**Public Policy Statement on Prevention**

## Background

The American Society of Addiction Medicine (ASAM) supports a wide variety of measures to prevent alcohol and other drug related problems in contemporary society, understanding that carefully thought-out prevention measures have demonstrably reduced the early onset of alcohol, nicotine, and other drug use in some populations. This has contributed to a reduction in deaths and serious injuries resulting from drug related injuries and illnesses. These and other identifiable results have major economic implications.

ASAM is committed to increasing access to and improving the quality of evidence-based addiction prevention and treatment. At the same time ASAM encourages the withdrawal of support for prevention practices that have been tested and found to be unhelpful. Although most people in the United States who use substances do not have a substance use disorder (SUD), any use can have potentially negative health consequences for individuals and their communities. This is particularly true for youth for whom early initiation, unhealthy substance use, and substance use disorders are associated with many negative medical and social consequences and increased morbidity and mortality. Additionally, it is well-established that substance use and addiction lead to major health and social problems and significant economic costs.[1,2,3,4,5,6,7] As a result, it is critical to prevent both unhealthy substance use and addiction.

Evidence-informed substance use prevention interventions can avert or delay the onset of substance use, stop the progression from use to harmful use or addiction, and reduce substance use-related health, social, and economic costs. Research has identified several robust risk and protective factors predictive of substance use that are amenable to prevention interventions. The health and strength of familial and social structures and one's mental and emotional well-being are powerful protective factors against substance use and its progression. Because these factors are also associated with the development of other behavioral and social problems, prevention policies and programs aimed at cultivating protective factors and mitigating risk factors for substance use can also protect against other negative behavioral and social issues. Effective prevention interventions may be universal (i.e., meant to reach all members of a given population), selective (i.e., aimed at a high-risk population subgroup), or indicated (i.e., targeted to individuals who already use substances but do not have a substance use disorder or addiction).

Two reports, one by the Surgeon General and another by the United Nations, reviewed the evidence and cost-effectiveness of numerous prevention programs.[8, 9] Unfortunately, the existing evidence-based substance use prevention programs and policies are not widely used or well implemented. Moreover, the 2016 *Surgeon General's Report on Alcohol, Drugs, and Health* notes that studies have found that many schools and communities use prevention programs that have little or no evidence of effectiveness.[10] Given the magnitude of the health, social, and economic consequences of substance use and addiction in our country, it is critical that programs and policies informed by prevention science are more widely adopted and brought to scale as quickly as possible. As a result, ASAM offers the recommendations below.

**Recommendations:**

The American Society of Addiction Medicine recommends that:

*ASAM Leadership and Members should:*

1. Include prevention whenever advocating for improved addiction treatment: i.e. "prevention and treatment" replace the singular term "treatment" wherever possible.
2. Include appropriately significant time blocks on prevention topics, at all prevention levels, at national and regional meetings.
3. Advocate for funding to expand physician and other health professional post-degree training in the field of Addiction Medicine, which promotes the dual goals of prevention and treatment.

*Healthcare Providers should:*

1. Be offered and participate in training on and subsequently use evidence-informed interventions to prevent the unhealthy use of alcohol[11], nicotine, and other substances.
2. Offer evidence-informed information about the harmful nature of alcohol, tobacco, and other substance use to patients during routine medical examinations.
3. Provide evidence-informed, integrated substance use disorder treatment services for pregnant women with a substance use disorder in order to minimize risk to the newborn.
4. Provide evidence-informed, integrated substance use disorder treatment services for parents with a substance use disorder to mitigate harmful consequences and/or modeling of substance us for their children.
5. Actively participate in community coalitions, school related activities and organizations, and the legislative/regulatory process at the county, state, and federal level to influence the adoption of policies that reduce risk factors and increase protective factors for unhealthy or harmful substance use, especially by youth.
6. Use Prescription Drug Monitoring Programs (PDMPs) as a means to prevent prescription drug misuse and related harms.
7. Identify those with and those at risk of developing an alcohol use disorder using a Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach.
8. Advocate for increased research into the best methods for primary care physicians and others to screen for and provide brief interventions for unhealthy and harmful substance use and early stage substance use disorders including the use of computer assisted and

mobile device interventions and the optimal use of non-physicians on the health care team when utilizing SBIRT approaches.
9. Support harm reduction policies such as those targeting injection drug use to prevent harms including the transmission of infectious disease.

*Health Professions Education and Training:*

1. Medical and other health professional schools should include or expand unhealthy use and addiction prevention contents to their basic science and treatment tracks.
2. Physician residency and fellowship training programs should adopt or add SUD prevention content into their curricula.

*Policymakers should:*

1. Appropriately fund prevention science research[12] to better understand the programs and policies that effectively prevent substance use initiation and the development of unhealthy use or addiction.
2. Increase or maintain significant taxes on legally available substances with addictive potential such as alcohol, cannabis, and nicotine, to reduce alcohol consumption, underage and binge use, and related problems. Tax revenue obtained from these sources should be earmarked for public health prevention and treatment efforts.
3. Reduce alcohol, tobacco, and cannabis retail outlet density and days and hours of sales and consistently enforce commercial host liability policies to reduce negative health and social consequences including motor vehicle crashes and crime.
4. Reduce underage drinking by consistently enforcing the Minimum Legal Drinking Age (MLDA) through compliance check surveys on alcohol sales to people younger than 21 and laws that allow states to suspend drivers' licenses for underage alcohol violations.
5. Reduce access by young persons to cannabis by opposing commercialization, by consistently enforcing age restrictions where it is already commercially available and by preventing diversion of "medical" cannabis to minors.
6. Require prescribers and dispensers to enroll in and query the state's PDMP to prevent prescription drug misuse and related harms.[13]
7. Require schools to institute evidence-informed prevention education and standards.
8. Work with physicians and other practitioners in the addiction medicine community to develop national standards for substance use prevention.
9. Discourage the implementation and maintenance of prevention measures which have been tested and found to be of no benefit.

*Schools, Families, and Communities should:*

1. Deploy evidence-informed programs to target youth at risk of using or misusing substances and use Evidence Based Interventions (EBIs) for school age children and adolescents in order to nurture the physical, cognitive and emotional development of children. Such programs should include:
    a. Social and cognitive development of youth through early childhood education;
    b. Personal and social skills development for children ages 6-12;

    c. Skills-based prevention programs for adolescents that develop substance and peer refusal skills;
    d. Programs that strengthen the classroom management abilities of teachers and instructors and enforcing policies that keep children in school;
    e. Policies that use the feedback of students, teachers, staff, and parents to bar use of substances on school premises and installs non-punitive measures and positive sanctions such as referral to healthcare services for policy breaches; and
    f. Programs that address the individual psychological vulnerabilities of students that have been identified as having risk for substance use disorders.
2. Mobilize and build prevention infrastructure at the local level by increasing awareness of evidence-informed interventions and appropriately disseminating and providing the necessary tools to implement evidence-informed interventions.
3. Provide mentoring between adolescents and responsible adults.
4. Provide prenatal and infancy visitation services for pregnant women and new mothers to address the socioeconomic needs of at-risk pregnant women and reinforce parenting skills.
5. Colleges and universities should include unhealthy substance use prevention programs for all students.

*Employers should:*

1. Develop and enforce workplace prevention and wellness programs as well as Employee Assistance Programs (EAPs) to meet the needs of employees and affected family members.
2. Ensure that all health insurance policies include coverage of services that target detection of and intervention against substance use, such as the utilization of SBIRT approaches for unhealthy and harmful alcohol use.
3. Safeguard employee confidentiality for all who avail themselves of EAPs and medically indicated addiction treatment services.

*Insurers should:*

1. Provide coverage of services that target early detection of and intervention for substance use, such as the utilization of SBIRT approaches for unhealthy and harmful alcohol use and evidence-informed prevention interventions offered by healthcare providers, and to do so without burdensome utilization management oversight.

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[1] Centers for Disease Control and Prevention (CDC). *Alcohol and Public Health: Alcohol-Related Disease Impact (ARDI). Average for United States 2006–2010 Alcohol-Attributable Deaths Due to Excessive Alcohol Use.* Available at: https://nccd.cdc.gov/DPH_ARDI/Default/Report.aspx?T=AAM&P=f6d7eda7-036e-4553-9968-9b17ffad620e&R=d7a9b303-48e9-4440-bf47-070a4827e1fd&M=8E1C5233-5640-4EE8-9247-1ECA7DA325B9&F=&D=

[2] U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress. A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.

[3] Hedegaard H, Warner M, Miniño AM. Drug overdose deaths in the United States, 1999–2016. NCHS Data Brief, no 294. Hyattsville, MD: National Center for Health Statistics. 2017.

[4] U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Washington, DC: HHS, November 2016.

[5] Sacks, J. J., Gonzales, K. R., Bouchery, E. E., Tomedi, L. E., & Brewer, R. D. (2015). 2010 national and state costs of excessive alcohol consumption. American Journal of Preventive Medicine, 49(5), e73-e79.

[6] National Drug Intelligence Center. (2011). National drug threat assessment. Washington, DC: U.S. Department of Justice.

[7] The Council of Economic Advisors. November 2017. The Underestimated Cost of the Opioid Crisis. Available at: https://www.whitehouse.gov/sites/whitehouse.gov/files/images/The%20Underestimated%20Cost%20of%20the%20Opioid%20Crisis.pdf

[8] U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Washington, DC: HHS, November 2016.

[9] International Standards on Drug Use Prevention (Publication). (2015). Vienna: United Nations.

[10] Ibid

[11] Saitz, Richard. (2005). Clinical practice. Unhealthy alcohol use. The New England journal of medicine. 352. 596-607. 10.1056/NEJMcp042262.

[12] The Surgeon General's report provides descriptions of successful programs. In Appendix A and then in Appendix B it presents more detailed review of evidence involving many programs. The United Nations Report in Appendix II Annex V has 150 pages of evidence-based reviews in which programs are organized into 18 groups. Addressing individual psychological vulnerabilities, alcohol policies, brief interventions,

classroom environment improvement programs, community-based multi-component initiatives, early childhood education, entertainment venues, interventions targeting pregnant women with substance abuse disorders, media campaigns, mentoring, parenting skills, personal and social skills education (middle childhood), prevention education based on personal and social skills and social influence (early adolescence & adolescence), policies to keep children in school, prenatal and infancy visitation, school policies and culture, tobacco policies and workplace interventions.

[13] ASAM Policy Statement on Prescription Drug Monitoring Programs (PDMPs). April 2018. https://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2018/04/24/prescription-drug-monitoring-programs-(pdmps)