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July 7, 2021

Regina LaBelle

Acting Director

Office of National Drug Control Policy Executive Office of the President

750 17th St NW

Washington, DC 20006

Dear Director LaBelle,

Thank you for the opportunity to provide input for the 2022 National Drug Control Strategy. I am writing on behalf of the American Psychiatric Association (APA), the medical specialty society representing over 37,400 physicians who specialize in the treatment of mental illnesses, including substance use disorders (SUD). As you know, an unprecedented number of Americans are struggling with mental health and substance use disorders as long-lasting results of the COVID-19 pandemic, as well as the ongoing opioid crisis. The Substance Abuse and Mental Health Services Administration's 2019 National Survey on Drug Use and Health (NSDUH) demonstrates that substance misuse and mental illness continue to be major problems for Americans, with cannabis use and methamphetamine use significantly increasing in adults.<sup>1</sup> Deaths from stimulants are now rising at rates similar to that of opioids.<sup>2</sup> ONDCP's leadership is important to addressing the rising substance use and relieving the trauma placed on communities and families. We appreciate and support many of the Administration's Drug Policy priorities announced for the first year. These include:

- Enforcement of the Mental Health Parity and Addiction Equity Act
- Improving the use of evidence-based treatment
- Advancing racial equity
- Expanding the addiction psychiatric workforce

As you develop the National Drug Control Strategy, below are specific strategies we recommend be included to provide people, families, and communities with the support needed to address substance use:

- **Support the increase of education and training in medical schools (including incentivizing more educators) and the development of a standardized,**

<sup>1</sup> National Survey on Drug Use and Health (U.S.), & United States. (2019). The NSDUH report. Rockville, Md.: U.S. Dept. of Health & Human Services, Substance Abuse & Mental Health Services Administration, Office of Applied Studies.

<sup>2</sup> National Institute on Drug Abuse. Rising Stimulant Deaths Show that We Face More than Just an Opioid Crisis. National Institute on Drug Abuse. Published November 12, 2020. Accessed November 12, 2020. <https://www.drugabuse.gov/about-nida/noras-blog/2020/11/rising-stimulant-deaths-show-we-face-more-than-just-opioid-crisis>

**interdisciplinary core curriculum on SUDs.** The current training of physicians in the recognition and treatment of SUD is inadequate to meet the needs of the diverse and growing population of people needing substance use disorder treatment. Medical schools, physician training (residency) programs, and continuing education programs for physicians in practice, provide limited training in the treatment of SUDs. The scope of the training is disproportionate to the population health need to address these problems, and many with SUDs go undiagnosed and untreated. We recommend a standardized, interdisciplinary core curriculum on SUDs that provides a base for future learning, helps reduce stigma towards individuals with SUD, introduces basic screening and treatment approaches, and addresses the complexities and comorbidities of SUD. In addition, the lack of availability of competently trained faculty to provide clinical supervision is cited as a major barrier by residency program directors working with physicians-in-training. We need broader, more systematic efforts at educating physicians. This can be implemented at every level from medical school, through residency training and continuing education for those in practice.

- **Improve access to care using evidence-based models, including:**
  - **Permanent removal of certain telehealth restrictions and permanent use of audio-only for certain services to extend flexibilities beyond the public health emergency.** During the public health emergency, CMS has extended coverage and payment for the telephone E/M services. This flexibility has allowed patients who do not always have the required devices or broadband connection to access care, including when the provider determines homebased services are safer or more feasible. This flexibility helps to improve health equity and increase access to high-quality psychiatric care.
    - During the public health emergency, the administration has also waived the in-person evaluation requirement for prescribing controlled substance required under the Ryan Haight Online Consumer Protection Act. We urge you to work with the Drug Enforcement Agency to permanently remove the in-person requirement to improve access to treatment.
  - **Support the Use of evidence-based integrated care models, including the Collaborative Care Model (CoCM).** Under the CoCM, primary care providers treating patients with common behavioral health problems (e.g., anxiety, depression, substance use disorders) are supported by a care manager and a psychiatric consultant who help implement effective, evidence-based treatment for common behavioral health problems in the primary care setting. This model, already implemented in many large health systems and individual practices, can detect the risk of mental health and substance use disorders before they become a crisis and is proven to improve patient outcomes. Properly integrating behavioral and medical care has the potential to save between \$37.6 - \$67.8 billion each year.
  - **Support efforts to implement contingency management for stimulant use disorders.** The best-evidenced, most effective approach to treating Stimulant Use Disorder is contingency management, i.e., providing motivational incentives to patients for healthy behaviors such as abstinence. Action is needed to direct the Centers for Medicare and Medicaid Services (CMS) to use the 1115 Waiver program to encourage state Medicaid programs to launch demonstration projects that implement contingency management for Stimulant Use Disorder.
- **Improve transition planning from inpatient care to the community.** Among individuals with SUDs, discharge from a higher level of care to the community provides an opportunity

for continued evidence-based treatment. However, when patients are discharged from hospitals and emergency rooms without a transitional care plan, they are at a greatly elevated risk for substance use relapse, worsened medical and psychiatric multimorbidity, and mortality from overdose. The following approaches should be used:

- Patients with SUDs should be given information about the available evidence-based treatment options for their specific SUD to facilitate informed decision making and to enable them to exercise autonomy where possible. For example, providing patients with specific information on the risks and benefits of different opioid use disorder treatments can facilitate the creation of a care plan, while also supporting recovery and decreasing the risks of relapse or overdose.
- Clinicians should familiarize themselves with the most recent treatment guidelines for the management of patients with SUDs in order to be able to discuss the pros and cons of different approaches with patients across settings of care.
- In the emergency room setting, detoxification strategies can be discussed, but should not be presented to patients with SUD as a sole treatment approach given the need for continued treatment following the cessation of substance use. In addition, when medications are part of a SUD treatment plan, they should be initiated before the patient is transitioned to the next level of care. For example, there is mounting evidence to support initiation of opioid agonist therapy for patients with opioid use disorder in the hospital or the emergency room prior to discharge as this improves retention in treatment and community engagement.
- The use of peer providers and patient navigators may also be helpful in providing follow-up contacts with patients with SUD transitions across settings of care and assisting with linkages to other treatment. Referrals for ongoing care that depend on the patient initiating contact are less desirable than securing appointments on behalf of individuals with SUD or doing warm handoffs whenever possible. Proactive outreach should occur after discharge as this approach enhances the patient experience and can also aid in ensuring follow up care.
- **Support legislation and policies that promote equity and improve the social and structural determinants of substance use and substance use disorders.** Inequities in access to and quality of healthcare are primary drivers of the disparate clinical outcomes among individuals with SUD; these inequities are either directly or indirectly affected by social and structural determinants of health including race. The impact of substance use and substance use disorders are greater in minority communities that suffer more severe health consequences than white populations.<sup>3</sup>
- **Raise awareness and work with states to implement policies that treat pregnant and parenting women with SUD as a public health issue.** Substance use in pregnant women is a major public health concern in the United States. The Substance Abuse and Mental Health Services and Administration estimated that approximately 400,000 infants each year are exposed to alcohol or illicit drugs in utero. A public health response, rather than a punitive legal approach to substance use during pregnancy is critical. This should include universal evidence-based screening and voluntary maternal drug testing with informed consent, improved access to substance use treatment, and comprehensive care approaches that include behavioral therapy, appropriate social services, and evidence-based pharmacotherapy.

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<sup>3</sup> Evans EA, Grella CE, Washington DL and Upchurch DM. Gender and race/ethnic differences in the persistence of alcohol, drug, and poly-substance use disorders. *Drug Alcohol Depend* 2017. May 1;174:128-136. doi: 10.1016/j.drugalcdep.2017.01.021.

- **Address cannabis use in youth populations and raise awareness about the risks.** As more states legalize cannabis use and access increases, we must carefully consider the impact on children and adolescents. Risk perception around the harms of cannabis is decreasing among youth, another cause for concern. Expansion in medical uses of marijuana, despite lack of scientific evidence, FDA approval, and regulation, introduces access to a potential comfort therapy for life threatening and severely debilitating conditions, but this access must be weighed against the risks of introducing an addicting substance into a still-developing brain.

Thank you again for providing the opportunity to comment on how to improve the care and delivery of effective drug treatment. If you have any questions, or if we could be of further assistance, please contact Michelle Dirst, Director Practice Management and Delivery Systems Policy, at [mdirst@psych.org](mailto:mdirst@psych.org).

Sincerely,



Saul Levin, M.D., M.P.A., FRCP-E, FRCPsych  
CEO and Medical Director