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Roger Klein, M.D., J.D.
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Sent via email to: REPORTSCLEARANCEOFFICER@ahrq.hhs.gov

Dear Director Klein,

On behalf of the American Psychiatric Association (APA), representing over 40,400 psychiatric physicians who treat mental health and substance use disorders, we appreciate the opportunity to respond to HHS's Request for Information on the prevention, treatment, and recovery of substance use disorders. The APA is responding to the following questions below with requested program solutions:

Question 2. Using existing funding, what policies or changes to federal programs might improve outcomes in:

- **substance use prevention, treatment, and recovery?**
- **mental illness, prevention, treatment, and recovery?**
- **care for co-occurring mental and chronic disease of addiction?**

Program 1

Title: Add validated initiation-pathway and perceived-need items to the National Survey on Drug Use and Health (NSDUH)

Type of activity: Federal survey instrument modification (existing program)

Description: NSDUH currently captures substance use prevalence but rarely how use is initiated, through what exposure channels, or why people with substance use disorder(s) (SUD) do or do not perceive a need for treatment. Adding a validated module on initiation pathways (e.g. who introduced the substance, through what channel), exposure source, and perceived treatment need would convert NSDUH from a prevalence instrument into one that also captures diffusion and the demand-side barrier to care. Because NSDUH is an existing, annually fielded SAMHSA instrument, this leverages current funding rather than building new infrastructure. The marginal cost is low, and the analytic yield — linking spread dynamics to the well-documented finding that the large majority of people with SUD do not believe they need treatment — is high.

Statutory authority: PHS 505, 42 U.S.C. § 290aa-4 (SAMHSA/CBHSQ annual behavioral-health data collection and statistical analysis authority).

Program 2

Title: Embed a transmission/diffusion analytic frame in existing federal substance use surveillance

Type of activity: Analytic methodology changes to existing surveillance programs

Description: Federal surveillance shifted decades ago from incidence-based, transmission-oriented tracking (who initiates whom, through what channels, at what velocity) toward prevalence estimation, leaving the question of how use

spreads largely unmeasured. Reintroducing transmission concepts — incidence trajectories, exposure sources, diffusion velocity — within existing data systems (NSDUH, poison center data, CDC syndromic surveillance) would let HHS detect emerging use patterns earlier and target prevention upstream. This is an analytic reorientation of data already being collected, not a new collection effort. It is especially relevant to fast-diffusing exposures such as psychedelics, where prevalence surged rapidly while health-system tracking lagged.

Statutory authority: PHSA § 505, 42 U.S.C. § 290aa–4; 42 U.S.C. § 241; and 42 U.S.C. § 247b.

Program 3

Title: Office-based methadone maintenance

Type of activity: Treatment of opiate use disorder (OUD)

Description: Methadone maintenance is limited by statute to Federally-licensed Opiate Treatment Programs (OTPs). This creates a barrier to treatment and recovery for people with OUD in rural, suburban, and urban areas due to the time and distance needed for travel and because of onerous requirements put in place by these OTPs in practice. Methadone should be able to be prescribed and dispensed in a clinical setting by physicians with training and resources to monitor the safety and efficacy of methadone maintenance. Concerns about diversion and overdose through increased access to treatment outside of OTPs can be addressed through systematic safeguards that reduce risk while greatly expanding access to this life-saving treatment.

Statutory authority: 21 U.S.C. § 823(h); 42 U.S.C. § 290bb–2a; and 42 C.F.R. Part 8.

Question 3. [E.O. 14379](#) calls for Federal efforts to, “increase awareness of the disease of addiction” and to “foster a culture that celebrates recovery.” How can Federal policies and programs be improved to mitigate the stigma against Americans seeking addiction treatment and recovery?

Program 1

Title: Reframe federal anti-stigma efforts to address non-recognition of illness, not only social stigma

Type of activity: Federal messaging/program redesign

Description: NSDUH data consistently show that among people with SUD who go untreated, roughly 95% do not believe they need treatment — a perception-of-need gap that is distinct from, and arguably larger than, externally imposed social stigma. Most federal anti-stigma messaging targets people who already self-identify as needing help and fear judgment, leaving untouched the much larger group who do not recognize the disease in themselves. Federal programs under EO 14379 should fund and evaluate messaging specifically designed to close this recognition gap, framing addiction as a treatable medical condition in ways that prompt self-identification. This directly serves the EO's call to “increase awareness of the disease of addiction.”

Statutory authority: 42 U.S.C. § 290aa; 42 U.S.C. § 290bb–22; and, where opioid-related messaging is involved, 42 U.S.C. § 290bb–25g. These provisions authorize SAMHSA to conduct policy development, evaluation, knowledge dissemination, and public information activities; support prevention knowledge-development and evaluation projects; and advance public education and awareness campaigns addressing substance use risks and early warning signs of addiction.

Program 2

Title: Counter narrative amplification that distorts risk perception

Type of activity: Prevention messaging strategy

Description: Information reaching potential users — particularly online — is frequently dominated by positive testimonials with minimal balanced risk information, a dynamic now accelerated by digital platforms and AI-generated content. This distorts public risk perception and can both deter treatment-

seeking (by normalizing harmful use) and inflate uptake. Federal “culture of recovery” efforts should include investment in prevention messaging that addresses narrative amplification at the population level, not merely individual pharmacology, but also ensuring that balanced risk information competes in the same channels where testimonials appear.

Statutory authority: 2 U.S.C. § 290aa; 42 U.S.C. § 290bb–22; and, where opioid-related messaging is involved, 42 U.S.C. § 290bb–25g.

This authority supports prevention messaging designed to counter distorted risk perception caused by narrative amplification and to ensure balanced risk information reaches the same population-level channels where substance-use testimonials and promotional content spread.

Program 3

Title: Acknowledge problematic gambling and Gambling Disorder as a legitimate and an increasing concern in the United States

Type of activity: Federal messaging strategy

With the increasing availability of gambling opportunities, via mobile apps, or the expansion of sports betting, there has been a great increase in the number of people with gambling problems. This often leads to challenges in an individual’s life, but also in their families and in their communities too. Despite this growing issue, only 1 in 10 people with Gambling Disorder seek treatment. This is largely due to the misperception that it isn’t a diagnosable condition, or that it isn’t as severe as other addictions or substance use disorders. Gambling Disorder very often co-occurs with substance use, and individuals with Gambling Disorder are at an increased risk of suicide. Federal programs should provide messaging to increase awareness of Gambling Disorder and the many pre-existing resources available, such as Responsible Gaming Initiatives like the National Council on Problem Gambling.

Statutory authority: PHSA § 501 & § 516

Question 4. [E.O. 14379](#) calls for Federal efforts to, “help Americans receive the treatment they need” including “aligning relevant Federal programs” and “all necessary steps to coordinate the Federal Government’s response to the addiction crisis.” One problem in this area is insufficient supply of addiction and mental health counselors (a shortfall estimated by HHS-HRSA at about 77,050 and 99,780 respectively).^[16] This means it is harder for Americans to find the help they need in their area and covered by their insurance, especially in rural or underserved areas. How can Federal policies and programs be improved to address this practitioner supply issue to better ensure that every American seeking addiction treatment can find affordable help covered by their insurance in their area?

Program 1

Title: Build a national outpatient SUD network as the foundational layer of treatment delivery

Type of activity: Service-delivery infrastructure development (existing programs/financing)

Description: Specialty SUD treatment capacity is structurally insufficient and will remain so even if the shortfall closes, because most people with SUD never reach specialty settings. The higher-yield strategy is to make existing outpatient and primary care practices the default site of foundational SUD intervention — identification, brief intervention, medication management, and ongoing follow-up — reserving specialized treatment for patients who need higher intensity care. This reframes the workforce problem: rather than conceptualizing the SUD workforce as a separate specialty category in chronic shortage, it incorporates the existing medical workforce — primary care physicians, pediatricians, and psychiatrists — as the foundational SUD workforce, expanding effective capacity by an order of magnitude without training new specialists. Structuring this build-out around the World Health Organization (WHO) six health-system building blocks (service delivery, workforce, information systems, essential medicines, financing, and leadership/governance) ensures the network develops coherently

rather than piecemeal. At the national level, this means aligning financing so foundational SUD care is reimbursable in outpatient settings (existing Collaborative Care Model (CoCM) and General Behavioral Health Integration (BHI) codes already provide pathways), establishing shared information systems and referral standards, and setting governance and quality expectations. At the local level, it means equipping individual practices to identify and manage SUD, connect patients to medications, and execute warm hand-offs to specialty care when needed. The foundation of the network is workforce capability: it requires training and education of existing outpatient practitioners so that primary care, pediatric, and psychiatric clinicians can deliver competent first-line SUD care. That training investment — not the creation of a separate specialty workforce — is what gives the network its strength and durability.

Statutory authority: *Section 1848 of the Social Security Act, Medicare Physician Fee Schedule; SAMHSA integrated-care, low-barrier-care, and workforce-training authorities 42 U.S.C. § 290aa.*

Program 2

Title: Finance clinician time for foundational SUD care, removing the fee-for-service disincentive

Type of activity: Reimbursement/financing change to existing federal programs

Description: CMS has introduced time-based and general behavioral health integration billing codes, but provider uptake has been mixed and limited, with administration reported as complex and billing systems poorly equipped for the requirements. HHS should simplify and promote these pathways — reducing administrative complexity, aligning codes across payers, and supporting practices' billing infrastructure — so that foundational SUD management becomes financially viable in the settings most patients already visit. Encouraging co-location of behavioral and primary care, where warm hand-offs are possible and stigma is reduced, increases treatment initiation and engagement and integrates SUD treatment into the general health care system.

Statutory authority: Section 1848 of the Social Security Act authorizes CMS to establish and update physician services under the Medicare Physician Fee Schedule and Section 1945 of the Social Security Act authorizes Medicaid payment and alignment of programs.

Question 5. How can HHS strengthen its ability to evaluate the effectiveness of substance use and mental health prevention, treatment, and recovery programs and initiatives? How can the Department leverage data modernization, advanced analytics, and emerging technologies such as artificial intelligence to enable performance measurement on a real time or continuing basis?

Program 1

Title: Transmission-oriented, near-real-time surveillance using media exposure events as analytic anchors

Type of activity: Surveillance modernization / advanced analytics

Description: High-reach media events (a widely viewed podcast episode, documentary, or policy announcement) function as exposure events analogous to contact events in infectious disease epidemiology, creating simultaneous exposure for millions of potential initiates. HHS could evaluate whether poison center call volumes, emergency department presentations, or initiation-coded online activity spike at predictable lag intervals following such events, enabling near-real-time detection of diffusion. This applies established outbreak-investigation logic, updated for platform-mediated spread, to data streams HHS and its partners already touch. It would let the Department measure emerging harms continuously rather than retrospectively.

Statutory authority: 42 U.S.C. §§ 241, 247b, 290aa, and 290aa–4 for CDC and SAMHSA supported research and surveillance studies.

Program 2

Title: Treat influencer and affiliate-linked marketing as a measurable exposure source

Type of activity: Advanced analytics / emerging-technology monitoring

Description: Commercial promotion — including social media influencers deploying affiliate codes to market psychoactive products — constitutes a measurable population-level exposure source. HHS could develop analytic capacity to correlate platform engagement metrics with downstream clinical signals (poison center calls, ED presentations), creating a leading indicator of uptake. This uses emerging analytic technologies to convert commercial activity into a surveillance signal, supporting performance measurement on a continuing basis.

Statutory authority: 42 U.S.C. §§ 241, 247b, 290aa, and 290aa–4

Program 3

Title: Build methodologically humble, platform-diverse surveillance with explicit AI-amplification monitoring

Type of activity: Surveillance infrastructure / AI monitoring

Description: Online communities are demographically non-representative (skewing male and younger people, under sampling women and older adults), and AI-generated content can now amplify messages faster than conventional surveillance can monitor. Any AI-enabled surveillance HHS builds must therefore invest in platform-diverse data sources and explicit attention to sampling limitations to avoid systematically mismeasuring diffusion in under sampled populations. This ensures that data modernization improves, rather than distorts, the Department's evaluative capacity.

Statutory authority: 42 U.S.C. §§ 241, 247b, 290aa, and 290aa–4 for CDC and SAMHSA supported research and surveillance studies.

Thank you for the opportunity to provide comments. We hope to work collaboratively with HHS to address this important issue. Please contact Esther Gershenson (egershenson@psych.org) with any questions or for more information.

Sincerely,



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