



Interdisciplinary Leaders in
Substance Use Education,
Research, Care and Policy



ADDRESSING ACCESS TO CARE IN THE OPIOID EPIDEMIC AND PREVENTING A FUTURE RECURRENCE

April 27, 2020

The non-profit organizations representing the front-line clinicians serving the patient population with opioid use disorder (OUD) and co-occurring mental illnesses submit this White Paper to inform discussions among litigants regarding settlement of the National Prescription Opioid Litigation (MDL) in a manner that is meaningful for those who have most suffered as a result of the Opioid Crisis – the patients and families impacted by addiction. As set forth herein, those suffering from substance use disorders (SUDs) including OUD and co-occurring mental illnesses need access to evidence-based care, which is woefully lacking in the United States. This crisis cannot be overcome without (1) expanding our addiction workforce; (2) increasing the adoption of clinical best practices; and (3) enforcing mental health parity and consumer protection laws at the state level. Settlement of this litigation and use of resulting funds to bolster these three efforts would ensure significant progress toward recovery for people with OUD and prevention of another such crisis in the future. This White Paper provides strategies to accomplish this laudable goal which we are committed to working with states and the litigants to achieve.

I. EXECUTIVE SUMMARY

To help remedy the health and economic damage caused by the non-medical and inappropriate medical use of opioid analgesic medications, we recommend the following three strategies to improve access to evidence-based services for the prevention and treatment of addiction and mental illness.

A. EXPANSION OF THE ADDICTION WORKFORCE

There is a dire need to expand the addiction specialist and psychiatry workforce as well as train primary care clinicians to diagnose and treat addiction. There are insufficient numbers of addiction specialist physicians, addiction psychiatrists, general psychiatrists, nurses, physician assistants,

and other skilled clinicians to meet the current need for substance use and mental health disorder treatment. Further, most healthcare professionals do not receive basic instruction or gain experience in addiction prevention and treatment during their training.

Funding is needed to grow the specialty workforce by integrating substance use and addiction-related content into curricula preparing these future healthcare professionals, supporting training/fellowship programs, and incentivizing clinicians to work in programs and practices that specialize in the prevention and treatment of substance use and/or mental health disorders. Mechanisms to expand capacity may include financial incentives, such as salary support for recruitment bonuses and/or loan repayment initiatives. Existing consultation, mentorship, and training programs that have proven effectiveness in expanding clinician capacity and competence to prevent and treat addiction and mental illness also need to be expanded.

B. INCREASED ADOPTION OF CLINICAL BEST PRACTICES

Treatment programs and clinicians must be trained in and required to practice according to evidence-based practices, including training in FDA-approved medications for OUD treatment. Treatment programs and clinicians need access to and training in nationally recognized guidelines and standards for the treatment of addiction and mental illness to increase the effectiveness of available treatment services in the community and criminal justice system – the de facto treatment provider for millions of people with addiction and mental illness. Additional investments in electronic health records need to be made; better data needs to be collected for research, and quality measurement implemented in order to follow progress, enhance research, and improve treatment outcomes.

C. ENFORCEMENT OF MENTAL HEALTH AND ADDICTION PARITY AND CONSUMER PROTECTION LAWS

Access to addiction treatment and mental health care is frequently hindered by insurance company policies that discriminate against patients with addiction and/or mental illness. These policies, such as lower reimbursement rates for addiction specialists and psychiatrists or non-reimbursement for care delivered by other healthcare providers, medical necessity criteria that do not conform to nationally recognized standards of care, and onerous utilization management requirements, leave patients without options for in-network providers or appropriate levels of care for their condition. Resources are needed to fund state and local enforcement of existing laws that require insurers to provide the services that are owed to their beneficiaries and to provide those health care services in a non-discriminatory manner.

II. INTRODUCTION TO THE AUTHORS

The **American Psychiatric Association (APA)** is a non-profit organization representing over 38,800 physicians who specialize in the practice of psychiatry. APA members engage in research into and education about diagnosis and treatment of mental health and substance use disorders, and are front-line physicians treating patients who experience mental health, substance use and other physical illnesses, many of which are co-occurring. Many of APA's members have been at the forefront of treating patients with OUD and the co-occurring, underlying, and resulting mental health disorders. APA is interested in providing information to the Court and the parties that may be helpful in resolving the current crisis and preventing a recurrence.

The **American Academy of Addiction Psychiatry (AAAP)** is a non-profit corporation representing almost 1800 addiction psychiatrists, physicians, and related health professionals committed to evidence-based clinical practices in the prevention and treatment of SUDs and co-occurring mental illness. With mental illness comorbidity at approximately fifty percent,

assuring that every patient with an addictive disorder has psychiatric evaluation and treatment is essential to promote sustained recovery. AAAP members are on the front lines of the opioid crisis treating OUD and co-occurring mental illness, training the next generation of physicians and health professionals, and performing cutting-edge research to improve addiction prevention, treatment, and recovery. AAAP is ideally positioned to provide information to the Court and the parties that may be helpful in resolving the current crisis and preventing its recurrence.

The **American Academy of Child and Adolescent Psychiatry (AACAP)** is headquartered in Washington, DC. With 9,600 members, AACAP is the leading national medical specialty organization dedicated to improving the quality of life for youth who are affected by mental illnesses. AACAP's mission is to promote the healthy development of children, adolescents, and families through advocacy, education, and research, and to meet the professional needs of child and adolescent psychiatrists throughout their careers. Many AACAP members are on the frontlines of treating patients with SUD and related mental health issues.

The **American College of Academic Addiction Medicine (ACAAM)** is a non-profit organization that advances the prevention and treatment of SUDs, including OUD, through expansion and support of physician training programs to address workforce shortages in the subspecialty of addiction medicine. ACAAM was the facilitating organization that brought the field of addiction medicine into formal recognition by the American Board of Medical Specialties and by the Accreditation Council for Graduate Medical Education – thus making addiction prevention and treatment a now fully accepted area of practice within medicine and health care. ACAAM promotes academic excellence and leadership in evidence-based addiction medicine by expanding and enhancing fellowships and by supporting the educational and professional activities of fellowship directors, faculty and fellows. ACAAM has specialized

insight into the need for and creation of programs to expand the workforce needed to treat those afflicted with addictions.

The **American Society of Addiction Medicine (ASAM)**, founded in 1954, is a professional medical society representing over 6,000 physicians, clinicians, and associated professionals in the field of addiction medicine. ASAM is dedicated to increasing access and improving the quality of addiction treatment, educating physicians and the public, supporting research and prevention, and promoting the appropriate role of physicians in the care of patients with addiction.

The **Association for Multidisciplinary Education and Research in Substance use and Addiction (AMERSA)** is a non-profit professional organization founded in 1976, whose mission is to improve health and well-being through interdisciplinary leadership in substance use education, research, clinical care, and policy. One of AMERSA's key goals is to improve education and clinical practice in the identification and management of substance-related problems by promoting leadership, mentorship, and collaboration among multiple healthcare professions including, but not limited to, physicians, nurses, social workers, psychologists, dentists, pharmacists, and public health professionals (hereafter "Health Care Professionals.>"). This goal is exemplified in the development and publication of substance use-related competencies for Health Care Professionals.¹

The **International Society of Addiction Medicine (ISAM)**, created in 1999, is an organization constituted of professional medical practitioners, physicians, and clinicians from 93 countries. ISAM as its mission has developed activities to bridge evidence with international practice. ISAM members are involved in research, education, policy and guideline development

¹ See <https://www.tandfonline.com/toc/wsub20/40/4?nav=toCList>.

and front-line treatment of individuals with OUD. ISAM works closely with the World Health Organization in providing global leadership and guidance about prevention and treatment of SUDs. ISAM is interested providing information to the Court and the parties that may be helpful in resolving the current crisis and preventing its recurrence.

III. BACKGROUND

A. Access to Care-Scope of the Problem

1. Opioid Use Disorder and Access to Care

In 2018, approximately 1.6 million adults in the United States had an OUD and 7.7 million adults misused opioids in the past year, with most of these adults having misused prescription pain relievers.² Additionally, approximately 108,000 adolescents aged 12-17 and 312,000 young adults aged 18-25 had an OUD in 2018.³ Data from the Centers for Disease Control and Prevention (CDC) indicate that there were 67,367 drug overdose deaths in 2018 – approximately 184 per day – and opioids were involved in 46,802 (69.5%) of all drug overdose deaths.⁴

In 2016, only 17.5% of the 2.1 million people in the United States diagnosed with a SUD related to prescription opioid pain medication received treatment, despite a five-fold increase in overdose deaths linked to prescription opioid pain medications from 1999-2016.⁵ More broadly,

² *Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, Aug. 2019, at 23-24, <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf>.

³ *Id.* at 39.

⁴ *Drug Overdose Deaths*, CENTERS FOR DISEASE CONTROL AND PREVENTION, <https://www.cdc.gov/drugoverdose/data/statedeaths.html> (last updated Mar. 19, 2020).

⁵ National Institute on Drug Abuse, National Institutes of Health, Medications to Treat Opioid Use Disorder, <https://www.drugabuse.gov/publications/research-reports/medications-to-treat-opioid-addiction/overview> (last updated June 2018).

approximately 21.2 million people aged 12 or older needed SUD treatment in 2018; however, **only 3.7 million (17.45%) people who needed treatment received it, while 17.5 million (82.55%) did not.**⁶

2. Mental illness and Access to Care

In 2018, approximately 47.6 million adults aged 18 or older, or 19.1% of all adults had a mental illness.⁷ Included in this number is an estimated 11.4 million adults, or 4.6% of all adults, who had a serious mental illness.⁸ **Among the 47.6 million adults aged 18 or older with a mental illness in 2018, only 20.6 million (43.3%) received mental health services.**⁹

Additionally, in 2018, about 7.3 million (64.1%) of the 11.4 million adults with a serious mental illness received mental health services.¹⁰ Among adolescents aged 12-17 in 2018, 3.9 million (16%) received mental health services in a specialty mental health setting (inpatient or outpatient care), and 767,000 (3.1%) received mental health services in a general medical setting.¹¹

3. Comorbidity of Substance Use and Mental Health Disorders

SUDs often coexist with mental illness.¹² There is a set of common risk factors that contribute to both mental illness and SUDs, including genetic and epigenetic vulnerabilities and environmental influences, such as chronic stress, trauma, and adverse childhood experiences.¹³

⁶ *Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health*, *supra* note 2, at 3.

⁷ *Id.* at 2.

⁸ *Id.*

⁹ *Id.* at 59.

¹⁰ *Id.* at 4.

¹¹ *Id.* at 57.

¹² National Institute on Drug Abuse, National Institutes of Health, Common Comorbidities with Substance Use Disorders, <https://www.drugabuse.gov/publications/research-reports/common-comorbidities-substance-use-disorders/introduction> (last updated Apr. 2020).

¹³ *Id.*

Certain mental illnesses are established risk factors for developing a SUD due to associated changes in brain activity.¹⁴ Inversely, substance use and addiction can contribute to the development of a mental illness as drug use that precedes the first symptoms of a mental illness may catalyze changes in the brain structure that can trigger an already existing, underlying predisposition to another mental illness.¹⁵ About 50% of those who experience a mental illness during their lifetime will also experience an SUD, and vice versa.¹⁶

Relative to the general population, the prevalence rates of psychiatric diagnoses are disproportionately high in substance use treatment samples reporting nonmedical prescription opioid use. One study showed that 43% of patients receiving SUD treatment for nonmedical use of prescription opioids also had a diagnosis, or exhibited symptoms, of another mental illness – most notably depression (27%) and anxiety (29%).¹⁷ Comprehensive and integrated therapy is needed to address the comorbidity of SUD and mental illness; however, **only about 18% of SUD treatment programs and 9% of mental health treatment organizations have the capacity to serve dually diagnosed patients.**¹⁸ In 2018, 48.6% of adults with a co-occurring mental illness and SUD, and 30.5% of adults with a co-occurring serious mental illness and SUD, did not receive either type of care.¹⁹

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ Elliot M. Goldner, Anna Lusted, Michael Roerecke, Jürgen Rehm, Benedikt Fischer, *Prevalence of Axis-I Psychiatric (with Focus on Depression and Anxiety) Disorder and Symptomatology Among Non-Medical Prescription Opioid Users in Substance Use Treatment: Systematic Review and Meta-Analyses*, 39, *Addictive Behaviors*. 520 (2014).

¹⁸ National Institute on Drug Abuse, *supra* note 12.

¹⁹ *Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health*, *supra* note 2, at 4.

Finally, it is important to note that psychiatric illness and suicide are frequently interconnected. Mental health and SUDs are one of several factors that can contribute to suicide. People with OUD are 13 times more likely than those who do not have the disorder to die by suicide.²⁰

4. *The Addiction Workforce Shortage*

There is a national shortage of psychiatrists and primary care providers in general, and of addiction, and child and adolescent psychiatrists and addiction medicine subspecialists in particular. Similar shortages exist throughout the addiction workforce, including nurses, physician assistants, psychologists, and social workers. These shortages are most deeply felt outside of big cities and in rural areas. Thus, even where healthcare provider surpluses exist, differences in provider distribution may mask local healthcare shortages.

In 2017, there were only about 4,400 actively practicing certified addiction specialist physicians (addiction medicine and addiction psychiatry) in the United States – far below the 6,000 that were needed based on a 2009 estimate, long before the peak of the opioid overdose epidemic.²¹ Additionally, **only 72²² of the nation’s 172 accredited medical schools²³ offer**

²⁰ Holly C. Wilcox, Kenneth R. Conner, Eric D. Caine, *Association of Alcohol and Drug Use Disorders and Completed Suicide: An Empirical Review of Cohort Studies*, 76, Drug and Alcohol Dependence. S11 (2004).

²¹ THE PRESIDENT’S COMMISSION ON COMBATING DRUG ADDICTION AND THE OPIOID CRISIS, Nov. 2017, at 76, https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf.

²² *Number of Accredited Programs by Academic Year 2019-2020*, ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION, <https://apps.acgme.org/ads/Public/Reports/Report/3> (last visited Mar. 20, 2020).

²³ *AAMC Medical School Members*, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, <https://members.aamc.org/eweb/DynamicPage.aspx?webcode=AAMCOrgSearchResult&orgtype=Medical%20School> (last visited Apr. 13, 2020).

addiction medicine fellowships²⁴, and only 54 offer addiction psychiatry fellowships.²⁵

Further, there should be approximately 14.7 psychiatrists per 100,000 people to ensure access to quality care.²⁶ All but six states fall well below this ratio and the national average is only 9.35 psychiatrists per 100,000.²⁷ **Only 1.1 percent of this group is trained in addiction medicine.²⁸** For child and adolescent psychiatry, a minimum of 47 per 100,000 children aged 0-18 is needed, with every state being in severe to extreme shortage, and most U.S. counties having zero child and adolescent psychiatrists.²⁹ Primary care practitioners also have contributed significantly to the addiction workforce in recent years, but demand chronically exceeds supply. The national shortage of primary care physicians is projected at more than 23,640 FTEs by 2025.³⁰

²⁴ *Number of Accredited Programs by Academic Year 2019-2020*, *supra* note 22.

²⁵ *Id.*

²⁶ *Id.* at 10.

²⁷ *Id.* at 8.

²⁸ *Id.* at 14.

²⁹ *Workforce Maps by State*, AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY, https://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx (last updated Mar. 2018).

³⁰ *National Projections of Supply and Demand for Selected Behavioral Health Practitioners: 2013-2025*, NATIONAL CENTER FOR HEALTH WORKFORCE ANALYSIS, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, Nov. 2016, <https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/behavioral-health2013-2025.pdf>.

Percent of Mental Health Need Met Per State³¹

<u>Location</u>	<u>Total Mental Health Care HPSA Designations³²</u>	<u>Percent of Need Met³³</u>	<u>Practitioners Needed to Remove HPSA Designation³⁴</u>
Alabama	63	24.14%	156
Alaska	269	22.98%	10
Arizona	212	11.15%	181
Arkansas	48	33.00%	61
California	544	29.20%	405
Colorado	77	31.39%	123
Connecticut	32	15.18%	56
Delaware	9	19.15%	15
District of Columbia	9	5.31%	28
Florida	202	15.90%	376
Georgia	95	39.14%	188
Hawaii	27	19.83%	25
Idaho	64	24.19%	53
Illinois	171	23.69%	215
Indiana	92	35.27%	155
Iowa	115	38.36%	51
Kansas	131	32.46%	53
Kentucky	131	30.33%	114

³¹ *Designated Health Professional Shortage Areas Statistics: Designated HPSA Quarterly Summary, as of Sept. 30, 2019*, BUREAU OF HEALTH WORKFORCE, HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA), U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES, Sept. 30, 2019, <https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

³² *Id.* Total Mental Health Care HPSA Designations represents areas and population groups within the United States that are experiencing a shortage of mental health professionals. For mental health, federal regulations stipulate that the population to provider ratio must be at least 30,000 to 1 (20,000 to 1 if there are unusually high needs in the community).

³³ *Id.* Percent of Need Met is the number of psychiatrists available to serve the population of the area, group, or facility divided by the number of psychiatrists that would be necessary to eliminate the mental health care HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).

³⁴ *Id.* Practitioners Needed to Remove HPSA Designation is the number of additional psychiatrists needed to achieve a population-to-psychiatrist ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated) in all designated mental health care HPSAs.

Louisiana	153	25.25%	161
Maine	60	33.00%	29
Maryland	41	34.80%	46
Massachusetts	57	32.19%	17
Michigan	299	22.88%	209
Minnesota	107	33.87%	75
Mississippi	83	26.96%	272
Missouri	266	3.68%	143
Montana	113	12.14%	71
Nebraska	101	50.97%	26
Nevada	59	35.39%	111
New Hampshire	22	45.19%	3
New Jersey	35	69.84%	13
New Mexico	85	12.72%	79
New York	170	21.07%	306
North Carolina	184	14.98%	149
North Dakota	76	18.75%	20
Ohio	115	39.67%	107
Oklahoma	150	28.72%	72
Oregon	124	21.69%	74
Pennsylvania	131	38.42%	101
Rhode Island	12	69.51%	9
South Carolina	71	35.08%	108
South Dakota	71	11.67%	35
Tennessee	84	11.39%	367
Texas	419	36.91%	547
Utah	55	46.66%	87
Vermont	20	---	---
Virginia	75	42.76%	106
Washington	187	12.23%	150
West Virginia	109	17.37%	122
Wisconsin	148	32.92%	107
Wyoming	30	31.46%	25
United States	6069	27.24%	6166

Addiction specialist physicians lead teams working in collaboration with other Health Care Professionals and other physician members of the interdisciplinary health care team.³⁵ In 2013, psychiatrists, clinical, counseling, and school psychologists, substance use and behavioral disorder counselors, mental health and substance use social workers, and mental health counselors all had estimated shortages of more than 10,000 full time equivalents (FTEs).³⁶ The demand for these behavioral health practitioners is expected to exponentially grow over the next several years. By 2025, an infusion of all types of qualified behavioral health practitioners will be needed to address the needs of the national population; however, shortages of greater than 10,000 FTEs continue to be projected for most types of behavioral health practitioners by 2025, and shortages of approximately 250,510 FTEs will exist in total.³⁷ Unless those gaps are filled, access to timely, evidence-based care will be further limited.³⁸

B. The Staggering Cost of Untreated Substance Use Disorders and Co-Occurring Mental Illnesses

Mental illness and SUDs can adversely impact multiple areas of employee performance, including focus and decision making, time management, physical tasks, social interactions, and communication. Depression is the leading cause of disability worldwide, and employees with depression miss an average of 31.4 working days per year and lose another 27.9 work days to unproductivity.³⁹ This costs the United States an average of \$210.5B per year in absenteeism,

³⁵ *National Projections of Supply and Demand for Selected Behavioral Health Practitioners: 2013-2025*, *supra* note 30.

³⁶ *Id.*

³⁷ *Id.*

³⁸ *Id.*

³⁹ *The Depression Calculator for Employers*, CENTER FOR WORKPLACE MENTAL HEALTH, <http://www.workplacementalhealth.org/depressioncalculator/> (last visited Apr. 9, 2020).

reduced productivity, and medical costs.⁴⁰ Additionally, nearly 1 in 10 United States workers will struggle with dependence or SUDs each year.⁴¹ Misuse of tobacco, alcohol, and illicit drugs has cost more than \$740B annually in costs related to crime, lost work productivity, and health care.⁴² Furthermore, the White House Council of Economic Advisers estimated the opioid crisis alone cost the United States \$696B in 2018 – or 3.4 percent of GDP – and more than \$2.5T from 2015 to 2018.⁴³

Additionally, nearly 2 million people with a serious mental illness are arrested each year, and almost three-quarters of them also have SUDs.⁴⁴ Moreover, 85% of the prison population has an active SUD or were incarcerated for a crime involving drugs or drug use.⁴⁵ This makes the correctional system the nation’s primary provider of inpatient psychiatric care⁴⁶; however, a survey of prison medical directors suggested that most are not aware of the benefits of using medications with treatment, and when treatment is offered, it usually consists of only behavioral counseling and/or detoxification without follow-up treatment.⁴⁷ In 2017, approximately \$918M

⁴⁰ *Id.*

⁴¹ *Substance Use Disorder Calculator*, CENTER FOR WORKPLACE MENTAL HEALTH, <http://www.workplacementalhealth.org/Making-The-Business-Case/Substance-Use-Disorder-Calculator> (last visited Apr. 9, 2020).

⁴² National Institute on Drug Abuse, National Institutes of Health, Trends & Statistics, <https://www.drugabuse.gov/related-topics/trends-statistics#supplemental-references-for-economic-costs> (last updated Feb. 2020).

⁴³ *The Full Cost of the Opioid Crisis: \$2.5 Trillion Over Four Years*, WHITEHOUSE.GOV, Oct. 28, 2019, <https://www.whitehouse.gov/articles/full-cost-opioid-crisis-2-5-trillion-four-years/>.

⁴⁴ *The Stepping Up Initiative*, AMERICAN PSYCHIATRIC ASSOCIATION FOUNDATION, <https://apafdn.org/impact/justice/the-stepping-up-initiative> (last visited Apr. 9, 2020).

⁴⁵ National Institute on Drug Abuse, National Institutes of Health, Criminal Justice, <https://www.drugabuse.gov/publications/drugfacts/criminal-justice#ref> (last updated June 2019).

⁴⁶ *The Stepping Up Initiative*, *supra* note 44.

⁴⁷ Alan I. Leshner and Michelle Mancher, *Medications for Opioid Use Disorder Saves Lives*, NATIONAL ACADEMIES OF SCIENCES, ENGINEERING, AND MEDICINE, 2019, <https://www.nap.edu/catalog/25310/medications-for-opioid-use-disorder-save-lives>.

was spent by law enforcement nationwide in transporting people with serious mental illness.⁴⁸ In 2016, the Federal Bureau of Prisons (BOP) spent about \$72M on psychology services, \$5.6M on psychotropic drugs, and \$4.1M on mental health care in residential reentry centers.⁴⁹

Furthermore, the estimated cost to American taxpayers is \$15B per year to house individuals with psychiatric disorders in jails and prisons.⁵⁰

In 2014, the average cost for a hospitalization in the United States ranged from approximately \$5,000 to almost \$9,000 per stay for patients with serious mental illness – despite a general absence of procedures or surgeries during these hospitalizations.⁵¹ Total hospital costs to the U.S. health care system related to opioid overdoses alone have been estimated at more than \$11 billion annually in 2018.⁵² The total cost for serious mental illness hospitalizations in the United States exceeded \$6B in 2014.⁵³ From 2006—2013, the rate of emergency department visits related to mental illness and SUDs increased substantially (approximately 50% and 37%, respectively).⁵⁴ Mental illness and SUD-related emergency department visits are more than

⁴⁸ The Treatment Advocacy Center, *Road Runners: The Role and Impact of Law Enforcement in Transporting Individuals with Severe Mental Illness, A National Survey*, May 2019, at 7, <https://www.treatmentadvocacycenter.org/storage/documents/Road-Runners.pdf>.

⁴⁹ U.S. GOVERNMENT ACCOUNTABILITY OFFICE, *FEDERAL PRISONS: INFORMATION ON INMATES WITH SERIOUS MENTAL ILLNESS AND STRATEGIES TO REDUCE RECIDIVISM*, GAO-18-182, p. 19 (Feb. 2018), <https://www.gao.gov/assets/700/690090.pdf>.

⁵⁰ Kathleen Maguire and Ann L. Pastore, eds., *Sourcebook of Criminal Justice Statistics 1996*, U.S. DEPARTMENT OF JUSTICE, BUREAU OF JUSTICE STATISTICS, (1997), <https://www.hsdl.org/?view&did=711239>.

⁵¹ Hanke Heun-Johnson, Michael Menchine, Dana Goldman, & Seth Seabury, *The Cost of Mental Illness: Pennsylvania Facts and Figures*, at 22, Feb. 2017, LEONARD D. SCHAEFFER CENTER FOR HEALTH POLICY AND ECONOMICS, <https://www.law.georgetown.edu/wp-content/uploads/2018/07/Rule-18-Handout-1.Secara-1.pdf>.

⁵² *Opioid Overdoses Costing U.S. Hospitals an Estimated \$11 Billion Annually*, PREMIER, Jan. 3, 2019, <https://www.premierinc.com/newsroom/press-releases/opioid-overdoses-costing-u-s-hospitals-an-estimated-11-billion-annually>.

⁵³ *Id.*

⁵⁴ Audrey J. Weiss, Ph.D., Marguerite L. Barrett, M.S., Kevin C. Heslin, Ph.D., & Carol Stocks, Ph.D., R.N., *Trends in Emergency Department Visits Involving Mental and Substance Use*

twice as likely to result in hospital admission compared with other types of emergency department visits.⁵⁵

Lack of access to care for mental illness and the failure to treat co-occurring mental illnesses and SUDs are significant factors in the continuation of the opioid addiction and overdose crisis. The personal and financial costs of these failures is staggering. Governments, health plans, employers, patients with addiction and their families pay dearly, including with their lives for this epidemic.

IV. WORKING TOWARDS A SOLUTION

A. Increasing the Number of Substance Use Disorder and Mental Health Clinicians.

Psychiatric specialists and addiction medicine subspecialists play an essential role in the leading the multidisciplinary teams treating complex patients with SUDs and co-occurring psychiatric disorders and coordinating their care. More addiction subspecialty positions are critically needed to fill the gaps identified above. Because addiction medicine is a new multi-subspecialty for which physicians who are not psychiatrists can now also train, the opportunity for expansion of the addiction physician workforce is substantial.

Mechanisms to expand capacity may include economic and financial incentives, salary support for recruitment bonuses, loan repayment initiatives, and/or full tuition scholarships⁵⁶. These incentives should be prioritized to systems that treat patients for addiction and mental illness and target places of highest need like Federally Qualified Health Centers

Disorders, 2006–2013, Healthcare Cost and Utilization Project Statistical Brief #216, Agency for Healthcare Research and Quality, Dec. 2016, at 1, <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb216-Mental-Substance-Use-Disorder-ED-Visit-Trends.pdf>.

⁵⁵*Id.*

⁵⁶ See National Health Service Corps, *Scholarships*, <https://nhsc.hrsa.gov/scholarships/index.html> (last visited Apr. 26, 2020).

(“FQHC”), Community Mental Health Centers, jails and prisons, and other underserved systems. Clinical efforts could be enhanced through matching funds to eligible institutions.

For example, states could institute a repository of funds for loan repayment programs for clinicians who demonstrate that they are engaged in practice for 50% or more of their professional time in the treatment of patients with opioid and other SUDs. Professional practices treating patients with opioid and other SUDs can take place in a diversity of settings utilizing evidence-based practices including prescribing FDA-approved medications for OUD. These settings may include FQHCs, private practice, community health care sites, hospitals, academic medical centers, and rural settings, among others. This loan repayment program can be modeled on programs such as the National Institutes of Health Loan Repayment Program for clinician-scientists engaged in research⁵⁷ or the newly-approved Loan Repayment Program for Substance Use Disorder Treatment Workforce described in Section 7071 of the SUPPORT for Patients and Communities Act of 2018,⁵⁸ modified to include pediatric subspecialties, particularly child and adolescent psychiatry.

Capacity can also be enhanced through investment in academic medical centers. General Psychiatry and primary care training programs for physicians, nurse practitioners, and physician assistants, often lack access to an addiction psychiatrist or an addiction medicine subspecialist, and therefore, psychiatrists and primary care practitioners do not all have necessary training in addiction psychiatry or addiction medicine. Adding key personnel to faculty can have numerous benefits, including access to specialty clinical care, enhanced teaching and mentoring in

⁵⁷ See National Institutes of Health Division of Loan Repayment, *Supporting Scientific Discovery*, <https://www.lrp.nih.gov> (last visited Apr. 13, 2020).

⁵⁸ See Section 7071 of the SUPPORT for Patients and Communities Act, WWW.CONGRESS.GOV, <https://www.congress.gov/115/plaws/publ271/PLAW-115publ271.pdf> (last visited Apr. 13, 2020).

addictions and the possibility of developing fellowship programs in Addiction Psychiatry, Addiction Medicine, and other disciplines to further expand the workforce capacity. It is estimated that about 2% of the training in psychiatry residency programs is dedicated to SUDs, demonstrating that even without the fellowship, there is ample evidence that most General Psychiatry programs lack access to training in addictions care and supervision of cases involving SUDs.⁵⁹

By way of example, states can create a repository to provide funding to increase residency and fellowship and other training positions in Psychiatry, Addiction Psychiatry, Child and Adolescent Psychiatry, and Addiction Medicine, as well as in Schools of Nursing, Pharmacy, and Social Work. Accreditation Council for Graduate Medical Education (ACGME) approved or accredited Psychiatry and Primary Care residency training programs, Addiction Psychiatry, and Addiction Medicine training programs could apply to use the funds to support salary and benefits for new trainee positions or a portion of the salaries of board-certified addiction trained faculty.

Funding is also needed to establish a coordinating program to develop and disseminate model interprofessional addiction curricula in Schools of Medicine, Nursing, Pharmacy, Social Work and other health professions. This would include at a minimum, the basic science of motivation, drive and pain; neurobiology of addiction, its typology and natural history, and the external reward-based, social, and economic factors that modify its development; clinical

⁵⁹ See *ACGME Program Requirements for Graduate Medical Education in Psychiatry*, ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION, July 1, 2019, https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/400_Psychiatry_2019.pdf?ver=2019-08-26-134127-827. (The educational program in psychiatry must be 48 months in length and resident experience in addiction psychiatry must include one month full-time equivalent focused on substance abuse/dependence).

training in evidence-based prevention and treatment of SUDs, including the appropriate use of all FDA-approved medications for SUDs and co-morbid medical and psychiatric disorders; brief intervention/motivational interviewing, evidence-based clinician management, and a systematic strategy for implementing evidence-based science. Evidence-based management has been found to be helpful in areas of other parts of medicine including chronic pain. This program could include a train-the-trainer program, model curricula, and scholarly peer reviews of the program to promote its expansion and adoption in medical schools.

One of the problems in obtaining interest in addiction medicine positions is the lack of funding for these programs resulting from and perpetuating the stigma associated with addiction. Placing addiction subspecialists in training programs for their primary specialty in graduate training programs, improving addictions training in general medical and other health professions education, continuous fellowship funding along with loan forgiveness and other incentives are the best way to develop a pipeline of addiction specialists who can work in areas of greatest need.

B. Promoting and Enhancing Programs that have Proven Effective in Expanding the Reach of the Existing Addiction Workforce

Settlement monies can be used to fund, promote, and/or incentivize participation in consultation, mentorship, and training programs that have proven effectiveness in expanding clinician capacity and competence to treat addiction and mental illness. Examples include the Collaborative Care Model (CoCM) Training that expands psychiatrists' reach;⁶⁰ the Severe Mental Illness (SMI) Advisor program;⁶¹ the SAMHSA-funded STR/SOR Technical Assistance

⁶⁰ See <https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care>.

⁶¹ See <https://smiadviser.org>.

Consortium,⁶² and The ASAM Fundamentals of Addiction Medicine Program for primary care clinicians.⁶³ These are a few of the many successful programs that have expanded access to needed knowledge and care models that states and localities could promote, update, and expand. These programs can also serve as models for building new programs to address specific needs in an economical manner by using collaboration and technology to increase the workforce of health care professionals qualified to treat substance use and mental health disorders.

C. Increasing Adoption of Clinical Best Practices

While improving training in addiction during schooling and fellowships will bring a new generation of addiction specialists into the workforce, the existing health care workforce also needs to be trained in evidence-based treatments. The gap in education and training in SUDs has resulted in non-uniform treatments which are not evidence-based. Accordingly, treatment and results vary significantly. There is a significant need to expand evidence-based practices to improve outcomes.⁶⁴

Addiction is a treatable disease. Patients can and do enter remission and recovery, and there is ample research showing that addiction treatment improves individual productivity,

⁶² See <https://opioidresponsenetwork.org/>.

⁶³ See <https://www.asam.org/education/live-online-cme/fundamentals-program>.

⁶⁴ Most individuals with opioid use disorder (OUD) seek treatment from treatment from outpatient physicians and other office-based practices and not from publicly-funded programs such as those administered by the SAMHSA. Thus, little is known about patient characteristics, services delivered, and treatment outcomes in outpatient practices for OUD treatment throughout the US; quality improvement and research in this area remains a missed opportunity. The Addiction Medicine Practice-based Research Network (AMNet), a patient registry under a grant provided by SAMHSA, aims to gather patient level data at point of care and in an ongoing manner from clinicians and practices across the country, providing unique opportunities to assess quality of care and conduct qualitative and quantitative research in the OUD gap areas.

health, and overall quality of life.⁶⁵ Medication treatment for opioid use disorder (MOUD, also known as medication-assisted treatment MAT) is considered to be the most effective treatment for OUD.⁶⁶ MOUD can be successfully paired with nondrug therapies (e.g. counseling or cognitive behavioral therapy) to treat OUD or used alone.⁶⁷ MOUD significantly increases a patient's adherence to treatment and reduces illicit opioid use compared with nondrug approaches.⁶⁸ MOUD reduces opioid craving, withdrawal, and stress reactivity, and competitively blocks or reduces the reinforcing effects of other opioids.⁶⁹ In doing so, up to 60% of patients taking MOUD avoid returning to opioid use, and MOUD has been shown to at least double the rates of opioid-abstinent outcomes when compared to placebo or no medication.⁷⁰ Additionally, individuals receiving buprenorphine with counseling have significantly lower total health care costs than individuals receiving little or no treatment for their OUD (\$13,578 compared to \$31,055).⁷¹

However, MOUD is often unavailable to those in need. Inadequate funding for treatment programs impedes the delivery of life-saving medication. Only 23% of publicly funded treatment programs and less than half of private-sector treatment programs reported offering any FDA-

⁶⁵ *Facing Addiction in America: The Surgeon General's Spotlight on Opioids*, OFFICE OF THE SURGEON GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, Sept. 2018, at 17, https://addiction.surgeongeneral.gov/sites/default/files/Spotlight-on-Opioids_09192018.pdf.

⁶⁶ *Medication-Assisted Treatment Improves Outcomes for Patients with Opioid Use Disorder*, THE PEW CHARITABLE TRUSTS, Nov. 2016, https://www.pewtrusts.org/-/media/assets/2016/11/medicationassistedtreatment_v3.pdf.

⁶⁷ *Id.*

⁶⁸ *Id.*

⁶⁹ Hillary Smith Connery, M.D., Ph.D., *Medication-Assisted Treatment of Opioid Use Disorder Review of the Evidence and Future Directions*, 23, *Harvard Review of Psychiatry*. 63 (2015).

⁷⁰ *Id.*

⁷¹ *Facing Addiction in America: The Surgeon General's Spotlight on Opioids*, *supra* note 65, at 10.

approved medications to treat SUDs.⁷² In jails and prison settings, only 5% of inmates with opioid use disorder receive MOUD.⁷³ There is also a lack of qualified medical personnel available to administer these treatments. The number of people with OUD significantly exceeds the number of authorized buprenorphine prescribers, and 30 million Americans live in counties that do not have any clinicians eligible to prescribe buprenorphine for OUD.⁷⁴ Expanding access to MOUD through funding to make the medications available and training for clinicians to prescribe them is essential to better outcomes at reasonable costs. Many programs are available to train medical providers. These training programs need to be disseminated and encouraged throughout the states.⁷⁵

Medical providers also need training and access to nationally recognized clinical practice guidelines such as The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder.⁷⁶ Guidelines and toolkits for expanding evidence-based treatment within county jails and state prisons could also facilitate effective treatment for those involved in the criminal justice system.⁷⁷ Funding to support dissemination of these resources, training on their content, and

⁷² *Medication-Assisted Treatment Improves Outcomes for Patients with Opioid Use Disorder*, *supra* note 66.

⁷³ Alan I. Leshner and Michelle Mancher, *supra* note 47.

⁷⁴ *Id.*

⁷⁵ See American Psychiatric Association, *Buprenorphine Prescriber Training*, PSYCHIATRY.ORG, <https://www.psychiatry.org/psychiatrists/education/signature-initiatives/buprenorphine-prescriber-training>;

American Psychiatric Nurses Association, *MAT Waiver Training for Nurses*, APNA.ORG, <https://www.apna.org/i4a/pages/index.cfm?pageID=6262>;

American Society of Addiction Medicine, *The ASAM Treatment of Opioid Use Disorder Course*, ASAM.ORG, <https://www.asam.org/education/live-online-cme/waiver-qualifying-training>.

⁷⁶ Available at: <https://www.asam.org/Quality-Science/quality/2020-national-practice-guideline>.

⁷⁷ *Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Recommendations for the Field*, NATIONAL SHERIFFS ASSOCIATION AND THE NATIONAL COMMISSION ON CORRECTIONAL HEALTHCARE, Oct. 2018, <https://www.sheriffs.org/publications/Jail-Based-MAT-PPG.pdf>; Shannon Mace, Anne Siegler, KC Wu, Amanda Latimore, Heather Flynn, *Medication-Assisted Treatment for Opioid Use*

implementation of their recommendations could break the far-too-common cycle of relapse and recidivism with its attendant personal and social costs.

Improving awareness of available resources and providing clinicians with evidence-based practices to treat OUD would significantly improve outcomes.

D. Funding to Ensure Enforcement of Mental Health Parity and Addiction Equity and Consumer Protection Laws

In 2008, Congress passed the “Mental Health Parity and Addiction Equity Act” to ensure that patients with mental health and SUDs would be able to access care on terms no less favorable than those on which they access all other health care. Regulations have been passed, the Act has been expanded, and most states have adopted their own versions of mental health parity legislation. All states have consumer protection statutes to protect consumers from vendors who misrepresent their products. Yet, grave disparities remain between access to healthcare for those seeking mental health and/or SUD treatment and those seeking care for other medical issues such as cancer or diabetes.⁷⁸ Patients with mental health and SUD pay insurance plans for mental health and SUD coverage that is advertised but never delivered.

Despite the grave consequences and costs in lives, incarceration, and work productivity of untreated mental health and SUDs, spending for SUD treatment was only 0.9% of total health-care spending in 2017, and spending for mental health treatment was only 2.4% of total health-

Disorder in Jails and Prisons: A Planning and Implementation Toolkit, THE NATIONAL COUNCIL FOR BEHAVIORAL HEALTH AND VITAL STRATEGIES, Jan. 2020, https://www.thenationalcouncil.org/wp-content/uploads/2020/01/MAT_in_Jails_Prisons_Toolkit_Final_2020-01-30.pdf?daf=375ateTbd56.

⁷⁸ Jenny Gold, *Affordable Treatment for Mental Illness and Substance Abuse Gets Harder to Find*, THE WASHINGTON POST (Dec. 1, 2019, 12:00 PM), https://www.washingtonpost.com/health/affordable-treatment-for-mental-illness-and-substance-abuse-gets-harder-to-find/2019/11/29/a8c689f6-0fce-11ea-bf62-eadd5d11f559_story.html.

care spending.⁷⁹ Those lucky enough to be in the 43%⁸⁰ and 17%⁸¹ of patients with mental health and SUDs (respectively) who access care for their illness, are likely to pay more for mental health and SUD care than for other health care because of discrimination and misrepresentation by insurance plans. Patients with mental health and SUDs who can afford an insurance plan that allows them to access care out of network were 5.41 times more likely to pay for a significant part of that care out of their own pocket than they would be if seeking care for cancer or diabetes, because insurers do not provide adequate networks of mental health providers.⁸² Patients utilized out-of-network services for behavioral health office visits an average of 5.41 times more often, and in some cases over 10 times more often, than they utilized out-of-network services for primary care office visits in 2017.⁸³

Insurance companies also use unfair standards in determining whether treatment is “medically necessary” and thus whether the plan will pay for it when assessing patients with mental health and/or SUDs.⁸⁴ Likewise, The Rhode Island Office of Health Insurance

⁷⁹ Milliman Research Report, *Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement*, http://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf, at 7 (Nov. 19, 2019).

⁸⁰ *Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health*, *supra* note 2, at 59.

⁸¹ *Id.* at 3.

⁸² Milliman Research Report, *Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement*, *supra* note 79, at 30.

⁸³ *Id.* Plans with out of network benefits tend to be the more expensive plans. These plans allow patients to choose a physician who is not contracted with the plan provided the patient pays the difference between the fee charged by the physician and the normal reimbursement amount that the plan would pay contracted physicians. The result is cost-prohibitive for most patients. While there are currently not enough mental health professionals to serve the needs of all who need treatment for mental health and substance use disorders, bringing those who are out of the network into the network would go a long way toward making access to care more affordable for average income Americans.

⁸⁴ *Wit v. United Behavioral Health*, No. 14-cv-02346-JCS, 2019 WL 1033730 at 53 (N.D. Cal. Feb. 28, 2019) (UBH “breached its fiduciary duty by violating its duty of loyalty, its duty of

Commissioner found that United Health Care used clinically inappropriate utilization review criteria to determine whether to approve or deny coverage of requested behavioral health services and behavioral health-related prescription drugs and/or applied the criteria in an inappropriate manner in violation of Rhode Island law. The utilization review criteria used by the plan’s review staff “were not based on objective, measurable, clinical criteria” and instead “relied on subjective vague and generalized conclusions or judgements.”⁸⁵ In other words, mental health coverage can be subject to vague, biased, and unfair medical necessity criteria designed to deny coverage that the medical community deems medically necessary for patients with mental health and SUDs.

Insurers do not provide adequate networks of mental health providers to serve their patient population. Instead, they intentionally discourage participation of mental health professionals in networks by paying substantially lower (in some cases up 80% lower) fees to medical doctors who provide psychiatric services than to any other physician provider.⁸⁶ Settlements between the state of Massachusetts and several health plans confirm violations arising from inaccurate provider directories, insufficient networks, and the use of faulty methodologies for determining reimbursement rates. Carriers also misrepresent to mental health patients the number of providers available to treat their illnesses, in violation of consumer

care, and its duty to comply with plan terms by adopting Guidelines that are unreasonable and do not reflect generally accepted standards of care” for both residential treatment and intensive outpatient treatment).

⁸⁵ *Examination Report of UnitedHealthcare Insurance Company, and United Healthcare of New England, Inc. in accordance with R.I.G.L. § 27-13.1-5(b)*, STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS, OFFICE OF THE HEALTH INSURANCE COMMISSIONER (Mar. 2020), http://www.ohic.ri.gov/documents/2020/March/United/UHC%20MCE_033020_WEBSITE.pdf

⁸⁶ Milliman Research Report, *Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement*, *supra* note 79, at 32.

protection laws.⁸⁷ These types of violations of federal and state laws are frequent and result in patients with mental health and SUDs being unable to access treatment even when they have paid for insurance coverage for these conditions. The result of this is that the cost of treatment for mental health and SUDs is shifted to the patients (if they can afford it) and the states (if they cannot). In most cases, the patient simply foregoes treatment altogether even though they have paid to have mental health and SUD coverage in their insurance plan. Moreover, the constant battle with the insurance plan in which physicians must engage in order to have them cover medically necessary treatments for their patients along with payment that is significantly less than their medical colleagues disincentivizes medical students from pursuing psychiatry and addiction specialties, thereby exacerbating the workforce problem.

While state regulators and state attorney generals' offices do their best to address complaints that they receive, at least two impediments preclude solutions to the problems. First,

⁸⁷ See, *Attorney General's Office Behavioral Health Parity Agreements*, MASS.GOV, <https://www.mass.gov/lists/attorney-generals-office-behavioral-health-parity-agreements> (last visited Apr. 13, 2020); Assurance of Discontinuance, *In re Allways Health Partners Inc.*, Feb. 27, 2020, available at <https://www.mass.gov/doc/allways-aod/download>; Assurance of Discontinuance, *In re Blue Cross and Blue Shield of Mass, Inc.*, Feb. 27, 2020, available at: <https://www.mass.gov/doc/blue-cross-blue-shield-aod/download>; Assurance of Discontinuance, *In re Fallon Community Health Plan, Inc.*, Feb. 27, 2020, available at: <https://www.mass.gov/doc/fallonbeacon-aod/download>; Assurance of Discontinuance, *In re Harvard Pilgrim Health Care, Inc.*, Feb. 27, 2020, available at: <https://www.mass.gov/doc/harvard-pilgrimoatum-aod/download>; Assurance of Discontinuance, *In re Tufts Associated Health Plans, Inc.*, Feb. 27, 2020, available at: <https://www.mass.gov/doc/tufts-health-plan-aod/download>. The District of Columbia Attorney General likewise settled investigations finding that health plans were publishing inaccurate provider directories. Assurance of Voluntary Compliance, *In re Aetna Health Inc.*, June 1, 2018, available at: <http://oag.dc.gov/sites/default/files/2018-06/AVC-signed-Aetna.pdf>; Assurance of Voluntary Compliance, *In re CareFirst BlueChoice, Inc.*, May 24, 2018, available at: <http://oag.dc.gov/sites/default/files/2018-06/AVC-signed-Carefirst-Bluechoice.pdf>; Assurance of Voluntary Compliance, *In re UnitedHealthcare of the Mid-Atlantic, Inc.*, June 6, 2018, available at: <http://oag.dc.gov/sites/default/files/2018-06/AVC-signed-UHC.pdf>.

a complaint-driven process does not work when the patients who must complain are stigmatized for their illness. They are unlikely to come forward to complain that their employer's insurance plan is discriminating against them.⁸⁸ Second, state insurance commissions and attorney generals have significant workloads of which parity and consumer health fraud are but a small part. These agencies need additional resources to aggressively and proactively ensure compliance with existing federal and state laws in order to guarantee that discrimination against those with mental health and SUDs and misrepresentations about insurance coverage do not preclude access to evidence-based care.

V. CONCLUSION

There is no silver bullet that will cure those with addiction and co-occurring mental illness or that will cure or prevent another crisis. However, the funding generated from this litigation could be used to make substantial progress toward controlling the OUD epidemic and ensuring that it or similar substance use consequences do not recur in the future. States, counties, and cities are paying substantial amounts of money on the backend for untreated mental health and SUDs through emergency care, emergency hospitalizations, and incarceration of persons with untreated mental health and/or SUDs. Money would be much better spent on the front-end training health care personnel and employing evidence-based treatments to prevent the emergency in the first instance.

What the litigants can do immediately is use some of the funds that will come out of this litigation to ensure that there is an adequately trained health care professional workforce to continue the research into prevention and treatment of addiction, to treat patients using clinical

⁸⁸ Robin Room, Jürgen Rehm, Robert T. Trotter II, Angela Paglia, *Disability and Culture: Universalism and Diversity*, p. 247-291 (2001).

best practices, and to guarantee that persons with addiction and/or mental illness have access to nondiscriminatory health insurance to afford their treatment. Many of the programs and resources needed to achieve these objectives already exist and others not mentioned here are also available. The authors stand ready to work with the parties and the Court in identifying potential solutions to these very complex issues.