President's Commission on Combating Drug Addiction and the Opioid Crisis
Friday, June 16th

My name is Joseph Parks. I am a board-certified Psychiatrist. I am the medical director for the National Council for Behavioral Health and I also treat patients on a weekly basis at a federally qualified health center. I previously served as both head of Missouri's mental health division and Missouri's Medicaid agency. My brother has struggled all his life with serious mental illness and addictions.

Our friends, family members, and fellow citizens are dying at an increasing rate from the two great epidemics of our generation: the opiate addiction epidemic and the suicide epidemic. Both continue to increase at alarming rates because we have not dedicated the same attention, effort, and resources that we did to the other great killers we've successfully fought back: polio, measles, heart disease, stroke, and cancer. Infectious diseases, cardiovascular diseases, and cancer. Every day, an estimated 121 Americans die by suicide[1] and 91 die from an opioid overdose[2]. We can and must do better. We must muster the same determination to make significant changes of practice, statute, and funding in fighting the opiate and suicide epidemics that we used to successfully combat previous epidemics.

We must be vigilant in our communities. Every American should know how to recognize when someone is in distress from an addiction or mental illness – and should know how to ensure they get help. Federal and local support for Mental Health First Aid should be continued and expanded.

Many persons with opiate addiction also face chronic pain or a mental illness, so successful treatment of addiction often requires concurrent treatment of those conditions. In the Epidemiologic Catchment Area Study, an estimated 72% of people with a drug use disorder had at least one co-occurring psychiatric disorder. In opiate addiction, rates of lifetime depression range from 16% to 75%.

To fight an epidemic, you must systematically screen for the illness and ensure those who screen positive have prompt access to effective treatments. We must monitor and screen for addictive disorders. Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. SBIRT should always be a covered benefit and all hospitals, emergency rooms, and clinics should provide SBIRT systematically.

Everyone must have health care coverage for addictions and mental illnesses. We must redouble our efforts to expand affordable coverage and require that all forms of coverage have comprehensive parity requirements that are systematically and firmly monitored and enforced.

- Health care legislation should expand parity requirements to all forms of health care coverage from all payers.
- Health care legislation should mandate coverage of treatments for addictions and mental illnesses.

Medicaid is the largest national payer for mental illness and addictions treatment. To successfully fight back the epidemics of suicide and addiction, Medicaid must continue as an entitlement. Since the

---

[1] AFSP. https://afsp.org/about-suicide/suicide-statistics/

[2] CDC. https://www.cdc.gov/drugoverdose/epidemic/

majority of increased opiate deaths and suicides occur in young and middle-aged adults, Medicaid expansions must be maintained and completed.

- Medication is proven to be effective in treating opioid addiction. Those drugs – interventions like methadone, buprenorphine, and naltrexone including Vivitrol – need to be categorized as a protected medication class in Medicaid and Medicare part D, requiring their open access on formularies.
- We must have laws and regulations exempting addiction treatments and mental health treatments from deductibles and co-pays.

All people must have access to clinicians who know how to treat and are willing to treat mental illnesses and addictions.

- We must expand Certified Community Behavioral Health Centers beyond the current demonstration limited to only eight states for two years. This will ensure access with care coordination to evidence-based outpatient treatment capacity that includes medication assisted treatment.

- We must expand the DATA 2000 waivers to continue recruitment and training of physicians, physician assistants, and nurse practitioners and to incentivize uptake in buprenorphine prescribing with continued post-training support

- We must provide resources for case based ECHO training programs nationally on MAT for Addiction and Treatment of Chronic Pain

- We need the DEA follow through on its telemedicine guidelines, and certification to prescribe controlled substances via telemedicine

- DEA Certification to prescribe controlled substances should require recent CME on preventing, screening, diagnosing and treating addiction to prescription medications, including treatment with MAT medications.

- We need educational loan forgiveness for members of the National Health Service Corps working in addiction treatment agencies, the same as is currently provided in mental health and primary care agencies.

- Professional schools (medical, nursing, social work, public health, etc.) should require expanded curriculum in addiction treatment and its integration with the rest of the healthcare workforce.

- CMS certification and accreditation of hospitals, person centered medical homes, FQHCs and health homes should require provision of SBIRT, MAT and addiction treatment availability.

- We must uphold current policies that encourage jail diversion from incarceration for those already in the criminal justice system. We must continue to build alliances between treatment providers and law enforcement to create collaborative deflection programs to prevent entry into the criminal justice system, drug court treatment programs, and to assure appropriate sentencing for addicted individuals

Enforcement of parity must include payment and rate parity. Many addiction and mental health treatment provider organizations report that they limit addiction and mental health and treatment services due to the rates being so low that they lose money and must cover those losses from other lines of treatment. Some hospitals and clinics have closed their mental illness and addiction services due to inadequate rates to cover the cost of providing the treatment. Mental illness and addiction treatment rates must be reset to be consistent with the current actual market costs of providing the treatments.

Enforcement of access and network adequacy standards for addiction and mental illness treatment should be done by systematic regular secret shopper surveys to reduce the all too common errors and "shadow networks" listed on payer websites and in department of insurance filings.

We must develop and fund models for a full, comprehensive continuum of care in the public sector: short-term residential and detox, longer-term residential treatment for chronic relapsers, recovery housing and other recovery support services to support outpatient treatment.

We must expand youth intervention and treatment of cannabis and alcohol because it is also opioid addiction prevention, and encourage youth prevention and early intervention collaborations between primary care that reinforce the message that no amount of substance use is safe for teens.

Finally, speaking individually and not in my role as Medical Director for the National Council of Behavioral Health, we must change 42 CFR part 2 and state laws that put more restrictions on addiction treatment information than on other healthcare information. The only additional restriction should be not allowing addiction treatment information to be used for arrest or prosecution. We can never succeed in fighting an epidemic by hiding information about the disease and treatment history from healthcare providers. Keeping a prior diagnosis and treatment history of addictive disorders secret deprives that person of the extra care and attention healthcare professionals routinely give to someone who has a known prior condition and makes early detection and treatment of relapse much less likely.