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

My name is Joe Parks and I am a board-certified psychiatrist. I am the Medical Director at the National Council for Behavioral Health. However, I also treat patients with mental illness and addiction on a weekly basis. My brother struggled all his life with addiction and with mental illness. I previously was head of Missouri’s mental health agency and I’ve been also in charge of Missouri’s Medicaid agency recently. And I want to thank you for the opportunity to testify.

Our families, our friends and our citizens are dying at an increasing rate of the two great epidemics of our generation: the opiate addiction epidemic and the suicide epidemic, and it’s not always easy to tell which one somebody died of – there’s an intermix. 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 that we’ve successfully fought back and got some control on: things like polio, HIV, heart disease, stroke, and cancer. Every day, an estimated 91 die from an opioid overdose\(^1\) and 121 die by suicide\(^2\). We can and must do better. We must muster the same determination to make significant changes of statute, practice and funding in fighting the opiate and suicide epidemics that we successfully used to 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 a mental illness – and should know how to ensure they can get help. To this end, federal and local support for Mental Health First Aid must be continued and expanded.

Many persons with opiate addiction also face mental illness, so successful treatment of addiction often requires concurrent treatment of both conditions. In the Epidemiologic Catchment Area Study, an estimated 72% of people with a drug use disorder had at least one co-occurring mental illness. 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 treatment. We must monitor and screen for addictive disorders. Screening, Brief Intervention, and Referral to Treatment, also known as SBIRT, is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse and dependence on alcohol and other addictive drugs including opiates. SBIRT should always be a covered benefit and all hospitals, emergency rooms and clinics should provide it systematically.

Everyone must have health care coverage for addictions and mental illness. 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.

Any health care legislation should expand parity requirements to all forms of coverage – not all fall under parity right now. There’s some holes still. Health care legislation should mandate coverage for addiction and mental illness.

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\(^1\) CDC. [https://www.cdc.gov/drugoverdose/epidemic/](https://www.cdc.gov/drugoverdose/epidemic/)

Now, 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 treatment services due to the rates being so low that they lose money and must cover those losses from other treatment lines of business. 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 actual market costs of providing the treatment.

Medicaid is the largest national payer for addiction and mental health treatment – there’s no larger payer. To successfully fight back these epidemics of addiction and suicide, Medicaid must continue as an entitlement. Since the majority of increased opiate deaths and suicide occur in young and middle-aged adults, which is the expansion population, the Medicaid expansions must be maintained and completed.

Medication is proven effective as has been noted by the other experts in treating opioid addiction, but they can’t always get these medications. Those drugs like methadone, buprenorphine, and naltrexone, including long-acting Vivitrol, need to be categorized as a protected medication class in Medicaid and in Medicare part D, requiring their open access on formularies so doctors can prescribe them.

All people need to have access to clinicians who know how to treat and are willing to treat mental illness and addictions. We must expand the Certified Community Behavioral Health Center program which provides that beyond the current demonstration which is limited to only eight states and only for two years – your great state of New Jersey is participating, Governor. This will ensure access to 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, nurse practitioners and to incentivize the uptake in buprenorphine prescribing with continued post-training support.

We need the DEA follow through on its telemedicine guidelines that have been promised, and a certification process to prescribe addiction treatment medications via telemedicine to broaden access. And frankly, DEA Certification to prescribe controlled substances should really require some Continuing Medical Education so if I can prescribe a controlled substance I have to know something about preventing, screening, diagnosing and treating addiction to prescription medications.

We must continue to build alliances between treatment providers and law enforcement to create drug treatment programs and to assure appropriate sentencing for addicted individuals. We need collaborative deflection programs to prevent entry into criminal justice and get people treatment first.

We must develop and fund a comprehensive continuum of care that includes short-term residential and detox, longer-term residential for people with chronic relapses like were just described, recovery housing and other recovery support services to support outpatient treatment.

Finally, I want to speak individually and not on behalf of the National Council. We must change 42 CFR part 2 and any other state law that puts more restrictions on addiction treatment information than on other health care information. The only additional restriction should be not allowing addiction treatment information to be used for arrest or prosecution or other punitive actions. We can never succeed in fighting any epidemic by hiding information about the disease and treatment history from health care providers. Keeping a prior diagnosis and
treatment history of addictive disorders secret deprives the person of the extra care and attention that any health care professional would routinely give to someone who has a known prior condition that makes early detection and treatment relapse much less likely.

Thank you for the opportunity to testify. Thank you for your efforts.