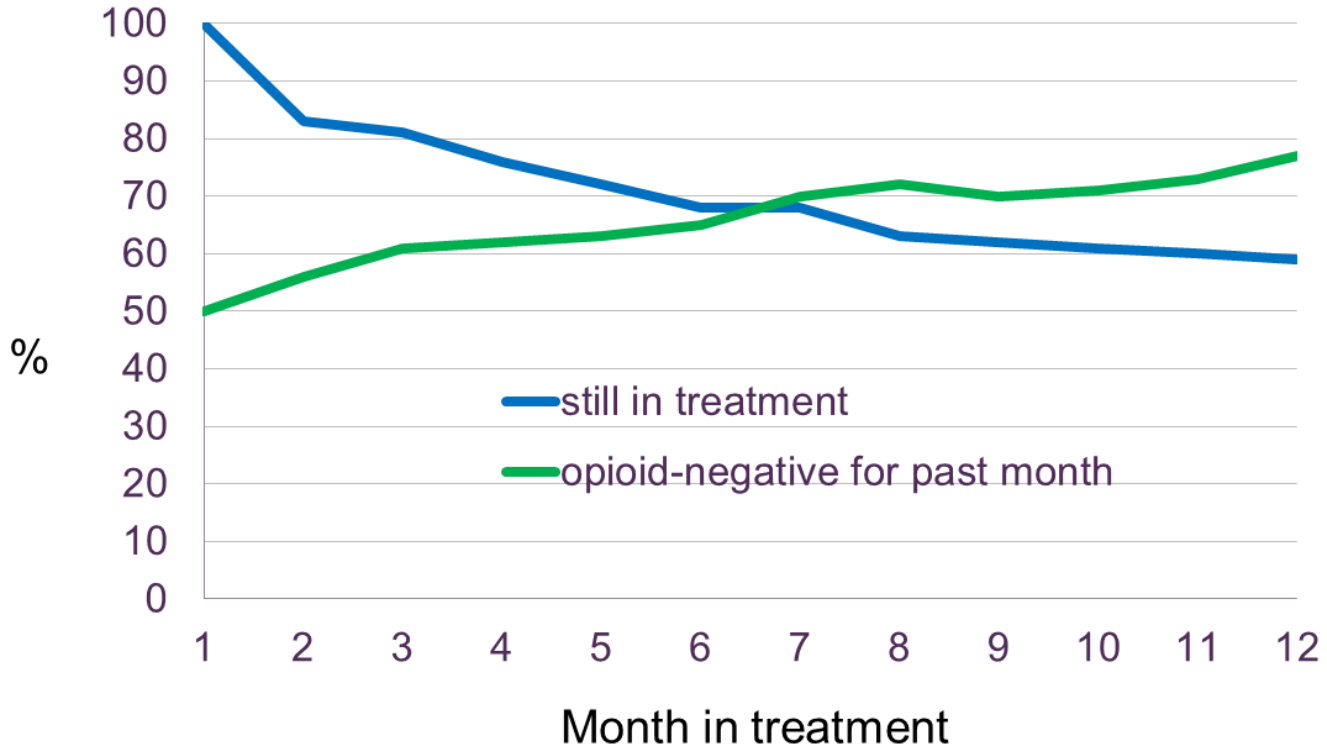
Death rates:



Dupouy et al., 2017
Evans et al., 2015
Sordo et al., 2017

Treatment Retention and Decreased Illicit Opioid Use on MAT

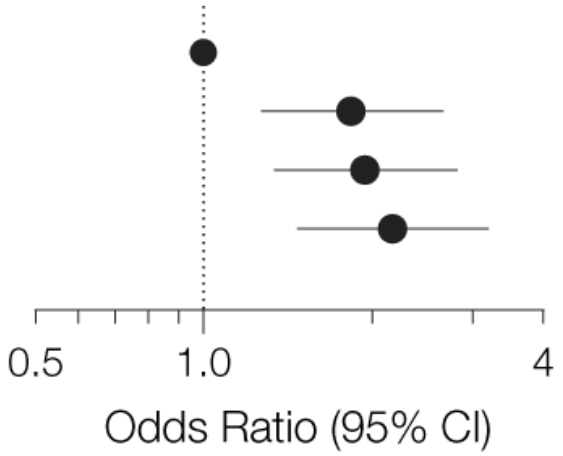
- Buprenorphine promotes retention, and those who remain in treatment become more likely over time to abstain from other opioids



Kakko et al, 2003
Soeffing et al., 2009

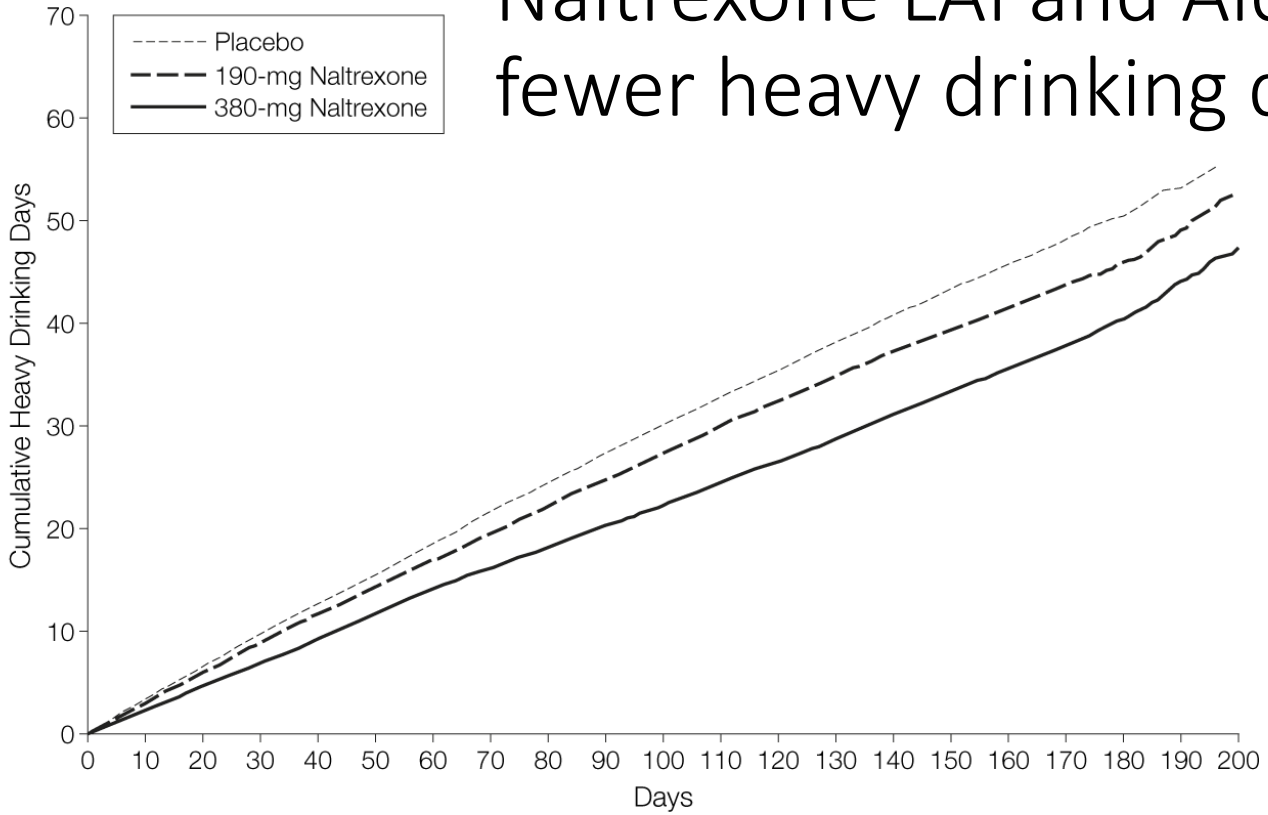
Project Combine

Treatment	Odds Ratio (95% CI)
Placebo Naltrexone/No CBI	1.00
Placebo Naltrexone/CBI	1.82 (1.26-2.65)
Naltrexone/CBI	1.93 (1.33-2.80)
Naltrexone/No CBI	2.16 (1.46-3.20)



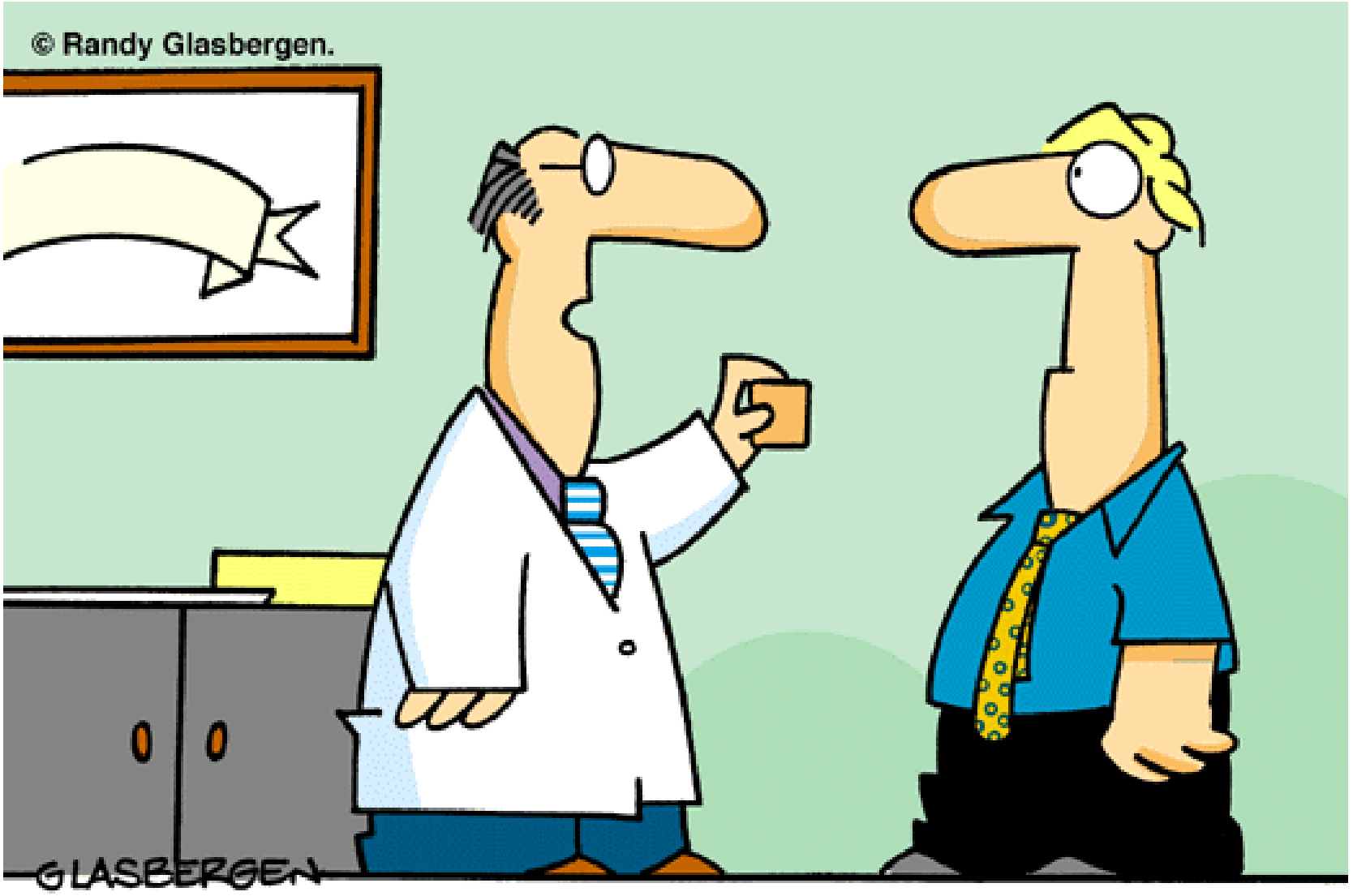
Anton, R. F., O'Malley, S. S., Ciraulo, D. A., Cisler, R. A., Couper, D., Donovan, D. M., ... & Longabaugh, R. (2006). Combined pharmacotherapies and behavioral interventions for alcohol dependence: the COMBINE study: a randomized controlled trial. *Jama*, *295*(17), 2003-2017.

Naltrexone LAI and Alcohol: fewer heavy drinking days



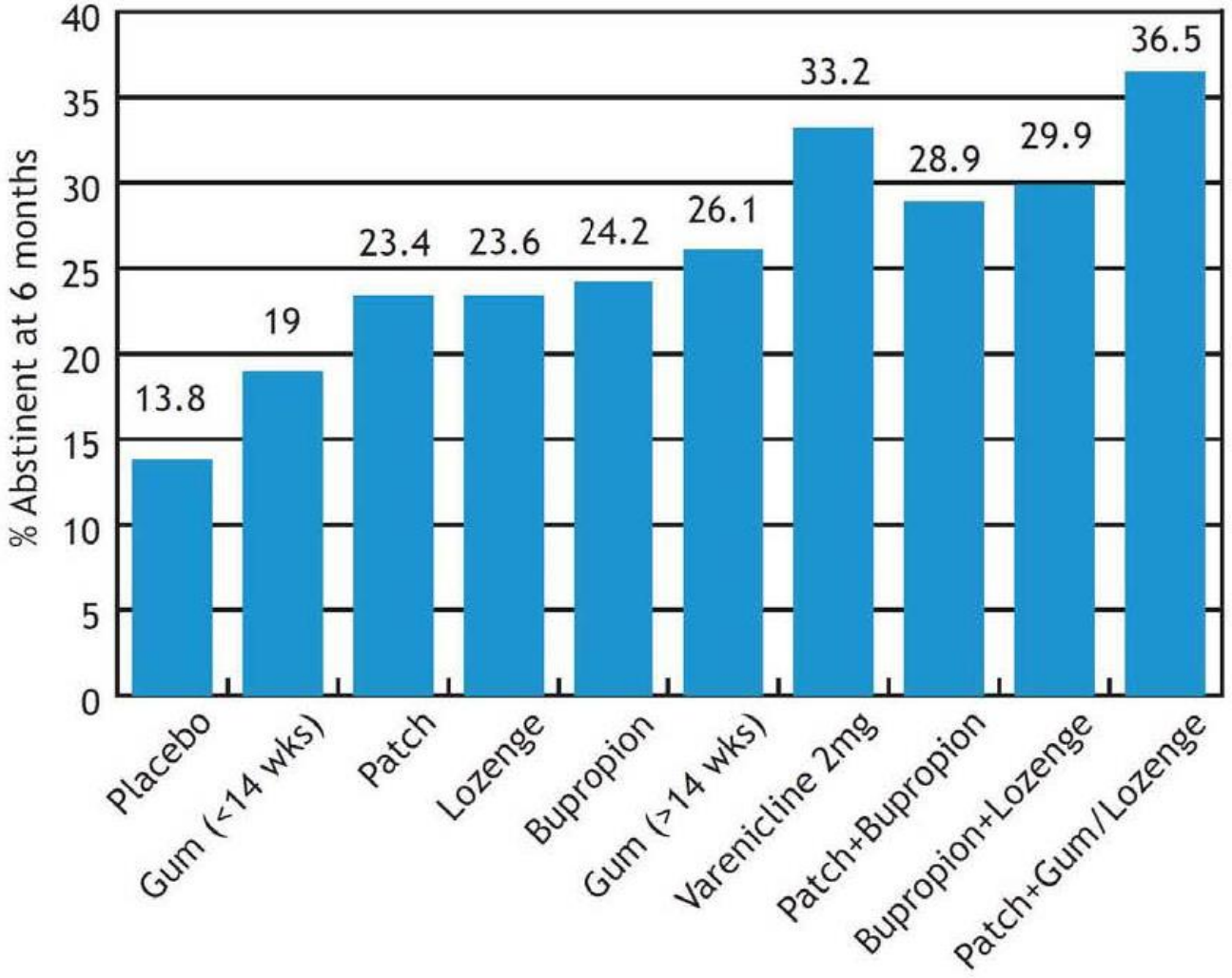
Treatment Dose	1	2	3	4	5	6
No. of Patients						
Placebo	209	194	169	160	142	134
Naltrexone						
190 mg	210	187	169	156	144	137
380 mg	205	186	161	147	139	130

Garbutt, J. C., Kranzler, H. R., O'Malley, S. S., Gastfriend, D. R., Pettinati, H. M., Silverman, B. L., ... & Vivitrex Study Group. (2005). Efficacy and tolerability of long-acting injectable naltrexone for alcohol dependence: a randomized controlled trial. *Jama*, *293*(13), 1617-1625.



"I'm prescribing a patch to help you quit smoking. Wear it over your mouth."

FIGURE 1. EFFICACY OF MEDICATIONS FOR SMOKING CESSATION[6,9,12-1]



United States Department of Veterans Affairs. Primary Care & Tobacco Cessation Handbook. Washington, DC : U.S. Department of Veterans Affairs, Veterans Health Administration, 2014. Retrieved from https://pulsearch.princeton.edu/catalog/9567271 - Accessed 12/1/2015.

Medications for Methamphetamine Use Disorder (none are FDA approved)

- ER Naltrexone injection and high dose bupropion
- Mirtazapine (two small studies)
- Bupropion (low-level users who will adhere)
- Topiramate (low-level users)

- Methylphenidate (moderate to high dose in frequent users/those with ADHD)

http://www.asam.org/quality-care/clinical-guidelines/stimulant-use-disorders

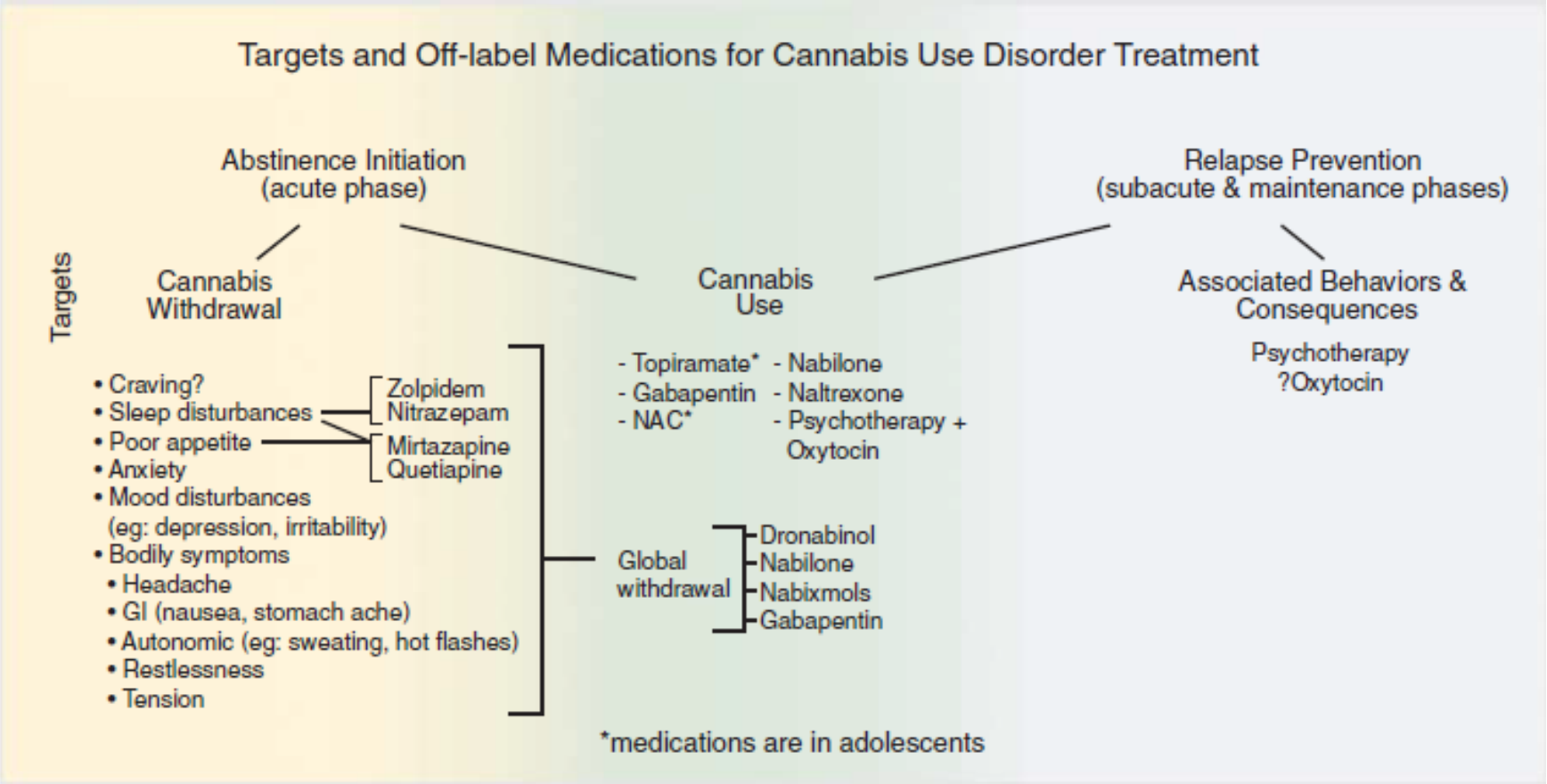
Medications for Cocaine Use Disorder (none are FDA approved)

- Bupropion (works best when combined with CM)
- Topiramate (low-level users)
- Modafinil (if the client does not have alcohol use disorder)

- Combination of Mixed Amphetamine Salts-Extended Release and Topiramate
- Mixed Amphetamine Salts-Extended Release

http://www.asam.org/quality-care/clinical-guidelines/stimulant-use-disorders

Medications for Cannabis Use Disorder



Brezing CA, et al. Am Col of Neuropsychopharm. 2018(43),173-194

Medication FIRST Model

- People with OUD receive pharmacotherapy treatment as quickly as possible, prior to lengthy assessments or treatments planning sessions;
- Maintenance pharmacotherapy is delivered without arbitrary tapering or time limits;
- Individualized psychosocial services are continually offered but not required as a condition of pharmacotherapy;
- Pharmacotherapy is discontinued only if it is worsening the person's condition.

http://www.nomodeaths.org/medication-first-implementation

Medication FIRST Model

- Medication *first* ***does not mean*** Medication *only*
- Medication is contingent upon the pt's benefit, not based upon a timeframe, patient's participation in counseling, an unexpectedly positive test result, etc

http://www.nomodeaths.org/medication-first-implementation

Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence

WHO. (2009) Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence. ISBN 978 92 4 154754 3
https://www.who.int/substance_abuse/publications/opioid_dependence_guidelines.pdf

The ASAM

CLINICAL PRACTICE GUIDELINE ON

Alcohol Withdrawal Management

https://www.asam.org/Quality-Science/quality/guideline-on-alcohol-withdrawal-management

ASAM American Society of Addiction Medicine

American Society of Addiction Medicine Practice Guidelines

- **Symptom-triggered** (q 1 when CIWA-Ar≥8)
  - Chlordiazepoxide 50-100 mg
  - Diazepam 10-20 mg
  - Lorazepam 2-4 mg
- **Fixed schedule** (q 6 for 4/8 doses + PRN)
  - Chlordiazepoxide 50 mg/25 mg
  - Diazepam 10 mg/5 mg
  - Lorazepam 2 mg/1 mg

Mayo-Smith and ASAM working group JAMA 1997;278:144-51
Saitz and O'Malley Med Clin N A 1997;81:881-907

Non-Benzodiazepine Anticonvulsants

- Carbamazepine
  - Fixed dose, 800 mg/day tapered over 4, 7, 9, 12 days OR
  - Symptom-triggered dosing at 200mg or 400mg prn (≤1200 mg/day)
- Gabapentin
  - Fixed dose, 300-600mg QID, tapered off in 5-7 days
- Valproate
  - 500mg TID x7d
  - Not great as a monotherapy

Hammond, C. J., Niciu, M. J., Drew, S., & Arias, A. J. (2015). Anticonvulsants for the treatment of alcohol withdrawal syndrome and alcohol use disorders. *CNS drugs*, *29*(4), 293-311.

Ambulatory Benzodiazepines

- Despite their proven usefulness in the management of alcohol withdrawal seizures and delirium tremens, the use of benzodiazepines for alcohol withdrawal in ambulatory settings is fraught with potential complications, which include high risk of the medication being diverted, high risk of benzodiazepines being taken by the patient in ways other than as prescribed, blunted cognition, respiratory and cognitive interactions with other central nervous system depressants such as alcohol, increased alcohol cravings, and psychomotor retardation including ataxia.
- If a DHS provider determines that the benefits of benzodiazepine treatment for alcohol withdrawal syndrome outweigh these risks for specific patients in the ambulatory setting, this risk-benefit analysis must be documented and a fixed dose (not symptom triggered) regimen of a long-acting benzodiazepine should be prescribed and the patient should be assessed daily for response.

Recent and Forthcoming ASAM Publications

- Clinical Guidance Document: Treatment of Opioid Use Disorder for Individuals using High Potency Synthetic Opioids
  - http://www.asam.org/quality-care/clinical-recommendations
- Clinical Guidance Document: Carceral Withdrawal Management
  - http://www.cossup.org/Content/Documents/JailResources/Guidelines_for_Managing_Substance_Withdrawal_in_Jails_6-6-23_508.pdf
- National Practice Guideline: Treatment of Stimulant Use Disorder
- 4th Edition of the ASAM Criteria
- National Practice Guideline: Sedative / Hypnotic Deprescribing
- White Paper: Addiction Treatment Within Carceral Systems

- Opioids
  - Methadone
  - Buprenorphine
  - Naltrexone
  - Naloxone* (not a maintenance medication)
- Alcohol
  - Disulfiram
  - Naltrexone
  - Acamprosate
- Tobacco
  - Nicotine
  - Bupropion
  - Varenicline
- Others
  - No FDA-approved medications (yet)

Off-Label Rx for AUD

- Topiramate
  - Known teratogen
  - Start 25mg qHS, titrate to 300mg / day (in split dosing) if pt tolerates (many don't tolerate >150mg daily)
- Gabapentin
  - 300-600mg TID used in maintenance protocols
- Baclofen
  - 30 mg/day has mixed results
- Ondansetron
  - Watch QTc
  - 4mg BID to 8mg BID

Kim, Y., Hack, L. M., Ahn, E. S., & Kim, J. (2018). Practical outpatient pharmacotherapy for alcohol use disorder. *Drugs in Context*, *7*.

Major Changes in the Fourth Edition of The ASAM Criteria

September 23, 2023

Fourth Edition of The ASAM Criteria

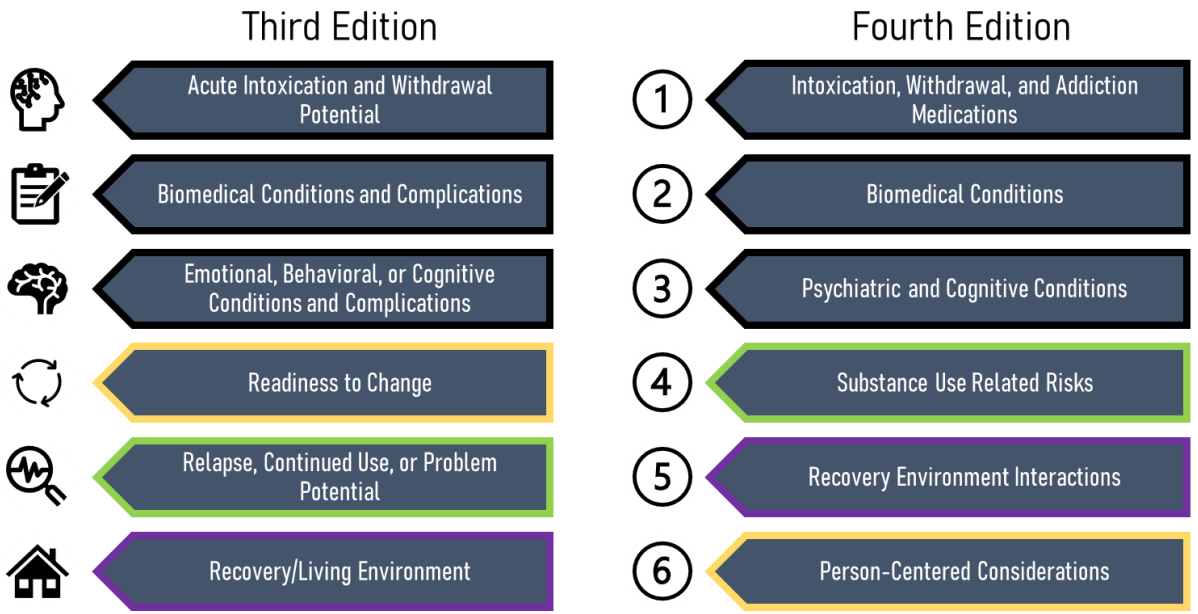
- Planned release in mid-November 2023
- Developed using a more formal methodology including structured evidence reviews
- Same core principles
  - Built on the bio-psycho-social model of addiction
  - Promoting individualized patient care
  - Advancing the chronic care model of treatment

Service Characteristic Standards

- Universal standards
  - Access to overdose reversal medication on site
  - Trauma-informed practices
  - Culturally responsive care
  - Care coordination
- Clinically managed levels of care have formal affiliations with medical providers
- Medically managed levels of care provide comprehensive psychosocial services (directly or through formal affiliation)

Reordering the dimensions

- Since readiness to change does not independently contribute to initial treatment treatment recommendations the dimensions will be adjusted
- Readiness considered across all dimensions.
- New Dimension 6 focuses on patient preferences, barriers to care, and need for motivational enhancement



Fourth Edition of The ASAM Criteria

Dimension 1: Intoxication, Withdrawal, and Addiction Medications

- Intoxication and Associated Risks
- Withdrawal and Associated Risks
- Addiction Medication Needs

Dimension 2: Biomedical Conditions

- Physical Health Concerns
- Pregnancy-Related Concerns
- Sleep Problems

Dimension 3: Psychiatric and Cognitive Conditions

- Active Psychiatric Symptoms
- Persistent Disability
- Cognitive Functioning
- Trauma-Related Needs
- Psychiatric and Cognitive History

Dimension 4: Substance Use-Related Risks

- Likelihood of Engaging in Risky Substance Use[1]
- Likelihood of Engaging in Risky SUD-Related Behaviors[2]

Dimension 5: Recovery Environment Interactions

- Ability to Function Effectively in Current Environment
- Safety in Current Environment
- Support in Current Environment
- Cultural Perceptions of Substance Use and Addiction

Dimension 6: Person-Centered Considerations

- Barriers to Care
- Patient Preferences
- Need for Motivational Enhancement

Access to Addiction Medications

- Dimension 1 updated to include "Addiction Medication Needs"
- All medically managed levels of care able to initiate all FDA-approved medications for SUD
- All patients should have a physical exam within a reasonable time that assesses addiction medication needs
- All clinically managed levels of care able to support continuation of any FDA-approved medication

Expansion of Level 1

- Level 1.0 – Long-Term Remission Monitoring
  - Recovery management checkups
  - Rapid reengagement in care when needed
- Level 1.5 – Outpatient Therapy
  - Less than 9 hours per week of psychosocial services
- Level 1.7 – Medically Managed Outpatient
  - Encompasses Level 1-WM from 3rd edition
  - Incorporates low threshold medication initiation
  - Able to provide psychosocial services equivalent to Level 1.5

Updated Continuum of Care

- Reframing early intervention and prevention
  - Includes chapter but no longer uses Level 0.5 nomenclature
- Treatment of cognitive impairments
  - Eliminates third edition Level 3.3
  - Includes chapter addressing treatment of individuals with cognitive impairments across the continuum
- Updating Level 3.7 to reflect residential care

Supporting Comprehensive Care

- Integrating withdrawal management and biomedical care in the continuum of care
  - Level 1.7: Medically Managed Outpatient Treatment
  - Level 2.7: Medically Managed Intensive Outpatient Treatment
  - Level 3.7: Medically Managed Residential
    - Level 3.7 BIO has advanced biomedical capabilities including intravenous (IV) fluids and medications, as well as advanced wound care
  - Level 4: Medically Managed Inpatient

Integrating Co-Occurring Capability

- All programs should be co-occurring capable at minimum
  - Program services designed with expectation that most patients have co-occurring conditions
  - Ability to manage mild to moderate acuity, instability, and/or functional impairment
  - At least one staff member qualified to assess and triage mental health conditions
  - Integrated plans of care
  - Coordination with external mental health providers as needed
  - Program content that addresses co-occurring conditions

Recovery Services

- Recovery service expectations at each LOC
- Dimensional Admission Criteria consider the need for recovery residence support
- Algorithm may recommend an outpatient level of care plus a recovery residence
- New chapter on Integrating Recovery Support Services (Chapter 15)

Continuity Along the Continuum

- Prevent sharp drop-offs in clinical care
- Structured services 7 days per week in Level 3.1 and 3.5
- Aligning clinical service standards
  - Aligning 2.1 and 3.1: 9-19 hours of clinical services per week
  - Aligning 2.5 and 3.5: 20 plus hours of clinical services per week

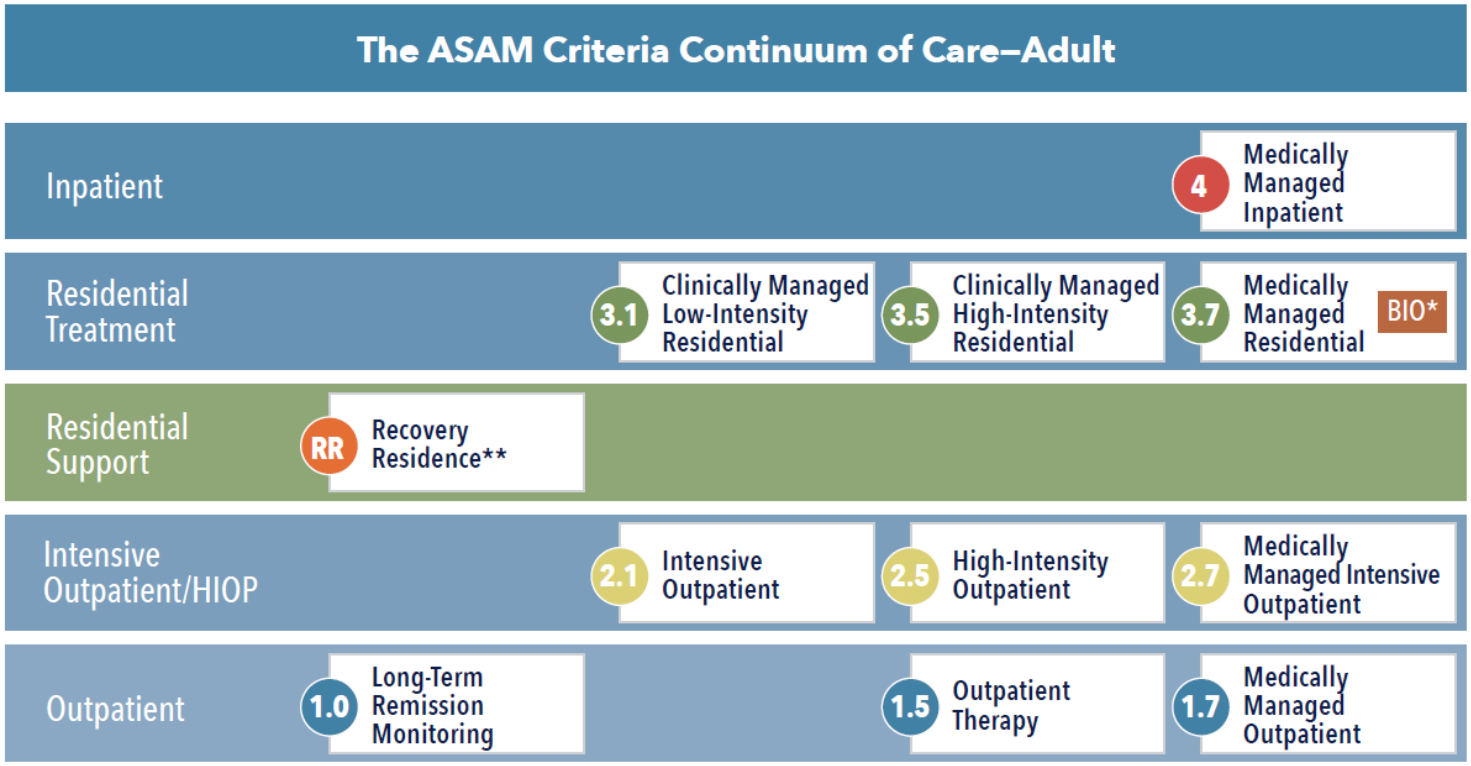
Chronic Care Model

- Integration of long-term remission monitoring (Level 1.0)
- Emphasis on recovery services (RSS)
  - Assessment of RSS needs
  - RSS service standards for each level of care
- Encouraging formal affiliations across levels of care to support seamless transitions

New Content

- Treatment Planning (Chapter 9)
- Telehealth and Other Health Technologies (Chapter 13)
- Integrating Recovery Support Services (Chapter 15)
- Integrating Trauma-Sensitive Practices, Culturally Humble Care, and Social Determinants of Health (Chapter 16)
- Addressing Pain (Chapter 18)
- Addressing Cognitive Impairment (Chapter 19)

Fourth Edition of The ASAM Criteria

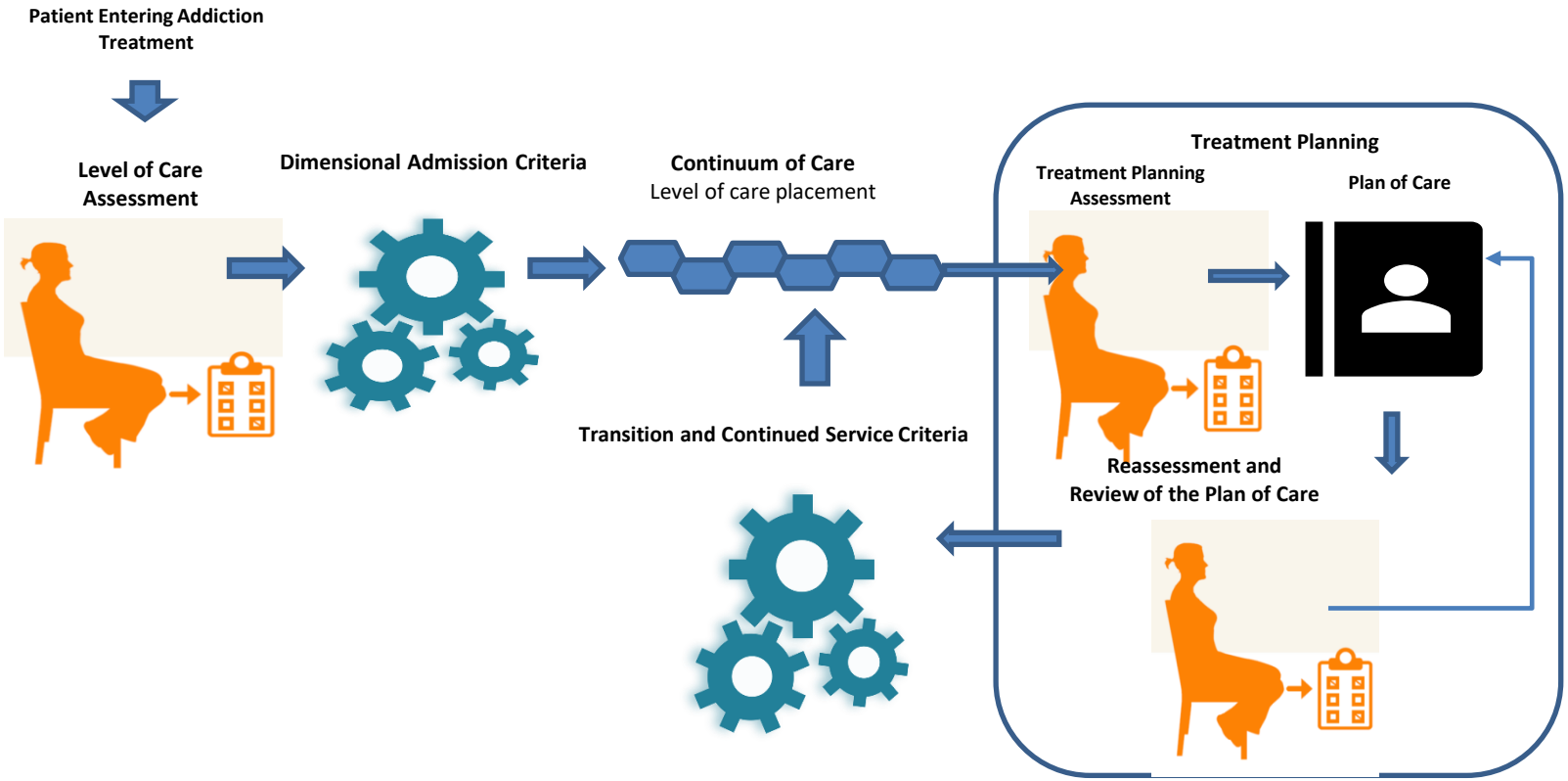


* Separate standards are defined for Levels 3.7 and 3.7 biomedically enhanced (BIO).

** The Dimensional Admission Criteria may recommend a recovery residence in addition to an outpatient level of care.

Co-occurring enhanced (COE) care standards defined for x.5, x.7, and Level 4

A Patient's Journey Through the Continuum of Care



Questions?

Brian Hurley, M.D., M.B.A., FAPA, DFASAM
bhurley@ph.lacounty.gov

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