DHHR's Bureau for Public Health

c/o Opioid Response Plan Comment

350 Capitol Street, Room 702

Charleston, WV 25301

January 19, 2018

Dear West Virginia DHHR Bureau for Public Health,

On behalf of the West Virginia Psychological Association Board of Directors and Substance Use Disorder Taskforce, we are grateful for the thoughtful and evidence-based plan that DHHR has developed to respond to the opioid abuse crisis in the mountain state. Psychologists in West Virginia are highly skilled in clinical assessment, psychotherapy treatment, program development, consultation, and research / outcomes assessment. We would like to offer the following nine feedback considerations for DHHR to consider as the process of developing a strategic statewide plan continues:

1. DHHR should be intentional about **de-stigmatizing substance use disorders by moving away from labelling a person as an addict and move towards referring to him or her as a person with a substance use disorder (SUD).** We don't call those with cardiac disease "cardiacs" and we don't call those with obesity, "fat". With other behavioral health related conditions, we've been careful about separating a diagnosis from an identity. We should do the same in the treatment of substance use disorders.

2. There is a significant focus on medication assisted treatment (MAT) in the plan, with less **focus on other evidence-based psychological treatments**. While MAT has its place and merits, DHHR should encourage treating persons with SUDs using evidenced based behavioral interventions and/or encourage MAT as time-limited treatments. Many behavioral interventions such as Cognitive Behavioral Therapy, Motivation Enhancement Treatment, and relapse prevention approaches demonstrate that those with addiction can reduce their dependence on addictive drugs over time and do not have to remain on MAT indefinitely.

3. DHHR should not only work to limit the prescriptions of opioids through prescription monitoring programs, but should also work to **limit the dispensing of opioids to pharmacies**. **This would mean monitoring and enforcement of prescription ordering and distribution networks directly between opioid manufacturers and local pharmacies.** The evidence is overwhelming that West Virginia citizens have been targeted by flooding the pharmacy markets with opioids disproportionate to the population or treatment needs, resulting in the ease of misuse and abuse of prescription practices.

4. DHHR should encourage legislation that increases penalties for physicians who enable SUD onset by **providing clearly medically contraindicated prescriptions, especially those who exchange cash for service.** Many who suffer with SUDs know the medical network of providers who provide legal prescriptions in exchange for cash.

5. The plan for intervention with incarcerated individuals seems to primarily focus on treatment of those who are already incarcerated. We recommend that the plan strongly consider **evidence-based alternatives to incarceration, such as community based corrections. This model provides treatment in lieu of prison and has been shown to reduce recidivism.** Additionally, instead of referencing out of state diversionary programs such as the Kings County, WA LEAD program, DHHR should recognize and expand diversionary partnerships already existing between West Virginia county judicial offices and community mental health centers or Day Report Centers. For instance, each month, in Berkeley and Jefferson County, hundreds of non-violent offenders with substance related offenses are redirected from jail or prison to outpatient behavioral and medical treatment programs through the county Day Report Centers. The Berkeley County Day Report Center in partnership with Mountaineer Behavioral Health provides daily evidence based programs such as peer recovery coaches, SAMSHA based Intensive Outpatient Programs, as well as step down programs to offenders in lieu of jail.

6. DHHR should explore various methods to **increase WV citizen enrollment in Medicaid or other managed care organizations (MCO) so that those with SUDs can increase access to care**. Despite their eligibility, too many West Virginians are not enrolled in MCOs and therefore are not accessing available treatment. The expansion and parity of mental health reimbursements for treatment remains underutilized in West Virginia since the Affordable Care Act was passed.

7. Another important **effort to expand access to SUD treatment is telehealth services**, as mentioned in the proposed plan. In order to meet the needs of the entire state, improving the broadband infrastructure, especially rural areas, would need to be included in this effort. Psychologists and behavioral health providers have encountered obstacles when trying to reach rural patients with telehealth solutions.

8. For prevention, **DHHR should use known predictive models to help identify youth at high risk for developing a SUD and encourage the expansion of resources available for those identified.** For example, the Martinsburg Initiative

(http://www.martinsburgpd.org/martinsburg-initiative/) identifies students by the number of Adverse Childhood Events (ACE) each child has experienced. In the Martinsburg Initiative, those youth with six or more ACEs are specifically and intentionally offered increased resources to decrease the SUD onset. This has been produced in collaboration with volunteers from the community, churches, civic groups, and mental health providers who are partnering with the local police and school system to stem the rise of SUDs.

9. While the Ryan Brown fund was an important initiative to increase residential treatment beds state-wide, the demand and need for residential treatment still exceeds the supply. **DHHR should encourage legislation to increase expansion of SUD treatment facilities and number of beds available.**

Thank you again for your interest in improving the behavioral health needs of West Virginians. As always, please never hesitate to contact WVPA at info@wvpsychology.org or 304-345-5805!

Best wishes,

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2018 WVPA President