

Dr. Stephen Taylor: Hello, and welcome back. This is ASAM Practice Pearls, a podcast series from the American Society of Addiction Medicine. I'm your host, Dr. Stephen Taylor, and I'm overjoyed to be joined by our respected expert and ASAM president, Dr. Brian Hurley. Dr. Hurley, please say hello.

Dr. Brian Hurley: Dr. Taylor. It's so good to see you. Thank you for having me on the podcast.

Dr. Stephen Taylor: It's great to have you. And folks, just be aware. I'm going to call him Brian because he is not only our president and a mentor of mine, but he's also a friend of mine. And I'm super excited to have him here.

Today's episode is on the complexities of stimulant use disorder. And so, the motivating experience for me that started me with the interest in this topic and made me, frankly, very excited to have Dr. Brian Hurley here on this podcast to discuss this topic of treatment of stimulant use disorder and the new clinical practice guideline, jointly produced by ASAM and the AAP, on managing stimulant use disorder, comes from the experience I had in Huntsville, Alabama, when I was practicing there over 20 years ago, taking care of a group of teenagers that had substance use disorder and co-occurring general psychiatric illness.

I started these young folks in this group of patients with both conditions. These adolescents were all kids that I took care of individually as their child and adolescent psychiatrist, who I evaluated and found to have a significant substance use disorder as well as a co-occurring general psych illness.

And I got this group together, and in this group, all of these kids had misused prescribed stimulants, some by snorting them, some by dissolving them and injecting them. And yet, the vast majority of young people in this group also had legitimately diagnosable ADHD, which I had either diagnosed myself or which I had confirmed the diagnosis after going over it and making sure that these young people had that condition.

And so, I had this issue of wanting to treat their co-occurring ADHD, knowing that's important to do, to treat co-occurring general psychiatric illness if you're going to provide adequate treatment for someone with a substance use disorder. And yet, feeling that stimulants would be a bad idea in a young person who has already misused prescribed stimulants and sometimes in some very frightening ways.

And so, I, from that point on, had adopted the philosophy that a prescription stimulant was essentially contraindicated in my mind for any person, not just adolescents, but even adults who had a significant substance use disorder, particularly a stimulant use disorder. Even if they had ADHD and, of course, for treatment of ADHD in patients who had co-occurring substance use disorder. No stimulants for me, and I was going to use some nonstimulant of choice that was available at the time.

Lo and behold, as we fast forward to recent years, when there's more and more research on the topic, we find that there is emerging evidence to suggest that isn't necessarily the way we need to approach it. And I find that has been a fascinating learning process for me, and I think it will be for many of our listeners.

And so, with that as a backdrop, I'd like to go ahead and start my questioning, Dr. Hurley, by just asking you, what do our listeners need to know about treating stimulant use disorder, in particular, including the most significant recommendations from the recent ASAM and AAAP guidelines on managing stimulant use disorder?

Dr. Brian Hurley: I think the most important takeaway from the Stimulant Use Disorder Clinical Practice Guideline is that we have a lot of good options for treating stimulant use disorder. I'll talk about some of those options, but I'm going to make a distinction. With opioid use disorder, ASAM's National Practice Guideline talks about specific medication strategies that are very effective for opioid use disorder. I talk with ASAM members who say, "Where's the buprenorphine for methamphetamine use disorder?" "Where's the methadone for cocaine use disorder?" "Where's the extended-release naltrexone for this or that?" And for stimulant use disorder, we have a different set of strategies. But the guideline really emphasizes that contingency management is the treatment of choice for stimulant use disorder.

And the evidence on that isn't subtle. It's not that it makes a modest difference. It's a substantial difference compared with treatment as usual. Our guideline also talks about the management of co-occurring conditions, medical management of co-occurring medical issues, psychiatric management of things like agitation or other co-occurring psychiatric conditions.

We have a specific set of strategies around ADHD management, and we also talk about medications that are clinically effective for the treatment of stimulant use disorder. They're not as effective as the medications we have for, say, alcohol or opioid use disorder, but we do have medications that are clinically effective. And so, what the National Practice Guideline does is create a framework so that clinicians treating stimulant use disorder have an approach, have tools, have options to treating stimulant use disorder in our patients.

Dr. Stephen Taylor: So, Brian, let me ask you specifically about contingency management because there are a lot of us and by us, I mean practitioners in addiction medicine or addiction psychiatry who haven't necessarily implemented contingency management programs in our settings of practice.

What would you add to our knowledge about contingency management that perhaps people haven't thought about or should really be thinking about?

Dr. Brian Hurley: Well, Steve, I think one of the reasons that many addiction physicians and other addiction medicine clinicians don't have a lot of experience with contingency management is that it's not widely available.

Now, fortunately, there are states that are really investing in making contingency management available. I happen to live in one of those states, California, where our Medicaid program, called MediCal, funds a contingency management program, but that's not true in every state across the United States. The Veterans Administration has taken a particular leadership position in wanting to make contingency management available, although, again, there are differences in which VA programs offer contingency management and which programs don't.

And what I've seen is when you find a local champion in a community, you can oftentimes find grant funding that can make contingency management available on a pilot level. Oftentimes, those pilots are in a specific clinic or for a specific community, right? They're not necessarily widespread, but we do see pockets of contingency management available through grant funding across the United States.

But one thing I'd say is for any addiction clinician working, the community has to be aware of what already exists, right? This idea of, "Oh, I've never heard of contingency management," or "I've heard of it, but it's just not available." You might actually overlook a key resource or opportunity in your community for contingency management, either already offered or of a feasible opportunity to bring it to the patients that you serve.

Dr. Stephen Taylor: That's actually helpful. And as you were speaking, I was thinking about the fact that sometimes Contingency management isn't always referred to as contingency management. There are places where that intervention is in place, but that terminology is not used to describe that intervention. And I think that's another thing that some of our colleagues need to be aware of.

Dr. Brian Hurley: Steve, as a practical example of that, California renamed our contingency management program to the Recovery Incentives Program. So, I think the full title is California's Recovery Incentives Program (Contingency Management). Because I don't think that the term contingency management was immediately apparent, or what is this? Whereas the recovery incentives program actually had a more intuitive naming that, for people that otherwise don't have a familiarity with the term, have an intuitive sense of what it means.

Dr. Stephen Taylor: Exactly. So, that's the other thing for people to be aware of, is contingency management, by any other name, may still be contingency management. And we need to be aware that there may be other names. So, that's great. I'm glad you mentioned that. Thank you. Let me just ask what is it that our listeners can learn in terms of implementing guidelines into their practice? Particularly when you talk about contingency management being a recommended treatment of choice for stimulant use disorder. And as you say, it's not subtle. It's not an incrementally useful strategy. It's actually got a fairly robust evidence base. Any practical tips for our listeners?

Dr. Brian Hurley: Sure. Before we talk about stimulant use disorder, I do want to just mention *The ASAM Criteria*, right? Our guidelines talk about when assessing a patient, consider a comprehensive psychosocial assessment so a patient is matched to the level of

care that would be appropriate for them, right? Some patients with stimulant use disorder, in order for them to be stabilized to the point where they could participate in treatments such as contingency management, need a hospital admission or a residential admission, or a high-intensity outpatient, right?

Just to be clear, ASAM has a level of care assessment framework called *The ASAM Criteria*. And the guideline speaks to clinicians using a level of care placement so the patient gets the appropriate level of care. So, one thing clinicians should be aware of is we all work in settings, and those settings can be somewhere within the ASAM Criteria in terms of intensity of care.

And within those settings, there is a role for contingency management at each level of care, right? So, if you're working in a hospital, you're probably not going to see a patient for long enough to be doing a full course of contingency management, but you can get a patient connected with contingency management or started with contingency management.

Similarly, with residential, right? Contingency management can show effectiveness in residential settings and be continued when the patient makes a transition to a non-residential level of care. Even before we talk about specific treatment modalities, the level of care determination really is like the first step.

What is the intensity of care that this patient needs right now? And then in terms of implementing these stimulant use disorder specific strategies, be aware of what contingency management resources exist in your setting. So, in California, our Medicaid program pays for contingency management.

So, I have a set of contingency management places in the community in which I live and work where I can refer a patient that has MediCal. Now, if I'm seeing a commercially-insured patient, I may not have that flexibility. I would have to look up what contingency management resources exist for patients.

So, I think one very practical tip is to be aware of where patients in your community, patients that are attached with the insurances that you know operate in your community. What are the contingency management resources that exist? And I do want to highlight the Veterans Administration, right? People that work in the VA. Various VAs have contingency management programs built into the service line.

So, just to say it directly, like contingency management capacity does exist in parts of the United States. But lots of communities are without feasible access to contingency management or easy access to contingency management. One thing our members can do is consider writing grants to actually get a contingency management program implemented. That's how most contingency management programs start, through grant funded initiatives. And if contingency management isn't available, which is always possible, right? If the treatment of choice isn't available work on making it available, but we have additional psychosocial treatment options.

For Stimulant Use Disorder, we have Cognitive Behavioral Therapy. There is an intensive outpatient curriculum called the Matrix Manual, and we have the Community Reinforcement Approach, each of which can be implemented with the standard workforce composition that many of us work in in substance use treatment.

So, like contingency management, treatment of choice, know what's available in your community, but cognitive behavioral therapy works, matrix manual works, that community reinforcement approach works. And it works implemented by the workforce that we commonly work with as addiction physicians.

Dr. Stephen Taylor: That's awesome. Yeah. Thanks a lot for that. Because, for example, I am sitting right now in Jackson, Mississippi. And it would be difficult to imagine a treatment landscape that's more different from the treatment landscape in Los Angeles than the landscape here in Jackson, Mississippi. And yet you're absolutely right.

There are ways that we can organize contingency management services and certainly ways that we can provide, and we do, in fact, provide cognitive behavioral therapy and other psychosocial services for the treatment of stimulant use disorder for our patients here in Mississippi. So, that is absolutely a very useful tip. Let me ask you this. What strategies do you think can help us understand and address some of the socioeconomic, cultural, and systemic factors that impact access to evidence-based treatment for stimulant use disorder and ensure equitable access for underserved and impacted communities such as those that we encounter even in communities that are as different, perhaps, as some of the communities in Los Angeles and some of the communities in some of the areas of Mississippi in which my company practices.

Dr. Brian Hurley: So, there's a long history of using criminal and carceral approaches towards individuals with substance use disorders.

And, as ASAM does public policy statements that speak to the history of race and racism in different substances, in different ways that substances are formulated and sold, right? We have a long history in the United States of using criminal and carceral approaches to try to push people away from substances.

Those have oftentimes been deployed at the expense of health or treatment approaches, right? So, one thing to just consider is one of the things that makes everything worse is incarcerating folks. And when I say it makes everything worse, overdose rates go up, people's connection to health services, their families, employment, everything gets worse when they're incarcerated.

So, one consideration for increasing health equity and decreasing the disparities we see around substance use is mitigating and trying to remove the criminal and carceral interference with the delivery of addiction treatment to patients and then actually investing in the treatment infrastructure.

So, the communities disproportionately impacted receive disproportionate investments. Now I'm not under the illusion that every ASAM member is immediately going to run and pen a CMS waiver to ensure that their Medicaid programs offer the full spectrum of substance use treatment. But, I will say California did that in 2015, and our waiver program went live in 2016 to 2017, which has substantially increased funding for health programs specific to the communities disproportionately impacted. I'm working in an addiction treatment program, there's a few things I'm going to think about in order to help mitigate the health disparities impacting our communities.

The first thing is, if I'm working in a treatment center in the four walls of a location, I have to be very attentive to who isn't coming in. Am I not seeing people experiencing homelessness? Am I not seeing black and brown communities? Am I seeing a patient population that reflects the demographic makeup of the communities in which I work. And one of the key ways to help engage the community is by taking what happens in a treatment center and delivering it out in the field.

So, creating relationships with everything from churches, community centers, harm reduction and syringe service programs, primary care clinics, other types of community health centers, community mental health programs, right?

There's an entire network in a community and many substance use disorder treatment programs have evolved in a silo from the rest of community health. So, one key opportunity is one that tends to resources and funding that can help support community-based substance use treatment and then make that treatment accessible to community members.

And I think another super important consideration is who do we have working in our treatment programs, right? The ideal treatment workforce actually has the demographic makeup of the communities we serve. So, when we hire counselors, when we hire clinicians, when we hire addiction physicians, we're being mindful to, are we hiring folks that are either from the community or reflective of the community understanding of, and able to effectively engage the patients that we need to bring into treatment, attending to the populations disproportionately impacted by substance use.

Dr. Stephen Taylor: That's great. And, to bring it back to this whole issue of treating folks with stimulant use disorder, it reminds me of the fact that one of the narratives, one of the trends that we saw, in what has become the opioid crisis that we've all talked about for many years now is that certain communities, particularly black and brown communities were known to have more of an issue with stimulants and stimulant use disorder even in the context of the opioid crisis that, everyone was focusing on and for a period of time, there was a higher rate of overdoses and overdose deaths among black communities and certain brown communities, as a result of stimulant use than opioid use. And one of the things that points out obviously is the fact that addiction is not a drug-specific disease.

And if we're going to be taking care of folks with stimulant use disorder, we're going to be taking care of folks who have addiction related to a number of different substances. And so,

the preparation of treatment for the full range of substances that may be impacting a community is very important.

I'd like to get your sense of utilizing that approach to make the treatment community reflective of the community as a whole, to make sure that we focus on providing treatment that is based on the healthcare system and not so much the carceral system. How do we, as a part of that effort, make sure that we make a stimulant use disorder treatment that is evidence-based available to those communities? Any other thoughts on how we would do that?

Dr. Brian Hurley: Part of being present in the community is being present in the community with information around what we know works. So, one of the things that I work on is trying to make sure when I go give talks on stimulant use disorder that we talk about the evidence-based options.

So, when I'm out, you know, I recently gave a talk in the LA County Jail with our correctional health workforce. And when I talk to clinical audiences, I hear from them, "Gosh, methamphetamine use disorder is really bad, and there's just nothing we can do," and I think the exact opposite is true.

There is so much we can do. Here is a framework for assessment, stabilization, and engagement in evidence-based psychosocial treatment that, just to emphasize the point, really emphasizes contingency management. Here's where you can send the people on release to contingency management programs in the community.

And here are some clinically effective medications that, while they're not FDA-approved for the indication of stimulant use disorder, are clinically effective at treating stimulant use disorder that you can get started right now. And now, you go from a clinical team that feels oftentimes disempowered, we don't have a tool, to, "Oh we refer people to psychosocial treatment all the time for a variety of conditions." "We start medications all the time for a variety of medical and psychiatric indications." You're now putting what we know works in a framework where people feel like they can carry it forward.

And so that's one of my core messages here is, let's go out to the places of the people at highest risk. So, where is that? Our carceral system, our public housing system, our street medicine and outreach teams. That's where I'm very focused because when we look at the data of who's at highest risk for overdose, it's largely the people disconnected from existing services. So, that's where, in my community, where I'm very focused on getting the word out around what we know works for stimulant use disorder.

Dr. Stephen Taylor: That's excellent.

Dr. Brian Hurley: Dr. Taylor, one more thing that I want to mention is we see a tremendous variability in the United States over illicit stimulants. And when I say illicit, I mean stimulants

that aren't prescribed, right, but are sold on the street. So, the most prevalent stimulant that we see sold in our communities is cocaine across the country, right?

And methamphetamine being second. But I live in California in a Western state, and in many Western states, the use of methamphetamine far exceeds the prevalence of the use of cocaine. And there's many eastern states where the opposite is true, methamphetamine is relatively rare, cocaine use is relatively common.

You know, I did my residency in Boston, where I saw, over the course of a four-year residency program, five patients with methamphetamine use disorder and hundreds of patients with cocaine use disorder. And I laugh because one of my first jobs when I came back to Los Angeles was working in a general hospital where I saw ten patients with methamphetamine use disorder that shift, you know what I mean? Like, already doubled the cumulative number of patients with methamphetamine use disorder that I saw.

And so, we see really big geographic differences in the types of stimulants illicitly sold between cocaine and methamphetamine that does impact the way that our health systems treat patients because methamphetamine is a much longer-acting stimulant. The use pattern is different. It's associated with different sorts of communities and behaviors. And so, we do see pretty big different geographic differences in the way that stimulant use and the communities impacted by stimulant use across the United States.

Dr. Stephen Taylor: Yeah, that's very true. And that's a good point in terms of having our listeners who are in various different communities, tailoring their efforts to the community in which they practice. So, thank you for that important observation. To talk very briefly about the future, I'd like to just get your ideas on how do you see stimulant use disorder treatment evolving over the next few years. Are there any promising developments or research that's underway that could lead to new therapeutic options or improve existing treatment paradigms?

Dr. Brian Hurley: One of the things that you had brought up earlier is, you know, you treat patients with a stimulant use disorder, and psycho stimulants, from your perspective, were contraindicated because patients had a stimulant use disorder.

And I hear that all the time. This patient has an addiction. So, any controlled substance would be problematic. And then, you know, when methadone was launched and when buprenorphine became available, we began to revisit. Okay, there are some controlled substances that are FDA-proven and evidence-based that can be helpful and some that aren't. And what I'd say is I think we're still very much evolving our thinking over the use of controlled substances in treating substance use disorders.

Our National Practice Guideline actually speaks to psychostimulant strategies that seem to be effective at treating stimulant use disorders. Our guideline speaks to a role for extended-release methylphenidate in treating amphetamine-type stimulant use disorder and extended-release dextroamphetamine amphetamine salts with or without topiramate; those are a couple of different medication strategies for the treatment of cocaine use

disorder, and that is countervailing to the conventional wisdom of psychostimulants are contraindicated in treating stimulant use disorder. Actually, there is some evidence for the use of psychostimulants in the treatment of stimulant use disorder.

But, the evaluation of the risk and benefit of those treatments, which that's the core measure of whether a treatment is appropriate, is the patient benefiting from it? And how is that a benefit exceeding the risks or the downsides of a given treatment? And so, we can use segment stimulants in that risk-benefit analysis.

I expect we're going to see additional medication options, some of which may be controlled substances, some of which may not be. The clinical practice guideline looked at medication strategies, and given what we have now, it made a set of recommendations about what medication strategies are appropriate.

I think that we may see additional medication options have a signal, that is to say, show some effectiveness at treating stimulant use disorder. Two things just wanted to remark on around the medication strategies.

Dr. Stephen Taylor: Please, go ahead.

Dr. Brian Hurley: The evaluation of patients with stimulant use disorder and consideration of psychostimulants should really be in a setting where clinicians have expertise in working with stimulant use disorder.

And the guideline specifies the use of psychostimulants for the indication of stimulant use disorder should really be managed by a physician specialist in addiction. Somebody who's really has a depth of experience in working with this patient population. But, the use of psychostimulants to treat ADHD co-occurring with stimulant use disorder, psychostimulants are an evidence-based strategy for ADHD. Or nonpsychostimulants. We have nonpsychostimulant options to treat ADHD. And we have behavioral coaching and other treatments for ADHD.

When putting together a treatment plan for co-occurring conditions, yeah, we have options, and I am excited to see how we can adapt what we know works with things like motivational interviewing or, additional adaptations of contingency management, or additional adaptations of types of cognitive behavioral therapy that I think are going to deepen the bench of tools we have to treat stimulant use disorder. So, that's what I see coming, is an additionally evolving evidence base that points to the effectiveness of strategies that will have available to us.

Dr. Stephen Taylor: That is awesome. Let me ask you if you have any thoughts or experience or if you've come across any literature on this sort of interesting new topic that we actually covered in our first podcast, the use of GLP-1 receptor agonists for treatment of SUD, whether you know of any or have any thoughts of any uses for those agents for patients

with stimulant use disorder. Obviously, we've talked about them for other addiction disorders.

Dr. Brian Hurley: You know, I'm very fortunate, Dr. Taylor, that you already mentioned my chief conflict of interest in speaking to this, which is I'm the president of ASAM. So, I will use this as an opportunity to plug the ASAM annual conference that has a plenary session focused on this category of medication treatments.

Forgive the shameless plug, but those listening to this podcast, register for the ASAM meeting. You'll get a chance to actually hear from experts speaking to the use of semaglutide and related medications in the treatment of SUD.

And from my vantage point, what a tantalizing prospect, right? I'm so interested to learn more around how on the evidence of these treatments is going to evolve and how we see that they can be effective for things like alcohol use disorder, other types of substance use disorders, you know, will stimulate use disorders become an indication for the use of these medications. It's just, it's a really tantalizing prospect. And I am looking forward to joining my ASAM family at the annual meeting to learn more.

Dr. Stephen Taylor: Thank you for that. We're about out of time for today, but before we wrap, Brian, I want to just ask you to please give us any key takeaways that you might have on either implementing the guidelines impact of socioeconomic and cultural factors, anything that you would want to round out to the sort of excellent insights you've already shared with us.

Dr. Brian Hurley: Sure. So, the guideline is really designed to emphasize patients with stimulant use disorders should be assessed and placed in an appropriate level of care. We have *The ASAM Criteria*. There's nothing magic about *The ASAM Criteria*, but consider the appropriate level of care for the patient.

And when putting together a treatment plan, we have good options for stimulant use disorder. And the best option for stimulant use disorder is contingency management. It can be delivered as a standalone treatment. It can be delivered in combination with other evidence-based psychosocial treatments, such as cognitive behavioral therapy, the matrix manual IOP curriculum, and the community reinforcement approach.

We have medications that are clinically effective at treating stimulant use disorder. They're not as effective as other medications that we have for alcohol or opioid use disorder, but they do help patients reduce their stimulant use, and those of us working in addiction treatment, I think, have an obligation to understand and be actively working to address the health disparities that we know have resulted from longstanding community inequities.

And so, that means bringing what we know works in treatment out into the community and supporting an addiction treatment workforce reflective of the communities we serve. So, I

appreciate Dr. Taylor giving me the chance to offer a summative recap. Treating stimulant use disorder is not hopeless. We have good options.

Dr. Stephen Taylor: Absolutely do. Thank you so much for that. Dr. Brian Hurley, our ASAM president, our expert guest for today on our podcast, ASAM Practice Pearls. I want to thank you so much, Brian, for taking your time out and sharing these incredible insights with all of us and our listeners.

For more information on treating stimulant use disorder, please be sure to register for ASAM's pre-conference session, Stimulant Use Disorder on Thursday, April 24th in Denver, which will precede the actual start of the conference. Gain practical insights during this preconference from leading experts like Dr. Brian Hurley.

Also, check out ASAM's free webinar series on the management of stimulant use disorder. You can find the link below in today's show notes.

We'd also love to hear your thoughts. What challenges have you faced with inequitable stimulant use disorder care? What solutions have worked for you? Be sure to comment and join the conversation. Thanks for listening. We'll see you next time on ASAM Practice Pearls.