

Chairman Richard Neal (D-MA), Ranking Member Kevin Brady (D-TX), and Members of the Ways and Means Committee.

Thank you for hosting this hearing and inviting me to provide testimony on how we can better address substance use, suicide risk, and the integration of care into our health systems. The Addiction Policy Forum is a nonprofit organization working in states and communities across the country to end the stigma around addiction, help patients and families in crisis, and translate the science around substance use disorders. Our vision is to eliminate addiction as a major health problem and help patients, families, and communities affected by the disease. We are grateful to the Committee and its Members for your work to improve mental health and substance use disorder treatment. We appreciate the opportunity to identify priorities and challenges as a network representing patients, families and caregivers, as well as practitioners.

## **Understanding Substance Use Disorder Patient Experiences**

In the substance use disorder (SUD) space, there is a pronounced absence of systematic input and feedback from people with substance use disorders (PWSUD) and their caregivers. Engaging SUD populations is often difficult even outside a pandemic, with barriers that include social stigma, confidentiality concerns, fear of exposure and retribution. As the opioid public health crisis collides with the COVID-19 crisis, Addiction Policy Forum gathered insights from the patient and caregiver community to better understand common elements, bright spots and pain points in accessing care and finding and maintaining long-term recovery. In 2021, we conducted 60 Life Course History interviews of individuals in recovery from substance use disorders nationwide to craft a patient journey map. SUD types included opioid use disorder, alcohol use disorder, stimulant use disorder, sedative use disorder, marijuana use disorder and polysubstance use disorder.

Findings from Addiction Policy Forum’s Patient Journey Map can help frame better responses to addiction, including prevention, early intervention, improved treatment outcomes and long-term health and wellness. Key APF data points include:

***Average Onset of Substance Use is 14 years old.*** The average age of onset of substance use was 14, with the earliest onset of 5 years old and oldest at 19 years old. Onset is the age at which an individual develops, or first experiences a condition or symptoms of a disease or disorder. First substances of use are predominantly alcohol, tobacco and marijuana.

***Polysubstance Use Disorder is the Dominant Issue.*** 98% of patients report polysubstance use, with an average of 6 different substances used during their active use disorder.

***Genetic Factors.*** Risk factors include genetic predisposition – 78% of patients reported a family history of SUD, with an average of 2 previous generations with an SUD history.

***Childhood Trauma is a Significant Risk Factor.*** Patients report an average Adverse Childhood Experiences (ACEs) score of 4.3, with 30% of patients reporting an ACEs score of 6 or higher. The most prevalent traumatic events include experiencing verbal abuse/neglect; living in a household with

substance use disorder, parental divorce, physical abuse and living in a household with a mental illness/suicide.

***Frequent Involvement Healthcare and Criminal Justice Systems.*** 77% of patients were hospitalized due to their SUD, most commonly for injuries, infections, overdose, suicide attempt/self-harm, and car accidents. 70% of patients report justice involvement, which includes 63% who experienced incarceration and 35% who participated in a diversion program, such as drug court.

***Accessing Help Identified as the Most Difficult Phase of the Recovery Process.*** The process of accessing help is identified by patients as extremely painful, disorganized, and difficult. Previous treatment and recovery experiences, along with recommendations from friends and family most frequently form the basis for the treatment pathway selected. One individual shared: “So in my experience, I was not able to get help when I needed it or when I asked for it, begged for it.”

***No Silver Bullet; Individualized Care Plans Needed.*** On average, patients utilized four different services for treatment and recovery support, not a single treatment or intervention. Services accessed were support groups (90%), followed by counseling/mental health treatment (53%), intensive outpatient treatment programs (52%), residential treatment (37%), medications for addiction treatment (28%), and aftercare programs (30%).

***People, Places and Things.*** Building a positive, supportive social network is a dominant feature of successful recovery, along with avoiding individuals, places and other triggers that present memory and physical cues to resuming substance use (i.e. using friends, bars, parties, concerts, boredom). The exact constellation of triggers is unique to each patient. Common lifestyle modifications include avoidance of high-risk people, places, and things (42%), changing friends (40%), self-care such as exercise, nutrition, and sleep (23%), becoming honest, open-minded and accountable (25%), and developing a consistent routine (13%). One interviewee shared: "The social aspect of it because your first couple of years of recovery can be lonely because everyone you know you had to cut out of your life."

***Long-term Lifestyle Modifications and Support Required for Success.*** Patients in recovery from substance use disorders continue supports specific to their needs for years or even decades. Service to others, support group attendance, and family/friends are the most significant components identified by patients. Patients rely on multiple supports in long-term recovery with an average of three services utilized. The most common services utilized were support groups (67%), family and friends (55%), volunteer and service work (38%), and mental health/counseling (22%). One interviewee shared: “I love being able to have a life that I couldn't have dreamed of over seven and a half years ago. I love the freedom, I love the serenity, the peace that I have, I love that I have skills today that I can use when I'm having a really good day or really bad day. I have a sense of purpose and meaning that largely accounts from my own spiritual beliefs and practice.”

## **A Perfect Storm: COVID, Mental Health Stressors, Fentanyl, and Workforce Shortages Collide with the Addiction Crisis**

As we make improvements to better understand the unique needs of individuals with substance use disorder, it's imperative to understand the significant challenges that COVID-19 has created for those struggling with addiction. Over the last two years, as our country has grappled with the pandemic, addiction has worsened at historic rates. Provisional data from the CDC's National Center for Health Statistics shows that there were over

104,000 drug overdose deaths in the United States for the 12-month period that ended in September 2021:<sup>1</sup> 285 deaths a day. And over 800,000 people have died from a drug overdose since 1999.<sup>2</sup>

**COVID Impact on SUD and Mental Health.** In 2020, in a survey of Addiction Policy Forum’s network of patients and families, two out of three reported that COVID-19 had a negative impact on their SUD or recovery status due to disruptions in key services and programs, combined with increased stress and isolation. One patient shared: “I relapsed four times during the pandemic and prior to that, I was sober for a year and a half. It’s made it a lot more difficult to do the 12-step work because most of that type of stuff is done face to face with a sponsor, and with COVID we’re not meeting face to face.” Another individual shared: “My biggest triggers are boredom and isolation, and so working from home and having to quarantine and isolate myself, it was just like jumping into the lion’s den.”

Patients cited the lack of access to 12-step or support group meetings as a major concern. One individual shared: “I would say living in recovery through this time and not being able to be active in meetings has been disappointing when they keep liquor stores and weed shops open. This society is so twisted.” A family member participant added, “the inability of attending meetings in person and meeting a sponsor in person has been very difficult for my child.”

The isolation, stress, anxiety and disruptions of the pandemic were in too many cases catastrophic for our patient group, resulting in increased rates of relapses and overdose nationwide. In their own words, our patients and caregivers shared the difficulties of managing a chronic health condition during COVID. “Many people are dying from overdoses due to lack of face-to-face treatment, being unable to get admitted into residential treatment facilities” and “social isolation is affecting our mental health.”

And as with addictive disorders, mental health disorders worsened in the pandemic. A study published in *The Lancet* showed the prevalence of depression grew by nearly 28 percent in 2020, and anxiety disorders rose by almost 26 percent.<sup>3</sup> Another study tracked helpline calls in 19 countries finding the volume of calls was up 35 percent compared with pre-pandemic levels, with callers struggling with fear and loneliness.

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<sup>1</sup> Drug Overdose Deaths in the U.S. Top 100,000 Annually. Atlanta, GA: CDC, National Center for Health Statistics;2021. Retrieved from [https://www.cdc.gov/nchs/pressroom/nchs\\_press\\_releases/2021/20211117.htm](https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm).

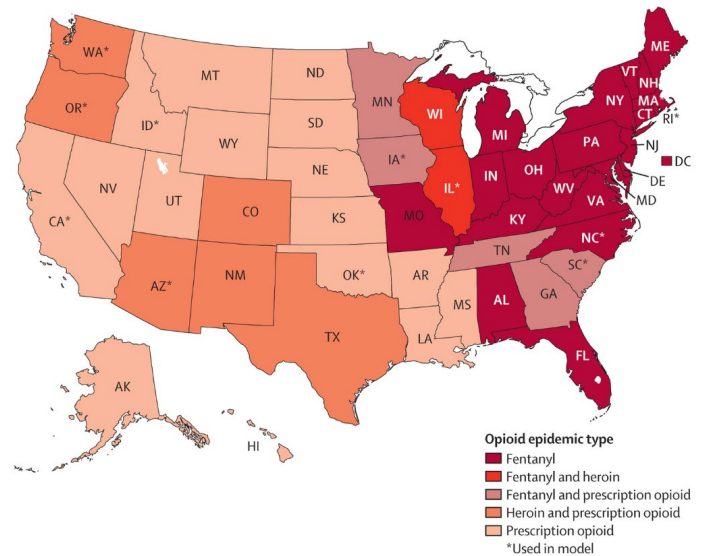
<sup>2</sup> Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics;2020. Retrieved from <http://wonder.cdc.gov>.

<sup>3</sup> “Global Prevalence and Burden of Depressive and Anxiety Disorders in 204 Countries and Territories in 2020 Due to the COVID-19 Pandemic,” by Damian Santomauro et al., in *Lancet*, Vol. 398; October 8, 2021 (*data*)

## The Emergence of Fentanyl in Drug Supply.

In addition, the introduction of fentanyl has significantly increased mortality rates. Fentanyl is approximately 100 times more potent than morphine and 50 times more potent than heroin. Breathing can stop after just two milligrams of fentanyl. The mass production of fake pills marketed as legitimate prescription pills has devastated communities. Counterfeit pills are easy to purchase, widely available, often contain fentanyl or methamphetamine, and made to look like prescription opioids such as oxycodone (Oxycontin®), Percocet®), hydrocodone (Vicodin®), and alprazolam (Xanax®); or stimulants like amphetamines (Adderall®). A new modeling study in *The Lancet* showed that fentanyl dominates the east coast market, while mixed epidemics of heroin, prescription opioids and fentanyl can be found in the Midwest and West.<sup>4</sup>

Map of Opioid Epidemic Types Across the USA



**Workforce Shortages.** Amidst these challenges, our field has also been hit with workforce shortages. The addiction field has long struggled to attract enough workers to address the demand for services due to a variety of factors, including stigma and inadequate compensation. Reimbursement rates and salaries for doctors, psychologists, social workers and counselors in the addiction field are significantly lower than salaries in other health care specialties even with the same level of education and training. A workforce report from the Health Resources and Services Administration (HRSA) estimates the treatment supply-demand gap will only widen, projecting a 15% increase in demand for addiction counselors by 2030 and only a 3% increase in supply.<sup>5</sup> There are significant barriers to care for Medicare beneficiaries as well. Access to care falls short in the lack of coverage for many providers in the field and low reimbursement rates. Providers missing in Medicare include Licensed Addiction Counselors, Certified Alcohol and Drug Counselors, Licensed Professional Counselors and Peer Support Specialists.

It is critically important to build a workforce to meet these challenges. Congress took important steps to address the workforce gap in **The SUPPORT for Patients and Communities Act (PL 115-271)** by helping incentivize pathways for becoming an addiction professional. The Loan Repayment Program for Substance Use Disorder Treatment Workforce (Section 7071) in SUPPORT, was established to help incentivize students to pursue substance use disorder treatment professions by providing student loan relief. The field would also benefit from expanding incentive structures to encourage more students to pursue substance use disorder treatment careers.

## The People and Families at the Epicenter of the Overdose Crisis

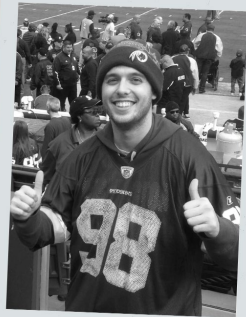
104,000 fatal overdoses in a single year – 285 deaths a day – is a staggering amount of loss for a preventable and treatable illness. I know firsthand this devastation as I lost both of my parents to opioid use disorder. My story is

<sup>4</sup> Irvine, M. (2022). Estimating naloxone need in the USA across fentanyl, heroin, and prescription opioid epidemics: a modeling study. Retrieved at [https://doi.org/10.1016/S2468-2667\(21\)00304-2](https://doi.org/10.1016/S2468-2667(21)00304-2)

<sup>5</sup> Behavioral Health Workforce Projections, Health Resources and Services Administration (HRSA), 2020. Retrieved at <https://bh.w.hrsa.gov/data-research/projecting-health-workforce-supply-demand/behavioral-health>

just one of the millions repeated daily across our nation. At Addiction Policy Forum we honor those lost and work to improve outcomes for patients and families by tackling the stigma of addiction. To put a different lens on 104,000 deaths in one year, I'd like to take a moment to share letters written by several of our families who have lost their loved ones to this disease.

This is **Tristan**. Her family described her as smart and opinionated and caring. Her sister Stephanie writes: "My sister Tristan died of a heroin overdose at age 18. Our mother found Tristan in our guest house. Our mother and little sister were told by the 911 operator to do CPR on Tristan's lifeless body until paramedics arrived on the scene - something no loved one should ever have to see or do." Stephanie writes: "Even though Tristan died from a drug overdose, drugs did not define who she was. There was much more to my sister than her addiction. Tristan was such a spirited, opinionated, smart, beautiful, creative and caring young woman. She is deeply missed. We found out after her death she purchased meals for the homeless at her work. Even in the darkness of her addiction, Tristan never lost her compassion."



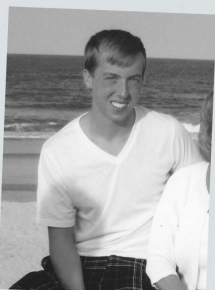
*Jonathan D*

**Jonathan** graduated college and wanted to be in construction management, loved sports and had the best smile. He died at 28 years old due to fentanyl adulterant. His mom, Cristina, writes: "He was my oldest son. He made me a mother... People need to know that it is a disease and not a choice. Since he died, on June 13, 2019, I have been transported into a parallel universe, where beautiful young people like my Jonathan die of this horrible disease, where mothers and fathers are grieving their ultimate loss. The stories are so similar. Since our tragedy, I have been feeling the need to help others and fight this terrible epidemic by bringing awareness and a better understanding of others. He hid his addiction because he was ashamed, but we are not hiding it. We are not ashamed of our son. People need to know that it is a disease and not a choice."



*Emily G*

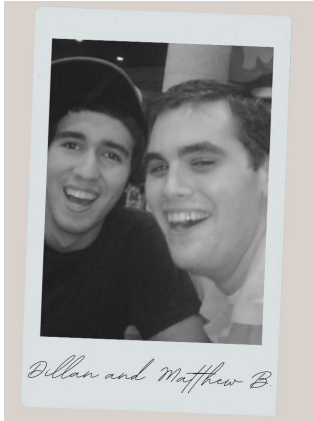
**Emily** was an athlete, artistic, smart. Her mom, Angela, shares: "Emily was the most amazing kid in the world and I was so proud of her. She was intellectually, artistically and athletically gifted. I always told her that with so many talents, comes the great responsibility to bring those gifts to the world. She died of a fentanyl overdose. Angela writes: "Everything in my instincts told me something was seriously wrong. Although she was 21 and living on her own, we would see her often, and the more time I spent around her before her death, the more alarm bells went off in my head. I convinced the rest of our family to take part in an intervention to get her into treatment. We met on a Saturday with the interventionist, and planned the intervention for the following Saturday. Emily died that Wednesday. My beautiful daughter, who was privileged and had every opportunity in life, had gone down this road. According to the autopsy report, Emily had six times what would be considered a therapeutic dose of fentanyl for the largest man. She was just a small young woman and didn't stand a chance. The fentanyl killed her almost instantly after she injected it."



*Scott F*

"**Scott** was a normal boy growing up – full of life and love for his family," shares his dad, Jim. "He struggled with mental health and an opioid use disorder. After three years in

treatment, Scott Freund relapsed, which led to his suicide on Aug.1, 2010, just two days before his 21st birthday. He left a letter for his dad and family: "I have not found one person who can help me out. I love you Mom, Dad and [sister] Ashley so much and there's nothing you could have done better. I just can't stand being in my own mind, it's torture and it hurts and I've tried for years to get help but nothing works."



Denise's sons, **Matthew and Dillan**, were born the same day, four years apart. She describes them: "With beautiful dark hair, gorgeous hazel eyes and thick eyebrows, Matthew could charm the shirt right off your back. Dillan's charismatic smile and gregarious personality made you never want to leave his side. Both boys were extremely outgoing, involved in sports; Matthew especially enjoyed football and basketball while Dillan excelled in baseball, hockey and, in his later years, chess."

Denise lost her younger son Dillan at just 19 years old to a heroin overdose. The grief and trauma of the loss contributed to Matthew's worsening opioid addiction and he died of a heroin overdose at 28 years old. Denise writes: "My boys had a bright future ahead of them but, because of their illness and lack of adequate treatment and medical coverage, their lives were cut tragically short. Had they suffered from diabetes or skin cancer, they would have been provided the medical care and attention necessary to live a full life and you wouldn't be reading about them now."

## The Research-to-Practice Gap

To change the trajectory of the epidemic, the gap between research and its application in the field must be addressed. The research-to-practice gap has been a topic of discussion for decades. Indeed, a whole host of fields have explored how to best translate research findings into clinically meaningful information and then apply it effectively. Balas and Boren (2000), Grant et al (2003), and Wratschko (2009) all estimated a **research-to-practice time lag of 17 years**, meaning it takes 17 years for research discovery to be used in daily practice. This delay in the translation of research into practice has hampered the adoption of new treatments, tests, and clinical standards for everything from flu vaccines to diabetic eye exams to cholesterol screenings. The gap also impacts patients with SUDs and creates barriers that affect treatment, continuity of care, policy, communication, and more.<sup>4</sup>

**Evidence-based treatments that have been proven for decades are drastically underutilized in the field of addiction.** We have most of the proven tools we need to address the opioid crisis, yet do not systematically implement these interventions for those in need. Congress could help turn the tide through incentivizing and prioritizing these four strategies to address the opioid epidemic by the expansion of 1) medication for addiction treatment; 2) naloxone distribution; 3) contingency management; and 4) syringe service programs.

1. **Medications for Addiction Treatment (MAT).** Individuals treated with buprenorphine and methadone after a nonfatal opioid overdose had a 40% to 60% reduction in mortality.<sup>6</sup> MAT *decreases* opioid use, overdose deaths, criminal activity, and infectious disease transmission.<sup>7,8,9</sup> And MAT also *increases* social functioning and retention in treatment. Yet less than 50% of privately-funded addiction treatment programs offer MAT and only 30% of patients with opioid dependence at these programs

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<sup>6</sup> Laroche, M. (2018). Medication for Opioid Use Disorder After Nonfatal Opioid Overdose and Association With Mortality

<sup>7</sup> RP Mattick et al. Cochrane Database of Systematic Reviews (2009)

<sup>8</sup> RP Mattick et al. Cochrane Database of Systematic Reviews (2014)

<sup>9</sup> Schwartz et al. Am J Public Health (2013)

actually receive it.<sup>10</sup> Can you imagine if less than half the oncology centers in America offered chemotherapy? And in that half, only 1 in 3 patients would be offered it? If we feel shock or horror even at that thought, why is this the case for addiction treatment?

MAT provision for high risk populations must also be addressed. Studies have found that individuals with a SUD returning from incarceration to the community are up to 129 times more likely to die of a drug overdose during the first two weeks of reentry,<sup>11</sup> but providing medications for addiction treatment prior to release and continuation during reentry cuts the risk of death up to 75%.<sup>12</sup>

2. **Naloxone** reverses an opioid overdose, yet a new study showed that almost all states have underdeveloped naloxone distribution and few states are able to avert 80% of witnessed overdose deaths.<sup>13</sup> A Massachusetts naloxone program reduced opioid overdose deaths by an estimated 11 percent in the nineteen communities that implemented the program.<sup>14</sup> High rates of naloxone distribution to community members and emergency personnel could avert 21% of opioid overdose deaths.<sup>15</sup> We have also learned that providing naloxone to patients prescribed opioids is associated with fewer opioid-related emergency department visits.<sup>16</sup> Other research suggests that when clinicians prescribe naloxone along with prescription opioids, the risk of opioid overdose decreases even when the patient doesn't fill the naloxone prescription.
3. **Contingency Management (CM)** is a behavioral treatment for substance use disorders based on operant conditioning principles. Decades of research demonstrate its effectiveness, particularly for stimulant use disorder (e.g., methamphetamine, cocaine), which involves giving patients tangible rewards to reinforce positive behaviors.<sup>17</sup> Studies show that CM is effective in increasing treatment retention and promoting abstinence. And while we have this treatment proven to help with methamphetamine and cocaine use disorder treatment, it is still almost impossible for patients to find.
4. **Syringe Service Programs.** The escalating opioid epidemic has increased injection drug use, which has contributed to the spread of human immunodeficiency virus (HIV), hepatitis C virus (HCV), and other infectious diseases.<sup>18</sup> Decades of research demonstrates syringe service programs (SSPs) are a key component to combat the opioid epidemic, prevent the spread of infectious diseases, save costs, and

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<sup>10</sup> HK Kundsén et al. *Journal of Addiction Medicine* (2011)

<sup>11</sup> Binswanger, I. A., Stern, M. F., Deyo, R. A., Heagerty, P. J., Cheadle, A., Elmore, J. G., & Koepsell, T. D. (2007). Release from Prison—A High Risk of Death for Former Inmates. *The New England Journal of Medicine*, 356, 157-165. doi:10.1056/NEJMsa06411

<sup>12</sup> Degenhardt, L., Larney, S., Kimber, J., Gisev, N., Farrell, M., Dobbins, T., Weatherburn, D.J., Gibson, A., Mattick, R., Butler, T., Burns, L. (2014). The impact of opioid substitution therapy on mortality post-release from prison: retrospective data linkage study. *Addiction*, 109(8), 1306-17. doi: 10.1111/add.12536

<sup>13</sup> Irvine, M. (2022). Estimating naloxone need in the USA across fentanyl, heroin, and prescription opioid epidemics: a modelling study. Retrieved at [https://doi.org/10.1016/S2468-2667\(21\)00304-2](https://doi.org/10.1016/S2468-2667(21)00304-2)

<sup>14</sup> Walley, A.Y., et al., *Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis*. *BMJ*, 2013. 346(jan30 5): p. f174-f174.

<sup>15</sup> Townsend, T., et al., *Cost-effectiveness analysis of alternative naloxone distribution strategies: First responder and lay distribution in the United States*. *International Journal of Drug Policy*, 2019.

<sup>16</sup> Coffin, P.O., et al., *Nonrandomized Intervention Study of Naloxone Coprescription for Primary Care Patients Receiving Long-Term Opioid Therapy for Pain*. *Annals of Internal Medicine*, 2016. 165(4): p. 245.

<sup>17</sup> National Institute on Drug Abuse. (2018). *Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition)*. <https://nida.nih.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition>

<sup>18</sup> National Institute on Drug Abuse. (2021). *Opioid Overdose Crisis*. Retrieved from [www.drugabuse.gov/drug-topics/opioids/opioid-overdose-crisis](http://www.drugabuse.gov/drug-topics/opioids/opioid-overdose-crisis)

control outbreaks in vulnerable communities.<sup>19, 20</sup> SSPs can reduce HIV and HCV cases by at least 50%.<sup>18</sup> In addition to providing free sterile syringes and the safe disposal of used syringes, research has demonstrated people who participate in SSPs are three times more likely to stop or reduce injection drug use, and five times more likely to enter SUD treatment programs compared to people not participating in SSPs.<sup>18i, 21</sup> In addition, the provision of naloxone by SSPs is associated with a 30% reduction in overdose deaths.<sup>22</sup> Additionally, SSPs are cost-effective and provide considerable cost-savings to communities. For example, the expansion of SSPs in New York City is associated with saving the city government \$1,300-\$3,000 per client in one year.<sup>23</sup> In Scott County Indiana, opening a SSP saved Indiana taxpayers approximately \$120 million in costs associated with averting additional people contracting HIV.<sup>21</sup> Baltimore and Philadelphia have also shown an annual return on investment for SSPs of \$62 million and \$243 million, respectively.<sup>24</sup> In spite of the overwhelmingly positive impacts of SSPs, they are still underutilized as a community strategy to address HIV and HCV, provide needed health services, and address opioid related overdose deaths. Given that the highest prevalence, transmission, and reinfection rates are among people with SUDs, who already have limited access to treatment and health care services, expanding access to SSPs can provide integrated care for both SUDs and infectious diseases and are an important part of any strategy to end the HIV epidemic.<sup>25</sup>

## Go Upstream

Addiction is a pediatric brain disorder, yet our treatment system is set up and geared towards adults. In addition, myths and misinformation abound, like waiting for rock bottom before seeking treatment, cultural attitudes that say SUD is just a phase or will work itself out on its own, and lack of knowledge around risk factors in adolescence for the development of a substance use disorder. In no other health condition would we intentionally wait for it to worsen before we engage patients in care.

We have decades of evidence around the risk and protective factors that can contribute to, or prevent, the onset of a substance use disorder. For example, the earlier someone starts using substances, the greater their chances of developing a SUD, and the more severe their illness is likely to be. Parental substance use disorder is a key risk factor to address. Traumatic childhood experiences can increase the likelihood of developing mental illnesses, substance use disorders, and other mental and physical health conditions that affect the overall quality of life.<sup>26</sup>

There are three main approaches to prevention and treatment: 1) universal, 2) selective and 3) indicated. While the universal approach applies to everyone, the selective approach focuses on subgroups that are at-risk for developing a substance use disorder, such as those with prior juvenile justice involvement and children of

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<sup>19</sup> Centers for Disease Control and Prevention. (2019). Summary of Information on The Safety and Effectiveness of Syringe Services Programs (SSPs). Retrieved from <https://www.cdc.gov/spp/syringe-services-programs-summary.html>

<sup>20</sup> Abdul-Quader, A. S., Feelemyer, J., Modi, S., Stein, E. S., Briceno, A., Semaan, S., Horvath, T., Kennedy, G. E., & Des Jarlais, D. C. (2013). Effectiveness of structural-level needle/syringe programs to reduce HCV and HIV infection among people who inject drugs: a systematic review. *AIDS and behavior*, 17(9), 2878–2892. <https://doi.org/10.1007/s10461-013-0593-y>

<sup>21</sup> National Institute on Drug Abuse. (n.d.). Syringe Services Programs. Retrieved from [www.drugabuse.gov/drug-topics/syringe-services-programs](http://www.drugabuse.gov/drug-topics/syringe-services-programs)

<sup>22</sup> Sighes, E., Ray, B., Watson, D., Huynh, P., & Lawrence, C. (2018). The Implementation of syringe services programs (SSPs) in Indiana: benefits, barriers, and best practices. IUPUI Richard M. Fairbanks School of Public Health. Retrieved from [https://fsph.iupui.edu/doc/research-centers/SSP\\_Report\\_20180516.pdf](https://fsph.iupui.edu/doc/research-centers/SSP_Report_20180516.pdf)

<sup>23</sup> Belani H. K., & Muennig, P. A. (2008) Cost-Effectiveness of Needle and Syringe Exchange for the Prevention of HIV in New York City, *Journal of HIV/AIDS & Social Services*, 7:3, 229-240, DOI: 10.1080/15381500802307492

<sup>24</sup> Ruiz, M. S., O'Rourke, A., Allen, S. T., Holtgrave, D. R., Metzger, D., Benitez, J., Brady, K. A., Chaulk, C. P., & Wen, L. S. (2019). Using Interrupted Time Series Analysis to Measure the Impact of Legalized Syringe Exchange on HIV Diagnoses in Baltimore and Philadelphia. *Journal of acquired immune deficiency syndromes (1999)*, 82 Suppl 2(2), S148–S154. <https://doi.org/10.1097/QAI.0000000000002176>

<sup>25</sup> Alshwaykh, O., & Kwo, P. Y. (2021). Current and future strategies for the treatment of chronic hepatitis C. *Clinical and molecular hepatology*, 27(2), 246–256. <https://doi.org/10.3350/cmh.2020.0230>

<sup>26</sup> Center on the Developing Child at Harvard University. ACEs and Toxic Stress: Frequently Asked Questions. Retrieved from <https://developingchild.harvard.edu/resources/aces-and-toxic-stress-frequently-asked-questions/>



parents with a substance use disorder. Indicated approaches target people who are beginning to use substances but may not have developed a substance use disorder (early intervention).

Evidence-based prevention strategies are available and yet underutilized, including screening, early intervention, programs to address ACEs and children impacted by parental substance use disorder, as well as primary prevention interventions. Preventing the development of substance use disorders must be a priority and can change the trajectory of the crisis.

Key evidence-based prevention interventions ready for widespread implementation include:

1. **SBIRT.** SBIRT stands for Screening, Brief Intervention, Referral to Treatment and is a comprehensive, public health approach to the delivery of early intervention and treatment services for people with substance use disorders and those at-risk. A study published in the journal *Drug and Alcohol Dependence* reviewed the effects of SBIRT services on 459,599 patients screened at various medical settings over a 6 month period. The study found a 68% reduction in drug use over a 6-month period among SBIRT patients.<sup>27</sup> Among those who reported problematic drinking at baseline, the rate of heavy alcohol use was 39% lower at the 6-month follow-up. Those who received brief interventions or referrals to specialty treatment also reported improved overall health, fewer arrests, more stable housing, and improved employment outcomes.<sup>28</sup>
2. **Student Assistance Programs.** School-based services are also crucial in primary, secondary and indicated prevention implementation. For example, Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students) is a school-based model to prevent and reduce substance use and misuse among adolescents. The program places trained counselors in public and alternative high schools to provide a full range of services, including prevention education, awareness, individual assessments, and specialized counseling groups. Like employee assistance programs, Project SUCCESS establishes a student assistance program. A randomized study assessed the effectiveness of Project SUCCESS for 363 students in a control school and a Project SUCCESS school.<sup>29</sup> Each school participated in school-wide events; however, only one school offered the education series and counseling groups. Middle and high schoolers were followed for three years with results showing Project SUCCESS to be beneficial for males, females, and diverse ethnic groups and ages. Students involved in Project SUCCESS groups were **4.3 times less likely to report continued use of alcohol, tobacco and marijuana** than those in the control group and **5 times less likely to report illicit substance use.** Project SUCCESS students who did use alcohol, tobacco and cannabis when given the pre-test were 4.14 times less likely to report continued use after 21 months and 7.33 less likely to report illicit substance use.
3. **ACEs Interventions.** Programs that provide targeted interventions to children impacted by addiction at home and have experienced trauma (ACEs) are a key strategy in disrupting intergenerational substance use disorders and providing targeted services to arguably one of the most at-risk populations of children. For example, a School-Based ACEs program in Essex, Massachusetts was created by the District Attorney, Jonathan Blodgett, in partnership with the school superintendent. The Essex program works with middle school students impacted by ACEs. The program consists of sixty 7th and 8th grade students who are selected for participation in the program based on factors such as attendance, discipline, academics and family history. The program begins with homework help and student/teacher

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<sup>27</sup> (Madras, et al, 2009)

<sup>28</sup> *Id.*

<sup>29</sup> Vaughan, R., & Johnson, P. (2007). The Effectiveness of Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students) in a Regular Secondary School Setting. Unpublished manuscript.

check-ins followed by a snack. The students then move into their intervention groups. These groups consist of 10-12 students and an assigned teacher facilitating the evidence-based social-emotional-learning curriculum. In addition to the curriculum, students participate in two recreational activities such as gym, art, shop, cooking, computers and life skills with monthly field trips and guest speakers. The program is staffed by a guidance counselor, a police officer, social workers, and teachers in the school. It hand selects teachers, police officers, and social workers to guide and teach students about substance misuse, prevention, and leadership. The program meets twice a week for three hours and uses a research-based curriculum to help participating students develop leadership skills and avoid harmful behaviors. Staff members form a positive rapport with students, allowing for a safe learning environment where difficult topics and experiences can be discussed and processed. The students view staff not only as teachers, but also as mentors. Program outcomes over seven years include **reduced alcohol and marijuana use, improved attendance, increased grade point average, decreased suspensions, increased participation in extracurricular activities, increased attachment to a trusted adult, reduced juvenile justice involvement, and increased high school completion.**

- 4. Child Welfare Interventions.** Many children and families receiving child welfare services are affected by parental substance use, but effective programs exist to intervene and improve outcomes for both parents and children. For example, Sobriety Treatment and Recovery Teams (START) is a Child Protective Services (CPS) program for families with parental substance use disorder and child abuse/neglect that helps parents achieve sobriety and keeps children with their parents when it is possible and safe. START was first implemented in Ohio and Kentucky, creating an integrated intervention that pairs a social worker with a family mentor to work collaboratively with a small number of families, providing peer support, intensive treatment and child welfare services. The program's goal is to keep children safe and reduce placement of these children in state custody, keeping children with their families when appropriate.

Each START team is made up of a dedicated supervisor and up to four "dyads," each of which is composed of a specially trained caseworker from CPS and a family mentor. Family mentors have at least three years of sustained recovery and personal experiences that sensitize them to child welfare issues. START engages eligible families at the investigation phase in a CPS case. Each dyad is assigned a small caseload of 12 to 15 families with whom they work closely, connecting parents with quick assessment for substance use disorders and to the appropriate treatment facilities, while engaging them in recovery support. The dyad also engages the family through a non-judgmental, strengths-based approach, using Motivational Interviewing and shared decision making. Because of the small caseload, each dyad conducts multiple visits to their assigned families each month, and together, they customize services based on the family's needs. For instance, in addition to treatment for substance use and co-occurring mental health disorders, parents may also be referred to domestic violence, legal, (repeated) transportation, parenting, and medical services, as needed. Each dyad works closely with START program partners in order to provide comprehensive services to families.

Mothers who participated in START achieved sobriety at nearly twice the rate of mothers treated without START (66 percent and 37 percent, respectively).<sup>30</sup> The program has also proven to be effective at keeping children at home. Children in families served by START were half as likely to be placed in state custody as compared with children in a matched control group (21 percent and 42 percent, respectively).

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<sup>30</sup> Ruth A. Huebner, Tina Willauer, & Lynn Posze, *The impact of sobriety treatment and recovery teams (START) on family outcomes*, Families in Society: The Journal of Contemporary Social Services, 93:3 (2012), 196-203.

This outcome also results in cost-effectiveness—for every \$1.00 spent on START, Kentucky avoided spending \$2.22 on foster care.<sup>31</sup>

## Recommendations

1. **Increase the uptake of evidence-based solutions to address the opioid epidemic** in cities, counties, communities, healthcare systems, schools and criminal justice agencies. Doing so would drastically improve our response to addiction nationwide. Key interventions to prioritize should include: a) MAT access nationwide, particularly in Emergency Departments post non-fatal overdose and in all jail and prison systems for individuals with opioid use disorder; 2) widespread community-based naloxone distribution; 3) Contingency Management therapy for stimulant use disorder; 4) expanding Syringe Service Programs which have decades of research that demonstrate that SSPs are effective, safe, and cost-saving, and connect people to needed health care services.
2. **Build the addiction workforce** by addressing the lack of coverage for many providers in the field, low reimbursement rates and creating incentives to build the workforce pipeline.
3. **Go upstream** and invest in prevention, early intervention and screening, interventions for children impacted by parental addiction and ACEs, and primary prevention programming.

Thank you for the opportunity to testify today and for your commitment to addressing such important issues that impact millions of American families every single day.

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<sup>31</sup> Levels of Research Evidence and Benefit-Cost Data for Title IV-E Waiver Interventions, Research Brief (Third Edition), Casey Family Programs (October 2015).