Medical Xpress

Q&A: Bringing addiction care 'inside the house of medicine'

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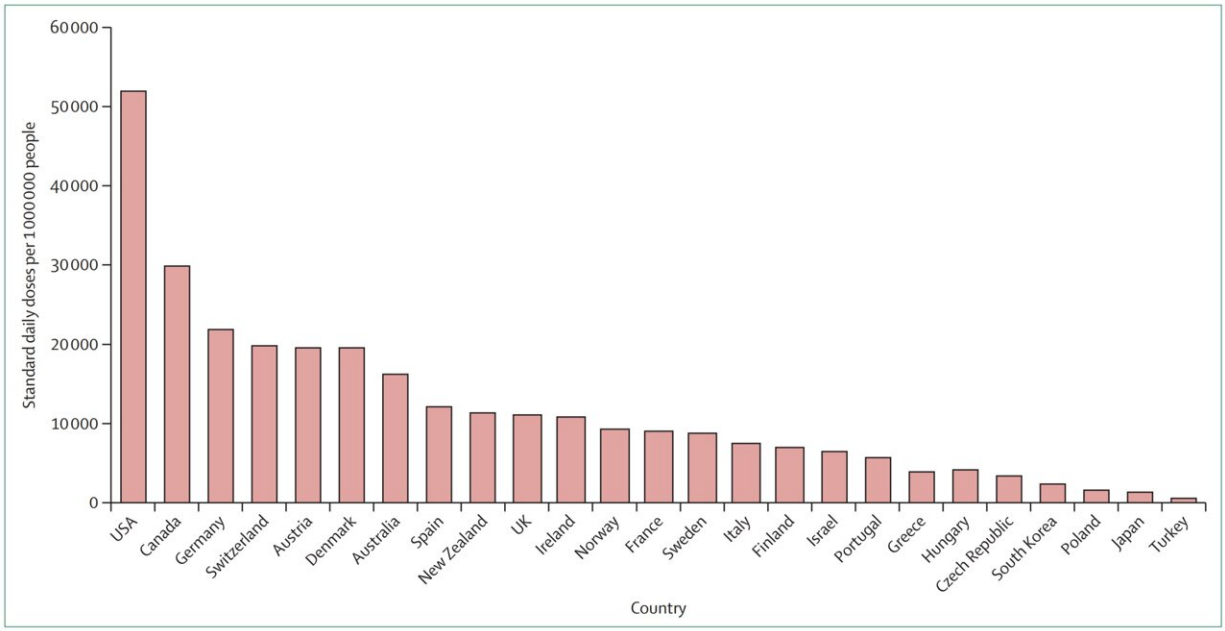

International per-person consumption of prescription opioids (2010–12). This period coincides with the peak of opioid prescribing in the USA and Canada. Credit: *The Lancet* (2022). DOI: 10.1016/S0140-6736(21)02252-2

As civilization ground to a halt during the COVID-19 pandemic, trapping humans like caged mice, addiction expert Keith Humphreys could only agonize over the collateral damage. America was already losing the war on addiction with 70,000 annual overdose casualties, even after a decade-long battle against opioids.

The opioid death rate spiked by nearly 40% in the first year of the pandemic, and in 2021 U.S. overdose deaths topped 100,000 for the first time in history. With all available public health resources and mental energy diverted to a virus and a vaccine, millions of struggling Americans—many already self-medicating with addictive substances—had little respite from a range of homebound conditions, from isolation to captivity with an abusive partner.

"It's pretty horrible that we're still losing more than 100,000 people a year to overdoses," said Humphreys, Ph.D., Stanford Medicine professor of psychiatry and behavioral sciences.

If there is an upside to the still-smoldering public health crisis, it's that people like Humphreys are finally seeing signs of progress.

In fact, since the Stanford-Lancet Commission released its 50-page report on the North American opioid crisis in February of 2022, Humphreys, the chair of that 17-person collective has been on a whirlwind tour.

"There's a lot of desperation, a lot of fear—and a lot of willingness to try things," he said.

Humphreys has advised the Biden administration, state legislatures, the Canadian parliament and even the British prime minister on policy adaptations that could finally change the opioid narrative and, he hopes, the way addiction is treated. The hurdles are considerable—a lack of long-term funding streams, physician buy-in and training, and insurance company reimbursement, for starters—but a fix must begin with a culture shift, he said.

"We've got to bring addiction care inside the house of medicine," said Humphreys, who is the Esther Ting Memorial Professor. "What if we

treated this like a chronic disease? You wouldn't have these set-aside specialty systems, these recovery farms off somewhere totally outside the medical system. Instead, you would have it set up the way we set up oncology or cardiology or pediatrics or geriatrics."

To Humphreys, it's part of a bigger-picture course correction that treats addiction as a naturally occurring human health condition, rather than an over-stigmatized and subversive human failing—particularly when medicine was the root from which the opioid crisis grew.

"If I walk in with a heart murmur or back pain, there are procedures in place," Humphreys said. "If I walk in and say, 'I can't stop taking oxycontin,' there should be the same."

Humphreys spoke about the hopeful signs as well as the challenges in shifting the addiction paradigm.

The Stanford-Lancet report called for sweeping reforms. What has happened in the year and a half since?

Within a month of the report coming out, I did multiple White House briefings, one with the office of the secretary of health and human services. I also did one at No. 10 Downing Street in Britain. A number of things we recommended have begun to take shape. One of those is enforcing parity laws, which require equal reimbursement for physical and behavioral health conditions, to make sure the insurance industry covers addiction treatment adequately.

You've emphasized the importance of doctors knowing how to treat addiction. Is there now a path

toward that?

Yes, we recommended universal physician training in which every U.S. doctor who prescribes addictive drugs has to get trained on addiction. That just got approved about six months ago—it's a pretty stunning change, because students at American medical schools get very little training in addiction or pain. Now, if they want to prescribe drugs, all 900,000 practicing doctors must receive continuing education about substance use disorder. The reality is that even doctors who don't think they are treating addiction are treating addiction. If you work in an emergency room or in family practice...one in four people who come in is going to have a substance-related issue.

Are you seeing a cultural shift in how addiction is perceived?

I've seen big strides. We now have a pretty robust recovery movement, which we didn't have when I started doing this. When the great singer Tony Bennett died recently, his obit mentioned his recovery from cocaine addiction. I don't think that would've happened 20 years ago—and it didn't seem to diminish him in people's eyes. But a lot of people are still dying. And when people die, human beings understandably get upset and they want to see the people they feel are responsible for the loss of their loved one punished.

You've strongly recommended pulling addiction treatment into medical care. Talk about the barriers that exist.

Addiction treatment stems from three parents: the criminal justice system; social welfare, such as the Salvation Army; and peer fellowships,

such as Alcoholics Anonymous. All of them have saved many lives, but they're not within the house of medicine. Those entities have less funding, and they are more stigmatized and poorly integrated with the health care system. The normal health care system needs to respond to substance use disorders adequately, which means consistent funding.

Currently, Congress gives addiction treatment two years of funding at a time. Two years won't resolve addiction. You need enduring funding streams, and you need parity—just like patients expect their Blue Cross plan to cover cancer, it must also cover someone who is addicted to alcohol, opioids or any other drug.

While COVID was devastating for addiction, you've spotted a potential upside, right?

Although you and I can get on our phone and find real-time data about COVID deaths, finding out how many people died of an opioid overdose takes six months. If we don't have that data, we cannot tell if certain addiction programs are working. I'm excited about some of the things we're working on to conduct better population-level studies around addiction. COVID showed what we can do on a national level. We need to make that same kind of commitment to this problem.

More information: Keith Humphreys et al, Responding to the opioid crisis in North America and beyond: recommendations of the Stanford–Lancet Commission, *The Lancet* (2022). DOI: 10.1016/S0140-6736(21)02252-2 www.thelancet-press.com/embarg … OpioidCommission.pdf

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