



AMERICAN  
PSYCHOLOGICAL  
ASSOCIATION

Testimony

of

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Before the U.S. House of Representatives  
Committee on Oversight and Reform

“Medical Experts: Inadequate Federal Approach to Opioid Treatment and the  
Need to Expand Care”

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Chairman Cummings, Ranking Member Jordan, and members of the Committee on Oversight and Reform, thank you for the opportunity to testify today on the topic of the federal response to the drug overdose epidemic and the need to expand care. I am Dr. Arthur C. Evans, Jr., and I am the Chief Executive Officer of the American Psychological Association (APA). APA is the nation's largest scientific and professional nonprofit membership organization representing the discipline and profession of psychology. APA has more than 118,400 members and associates who are clinicians, researchers, educators, consultants, and students. Through the application of psychological science and practice, our association's mission is to make a positive impact on critical societal issues.

My testimony will focus on:

- the need for a 'whole person' approach in addressing substance use disorders, including the provision of behavioral health services, together with employment, education, and housing supports to enable long-term recovery, and the role that psychological services can play in preventing, treating, and supporting recovery from opioid and other substance use disorders;
- the vital role that evidence-based psychological services can play in more effective pain management care and reduced exposure to opioids; and
- the key provisions of the Comprehensive Addiction Resources Emergency (CARE) Act introduced by Chairman Cummings.

Psychologists are on the front lines providing clinical services, conducting research, developing policy, and providing education to help combat this crisis. They are the primary developers and providers of the behavioral interventions that are preferred alternatives to the use of opioids for treating chronic pain, and of assessment methods for identifying patients most at risk of developing an opioid use disorder if they are prescribed opioids. Psychologists provide substance use disorder treatment, including behavioral services to improve the effectiveness of medication-assisted treatment (MAT), and treat co-occurring conditions such as anxiety, depression, and chronic pain. They educate families about early intervention, rescue interventions, and strategies to engage their members with opioid use disorder in treatment. Psychologists also oversee service delivery systems, as I have done in my career.

My comments are informed by thirty years of work in the areas of substance use and mental health disorders, as a clinician working directly with individuals, as an administrator and program director overseeing treatment programs for people with opioid dependency, as an educator training psychologists and physicians, and as a scientist working on treatment studies. Before joining APA, I spent 12 years as commissioner of Philadelphia's Department of Behavioral Health and Intellectual disAbility Services, which provides behavioral health and intellectual disability safety net services for 1.5 million Philadelphians, as well as Deputy Commissioner for the Connecticut Department of Mental Health and Addiction Services.

APA is grateful for the leadership shown by Chairman Cummings and members of the committee in introducing the Comprehensive Addiction Resources Emergency (CARE) Act (H.R. 2569), and strongly supports the legislation. The bipartisan enactment last year of the Substance Use-disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act; P.L. 115-271), was a good step forward, but data show that our nation is falling further behind in addressing the drug overdose and misuse crisis. Centers for Disease Control (CDC) data shows that the rate at which Americans are dying from an opioid overdose rose 12% between 2016 and 2017, contributing to more than 70,000 drug overdose deaths in 2017. We are losing lives, families, and communities on a daily basis.

The CARE Act acknowledges that a fundamental requirement for successfully addressing the drug overdose epidemic is treating the whole person. APA strongly supports the use of medication-assisted therapy drugs in treating opioid use disorder, and we support policies to ensure that the full range of such drug therapies are available to patients and their providers. However, it is important to remember that term “medication-assisted treatment” means that the use of medications is assisting in treatment. We appreciate that the bill acknowledges the importance of behavioral health services as an integral part of addiction prevention, treatment, and long-term recovery—both in treatment delivery and research funding. Just as we do not treat diabetes solely by providing patients with a packet of insulin and syringes, we will not be successful in treating opioid use disorders solely by providing medication without the full range of psychosocial treatments and supports that people need to initiate and sustain recovery. As a former director of a MAT program, I can attest to their importance in improving clinical outcomes.

Before describing the components of a ‘whole person’ approach to the drug overdose epidemic in more detail, I would like to remind the committee that opioid use disorders must be understood and responded to as chronic diseases, not acute conditions. Substance use disorders share many features with other chronic illnesses, including a tendency to run in families, having an onset and course that is impacted by a complex interaction of environmental conditions and behavior, being responsive to appropriate treatment, and requiring ongoing support and services beyond the acute phase of the condition. Substance use disorders also share similar rates of relapse with other chronic illnesses, including type II diabetes, cancer, and cardiovascular disease. Just as with these other conditions, relapses that occur in the course of treating individuals with opioid use disorder should encourage us to provide more aggressive treatment, not give up on the patient, especially considering the high mortality rate of these disorders.

## **The Whole Person Approach: Behavioral Health Services, Housing, Employment, and Recovery Supports**

Psychosocial interventions are the primary form of treatment for many drug use disorders, including for the drugs cocaine and methamphetamine.<sup>i,ii</sup> Research shows that the most effective treatment of opioid use disorder requires psychosocial interventions in combination with medications.<sup>iii</sup> The three forms of treatment with the strongest evidence base for use in treating opioid use disorders are contingency management, cognitive behavioral therapy, and multidimensional family therapy. Contingency management therapy uses positive reinforcement to encourage abstinence from drug use. Cognitive behavioral therapy (CBT) helps patients recognize, avoid, and cope with the situations in which they are most likely to use drugs. Multidimensional family therapy, developed for adolescents with drug use problems, addresses a range of personal and family influences on drug use patterns.

As described in a recently published article, researchers compared the efficacy of a combination of extended-release injectable naltrexone and contingency management to treatment using either the naltrexone or contingency management alone, and found that the combination of naltrexone and contingency management had significant, robust effects on opiate abstinence compared to either treatment alone.<sup>iv</sup>

Individuals with substance use disorders often struggle to enter or stay in treatment because of challenging life circumstances, such as complications with family, employment, and housing.<sup>v</sup> Consequently, addressing these environmental risk factors is key to supporting a person-centered approach to treatment that promotes long-term recovery. Studies show that psychological support programs, including programs focused on providing individuals with stable housing and family therapy, and addressing employment problems, can help people with substance use disorders stick to an effective treatment plan. For example, research has shown that programs such as *Housing First*, which helps homeless individuals with substance use disorders find stable housing without first needing to demonstrate abstinence, is an effective entryway into treatment.<sup>vi</sup> Individuals with an opioid use disorder may actually choose to remain homeless—severely damaging their health, well-being, and chances of recovery—rather than face eviction from abstinence-only housing programs upon subsequent substance use. Programs like the Harm Reduction Research and Treatment (HaRRT) Center in Seattle, Washington provide combined behavioral and pharmacotherapy, vocational rehabilitation, and other psychosocial supports to individuals with opioid use disorders, along with a secure place to live.

Families and friends can also be a potent force in supporting treatment and recovery for individuals with SUDs. Research studies have shown that behavioral interventions involving family members and concerned significant others in treatment for opioid use disorder (OUD) can improve treatment engagement and outcomes – especially for youth and adolescents.<sup>vii</sup> Traditionally, programs that engage friends and family members of a person who has a substance use disorder counsel them to either detach from or confront the

patient. However, research shows that alternative evidence-based behavioral interventions for families such as the Community Reinforcement and Family Training (CRAFT) program can dramatically increase treatment participation rates compared to more traditional programs.<sup>viii</sup>

Employment supports are another effective component of a ‘whole person’ approach. For example, researchers evaluating an employment-based abstinence reinforcement program based on contingency management found a clear difference in the percentage of patients who were able to initiate and maintain periods of sustained opiate and cocaine abstinence after exposure to each contingency.<sup>ix</sup> Such promising programs need to be developed and evaluated, with effective models disseminated and brought to scale. In the absence of employer programs, publicly-funded programs should be available to fill the gap. Stigma is also a significant factor in the opioid epidemic. Individuals with a substance use disorder remain heavily stigmatized in our society, and research shows that people who feel more stigmatized are less likely to seek treatment and to remain in treatment. In addition to affecting the individual patient, stigma also has adverse effects on the response of health care providers, fellow patients struggling with addictive disorders, family members, and the general public<sup>x</sup>, suggesting that public education to combat the stigma associated with substance use disorders could improve treatment engagement and success.

Another reason the ‘whole person’ approach is essential is that co-occurring substance use and mental disorders are common among adults with opioid use disorders. A paper published earlier this year—and coauthored by Elinore McCance-Katz, M.D., Ph.D., the Assistant Secretary for Mental Health and Substance Use—estimates that more than a quarter of adults with OUD had an alcohol use disorder, 10% had a methamphetamine use disorder, and 27% had a serious mental illness, leading the authors to conclude that “Expanding access to comprehensive service delivery models that address the substance use and mental health co-morbidities of this population is urgently needed.”<sup>xi</sup> This is why APA strongly supports efforts to strengthen federal and state enforcement of the Mental Health Parity and Addiction Equity Act (MHPAEA).

### **The Biopsychosocial Nature of Pain, and Psychological Pain Management**

The difficulty of treating opioid use disorders and their associated morbidity and mortality make it imperative that we minimize exposure to opioids. Fortunately, our health care system is turning away from indiscriminate use of opioids for treating pain, and opioid prescribing rates are beginning to fall. The CDC Guideline for Prescribing Opioids for Chronic Pain, released in 2016, states that “evidence on long-term opioid therapy for chronic pain outside of end-of-life care remains limited, with insufficient evidence to determine long-term benefits versus no opioid therapy, though evidence suggests risk for serious harm that appears to be dose-dependent.”<sup>xii</sup> (p.9) The CDC Guideline states that nonpharmacologic therapy—such as cognitive behavioral therapy, exercise therapy, and multimodal pain treatment—and nonopioid pharmacologic therapy are preferred for treating chronic pain.

There is still substantial room for improvement in our management of acute and chronic pain. Americans use roughly one-third of the world's opioid supply, and more than 11 million Americans misuse opioids. We need to continue reducing the inappropriate use of opioids and do a better job of providing pain care by ensuring that psychological and other non-pharmacological pain management services are first-line options available to patients, replacing opioids.

Psychologists have been at the forefront of the shift away from responding to pain as solely a physiological condition and toward an understanding of pain as a biopsychosocial phenomenon involving biological, psychological, and social aspects of the individual's health and functioning. There is a substantial body of evidence delineating the interrelationship between mental disorders, psychological tendencies, the experience of pain, and opioid misuse and addiction, as well as the clear efficacy of cognitive behavioral approaches to pain management disability, and mood disorders. Studies show that patient tendencies toward catastrophizing are a significant, unique predictor of risk for opioid misuse, even when controlling for patients' levels of pain severity, anxiety, and depressive symptoms.<sup>xiii,xiv</sup> Reviews show that CBT can counter catastrophizing, and is efficacious for treating chronic pain for patients with rheumatoid arthritis.<sup>xv,xvi</sup>

Not only do psychological assessments and interventions work, they are cost effective. In 1992 Colorado enacted legislation reforming the state's workers compensation program, in response to costs that were high enough to cause businesses to consider leaving the state. The new medical treatment guidelines subsequently developed recommended a psychosocial assessment of patients failing to make expected progress six to 12 weeks after injury, and the management of psychosocial factors that might be contributing to disability. Implementation of the guidelines resulted in a 62.5% drop in mean medical cost per case in Colorado relative to the national average.<sup>xvii</sup>

We strongly endorse the findings of the recently-issued final report from the Administration's Pain Management Best Practices Inter-Agency Task Force, developed pursuant to the Comprehensive Addiction and Recovery Act (CARA).<sup>xviii</sup> The report includes an entire chapter entitled "Behavioral Health Approaches", and notes that "[d]espite widespread understanding of the importance of psychological interventions in the management of pain, many patients with pain receive inadequate care."<sup>xix</sup> The report goes on to state:

To further enhance patient acceptance and engagement in psychological treatment, patients and providers need to know about psychological treatments. Health professionals should have sufficient understanding of the biopsychosocial model of pain and how to appropriately assess and refer patients for behavioral health treatment.... Both a need for trained pain psychologists and appropriate incentives are required to fill the work gap.<sup>xx</sup>

The Inter-Agency report also calls for improved screening and treatment of individuals with comorbid mental and substance use disorders in addition to chronic pain; the education of physicians, dentists, and health care providers on the benefits of psychological and behavioral health treatment modalities; and improved reimbursement policies for integrated treatment approaches that include psychological and behavioral health interventions through traditional and nontraditional delivery methods.<sup>xxi</sup> We are hopeful the Task Force's report will contribute to a wide array of initiatives in both the public and private sector to modernize the provision of integrated, multidisciplinary pain management services reflective of the biopsychosocial model of care.

### **Comprehensive Addiction Resources Emergency (CARE) Act**

APA has joined with over 100 national, state, and local organizations in endorsing the CARE Act. Earlier I stated our belief that success in fighting the overdose epidemic will require enabling the delivery of an array of services spanning prevention, treatment, recovery, and supports, and our appreciation for the CARE Act's comprehensiveness in embracing this 'whole person' approach. A second aspect of the legislation that we believe would contribute to its success is its provision of sustained, flexible funding to areas most heavily impacted by the epidemic.

Over the course of twenty years of policy work in Connecticut and Philadelphia, I learned that each community-based substance use treatment system is different and while all systems need the broad range of services and supports that I have described here, each community will need to emphasize different solutions. Furthermore, individuals with substance use disorders should have multiple pathways to getting the help they need. The ultimate mix of services will vary greatly depending on the population, the characteristics of the substance use treatment system, the nature of the epidemic in their community, the policy environment of the state and the non-treatment resources available to assist people in their recovery. Delivering effective care often requires drawing upon resources and supports provided by disparate community organization partners, including faith-based organizations, vocational rehabilitation centers, employers, housing agencies, and others.

As a former system administrator responsible for the use of \$1.5 billion in public funding, I understand the importance of attaching strings to the use of grant dollars. However, I also understand that such strings can stifle the flexibility and creativity of those on the front lines who were closest to the problems. The CARE Act provides that flexibility to localities, while at the same time ensuring that an inclusive community planning process guides program and system design.

The CARE Act combines this structure with substantial, sustained funding. One factor contributing to the explosion of drug overdose deaths is the chronic underfunding of substance use disorder and mental health treatment services in many parts of the country. Building adequate treatment capacity cannot happen overnight. State and local administrators and program directors will not take the steps necessary to build treatment

capacity unless they are confident that they will have long-term financial support. The CARE Act's commitment of \$100 billion over 10 years goes farther than previous legislation considered by Congress in providing this backing. The Ryan White CARE Act template—providing sustained, flexible funding to communities to support them in addressing a deadly public health crisis—is needed as much for the drug overdose epidemic today as it was for HIV/AIDS in the 1980's.

We also strongly support the CARE Act's substantial investment in the education and training of psychologists and other substance use and mental health service providers. There is dire shortage of professionals in this area, and a need for greater expertise among the existing health care provider workforce. APA recognizes the importance of a well-trained workforce, and we are developing a pain management training curriculum to meet the need for improved access to nonpharmacological pain services. The CARE Act also invests in developing more effective treatments by authorizing new funding for research at the National Institutes of Health on addiction and pain, including on nonpharmacological pain management. There is a need to better understand the characteristics of people who are susceptible to transition from acute to chronic pain following a surgical procedure or musculoskeletal trauma, in order to improve the design, timing, and targeting of interventions. Research should also be focused on determining the most effective behavioral therapies to maximize outcomes, and the potential effect of interventions such as mindfulness meditation and multi-disciplinary rehabilitation.

APA applauds your leadership of the committee in putting forward this major piece of legislation, which we believe is commensurate with the scale of the challenge we face. My colleagues and I at APA are committed to continue to work with you to bring an end to the tragic epidemic of drug overdose deaths.

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