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The American Medical Association Opioid Task Force: Support for Evidence-Based Care for Substance Use Disorders

Narrator:
In the face of increasing numbers of Americans dying from a drug-related overdose, physicians and other healthcare professionals are calling for removing all barriers to evidence-based care for the treatment of substance use disorders. More physicians than ever are becoming trained to treat opioid use disorder, and the U.S. Surgeon General has put his weight behind treatment as the way out of this epidemic. But despite widespread recognition of evidence-based, proven solutions, health insurance companies continue to put up barriers to evidence-based care, death from heroin and illicitly manufactured fentanyl and fentanyl analogs are at historic levels, and death due to cocaine and stimulants are increasing rapidly. The AMA Opioid Task Force is calling on policymakers and other stakeholders to eliminate all barriers to evidence-based treatment. But what does this actually look like in practice?

Welcome to ReachMD. On this episode, we caught up with several leading experts in addiction medicine at the annual meeting, who shared their roles and respective backgrounds guiding them to where they are today. Let's hear from them now.

Dr. Harris:
Well, I am Dr. Patrice Harris, President of the American Medical Association and Chair of the AMA's Opioid Task Force, and the AMA convened the Opioid Task Force in 2014 for two reasons. We wanted to amplify the efforts already underway by physicians across this country to address the opioid epidemic, and we also wanted to identify new ways to coordinate and collaborate on efforts to end the opioid crisis.

I am a child and adolescent psychiatrist, but I've done a lot of work in addiction. I've worked on the public health front leading a public health agency, and I also work a lot with children, and so I see the impact of parents who have substance use disorders, and so for all those reasons this opioid epidemic touches me on so many levels both personally and professionally, and that is why it has been my honor and privilege to lead this Opioid Task Force.

Policymakers certainly need to be at the table, and at this point in the opioid epidemic we need our policymakers to be laser-focused on increasing access to treatment and eliminating any barriers to those who need treatment for an opioid use disorder.

Dr. Dowling:
I'm Frank Dowling. I'm an Addiction Medicine and Psychiatric Medicine Physician from New York and a member of the AMA's Opioid Task Force. I went into addiction medicine because I saw early in my life, growing up in a town on Long Island, addiction in my family, particularly with alcohol, but in school I saw addiction problems with alcohol and cocaine, and I saw, in my view at least, how schools, officials, public officials, families really tried to sweep addiction issues under the rug, and going into medicine, I knew it was something that I wanted to address differently. As I went through residency and started practicing, I recognized that so many of my patients were self-medicating their depression, their anxiety, their traumatic stress, other illnesses by using substances – alcohol,

cocaine, marijuana, opioids, abusing prescription medications – and then especially over the last ten years as illicit use of opioids and heroin has soared, other drugs are also rising that we need to start addressing. I shifted my practice to really more openly get the word out that I do treat primary addictions as well as addictions when they're part and parcel of other mental-health conditions.

Dr. Salisbury-Afshar:
I am Elizabeth Salisbury-Afshar, and I went into family medicine because I had a broad recognition pretty early on that most of health actually happens outside of the hospital and outside of the clinic and was really drawn to community-based medicine. I also recognized that health is impacted by the relationships to our environment and our families, and of all the specialties I was exposed to, I really saw that family medicine embraced that, and I was just really drawn to sort of the broader view of health. For similar reasons, I actually did a second residency in preventive medicine or public health, and I did that out in Baltimore, and when I was in Baltimore I had the opportunity to work in a variety of community-based settings and federally qualified health centers and quickly recognized that heroin in particular and opioid use disorders had really had detrimental impact on the community that I was serving. I was also working with public health departments in the city and the state and seeing similar trends in data and epidemiology and became really drawn to the field of addiction medicine.

Dr. Levy:
My name is Dr. Sharon Levy, and after training in medical school, I knew that I was going to be a pediatrician. I just love working with young people, and from the very start, that was really the only choice for me. I was trained as a developmental behavioral pediatrician, and about 20 years ago, the opportunity became available to open a substance use disorders treatment program for children, adolescents, and young adults in an academic medical center, and this was really, at the time, very unique. It was the only program like it, in the entire country and really gave us a chance to professionalize the care of substance use in young people, and we've been doing that for 20 years.

Dr. Renner:
Well, I'm Dr. John Renner. I'm an Addiction Psychiatrist. I've been at the VA for almost 40 years now, work in outpatient substance abuse, and primarily for the last 10-20 years I've been working with people with opiate use problems, and what you learn very quickly is that your patients are all complicated. It is very unusual for us to see someone who has just has problems with alcohol or just has problems with opioids. Most of our patients have histories of multiple drug problems. Even though their now primary problem may be opioids, they usually also have significant other psychiatric problems.

Narrator:
We asked each of these members of the Opioid Task Force about their perspectives on individualized care for substance use disorders. Here's what they shared with us, starting with Dr. Dowling, Addiction Medicine and Psychiatric Medicine Physician from New York:

Dr. Dowling:
We're always treating a person and not just an illness or a syndrome, and we always have to tailor the treatment to that individual person. In addiction medicine where we only have some medications to treat some addictions, mostly opioid and alcohol, we have to recognize that there are other addictions and that even the best medications for opioid or alcohol may not always work well, so we always have to come back to what's best for the patient in front of me. What's the best way to help this person when that door closes and we have this conversation about the best way to help them to recover and to live their life better?

Narrator:
Dr. Salisbury-Afshar also offered her perspective on this topic from her viewpoint as a family medicine physician. Let's hear what she had to say now.

Dr. Salisbury-Afshar:
I think that all of us as individuals understand that we know our bodies and our circumstances better than any provider that, that we meet. As a provider, as a physician, I, of course, like to feel like it's my role to help people make the decisions that are right for them

and recognize that the input that they have is critical. In addiction medicine, I often joke that the only medicine that works is the one that someone's willing to take and it's really not a joke. It's very, very real, but I think that we come across so many patients who have really strong preferences or beliefs, and while I know what the science says, if my patient isn't in agreement for whatever reason it may be my advice only goes so far, and so I, I really see my role as a physician as being one to support people, to understand where they're coming from, and to provide them with the information that they need to make the right decision for them.

Narrator:
Dr. Levy also touched upon barriers that patients with pain often face.

Dr. Levy:
If I could change one thing in healthcare policy regarding treating patients with pain, it would really be the way that we make medications available, including prescribing and prior authorizations and the restrictions on medicines. It would make all of that just a little bit easier, not only for treating patients with pain but also, of course, treating patients with substance use disorders.

Narrator:
And here's Dr. Renner from the VA, who talks about how common psychiatric disorders are among his patients.

Dr. Renner:
I don't think I have a single patient that doesn't have at least one other psychiatric problem. Being at the VA, a lot of these young men have PTSD because of combat experience, but we see the whole range of other psychiatric problems, and I think it's very critical that the treatment cover the whole spectrum of care for their medical problems, care for their psychiatric problems, care for their addiction problems. I think it all has to be integrated into a comprehensive package.

Narrator:
Lastly, we asked these Task Force members about some of their priority issues needing to be addressed to help improve care standards in addiction medicine.

Dr. Dowling spoke to the educational reforms needed to make screening and treatment for addiction disorders a higher priority in clinical practices.

Dr. Dowling:
If I could change one thing in healthcare policy to assist patients with substance use disorders, it would be that we finally recognize and really accept in medicine and in our country as a whole that substance use disorders are treatable medical conditions, not weaknesses, not character flaws, and not the result of evil or sin or however people too often look at it. Now having said that, this is going to require wholesale change at many levels. We need to educate in schools – grammar schools, middle schools, high schools – we need to educate in community groups, churches, parishes, synagogues, kids' sports adults' group activities. We need to really change education in medical school. We're here, and we're here to supply support, education, and backup, and we can take referrals for the more complicated cases, but we really need to start treating addictions in primary care offices just like the way they treat high blood pressure, diabetes, thyroid abnormalities, and don't always just refer to the specialists.

Narrator:
Dr. Salisbury-Afshar focused on addressing the heavy tolls of stigmatization against people with substance use disorders.

Dr. Salisbury-Afshar:
For me, when I think about the impact that various policies have on people with substance use disorders, really the one that the, the sort of theme that comes to mind is that we as a society have decided that much of our approach to working with people who use drugs involves criminalization, and as a medical person and as medical societies, we have all agreed that addiction is a medical condition, a chronic medical condition that has evidence-based treatments . So for me it's sort of a broader recognition that a lot of the policies that we have in place are not treating addiction as a chronic condition and that the penalties that respond may actually be increasing the trauma that people experience. And so when I see the impact that incarceration has on my patients, what I see is that

people are being removed from their homes or whatever that home environment may look like for them, they're being removed from their communities. Whatever their sense of purpose is, whether it be caring for a loved one or, working at a job, they're also removed from that environment, and then the sense of connection to others around them. So, they lose all of that during periods of incarceration, and then when people are released, and particularly in the case that people leave with a criminal charge, we've now actually made it harder for people to go back out there and get a job, for people to get housing. People have to reintegrate with their family and social networks. So, I'm really hopeful that as we look at our broader policy arena as it relates to substance use disorders and, and people who use drugs, that we use a framework that's not one focused on criminalization but rather focused on evidence-based intervention and health.

Narrator:
Dr. Renner continued on this theme with a focus on justice system reforms.

Dr. Renner:
Well, unfortunately in the United States, we probably have more people with substance abuse problems inside the criminal justice system than we do in the mental health system, and I think we're still struggling as a culture to try and decide whether this is really a moral issue or is it a health issue and a lot of our criminal laws are built around the notion that the way you respond to people with addictions is to put them in jail, and I think we're learning very clearly that that's not a very effective way. It's a highly costly way to respond to these problems, and we're working very hard to make sure that people get services within the criminal justice system, and I think even better, I think we're looking now at diversion programs. We have veterans' courts so that there are opportunities for people if they get into difficulty with the justice system. And usually the goal there is that they don't end up in jail but they end up in probation, so the probation works with the treatment people to make sure they stay in treatment, and if you can pair up that external support from the justice system with the treatment, that keeps people in treatment longer, and they ultimately do better and that's a much more productive way for the justice system to be involved than to have people locked up in settings where they often get no treatment at all.

Narrator:
Closing out the discussion, President of the American Medical Association and Chair of the AMA's Opioid Task Force, Dr. Harris, shares one final, important message.

Dr. Harris:
There are no one-size-fits-all approaches that will work. Every patient is unique. Every patient has their own biology, their own psychology, their own sociology, and so they really need treatment that is tailored best to meet their individual needs.

Narrator:
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