Tricia Johnson (00:00):

And for too long, all of us have been saying, well, it's somebody else's problem. It's not our problem. It's not going to happen to me. The fact of the matter is it's happening to a lot of people, too. Our parents, our children, our cousins, and our friends. It's Aspen ideas to go. I'm Trisha Johnson, Perry pellets is a journalist and documentary filmmaker. She directed HBO's warning. This drug may kill you about the opioid addiction epidemic. In today's episode, we'll look at the crisis. That's killing 90 people every day. Aspen ideas to go is a weekly show that brings you compelling talks from the Aspen ideas festival and other programs presented by the Aspen Institute. The Institute is a non-partisan forum for values based leadership and the exchange of ideas it's been called the most perilous drug crisis ever. And it was generated. And the healthcare system, the U S is the epicenter of the opioid epidemic.

Tricia Johnson (01:08):

Overdose deaths here have quadrupled since 1999. This week, president Trump pledged to combat the problem by stepping up law enforcement and working to prevent people from using opioids in the first place in today's show a panel of experts onstage at spotlight health, discuss what's being done, what needs to be done and what we know works and doesn't to fight the epidemic. Nora Volkow leads the national Institute of drug abuse at the national institutes of health. Her work shows drug addiction is a disease of the brain. Yasmin Hurd has the addictive Institute for Mount Sinai health system. Vivek Murthy served as us surgeon general under president Obama and Perry Peltz, who you heard from at the top of the show advocates for public health. In addition to reporting on it, Jackie JAG, moderates, the conversation she covers domestic policy for the PBS news hour. Here's Jud Vivek. I'd like to start with you. What does this epidemic look like in 2017? What is the big picture?

Vivek Murthy (02:13):

Well, it looks pretty bad. The opiod epidemic and addiction more broadly have become the defining public health crisis of our generation. And you heard some of the numbers, uh, you know, just a moment ago, we have over 50,000 people, uh, who have died from drug overdoses in 2015. And over 60% of those are from prescription opioids. Now you might be asking just to back up for a moment, what is an opioid to begin with? You're seeing this term everywhere. You're reading it in the newspapers, but opioids are substances. Sometimes medication, sometimes illicit substances like heroin, uh, which act on receptors in the brain and diminish pain and can also cause you for you. And they're used very commonly in the medical world, uh, to address pain, both and chronically, but we have a come to a place where we have more than 2.5 million people who are now addicted to opioids.

Vivek Murthy (03:09):

We have about 1.9 million who have an opioid use disorder that involves prescription painkillers, a little over 600,000, uh, who have a disorder involving heroin. We have 12 million people, nearly 12 million people who are also misusing these opioids. They may not have a full blown, uh, substance use disorder yet, but they were at risk, uh, for that because they're misusing those opioids. And that might mean borrowing it from a friend when it's not prescribed to them. It might mean using it for purposes, other than for pain relief to reduce stress or to choose, create pleasurable feeling. Uh, so we have numbers that are quite staggering, but what has really been striking to me are the stories behind those numbers, because what you see when you go out and you meet people who have, uh, struggled with opiate addiction is that this is a truly devastating illness. Uh, it's one that tears people lives apart that destroys families and that weakens communities, uh, I've, you know, sat over the years with parents who have lost children to drug overdoses, uh, and it has just been devastating for them.

Vivek Murthy (04:13):

I've done. I've also visited communities which have a growing number of children who are being placed in foster care because their parents have overdosed and died, uh, because of our prescription opiod crisis. So this is a real serious problem as you will hear during the next hour or so, uh, there is progress that's been made. You know, we have been able to expand treatment. We've been able to get in the lock zone in the hands of first responders. That's a medicine that reduces, they reverses rather the effect of opioids and can save people from an overdose death. But we have a long, long, long way to go because we not only have to continue to expand treatment, but we have a lot more to work to do on the prevention side when it comes to public education. And particularly when it comes to eradicating stigma around addiction, which prevents people from coming forward and seeking help.

Yasmin Hurd (05:01):

Thank you. That was a terrific preamble. Perry, you put the human face that Vivek was just talking about. You put the human face to this epidemic in your documentary. What drew you to the subject?

Perri Peltz (05:15):

You know, it's a great question. About two years ago, I was having a meeting with my boss at HBO. I wonder the legendary really Sheila Nevins. And Sheila said she was reading these articles and she said, what's going on? All of these people are overdosing and dying, but we didn't really quite understand. I had heard something about it, but didn't really know what it was. And of course, as we researched it, we learned that it was this opioid addiction epidemic that was sweeping the country. But the narrative at the time was it was bad kids abusing good drugs that were meant for pain patients. And what we learned is that's just not the case. There is some abuse, obviously that is a part of this, the vast majority of people who first of all, go to heroin, started with a prescription opioid. And they're not bad people.

Perri Peltz (06:05):

They are people who have become addicted. And we decided that what we wanted to do and what we think we can do best in documentary is tells stories. The people who are becoming, um, trapped in this, in this epidemic of addiction, not this epidemic of abuse. And we really wanted to try to help change that narrative. We started the film in a very shocking way. You're going to see it in, in just a second. Um, we didn't have originally, we didn't start the film that way. And we decided at the last minute to make the change, because we want to show people what this actually looks like. And for too long, all of us have been saying, well, it's somebody else's problem. It's not our problem. It's not going to happen to me. The fact of the matter is it's happening to a lot of people to our parents, our children, our cousins, and our friends. And we really want it to show what that looked like and what it looks like to overdose

Yasmin Hurd (07:02):

Yasmin it's abundantly clear. And if you see Perry's documentary, it becomes abundantly clear that that the addiction happens so fast. Why, what is the neurobiology behind it? And explain it in a way that this general audience, including myself, will understand

Speaker 5 (07:23):

Well as a neuroscientist. And I think Nora touched on a couple points this morning in her talk, you know, for us neuroscientists, it is challenging to come up with, um, the mechanism of action of why the addiction necessarily is that quick. However, there are a couple of things that make it, um, important in

that respect. And one is a lot of these, um, opioids. They pass the blood brain barrier very quickly. They get into the brain very quickly and we know that many drugs that are have the higher addictive potential, the faster they get into the brain and the faster they leave, the faster they, they bind to the receptor. Um, for example, the mule pit receptor is where, um, the opioid spine and simulating, um, pain, uh, mechanisms and also, um, reward euphoria. So the faster they bind the faster and leave the faster they become addicted, why it is that some people even like three days of, uh, being exposed to an opioid, it starts that very rapid, um, trajectory into addiction while others, it can go take a longer time. We still don't know, but genetics come into play. And there are things we can talk about later with that in terms of the individual vulnerability for most addictions, there are also there for, um, opioid abuse. We know that some of the, um, genetic variance of the receptor where, um, all the opioids bind, um, they're different in everybody in this room practically. And some of those variants make certain people more vulnerable, but the addiction capacity is really for the large part, the rapid binding to the receptor and the signaling cascade in the cells.

Yasmin Hurd (09:06):

And is there a way to quantify what number of people will be prone to addiction versus someone else who could take a prescription given by adopter ended? And that's it,

Speaker 5 (09:19):

There are studies, um, starting now. Um, there are ongoing studies now. I mean, I think that a lot of the, the research had been done before had small sample sizes for us to really make the definitive answers in that respect. But there are a number of big studies that are going on. For example, people who are getting the same amount of opioids for pain, and you're looking to see which percentage of those individuals develop an a D a substance use disorder later on, as we get larger numbers, we'll be able to give better information about what genetic risk and also the environmental risk that comes into that, um, of the studies that have gone on, I don't know, probably Nora would feel more comfortable. I think that we still need more studies, much more research to really give those definitive answers as to which person in this room, um, would be the person who become addicted. But the type of opioid is also important. Um, fentanyl and now carfentanil these extremely, extremely potent opioids. Um, even if you are not at high risk taking those will definitely put you over the edge. So again, it's a type of opioids and your genetics, and certainly environmental factors that really come into play.

Tricia Johnson (10:40):

You're listening to Aspen ideas to go on the show today, the opioid tsunami featuring Nora Volkow, Perry, Peltz, Yasmin Hurd, Vivek Murthy, and moderator, Jackie Judd find Aspen ideas to go on Apple podcasts, NPR, one Google play and Sirius XM insight channel that's channel one 21, discover previous episodes that cover relevant topics that introduce you to new ideas and different perspectives. Subscribe today on Apple podcasts. Now back to the show, here's Jackie Judd,

Yasmin Hurd (11:31):

Nora, I'd like to ask you a two-prong question. One, take us back in history a little bit to help us understand where this epidemic began. The Purdue campaign that Perry highlighted took place in the late 1990s. One, two. So it's clear this epidemic didn't start yesterday. It didn't even start last year, but it's only getting attention at a national level. I think in a way it hasn't until recently just it's just happening. So are we at an inflection point? Is it getting more attention now because it's happening to people who look like us?

Speaker 6 (12:11):

Yeah, no. And I, I had a presentation this morning and I commented on this, and that was the notion of coming to your question about little, bring us back. And I like to speak about this epidemic in terms of three things that make it very notable. One of them is the number of people that are dying. Number two, that the people is actually not the classical demographics that we're seeing. And it's making it clear that anyone can become addicted to drugs is not just the person over there. And the third one, which brings it to the point that this is the first time that we have an epidemic like this, that is so severe, the most severe that we've had, and it was generated in the healthcare system. And it was an, and that is something that we need to be aware of because it's important in order to actually address it.

Speaker 6 (12:53):

And it was a good intention that would intention of treating patients suffering from pain. That can be very debilitating. And physicians actually not having the knowledge at the same time, that there was very strong advertisement practices from pharmaceuticals. Like the one that we just showed that would capitalize with a notion that we were all taught in medicine, that if you have pain, you will not become addicted to your opiate medication. And so that led physicians on the one hand to become overconfident about the utility of these medications that are very good for acute, but not for chronic pain on the one con the other reality was that there were not many alternatives. So if you have a patient suffering from severe chronic pain, there may not many things that you can give them. So they rely very rapidly then of course, on, on the opiates. And again, coupled by the fact that there was a push from pharmaceutical to, to move these drugs and also from insurance companies, because in many ways, it's more cheaper to provide an opiod medications for someone suffering from chronic pain, that to actually give it, give them that integrated model of Gerda,

Yasmin Hurd (14:05):

Behavioral counseling, physical therapy.

Speaker 6 (14:09):

And that is again, much more time consuming and the insurances are not covering for it. And so I get physicians writing to me and says, yes, we agree with you with all of the points that you're saying, but I cannot endorse those treatments to my patients because they are not going to be reimbursed on over primary care. Physicians are the main ones prescribing opioids, and they have 12 or 13 minutes to see a patient. So cow, practically, are they going to be able to properly engage on the treatment

Yasmin Hurd (14:39):

About why now? Why are we here now? Why is Nicholas Kristoff writing now? Why is Perry doing a documentary now?

Speaker 6 (14:45):

Yeah, the question was what led and, you know, and I also mentioned it earlier this morning because I came to NIH in two and three and six months into my tenure. They showed me these data showing extremely high levels of opioid use among teenagers. And that immediately caught my brain because I had never seen adolescents abusing opioids. So we started and I started to look at it and I realized that there was a significant increase in the abuse of opioids across all ages. And I started to try to engage the healthcare system and my clinicians and friends and colleagues. And actually, I remember going to the

director of the dental Institute, and I said, do you realize that dentists are the main prescriber of opioids for teenagers and says, no, Nora, that's not an indication. That's not what the guidelines say. And I says, well, this is what the prescription numbers are.

Speaker 6 (15:30):

So there was a lot of lack of knowledge. And, and even though I, you spoke and I felt very frustrated because he looked like no one was listening and I commented. So I've thought about it a lot. What made the difference? And it gave me a lesson because I think that the way that you see things is fundamentally in making themselves and doing the media most obviously are the experts on this. But I think that the narrative that make that difference, the, the, the point that, that three GIP trigger, it was that when they started to make the comparison, there are so many people dying as they are in a car crash accidents. That narrative actually got the attention of the public and it got the attention of the agencies. And that's when they actually realized that we have a massive problem in our hands.

Speaker 6 (16:14):

And it was very unfortunate because by not being able to tackle it very early on, what did they allow also at the same time, unbeknownst for many of us, including me, that is something I did not pick up. There was a major entry of pure heroin coming from Mexico that was sitting in the whole country and taking cover very nicely. So like basically the soil was ready on people that have become addicted to prescription opioids. So we were not predicting that carer in the rice. One vary on the use of a very cheaper Cairo in very, very potent. That then is increasing the number of people overdosing and dying. And then the new component, which is what Jasmine was referring to, the opportunity that the drug dealers see of introducing even more potent synthetic opioids, because then you don't need a need to grow a plant. And the doses that you require, the volume is so small that it's very difficult to control across the borders. So in the past you need these big volumes of drugs. Now they are minuscule. So it's, it's changed us all upside down in terms of prescription opioids then led to the heroin epidemic. And that's now bringing it up. These new synthetic opioids, many of them, we actually don't even know what they're pharmacological.

Yasmin Hurd (17:27):

It was. I think it was last year that the CDC issued prescribing guidelines for opioids. Vivek, part of your turning the tide campaign was to send a letter to, to almost over 2 million physicians about this subject. What did you say to them and what was the reaction and did it have an impact? So it's a good, um,

Vivek Murthy (17:50):

Let me, let me comment also, just to, if I can add some color to the last question as well. I agree with everything Nora said, I mean, this is the origins of this epidemic are very complex. Um, and they were people like Nora and others who 10, 15 years ago were trying to raise the alarm about this, but it took a long time for people as a profession to, to fully get on board. Now, I think that part of that, part of the reason why we've seen a switch in terms of awareness has to do with who's affected. Now, the truth is you would like to believe that leaders in society, whether it's leaders in Congress or in the media and our institutions, whatever, uh, decide what to cover and what to target in terms of legislation, based on the scope and volume of impact.

Vivek Murthy (18:31):

But that isn't always the case. It turns out that personal narrative and personal experience. So drive a lot of what people think about because people are people and as the legislators and other leaders started to see more people who look like them and who they knew affected by this crisis, then I think it started to take hold in people's minds that, Hey, maybe there's something real here. Like truth is a drug crisis in America. It did not crop up five years ago, 10 years ago, 15 years ago, you know, we spent many decades, uh, dealing with the drug crisis, but for there during much of that time, the drug epidemic was focused in and concentrated in poor communities. And often in communities of color. And many of those communities are very upset now because they say, where were you when we were struggling 30 years ago?

Vivek Murthy (19:11):

Where was all of this outrage and the effort, uh, the focus, uh, from both both sides of the aisle. And the truth is that 30 years, uh, as a country, we largely, you said, not everybody, but many people understood addiction to be a disease of choice, a disease that was effected people who were of weak character or weak morals. And didn't have the willpower to say no to drugs. Uh, we now know that that's not the case and a big, a focus of my work when I was surgeon general, a big focus of Nora's work. And, uh, many of our colleagues has been to redefine addiction as a disease of the brain, a chronic illness, just like diabetes or heart disease. Last year, when I was launching the turn, the tide campaign, this was one of the points we were trying to make to doctors, because you would, you might ask yourself the question isn't this normally taught in medical school for years, that addiction is a chronic disease and how to treat it, et cetera.

Vivek Murthy (20:02):

Short answer is no it's perhaps better taught now than it was 15, 20 years ago. Uh, but the science has evolved a lot, but doctors still have to catch up, uh, with a lot of that. So in the letter that I issued, it was say 2.3 million healthcare providers, including doctors and nurses and dentists. And what we did is we urged clinicians to understand that this is an epidemic that we had to partially take responsibility for that it was, there were things that we did well-intentioned though they may be inadvertently, may have contributed to this crisis. And the flip to that was to say that we also, as clinicians have an incredible opportunity to come in and make a difference because we can change how we prescribe and dramatically reduce the supply of opioids that are misused. We can use opportunities to, uh, educate the public about addiction being a chronic illness.

Vivek Murthy (20:53):

And we can connect people to treatment. We still have over a million people who are living with an opioid use disorder who are not getting treatment. That's a massive treatment gap, and we have to close that. So that's why we issued the letter was the first time actually in the history of our office, it's such a letter had been issued. And we got a lot of really interesting feedback from it. We heard from some doctors who took the letter and actually pinned it up in their medical conference rooms because they wanted their colleagues to learn about it. We heard from patients actually who printed that letter and took it to their doctor to make sure their doctor was aware that this was an issue. And they wanted them to be aware of it when they were treating their pain. We heard from doctors who said, wrote, wrote to us and said, you know, I knew this was a problem, but I had no idea that our profession had such a role to play in it. And we heard from many who voiced concern and frustration saying, gosh, we know now know how bad this is, but we feel there are so many roadblocks to us doing the right thing. You tell us to connect people to physical therapy and cognitive behavioral therapy is alternatives to

opioids. But a lot of times, those aren't covered, as Nora said, their copays are more expensive and more frequent for patients. And it takes more time, uh, which is a barrier, uh, for, for patients and for clinicians.

Perri Peltz (22:02):

Let's talk about the patients for a moment. You interviewed many people. I think even more than showed up in the documentary who had become addicts from your point of view, Perry, what should these people have asked their doctor when they were given these prescriptions? And there was one woman in particular in your documentary who might've asked some questions. Um, I want to add Jackie though, when you talk about the issue of color and the fact that communities of color are upset now, rightfully so saying, where was this big public health response in the past white community? White people have been upset about our documentary because everybody in the film is white. The fact of the matter is this epidemic has largely impacted white people. And the question is why, why is that? And the fact of the matter is it's complicated, but evidence suggests that when patients are black, they are undertreated for pain.

Perri Peltz (22:57):

And so they weren't getting the prescribed in the same amount that white people were. And it's oddly had this protective effect. So I'm not suggesting by any stretch that people of color aren't being impacted by this epidemic, but not in the same proportion. So that's why I'm in the film. That's what you see the Jackie, the person that you're talking about, um, is a woman named wind Doyle and Wynn is, was from Marin County, California, very wealthy family. And she, um, to the best of our research and knowledge did not have an addiction problem. Previous to her third [inaudible] third child was born. She had a suzerain section. This was in 1997, right? At kind of ground zero for what was going on. Um, in this epidemic, she was prescribed Oxycontin. She became addicted. And for 17 years battled this addiction, um, we're going to show you a clip.

Speaker 7 (23:56):

Each one of our three kids were C-sections, but the third one was a particularly hard pregnancy. So when, when I got out of the hospital, they gave her a lot of prescriptions. I mean, in a row, I had no idea that she'd been given Oxycontin or Vicodin or any of the opiates that we all know about. Now. We had no idea that there were any dangers about a month and a half after the baby was born, when was starting not to get out of bed. And that's when I started finding the pill bottles around the house, all of a sudden now there's pills all the time and there's more and more doctor visits and there's more and more trips to the pharmacy. And she's getting less and less interested in anything. She was hiding them. And she was getting them from multiple doctors, different doctors that started showing up on pill bottles.

Speaker 7 (24:54):

Doctors were just throwing pills at her. And by the end of the year, you know, she just was a totally different person, completely different. It was like Jacqueline and I, when we were dating, I had never thought about any kind of addiction or alcohol. I mean, anything. We went out a few times a week, we'd go to restaurants and drink wine. I mean, it was nothing. I mean, I never saw anything. She was driven and fun to be around. And it felt right. We had a couple of kids, she was a great mom. We were going on vacations. We were visiting family with friends overalls. We had dinner parties. She was raised really

well. She was like a track star, cross country, cheerleader. Everyone loved her. I just always looked up to her when I was little being like that is the most beautiful woman like ever.

Speaker 7 (25:56):

And I wear all of her clothes, all her jewelry. I do makeup with her ever since I was, I could walk. I feel like Christmas morning of 2000, about five or six months after baby was born. I woke her up and it had been a couple of days since she'd been up. And, uh, I got the kids out of bed and, you know, she didn't even realize it was Christmas. I asked her if she would consider going to a treatment facility and I had already talked to Betty Ford clinic down in Palm Springs. She stayed for three days and then went missing and went down and tried to find her. She checked into a motel and she was passed out. I had just no idea what was going on. She went to the second rehab facility and I figured since I could afford it at the time, maybe this place would be better. Cause it was three times as expensive. When she checked out 28 days later, she had a whole bunch of new pills and it happened all over again.

Perri Peltz (27:11):

I think that the one thing that I would say about the wind story, she obviously developed a severe opioid use disorder. Um, she went to rehab facility. She did not get drugs like buprenorphine, which I'll let the experts speak to. But the important point about when is to drive home, the point you do not necessarily have to overdose from heroin. You can overdose taking these pills. And I think too often we think that that's just not a possibility. Yes. And when did pass away? Correct? Uh, she passed away. Her kids found her, they went to wake her up and she didn't wake up and her son took her foot and tried to shake it. And it was cold. If we can, for a moment, take this from the consumer perspective, understanding how these drugs work in the brain and the body. What do you think a patient should ask a doctor when prescribed an opioid? What would your questions be?

Speaker 5 (28:06):

My questions would be, and perhaps again, coming from the science perspective, you know, how long should I take this? Um, is this, is this opioid, um, I would say, is it a full agonist or a partial agonist, which is bad in terms of my scientists, meaning does the drug bind fully, completely to all of my mule opiate receptors in my brain? Or does it partially bind to it so that we know that a lot of the, you know, the full agonist have, um, much more potent effects. Um, how long does it last in the body? Because as I said earlier, when, uh, the fast action of these opioids make them more addictive. So if, if the, if the drug, you know, goes in and out faster, those are things that can increase the addiction. Vulnerability. You know, I will bring in a science part in terms of how do the drugs change the brain because the acute pharmacology of the drug is very different from addiction.

Speaker 5 (29:08):

When we look in the brains of people who unfortunately died from, uh, opioid overdose, um, you can see there are many fundamental, um, things different in their brains and to the point where the, the shape of their DNA, that does the confirmation of your DNA, the shape of their cells, their, their neurons are different. And the sh we see that some of the shape of in way their DNA is structured, even relate to how much of the drug and their history of heroin abuse, for example. So when someone says, Oh, you can stop. You know, if you want to, you know, the whole aspect of the, your, you know, the moral, uh, their brains are changed fundamentally, it's very different. So it's, I think that that's one of the things that people need to understand. We're not talking about someone that's, uh, everybody wants to stop their addiction. Their brains have changed. So treatments have to be implemented that can help their

brain. I don't know if we can say normalize ever, but at least get back to as a level where they can better control their behavior.

Tricia Johnson (30:22):

It's Aspen ideas to go. I'm Trisha Johnson. Thanks for listening. Our featured speakers today include Nora Volkow, who pioneered the use of brain imaging to investigate the toxic effects of drugs. She leads the national Institute on drug abuse, Perry Peltz directed the HBO film warning. This drug may kill you. Former us surgeon, general, Vivek Murthy launched the turn, the tide campaign to address the nation's opioid crisis. Yasmin Hurd researches in neurobiology, underlying addiction disorders. She's a professor of psychiatry, neuroscience, and pharmacological sciences. Jackie Jad is a longtime journalist. Here's more of their conversation, which took place at spotlight health. Jackie Judd.

Speaker 5 (31:10):

Let's talk about prevention for a few moments. Uh, the back. I know when it, it, we talk about the reasons for addiction, something you talk about in addition to what Yasmine understands is emotional pain that will lead some people to this. And how does understanding emotional pain possibly help come up with a strategy for prevention?

Vivek Murthy (31:35):

You know, I'll tell you that. When, when I began my tenure as surgeon general, I began with the listening tour. So I visited small towns and big cities across the country and asked people, what could I do to be helpful? What would you like? And what I heard in this stories, uh, of, of nearly every community I went to were stories of pain, not just physical pain, but this deeper emotional pain. And I realized very quickly that we have an epidemic of chronic stress in our country that is in fact, causing people this deeper emotional pain. And here's the thing about emotional pain and physical pain is that the pathways in our brain, which allow us to interpret that, uh, you know, those emotional pain and physical pain actually overlaps. So you can actually experience a physical, emotional pain as physical pain. How many of you have ever heard the expression?

Vivek Murthy (32:18):

You know, when I got that bad news, it was like a punch in my gut, right? Like, and sometimes some of you probably felt that too, like, it feels like somebody, you know, hits you when you get some really shocking or surprising news. Uh, there are, there's an overlap here. And the reasons it's so important for us to think about is because when we're, if we try to address pain, if I have a patient who's coming to see me and they're in pain, I need to not only look for a physical injury, but I need to think about what else is happening in their life at an emotional level that may be contributing to that pain. Now, one important caveat here, many patients have had the somewhat scarring experience of having something wrong, going to the doctor and being told, Oh, don't worry. It's all in your head, right?

Vivek Murthy (33:01):

We have to be careful about that, because that is often said in a way that somewhat dismissive or pejorative, like it's not real, it's just in your head. But what I'm telling you is that what's in your head is actually very real and that it can actually influence your perception of pain. And if our, if we are simply increasing the amount of opioids people are getting in order to drive their pain down to zero, and we're not looking at the nonphysical drivers of their pain, then we're missing the boat. We're not addressing the root root cause, you know, prevention. I'm so glad you just even saying that word is important,

because if we look at what we do as a country with addiction and with other illnesses, we don't do prevention very well. And so, as we think about addiction and how we want to address addiction, we have to make prevention a priority. Then not only means improving prescribing, uh, it not only means making sure that doctors and nurse practitioners have the tools they need to treat pain safely and effectively. It also means working further upstream, looking at these emotional drivers of pain, asking ourselves the question, what is driving stress in our elderly and middle-aged folks. And even among our kids that in turn is leading them to experiment with alcohol and other drugs, and to often relapse with their addiction,

Speaker 6 (34:14):

Nora, when it comes to treatment, what do you see as the most promising developments of late? If there are any who know they are absolutely. And you know, I am I say it this way. We are lucky for opioids because we have three different classes of medications and we don't have any treatments for marijuana addiction for cocaine addiction, for methamphetamine addiction for in Caitlin's. But for opiates, we have methadone, buprenorphine and Vivitrol, and these three classes of drugs, actually, all of them interact with a meal period receptor, but they are interact in different ways. And every single story that has been done, and we found that multiple stories, all of them independently have shown. Number one, that when you treat, uh, these an individual with an opiod use disorder with any one of these medications, you not only decrease the consumption of heroin or the opioid, you actually prevent overdoses.

Speaker 6 (35:10):

You prevent criminal behavior. You prevent them from, uh, actually recycling back into the prison system and you improve the outcomes on your natal abstinence syndrome. And that's the syndrome of a baby that's born out of a mother that is consuming. And if you treat them with buprenorphine, their outcomes are much better. So that treatment, every single story shows that the treatments are improved. The outcomes are significantly improved by the use of the medications. Now, what are the challenges I was mentioned there, despite the fact that there is strong evidence that they are effective, they are not being used. And there are two things driving. The lack of utilization. One of them is the stigma and the notion and the polarized polarization in the community of people say, you're just changing one drop for the other, without a real understanding that these medications behave very differently from heroin in part, because of what Jasmine was mentioning in terms of that rapidity at which they enter and leave the brain, but also in part of own its spot.

Speaker 6 (36:12):

And so that's one, but the other one is the lack of infrastructure. We just don't have sufficient treatment programs in the United States right now to take care of so many people that are addicted to opioids. And as a result of that, they are not being treated. And there's a, another structural barrier, which is insurance program and even Medicaid, which is actually implemented differently. According to the States, may not in any, in some States provide coverage for these medications. And if they provide for coverage, they limited, for example, to two years, there's no evidence whatsoever that it justifies limiting it two years. So we have stigma, we have structural changes. And again, ultimately that need to, I think, a, a problem in all of this is the healthcare system has always stand behind of not considering addiction, part of the responsibility of not seeing it as a disease that they should be screening and treating. And I think that's why now with the CRA prices they are being brought into, how important is them for them to get engaged

Yasmin Hurd (37:12):

When you have written about the potential use of marijuana as a partial answer to this, explain that to,

Speaker 5 (37:20):

Okay. So an epidemic calls for a different way of thinking, you know, you can't, you know, Einstein's classic, the definition of insanity is doing the same thing over and over and expecting a different outcome. And we are in an epidemic yet still. We're still having the same way in which we, we think about, um, opioid addiction and how we treated. And we do need to come up with new ways for prevention and treatment. So, um, marijuana is, I hate the term now in a way medical marijuana, because I think it has gotten, uh, confused. The marijuana plant is a very complex plan. So in addition to THC, which is the part of the plant that makes everybody have the rewarding aspects of it, there are many cannabinoids and one of the cannabinoids is called cannabidiol. And that's the cannabinoid. The cannabinoid that for example, has been used for treating epilepsy and epileptic kids.

Speaker 5 (38:13):

And, um, and a number of basic research showed that can not be dial actually decreased, um, heroin seeking behavior. It, it also even for alcohol use in animal models as well, and we've done pilot studies and we just finished another one. So we'll hopefully see the results of that. Um, but we can potentially use other drugs that are non opioid drugs where you wouldn't then, um, have such diversion issues because cannabidiol does not have any rewarding effects. And so if giving cannabidiol can decrease opioid use disorder, that's something definitely, um, we're trying and looking at not only, um, cannabidiol, but other compounds that don't have an opioid component to them so that you wouldn't have to, um, the complication that nor talked about in terms of how do you treat, um, you know, hundreds of thousands of people with opioids when that, that has to be regulated and the diversion potential of opioids. So we are trying, um, we're bringing science to bear. We really tried to come up with different ways and quote unquote, medical marijuana. But when people say medical marijuana always ask them, are you talking about THC or are you talking about other cannabinoids? So we were thinking that, you know, um, four aspects of pain and aspects of opioid, um, abuse that the cannabinoids have potential I'd like to, uh,

Vivek Murthy (39:44):

Can I ask you to just add one? This is a very important, I mean, w w what you just heard from Jasmine is right. But I also want to cautious caution people against confusing what you just heard with the notion that going out and smoking marijuana relieves your pain. Yeah. Okay. And this is actually very important because many people, you know, have had the experience of smoking marijuana and say that it helps their symptoms, whether it's nausea or pain. And that very well may be for some people, but here's, the problem is if we, don't the kind of studies that you asked me, I was talking about, these are where you in carefully controlled clinical studies, you study a very specific component of marijuana, and that's very different from taking the whole plant and actually likes, and actually smoking marijuana, because you're getting actually a whole plethora of chemicals and compounds there.

Vivek Murthy (40:36):

And you're getting an, a dose that's hard to measure, maybe inconsistent between five or 10 different people who smoke marijuana. So when we come see marijuana being used for pain, for nausea, for any other medical symptom, um, my general feeling on this is we should let science drive our policy making in our practice. And that means that we need to invest more in, in studies. We have already invested a

fair amount of Ana NIH, more than I think most people know, uh, in studies, but certainly more investment in research. Reducing the barriers to doing that research, uh, is very important because there are a lot of researchers who historically have had a hard time because of the way it's scheduled and other administrative barriers. Some of those started to come down during the Obama administration, but we have more work to do. And during the Obama administration, there was also a move to increase the amount of research grade marijuana that was available for researchers to use for their study.

Vivek Murthy (41:25):

Imagine you're trying to test a drug, but each sample you're giving, uh, your research subjects has a different amount of the drug in it. How consistent is the result going to be? Well, that was the problem that many people were facing in doing research on marijuana. Is there, wasn't always the standard grade, uh, that everyone was using. So we need more research on this research or driver decision-making, but we shouldn't allow that, uh, we shouldn't use allow that to be confused with the notion that marijuana should, that we have enough evidence to say that marijuana is useful for medicinal purposes and that it should be made available for that.

Perri Peltz (41:57):

Sorry, I was just saying no clinical research, no clinical applications for treatment will ever have a smoking. Smoking is not ever going to be. And just being in Colorado, even the dispensary's, you don't know when it says cannabidiol, what is in there. In fact, people we've analyzed from different dispensers and they have very different amounts. So it's very important that it has to be evidence-based even though Nora and I were going to check out some dispensers later,

Speaker 7 (42:27):

So it was being televised and we'll be careful the scientific career. Yeah. For scientific purposes very quickly. I just want it

Perri Peltz (42:38):

That's something on, cause you asked a really important question earlier, Jackie, but I want that photo up

Speaker 7 (42:42):

By the way. But the question

Perri Peltz (42:44):

Was, what is it that you can ask your doctor? And then I want to make something really clear. Opioids are really good and effective medications for short term, acute pain. They are far less effective and I'll let the doctors speak to this when it comes to long-term chronic pain. So when you get a prescription, which may very well be the right thing to be prescribed, and it says, did you know that it's a month supply? Don't necessarily take it for a month, take it for as short a time period that you can. I very quickly, my son, it's a personal story. I had a really bad case of strep throat. We were in the emergency room. The doctor I had just started working on this film. It was a year and a half ago. The doctor prescribed him 30 Percocet. And I said to the, I said to the doctor, you know, I was working on this film and he was in a lie.

Perri Peltz (43:31):

He used to, well, I want to make sure that if your son has pain, that he'll be okay. And I said, all right, then why not? And I think it's gotten much better in the last year and a half. Why not give them a prescription for three or four or five pills? And he said, if you don't like the way I've treated your son's pain, you can give me a bad review and that can impact his license. And that changed, that changed that has changed. And the other thing that has changed is that CDC guidelines very clearly stipulated that a minimal amount of opioids should be given for the management of acute pain. And so, and that has been enforcing. And in fact, one of the things that you can see is a decrease in the total number of prescriptions that we're giving in the United States. So in my view is very slow, how we're going down, but at least it's in the right direction. But I think the message is when a doctor gives you a medication, you should always ask, regardless of whether you still it or something, what are the side effects of these medications and why should I expect to get, and how long, what is, how long do I have to take it? I think that those are very important questions

Yasmin Hurd (44:32):

That you, as a patient should be asked your doctor, be pro active. Don't just

Tricia Johnson (44:38):

Awesome. Today's speakers are Norvell co Jackie Judd, Yasmin Hurd, Vivek Murthy, and Perry pelts their conversation. The opioid tsunami was held at spotlight health in June. If you liked today's show, check out our recent episode, featuring us health and human services, secretary Tom price, he touches on federal healthcare policy, the opioid crisis, and what it's like to work with president Trump, find the episode by searching Aspen ideas to go on Apple podcasts. Now back to our featured conversation, here's Jackie Judd

Yasmin Hurd (45:28):

Perry raises a good point though, to emphasize that opioids do have a place in a doctor's toolkit. The, do you have any concern that the pendulum may swing too far in the other direction? And doctors will be reluctant to prescribe that when a patient needs it in a safe way, that they won't be prescribing when it's truly needed.

Vivek Murthy (45:48):

So I am concerned about the pendulum swinging to the other extreme, where people who actually would benefit from opioids, aren't able to get them. And we've already seen that start to happen. We have emergency rooms that are putting signs outside saying we don't dispense opioids here. We have doctor's offices. We're increasingly saying, you know what? It's just too complicated dealing with these opiates. We're just not going to prescribe them at all. So that is already happening to some extent, and it's understandably worrying. Uh, some people who recognize that opioids have been helpful for them or their family members, and they want to make sure that we don't swing to the other extreme. So, so that's a real thing. Uh, but the way that we're going to get to a balance most quickly is it both patients and healthcare practitioners are both informed and are educating and are working together on this.

Vivek Murthy (46:33):

There's an analog here to the antibiotics. You know, for years, we've been talking about the problem we have in the United States and around the world with the overuse of antibiotics and particularly with, uh,

in pediatrics, when young kids get ear infections and they go to the doctor, it often used to be standard fare that every year infection you would basically get antibiotics until we realized that actually much of the time you don't need antibiotics. And that was helping to fuel the overprescription. Well, what helped it shift us toward a safer prescribing? Well, it was a combination of educating doctors, but also educating patients so that people would go to their doctor. If a doctor wasn't as fully informed and tried to give them an antibiotic, they could say, wait, can we pause for a moment and see if my child really needs these antibiotics? And sometimes the answer is yes, actually they really do.

Vivek Murthy (47:17):

But at least that conversation took place. Similarly with opioids, we need to do the same thing. If you are going to your doctor and getting a 30 day supply of opioids for acute pain, there is something wrong. Yes. Okay. So you should pause at that moment and ask the question. Do I really need this much, uh, because what we were recommending and what the CDC was also, uh, recommending as well and their guidelines is, is to start low and to go slow. When it comes to opioids for acute pain, a prescription that covers three days is usually sufficient. Uh, we're used to just prescribing it for a longer period of time, but three days is actually quite a reasonable initial prescription. And you should then try to get off the opioids and get on to other things where if you need more opioids coming back to check in with your doctor to be examined. So your doctor can look for warning signs or their sources of concern is incredibly important. Okay.

Speaker 6 (48:07):

I make a point here because I think this is also very important in, in just reiterating this issue. The problem of the, uh, the use of opioids for longer term brain is that you rapidly become tolerant to at the analgesic effects of the opioids. And this means that to achieve the same level of analgesia, you will require higher and higher and higher doses of the opiate, which increases the risk of overdose and addiction. But the other side about opioids, when you give them repeatedly is that they make you more sensitive to pain. And this is known in the medical world as hyperalgesia. And it makes it very difficult to handle a patient with chronic pain that still complaints of, of pain that has opioids, because physicians may actually increase the dose and that exacerbates rather than improve the pain. And in many instances, when they withdraw the opioids, the pain actually improves. So opioids has that ability also of making your body much more sensitive to pain sensation. And, and again, that's another one of the reasons why, uh, opioids are not good medications for chronic management of pain.

Yasmin Hurd (49:09):

Before we open it up to questions from all of you. I wanted to ask two more questions. Um, one the news of the day, the Senate released its healthcare plan yesterday. There were a couple of senators, including Rob Portman from Ohio, who very much was advocating for, um, a discreet amount of money to be used for opioid treatment because of the Medicaid cutbacks. He felt that would be necessary ended up in the, in the draft with $2 billion. What does that get you Nora?

Speaker 6 (49:46):

Well, I think that I actually 2 billion daughters, and again, I'm always very grateful for the notion of bringing money that can improve, uh, treatment. My concern is, first of all, um, is that sufficient number one and two? How do you deploy those resources? And number three, what is treatment? One of my concerns in the treatment of substance use disorders, including opiod use disorders is that we have no standards for quality of treatment. So anyone can go. And I actually in, is pointed out here in, uh, in sort

of in a way that he says, because it's more expensive, it's going to be better. It's not necessarily. And again, one of the things that we're trying to engage, uh, changes structured that structural changes that are needed is not just to put money, but to actually put money on treatments for which there is evidence, and to create a mechanism that you can feed back in terms of the outcome.

Speaker 6 (50:39):

So if you're going to have heart surgery, you can look at what are the right course of the hospital or the surgeon you are going on and make that selection on the basis of that in the treatment of opioid use disorders, there's nothing like that. And patients don't know, or their family work to go through. And they sometimes feel because it's more expensive, it's going to be very better. So we need to, in addition to putting resources, to actually create an infrastructure that will be demanding quality of care, and we'll make that reimbursement, contingent contingent on those measures. And I also think that in this, as we deploy these resources, we need to bring forward the healthcare system to be actively participant, but our primary care physicians, the emergency departments, neonatalogist decisions, pain physicians are not trained to deal with a substance use disorder of their patients. So we need to engage them and make them able to participate in screening on 3d and fi yes, go ahead.

Vivek Murthy (51:37):

This is an important point here. If you take coverage away from 20 million plus people, including millions of people who are struggling with addiction, and you try to put a few billion dollars into a fund for opioid treatment, that is absolutely insufficient. Absolutely. [inaudible] it's like me taking your car away, giving you a bike and telling you to get to the airport in the same amount of time, because, Hey, you have a mode of transportation. It doesn't work like that. If you spend time on the ground with people who are struggling with addiction and follow the course of their treatment, what you recognize is that to treat somebody who is struggling with addiction, to get them to a place where they can live fulfilling lives, where they can contribute to society who can contribute to their family and they can be content, you need to treat their entire health.

Vivek Murthy (52:32):

People with addiction are often struggling also with anxiety, with depression, with other chronic illnesses like diabetes and heart disease. If you take away coverage from them and you remove their ability to get care for all of those other conditions, and while you might be providing a little bit of extra funds to try to cover some of their addiction care, their inability to care for their other conditions is ultimately going to impact their ability to ultimately deal with their struggles with addiction. So it's important that we realize that this is not a simple math problem where you can move things around, you know, and I take a little bit of money out of here and put a little bit money out there. Coverage is incredibly important for the quality of life and for the quantity of life that we experience. And so this is important for us because this should not be a partisan issue.

Vivek Murthy (53:19):

You know, I, I, you know, practice medicine in Massachusetts, which took steps under a Republican governor Romney to make healthcare coverage universal. And I practiced both before and after that law was implemented. And I saw firsthand that coverage does in fact save people's lives. The young woman, I saw the woman, I saw it. I remember as a resident who came in with advanced breast cancer, uh, and it was advanced in the sense that she had noticed a lump a year ago, but hadn't sought attention for it because she didn't have coverage. It got bigger and bigger until the finally broke through her skin and

became infected. And when we saw her in the emergency room that night, we had this horrible, sinking feeling that she had likely advanced breast cancer and that the treatment options that would have been available six months ago, or nine months ago were no longer available. I saw fewer patients like that after universal health care was implemented Massachusetts. This is why coverage is so important. And if we do, if we do not continue to advance the coverage of people in America, we will move backward when it comes to addressing addiction. That's how fundamental coverage is. Thank you all for being a great audience. And I want to really thank you.

Tricia Johnson (54:32):

Each of you, it was such a rich conversation about an important subject. Vivek Murthy served as us surgeon general under president Obama, Nora Volkow leads the national Institute of drug abuse at the national institutes of health. Jackie Jad reports on domestic policy for the PBS news hour. Perry pelts is a journalist and documentary filmmaker and Yasmin Hurd leads the addictive Institute for Mount Sinai health system. Their conversation was held in June at spotlight health. The three-day symposium that kicks off the Aspen ideas festival, make sure to subscribe to Aspen ideas, to go on Apple podcasts or wherever you listen to podcasts. Follow the Aspen ideas festival year-round on Twitter and Facebook at Aspen ideas. Today's show was produced by Marcy Krishnan and me and recorded by our team at the Aspen Institute. I'm Trisha Johnson. Thanks for joining me.