Evolution of Addiction Treatment - Earley

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00:00

This presentation is entitled Evolution of Addiction and Treatment: History and Impact. I will now turn it over to Dr. Paul Earley to begin our presentation.

00:09

Good morning. My name is Paul Earley. I'm the past president of the American Society of Addiction Medicine. And I'm currently the director of the Professionals Health Program in Georgia.

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Today, we have three specific items to go over quickly. One is the evolution of treatment, something about the ASAM criteria, and the definition of addiction, according to ASAM. So let's dive right in. I have no relevant financial disclosures for this presentation.

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We'll start with talking about addiction treatment history. When one thinks about the history of addiction treatment, it really begins with one of our founders, signers of the Constitution, Dr. Benjamin Rush. He was interested in alcohol use disorder, and he asserted that alcohol was a causal agent in alcoholism versus something else. And he assessed that there are some really important basic principles that we hold true to this day. That loss of control of drinking is the characteristic sym- symptom of what was then called inebriety or alcoholism. He stated that total abstinence from alcohol was the only effective cure, and he called for creation of sober houses for the care of the drunkard.

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This was against a backdrop of, later on in the late 1800s, increased grain supply, rapid crop spoilage, and an emerging entrepreneurial spirit, increased the supply of distilled alcohol, which as we all know that when people tend to drink more potent alcohol, forms of alcohol, the illness can often accelerate.

This, it seems to be that this was at least part of the causal agent for an increase of alcoholism to be noticed or occurring, especially in urban areas.

02:08

Then in the 1840s, in response to this, there was a temperance movement which took on the alcohol problem.

02:17

Some early treatment experiences, one of them- this is in Binghamton, New York, a large facility that was an inebriate asylum. The thought was to house people away from alcohol would save them from drinking it, and the brain would return to normal. And this is actually one of the important parts of- that we hold dear today for remission from an alcohol, alcohol or other drug problem- is containing the illness or placing it under some sort of restraint so that continued access to substances does not occur, especially early on in the phase of recovery.

02:58

Several early term temperance movements in addition that were important, is the Washingtonians which was a social network. As you can see here, this the Washingtonians actually owned some buildings in several cities. In the evening, they would have meetings where the individuals would recite or talk about their experiences falling into alcoholism and falling back into recovery from that, although they didn't call it that at the time.

03:32

Importantly, in the late 18-, in the mid 1860s, one of the oldest and actually the largest addiction treatment system in the world was started. That was called The Salvation Army. And the Salvation Army exists today and it continues to be the largest worldwide provider of addiction treatment. Although we don't hear much about it, do we? The- one of the things that's important about the Salvation Army's program is that people stay for a minimum of six months. And the thought from their research is that longer containment of the illness in a safe recovery environment is essential for long term remission, which we hold to be true today.

04:18

Other early treatment experiences were the Keeley League, which was formed by a a surgeon from the Civil War. You see him just to the right of the table sitting with his hands in his pockets. He, if you notice also the sign above one of his treatment centers says the law must recognize a leading fact medical not penal treatment reforms the drunkard. Something that unfortunately we haven't learned quite well in the United States today. Best to have an amalgam between- actually between legal interdictions and medical interdictions to help people go into remission. But the Keeley League was a first franchised private and for profit addiction treatment system. He had several different treatment centers in several cities across the eastern United States. Interestingly enough, Dr. Keeley also

formed a patient mutual aid society, formed by other individuals who were in remission from the illness after going through his program, which helped other people remain in remission themselves. A concept which we will see is important moving forward into this century.

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One other early treatment system was called Charles Towns hospital. This- this was a center which is famous for helping Bill Wilson, the founder of Alcoholics Anonymous, attain his first remission from alcohol use disorder. It was slightly different. It was focused on resolving the craving and resolving and restoring physical health through diet. And it- there was no treatment coercion at all in this center. Unlike the Binghamton, New York inebriate asylum, people could come and go as they see fit. And interestingly enough, physicians who referred their patients were often urged to accompany their patients and stay with them so they could observe the process and learn more about alcohol. So teaching really began with the Towns Hospital.

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We've all heard and know about prohibition. Prohibition really lasted in the United States for a short period of time, as you see here. But it was- occurred in many other countries across continental Europe simultaneously. It was a huge, worldwide movement. Importantly, prohibition was based on the concept that alcohol itself was the cause of alcoholism. And it was described as a personal and social evil, evil. Thus, the thinking was that no one should drink alcohol. And it was, we all know this today, as we all know today, there are certain individuals who will not safely consume alcohol for reasons that are still a bit evasive in our research. But that alcohol use is- occurs very frequently in the population. And only around 10% of people who develop, who drink to a heavier extent, will develop alcohol use disorder.

07:45

Importantly, we're going to turn away from alcohol for a minute and talk about drugs and the legal system and how that's changed. Many of you probably know this, but at the turn of the century, the sale of drugs was not controlled in any manner. Manufacturers could purify morphine, could extract things from the opium plant. You could also sell various health aides that had cocaine in them. In the late 1800s, we had really three basic substances which were involved in the patent medicine industry: morphine, cocaine and cannabis, and would often profess cures for any number of illnesses. At the same time, Sigmund Freud was experimenting with cocaine and unfortunately wound up rec- recommending it for the treatment of morphinism in his friend and colleague Ernst von Fleischl-Marxow. So unfortunately, Dr. Fleischl-Marxow then shifted to having a cocaine problem, and was probably the best-documented individual that showed that certain drugs share the crossreactivity in producing addiction disorders.

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In response to the drugs in the legal system, we had the first act- national act in the United States- the Pure Food and Drug Act, which later became the Harrison Act in 1914, which created a split between legal and illegal drugs consumed by the United States citizens.

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This was followed by the resolution of having a- the Controlled Substances Act in 1970 where illegal drugs were placed into the hierarchy that we know and recognize as physicians today. In that hierarchy of some- and remember the thing that's important about the hierarchies- that has nothing to do with the neurotoxicity, the toxicity of the drugs or the safety of the drugs. It only has to do really with the addiction liability. The Harrison Act and then this subsequent Controlled Substances Act of 1970 was really about trying, trying to figure out how we could help kind of constrict the- how doctors prescribe medicine and therefore decrease the probability of individuals having access to substances which produce addiction.

10:20

Now, as we all know, heroin and cocaine and some hallucinogens were placed as schedule one drugs. These schedule one- one drugs can own- can be only used in rare conditions. And today, as we all know, we're having a resurgence of the hallucinogenic drugs for various psychotherapeutic purposes. Native Americans could ask for special dispensation as a religious sacrament for certain medications that were in that category. But basically, those were not usable by anyone in medicine.

10:53

The problem with this is that also certain drugs, notably marijuana, was placed in in in category one, and that increased the the, the general consensus that the pub- that the legal system did not understand addiction risk, and is uninterested in medical or social safety. And push back- created some pushback that we see today, starting in the 60s with the increased consumption of marijuana.

11:26

And remember, paradoxically, the two legal drugs are the most medically toxic to the body. Those are nicotine and alcohol. So this does not have anything to do with medical toxicity, but rather with the the addiction liability of all the substances. Addiction indeed has created a change in the legislative agenda of the American legislature.

11:55

So we also know that the brain center that drives addiction was unaltered by the Harrison Act. That once addicted, the economics of supply and demand. What goes away- that supply and demand does not change things in individuals once they develop the disease of addiction. People with addiction have what's called inelastic demand, that the economists called inelastic demand. An inelastic demand means that is if a cost of a drug goes up, people will find better ways of procuring enough money to supply their habit. And this creates much of the legal problems that individuals who develop addiction evidenced today.

12:38

Many individuals who develop addiction violate laws and become criminals in the eyes of our legal system, when in fact they're just victims of the illness. And tragically, the prison industry flourishes today and the tree- treatment industry is all but defunct, with 65% of prison inmates meeting the criteria for SUDs. And, but there are some hopes on the horizon. The evolution of state and local drug courts promise an innovative and effective solutions, something we all should become familiar with. Because this combination of containment of the use through a the the legal system combined with with treatment is often highly effective in helping people maintain long term remission if they're properly crafted.

13:28

One other change in the history comes- that becomes clear is to consider is the work of what's called the self-medication hypothesis. Self-medication hypothesis was promoted as a way of understanding addiction. And many people in the general public see addiction in this way, as well. So as addiction medicine physicians, it's important for us to kind of understand the the relevance of this or the lack of relevance to the devel- of addiction or development of addiction. According to the self-medication hypothesis. The symptoms that an individual have drive the substance use. So if an individual is anxious, they tend to take benzodiazepines, sedatives, or opioids. If a person feels empty inside and needs excitation, they will tend to take stimulants. That produces substance use. That is the primary concept of the of this more psychodynamic theory of what causes addiction to appear.

14:42

But the brain biochemistry says otherwise. Much more critical to understand, especially in the earlier parts of remission, is that substance use itself produces the symptoms. If one develops an Addiction Disorder to psychostimulants, those individuals come in feeling flat, empty, aimless. And because the drugs actually robbed the system of the ability to appreciate life's pleasures. And conversely, those who take benzodiazepines or alcohol often come in quite anxious. And that doesn't mean the self-medication hypothesis is useless. It means that it should be applied in a proper time later on in psychotherapy, to understand about drivers for relapse and understand the individual as a whole. But in terms of the biochemistry, it appears that the bottom arrow is more important than the top.

15:41

So let's talk about various recovery movements for a second. Arguably the most powerful and effective recovery movement in the world was the meeting of these two men, Dr. Bob Smith on the left and Dr. Bill Wilson on the right in 1935. Bill Wilson was trying to remain in remission. When he was in Akron, Ohio as a businessman, and he had a strong craving for a drink. And he had the odd idea that what would help him is to talk to another alcoholic, who he could talk to about his experiences and therefore hold himself in recovery. And through a series of convoluted, incredibly interesting, serendipitous occurrences he met Bob Smith. Now Bob Smith is the dour physician on the left, who was a proctologist at the time.

16:41

Alcoholics Anonymous really is important in understanding the long term curve of remission. What

Alcoholics Anonymous really is important in understanding the long term curve of remission. What- there are some innovations that AA brought to the recovery process. First of all, it emancipated spirituality from its roots- roots in religious institutions. Many religious institutions helped some people attain remission from their alcohol or other drug use disorders by developing a profound religious faith. But AA started talking about spirituality as a distinct event that occurred that is not necessarily part of a religious experience. Many people that don't understand AA confuse those two things.

17:24

It also legitimized the various varieties of spiritual experiences and recovery, not saying that it had to be one way or another. Although it did start in a traditional Judeo-Christian kind of format. It found alternatives to religious antidotes for guilt. Because everyone who develops addiction has guilt because of their behaviors, including self-inventory, confession, acts of restitution and acts of service. It encouraged service work and working with others, and established really what's the first chronic care system for a chronic disease. Addiction is a chronic illness, and people that develop it have problems remaining in remission and need to have a constant vigilance through the rest of their life to do so. AA was also a peer-led social movement that used spiritually based- a program that was spiritual based, but without explicit, demanding instructions. They say "these are our suggestions."

18:27

Now in- one of the first treatment centers in the United States is Hazelden and all of us are familiar with this. Hazelden was opened in 1949. At a farmhouse outside of Minneapolis. in Center City, Minnesota. It used the principles of Alcoholics Anonymous and detoxification to help people attain remission from initially really alcohol use disorder. It was a centralized treatment system that focused on detoxification and the principles of AA.

19:01

But addiction treatment has evolved since then involving many other components. Interestingly enough, even Hazelden, the the individuals that worked in that system came from traditional psychiatric hospital care. And so parts of that traditional psychiatric hospital care, such as therapeutic environments, talking in groups, and having psychotherapists around to assist people with their emotional unrest was part of that addiction treatment as well. In addition, there was a movement called therapeutic communities that we'll talk about in a minute, and that became part of addiction treatment. And then we also had the social support of Alcoholics Anonymous, and their sister organizations Narcotics Anonymous, Cocaine Anonymous, Methamphetamine Anonymous, and those Allanon in those allied support networks as well.

19:57

All of this together, more recently is combined with the use of effective addiction medications, especially in the use, in use in treatment of opioid use disorder, but also helpful in alcohol use disorder today. These medications help increase the prognosis for long term remission.

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So what did the Minnesota model bring to us? Some really important principles that we use today in the care of patients with all types of addiction disorders. First of all, it stated that alcoholism was an involuntary primary chronic progressive biopsychosocial spiritual disease. That it had elements of not only medical concerns, but sociological concerns, psychological concerns, and even spiritual concerns. It asserted that recovery was the goal of treatment and not abstinence, and that recovery was something different than abstinence. Abstinence means that the drug is no longer being consumed anymore. But recovery is a broader concept of an ongoing pursuit of health, wellness, and, and freedom from the substances which have been so devastating to the individual. It focused on treatment- of the treatment of the alcoholism was the central process or the drug dependence was the central process. And it abandoned the psychoanalytic and moral models of addiction. Now, again, the specialty the psychotherapeutic issues become really important as we move further along in remi- remission. But the first focus of recovery is recovery from the substance use. In addition, addiction was treated with in a milieu of dignity and respect, the patients were treated with dignity and respect. And as individuals, each one was slightly different. And importantly, there was a revised notion of motivation. That the initial motivation or lack thereof, of an individual showing up in treatment is not a predictor of outcome. By holding on to the patients long enough, finding the motivation in any given individual is one of the central themes of the first part of treatment. And that motivation is caused- is produced by the milieu in which the patient is existing. So the hold- that's the part about group treatment, which makes it different from individual therapy is there's a social holding tank where the individual can find their own motivation. And the motivation of the group helps that individual attain remission.

22:51

So let's shift now to some other interesting treatment events. Probably the one of the most important and under- and under valued concepts is the knowledge that we learned from the Federal Narcotics Farm. The Federal Narcotics Farm was a outgrowth of the federal penal system. Individuals that had narcotics charges against them were often sent to one of two programs, the first one being in Kentucky. And for a long period of time, it was really the world's epicenter for addiction research and drug treatment, in that convicts who are in the federal penal system for drug dependence did time, but also individuals who would- could volunteer to enter the Center for treatment, if there were openings within that- treatments within that treatment system. People stayed for a long period of time. They had lots of research and understanding what was happening with those particular individuals as they moved from the addicted state into remission. And that was eventually dismantled in the early 1970s. But you can see there for 35 years it contributed enormous body of research, to our state understanding of addiction treatment.

24:08

One other important is the work of George De Leon. George de Leon was a psychologist who created the therapeutic community. And the therapeutic community is a community that focused on lifestyle changes, learning how to become pro social, learning about how to be more honest, because individuals with addiction start becoming dishonest about their substance use and then unfortunately, there's slippage in their honesty machine in their brain oftentimes. Taking responsibility and willingness to learn from others, all those things are part of a therapeutic community. Interestingly enough, this is a democratically run type of system where everyone including the staff are part of the

community and they all work together to create the recovery of all of the individual in that, in that community. This fascinating experiment led to some- this concept of community as method, that community is what heals the individual, much like a community in your church or your synagogue helps help helps you with your own spiritual growth. The type of therapeutic community that occurs from peers from even in the work environment can help people move towards health or illness. And in this case, the whole purpose was to move towards health. It also introduced the concept of ongoing support and was important and reiterated that addiction is a lifelong disease.

25:41

One other important, very important change came with the emergence of medications for the treatment of opioid use disorder. And that's Robert Dole. Dole and Marie Nywsander in that picture. The in the 19- in the 1960s, we had this increase in numbers of individuals coming back from the Vietnam War, who were opioid dependent, and Drs. Dole and Nyswander begin this experiment of treating them with another opioid and that opioid was methadone. Methadone was the first really humane treatment in an era of discrimination and legal interdiction for opioid use disorder.

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It really helped us see that to- that addiction is a is a biological brain disease, because individuals on methadone could return to a healthy productive life. And although this was really...AA took the stand earlier, but this was really when medic- medicine started to endorse a medical treatment for medical illness of addiction.

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We know this exists today in the ASAM criteria, it's referred to as opioid treatment services.

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Some other important changes to occur include understanding that addiction is a brain disease. This is one of my favorites. This is when the former head of the National Institute of Drug Abuse, described addiction as a brain disease and that recovery takes time and measured in years.

27:19

Okay, so let's take a look at these lessons. Addiction is an ever present phenomenon changing in focus from time to time to different substances and behaviors. Don't- please don't believe that the current drugs abused will be the primary drugs of misuse in the future. It will change. It certainly changed in my lifetime. Treatment has focused on religious conversion, psychotherapy, characterlogical manipulation, legal interdiction, and pharmaceutical intervention of various times. The other piece that we know is a single modality universally applied has inevitably failed, we need to use all of the tools in the toolbox. Short term interventions do not work. Addiction is a chronic disease requiring long term care. And the illness is very complex with multiple antecedents.

28:05

Alright, so we have a very brief time to cover two other topics. The next one is something called the ASAM criteria, which I hopefully you're all familiar with at this time.

28:15

So what is the ASAM criteria? Well, ASAM criteria was a series of books and understandings about the framework about addiction, that tried to understand how to stage addiction care according to severity of illness and typology of illness. The concept is to use the least intensive or restrictive care that meets the patient's multi-dimensional needs, not just medical, not just psychiatric... social, and, and addiction recovery needs to ensure ongoing care. As you can see here, we actually have four current editions and the fourth edition will be coming out in 2024- a vast and incredible work by a wonderful team of ASAM staff and ASAM experts.

29:10

The ASAM criteria has had widespread adoption over the years starting in 1991, in really Cleveland, Ohio, all the way up to it being used for waiver expansions for states to be able to modify how they give treatment care. You see some of the hallmarking changes there, including the development in 2016 of the continuum and assessment tool, which is used to understand... to have a very thorough evaluation of the Addiction Disorder.

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It's important to remember that the ASAM criteria has a treatment axis that's part of it and then and then a type of... a disease typology axis. So along the treatment axis we have early intervention, which is often prevention services. This is- this is going to, by the way change and, and obviously in, in the fourth edition. We have outpatient treatment, which is less than three times a week and is commonly individual services. We have intensive outpatient and partial hospitalization services, which are now group-based treatment, based upon what you've learned earlier about the importance of the power of a community and helping people get better, at a specialized center.

30:27

Then we have residential services, where people actually live for a period of time from ASAM level 3.1 to 3.7. And finally, the medically managed illness in a hospital for extreme medical consequences of addiction.

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And then, on the other side of this, we have the dimensional axis and the dimensional axis takes a look at the again, this is the third edition, this will change in the fourth edition, but currently the six dimensions talk about the typology of the illness. And it's important to know this, by the way for the

exam, I'm sure, is that the dimension one is intoxication withdrawal potential. And dimension two is a biomedical conditions and complications. Dimension three being emotional, behavioral, and cognitive conditions. Dimension four being readiness to change, helping people move along with change continuum. Dimension five is relapse and continued use problems. And dimension six is, is difficulties in the recovery environment. You have to take a look at all of these if you want the best prognosis for remission.

31:37

When we put these two axes together, we can understand severity along a different level. So if people have, for instance, in dimension one- severe medical complications, they would move all the way to the right to level of care four because they would need to be in a hospital. If their dimension one withdrawal, for instance, was very, very severe, or their medical complications and dimension two were very severe.

32:05

In addition, the ASAM criteria also talks about specialty services for specialty conditions. These are the first two- are a dimension three co-occurring capable- meaning illnesses that occur across the psychiatric or psychological spectrum. And those services have special... varying levels of specialty. The enhanced services being more thorough for dimension three problems. And a dimension two problem of biomedical concern, such as individuals with mobility problems as a result of their alcohol use disorder, might need a special bio program. Withdrawal management services- and dimension one require withdrawal management services. And finally, the revised version three talk more and more about the importance of opioid treatment services. And the fact that opioid treatment services must be available at all levels of care. And in order to produce the best remission from substance use disorders.

33:11

So we have a this feedback loop where the individual has a multidisciplinary assessment. There's a decision rules within the algorithm which produces a continuum of care and regular reassessment updates that person status.

33:29

All right, and finally, let's move on to the ASAM criteria. This last part of the ASAM criteria and what it does. The ASAM criteria really provides a template for the type and intensity of addiction care. It reiterates the importance of long term disease management. It ensures that current care is cost effective, and ensures adequate staffing for the different levels of care. It emphi- emphasizes the importance of patient evaluation and ongoing reevaluation and is the emerging national standard which every addiction medicine physician should know.

34:04

The ASAM criteria is also part of a larger system in terms of training, permissions and fair use, level of

The ASAM criteria is also part of a larger system in terms of training, permissions and fair use, level of care certification and continuum. So this is actually part of a huge effort on the part of the ASAM staff.

34:19

The fourth edition will be expanded and become more consistent. The dimensions will be rearranged for a more logical assessment and "mor" is misspelled there I see it, more logical assessment and treatment will be expanded in scope and timeframe through recognising the need for chronic condition.

34:39

We have about 20 seconds to review the ASAM definition. So let's dive in. The ASAM definition is as follows: that addiction is a treatable chronic medical condition involving the complex interactions among brain circuits, genetics, the environment and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences. Important to know this for your understanding of the illness, and obviously for the exam. Prevention efforts and treatment approaches for addiction are also generally as successful as other chronic diseases. Remember that as well, that we are doing very a very good job compared with other chronic diseases in the United States today, because of our efforts in building a good treatment model.

35:33

So, it's important to note that ASAM's definition of addiction is slightly different than the DSM-5. Its- its purposes are different. The DSM-5 uses characteristic signs and symptoms to make a diagnosis. And the ASAM definition and the word addiction is used and it outlines causation and characterizes the disease. This definition emphasizes that addiction is chronic, it is treatable, that it's complex with many etiologies are important in its genesis and in its treatment, and the response to prevention and treatment is similar to other chronic conditions. That's all I have for you today. And thank you for your attention during my time.