



ASAM American Society of
Addiction Medicine

Public Policy Statement on Prevention

Introduction

The American Society of Addiction Medicine supports a wide variety of effective measures to prevent substance use-related problems, especially among youth.¹⁻⁴ Although not widely adopted,⁵ effective prevention measures can reduce serious injury and death associated with substance use, misuse, and substance use disorder (SUD)^{6-8*} and improve quality of life⁸⁻¹⁰ and productivity.¹¹ Utilization of effective prevention measures also has major economic implications. Opioid and excessive alcohol use and related deaths alone cost the nation almost \$2 trillion annually in recent years, or nearly a tenth of the nation's gross domestic product.^{12,13}

Background

ASAM is committed to increasing access to high-quality, evidence-based prevention measures, which not only prevent substance use and related harms, but also promote health, wellbeing, and advance equity in society. Although most people who use substances do not develop addiction, any use can have potentially negative consequences for individuals and their communities. This is especially true for adolescents for whom any nonmedical substance use has more potential to have harmful and long-lasting effects on the still-developing brain,¹⁴⁻¹⁶ and substance use, misuse, and SUD vary and can lead to early and long-term morbidity and mortality.¹⁷ Moreover, moderate to severe SUD symptoms in adolescence often carry over to adulthood.¹⁸ Due to magnitude of the implications above, the wider adoption of effective prevention measures is imperative.

Early initiation of substance use, family history of substance use, mental health problems, or experiences of trauma create a high risk of transition to SUD.¹⁹⁻²¹ Of particular concern is a graded, dose-response relationship between risk for development and severity of SUD and the number of potentially traumatic events an individual encounters as a child, collectively referred to as adverse childhood experiences (ACEs).²²⁻²⁴ As an example, enduring four or more ACEs before the age of 18 multiplies an individual's risk for smoking by three, alcohol misuse by four, and any substance misuse by seven.²⁵ Traumatic incidents drive multi-level changes through chronic

*Substances are any legal or illegal, scheduled, or unscheduled psychoactive compound with the potential to cause health and social problems, including addiction. "Substance misuse" is use at high doses and/or frequency, or in a manner that elevates risk to self or others, and includes nonmedical use of prescription medication, and in adolescence, includes any nonmedical use of substances. Some prefer "unhealthy use" to substance misuse (Saitz, et al., 2021 and Alinsky, et. al., 2022), both terms encompass "hazardous" or "at-risk use," which increases the risk for health consequences to the individual, and "harmful use," which has resulted in health consequences to the individual. "Substance use disorder (SUD)" should not be conflated with "substance dependence" and SUD can range from mild to severe and transient to persistent; it is a separate, independent, diagnosable illness that significantly impairs health and function and may require special treatment (McClellan, 2017).

activation of the stress response system;²⁶ however, more longitudinal research is necessary for understanding the causal effects of traumatic stress on an individual's risk behaviors and biology, including genetics, and applying this to prevention interventions.^{23,27–29}

Often underappreciated structural conditions, such as the long-term effects of racism and poverty, unstable housing, and food insecurity, contribute to and exacerbate ACEs,²⁶ and have profound implications for individuals' health outcomes.^{30,31} Indeed, the persistence of structural inequities renders minoritized youth more likely to experience severe consequences from using substances and less likely to receive evidence-based treatment than their White counterparts.^{32–36} Some prevention models recognize experiences of racism as risk factors for SUD.² Therefore, a critical component of prevention prioritizes equity and the needs of Black, Indigenous, and Other People of Color (BIPOC), and additionally, those of Lesbian, Gay, Bisexual, Transgender, and Queer, Plus (LGBTQ+), youth.

Research has identified risk and protective factors³⁷ that change over the life course and are consistent across diverse populations.³⁸ These factors shape the presence of safe, stable, and nurturing relationships and environments, which are powerful potential safeguards against the initiation and progression of substance use, misuse, and SUD.³⁹ Risk factors predict compromised youth health and wellbeing,⁵ increase the likelihood of morbidity and mortality,⁴⁰ and are associated with other behavioral problems, such as minor crime, early pregnancy, school misbehavior, and abandonment of education.³⁷ Protective factors are not simply indicated by an absence of risk factors, rather, the presence of protective factors may lessen or stunt risk factors' negative impacts.⁴¹ Risk and protective factors are categorized as biological or environmental in nature;¹⁶ environmental risk factors are amenable to available prevention interventions.³⁹

General prevention measures

Experts have reviewed the impact and characteristics of prevention interventions and found that they are effective at all ages to reduce substance use.^{38,42} Effective prevention interventions may be universal (i.e., meant to reach whole communities), selective (i.e., aimed at high-risk individuals or a subgroup), or indicated (i.e., targeted to individuals who already use substances, but do not have SUD).² Prevention interventions that are tailored to be culturally appropriate³⁹ to address racial and ethnic inequities in access to substance use-related interventions,^{32,33,39,43} can help reduce the social consequences of early onset of SUD.^{44,45}

Prevention measures that bolster protective factors and mitigate risk factors, such as home visitation before and during infancy^{46–51} and family skills training programs to reinforce parenting skills^{52,53} impact individuals' lives more broadly.^{37,39,54} However, interventions interact with individuals that live in complex systems with broad social, environmental, and legal contexts and may have unintended, adverse consequences.⁵⁴ For example, home visiting may be implemented with legal surveillance by child welfare agencies, and result in child removal under circumstances that are inconsistent with a public health approach.^{55–57}

In addition, exclusionary school laws or policies that respond to substance-related infractions by suspending students or referring them to the legal system are still commonplace,⁵⁸ but lack evidence,^{59–62} and may lead to more criminal offenses.⁶³ Random drug testing of students in schools, although seemingly straightforward, can have adverse consequences such as false positives, discouraging students from participating in extracurricular activities, and implementing exclusionary and strict punishments based on test results.^{62,64–66} Lastly, policies that focus on the

carceral rehabilitation or confinement of youth who use substances increase social inequities,^{67,68} while prevention measures can forestall youth health problems from occurring at all.⁵

Though prevention interventions can improve behavioral and health outcomes across generations,⁶⁹ inadequate government financing and limited public knowledge are significant barriers to widespread implementation.⁴⁰ The federal drug control budget allocates relatively limited funding for prevention, including for scientific research and intervention implementation.^{70–74} Less than 3 percent of the National Institute of Health’s (NIH) annual research awards were for prevention science in recent years, namely to the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA).⁷⁵ When adjusted for inflation, the funding level has decreased for the federal block grant to states that requires 20 percent be spent on primary prevention programs,^{76,77} and the pace of the federal grant process may restrict states from quickly responding to changing trends in substance use.⁷⁶ Other longstanding federal efforts fund coordination of substance use and violence prevention efforts at schools and in their surrounding communities.⁷⁸ However, historically, less than half of middle school programs used evidence-based prevention curricula.^{79,80} Fostering collaborative approaches among education and other community systems may help schools lacking capacity to better identify and serve students at risk or already affected by substance use.⁸¹

Neglected opportunities within the healthcare system

In addition to a historical emphasis on prevention initiatives at schools, visits in primary care settings represent a wide-reaching opportunity for implementation of universal screening, brief intervention, and referral to treatment (SBIRT).^{82–84} Among adults, SBIRT reduces heavy alcohol use,^{85–88} and is a recommended practice by the U.S. Preventive Services Task Force (USPSTF).⁸⁶ However, limitations have been demonstrated in SBIRT’s efficacy among adults to reduce unhealthy drug use⁸⁹ and the USPSTF recommendation is that screening for unhealthy drug use should be implemented when “services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred.” The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for unhealthy alcohol or drug use in adolescents.⁹⁰ The American Academy of Pediatrics reaches a different conclusion and recommends increased implementation of SBIRT for adolescents.⁸³ Furthermore, constraints to the study of SBIRT among adolescents have likely stymied uptake.⁹¹ An evolving evidence base, low cost, and minimal evidence of harms may support SBIRT’s potential population-level benefit and further deliberate incorporation into primary care settings.^{92,93}

Even now, in spite of the prevalence of substance misuse in primary care settings, there is limited access to screening, assessment, and follow-up, especially in rural areas.^{94,95} Integrating family-focused prevention and early intervention and reducing barriers to reimbursement upstream can save healthcare payers costs in hospital charges from adolescent substance use,^{82,96,97} and sustain such services in primary care settings.⁹⁸ Furthermore, sufficient education and training can increase the professional competencies that are necessary to facilitate discussion of substance use and may strengthen critical patient-practitioner relationships in primary care settings.^{82,99}

Substance-specific measures

Tobacco use, and the harmful use of alcohol, respectively, are the nation’s number one and four leading causes of preventable death.^{100,101} The most cost-effective activities for tobacco control and cessation and reducing alcohol use are increased tobacco and alcohol taxes and restrictions

on alcohol availability, such as reduced hours of sale.¹⁰² Effective health policy advocacy predictably generates resistance by the tobacco and alcohol industries, the majority of whose sales are to individuals with heavy use associated with harm.¹⁰³ Of concern is that alcohol has become more affordable since its federal excise tax was last set in 1991.¹⁰⁴ Furthermore, some options for increasing federal tobacco and alcohol excise taxes could create an estimated \$150 billion in federal revenue over nine years.^{105,106}

System-level prevention and response strategies are also needed to reduce the burden associated with the ongoing opioid addiction and overdose crisis in America,^{107,108} in which the marketing of pharmaceutical opioids for pain to prescribers and patients and the inappropriate prescribing thereof have played a significant role.^{109–112} While people who misuse pharmaceutical opioids frequently obtain them from friends and family, the original source of shared pharmaceutical opioids is often traceable to excess prescribing for pain.¹¹³ Furthermore, six percent of patients undergoing both minor and major surgery develop the new onset of long-term opioid use, suggesting that over two million people may transition to persistent opioid use following elective surgery each year in the U.S.,¹¹⁴ potentially placing them and those around them at risk for associated adverse events. However, such risks can be addressed: after an educational intervention for surgical faculty, residents, and staff in one hospital following gallbladder surgery, the median dosage of opioid prescriptions was decreased by 70 percent, with no change in patient-reported pain management effectiveness score or refill requests.¹¹⁵

Given evidence of an increased and dose-dependent risk between opioid prescribing and the development of opioid use disorder (OUD) as well as other, serious harms in the treatment of patients with chronic, non-cancer pain,^{109,116} reducing exposure to the supply of inappropriately prescribed opioids among such patients (and by extension, reducing such exposure by their friends and family), warrants sustained attention.[†] This may be especially true for opioid-naïve patients, who can benefit from parallel prevention measures such as multimodal pain care plans.¹¹⁷ Further, developing effective, evidence-based interventions to address modifiable aspects of underlying risk factors for the transition from opioid use and misuse to OUD also warrants sustained attention.¹¹⁸

Widespread use of illicitly manufactured fentanyl (IMF), increasingly pressed into counterfeit pills resembling oxycodone, alprazolam, and other prescription medications, appear to be contributing to the steep, recent rise in opioid overdose deaths.^{119,120} Counterfeit pills are available outside licensed pharmacies, and one problematic point of access is online social media sites and marketplaces.^{121–124}

Youth cannabis use is associated with harms above those reported by adults. Early initiation and frequency of use and use of high-potency THC products are associated with risk for individuals to use other substances,^{125,126} developing substance misuse and SUD,¹²⁷ and encountering additional adverse consequences to their mental health and functional wellbeing.^{128–131} Therefore, as state commercialization and legalization of recreational cannabis use becomes more commonplace, limiting such products' availability to youth has significant public health importance, and implementation of evidence-based policies is warranted – not limited to restricting advertising, including for social media; enacting minimum distances between retailers and residential zones;

[†] While tapering of opioids among patients established on a long-term opioid therapy for chronic non-cancer pain may reduce opioid use and pharmaceutical opioid exposure, it has also been associated with “numerous potential harms,” (Stringfellow, et. al., 2021) and the need for and approach to tapering should be determined on a case-by-case basis, with patients involved in shared decision-making whenever possible.

and preventing high retailer density in disadvantaged neighborhoods, densely populated areas, and for the product-naïve.^{132–136}

The future of prevention

The lessons the nation is learning from the past decades underscore the need to fund and deploy validated and vigorous prevention measures in medical and nonmedical settings. While the nation's current approach to substance use prevention has value, it also has fundamental weaknesses, including its constraint by commercial influence and the need to demonstrate visible policy impacts in the short-term.^{5,137,138} The imminent challenge to governments is to substantially support research for better insight into longstanding uncertainties, including implementation fidelity and adaptation, and long-term sustainability of prevention interventions,^{39,40,139–142} and furthermore, to swiftly adopt and implement evidence-based prevention policies and programs at scale.

In addition, the nation requires new, innovative solutions that aim to address structural inequities, stigma, and discrimination, which adversely affect access, utilization, experiences, and outcomes in healthcare services.^{143–148} New state financing structures are emerging to reorient the health care system from a traditional focus on short-term and acute illness and incentivize a variety of public and private entities to address the long-term health-related social needs of children and their families.¹⁴⁹ Finally, states and localities expect billions of dollars in settlement and judgment proceeds from opioid manufacturers, distributors, and pharmacies over the coming decades; historical lessons from the spending of tobacco litigation settlement funds illustrate the importance of ensuring that such proceeds are spent to abate substance use, misuse, and SUD, and maximize public health benefit.^{150,151}

Recommendations

General prevention policy measures

1. The federal government should increase funding for prevention science research that assesses and proliferates evidence-based prevention interventions, as well as addresses the influence of social adversity on behavioral risk for substance misuse and SUD,¹⁵² including the longitudinal, potentially causal effects of traumatic stress. NIDA should dedicate a significant, baseline portion of its funding to actionable research addressing the causal and consequential role of health inequities and adverse childhood experiences (ACEs) in the development and severity of substance misuse and SUD, and to developing interventions for the mechanistic drivers of elevated risk for substance misuse and SUD.^{21,153}
2. At a minimum, the federal government should adjust prevention funding for inflation and ensure related programming can adapt quickly to changing local substance use trends.⁷⁶
3. States should ensure that communities implement prevention interventions that are evidence-based, equity enhancing, and cost beneficial, by establishing and implementing criteria for such interventions. Furthermore, states should use outcome data from controlled studies and information from cost-benefit analyses to inform policy decisions.⁵

4. States should provide communities with assessment and capacity-building tools to prioritize risk and protective factors systematically, and target such factors with selected implementation of evidence-based prevention programs.^{154,155}
5. States should adequately fund public health agencies to provide comprehensive, evidence-based prevention programs to families throughout the life course, including home visitation before and during infancy and family skills training programs, which support and reinforce parenting abilities. Home visitation interventions should be implemented with the intention to prevent potential adverse and unintended consequences, for example, by reserving child removal from families for cases in which other risk factors or harms have been assessed or identified, and there is objective evidence of abuse, neglect, or other danger to the child.⁵⁵
6. States should require proven prevention programming for all students in publicly funded school districts and postsecondary institutions that meets quality, impact, specificity, and dissemination readiness criteria.^{4,156} Moreover, states should refrain from implementing and/or repeal exclusionary school laws or policies that suspend students or refer them to the legal system for substance use-related infractions, or that mandate random drug testing in schools.⁶¹
7. States should implement trauma-informed crisis intervention models, which are based on interagency collaboration among schools, law enforcement agencies, and mental health providers.

Maximizing opportunities within the healthcare system

8. The federal government should increase funding for programs that ensure a diverse and inclusive healthcare professional workforce with adequate capacity to provide high-quality prevention and early intervention services, including the Addiction Medicine Fellowship, the Teaching Health Center Graduate Medical Education (THCGME), the Minority Fellowship Program (MFP), and the Substance Use Disorder Treatment and Recovery Loan Repayment Program (STAR-LRP).
9. The federal government should provide funding to encourage medical and other healthcare professional schools to expand substance use-related content in clinical and basic science curricula, including in residency and fellowship training for physicians, and similar programs for advanced practitioners, pharmacists, and other clinicians. Graduate medical education and healthcare professional associations that are responsible for training the workforce should foster skills and experiences that increase professional competence in screening, early intervention, and consultation with addiction specialist physicians, as well as the development of competencies in screening and prevention programs.”^{82,157}
10. States should implement public health approaches for youth and families affected by substance use,⁵⁵ and encourage pediatric healthcare professionals working in primary care settings to increase their core competencies in providing preventive care for such individuals and families.^{158,159}

11. States should advance policies that support primary care and allied healthcare professionals in increasing their capacity to offer state-of-the-art, evidence-based interventions to detect, assess, and intervene for substance use, misuse, and SUD, and participate in training on models of prevention and early intervention, including family focused SBIRT, which screens whole households during well-child visits.
12. States should support strategies for well-defined and operationalized plans for SBIRT implementation – where an appropriate diagnosis, effective treatment, and appropriate care can be offered or referred – in primary care practices, federally qualified health centers, school-based health centers (SBHCs), safety-net emergency departments, and other medical settings.¹⁶⁰ Concurrently, states should support funding for the continued study of SBIRT’s efficacy, especially among adolescents.^{91,93}
13. Public and private healthcare payers should promote and provide prevention and early intervention services by ensuring such services are offered, covered, and reimbursed without burdensome utilization management oversight, as well as a standard payment mechanism for confidential follow-up for patients to receive continuity of care.
14. State Medicaid/Children’s Health Insurance Programs (CHIP) programs should advance policies that would increase receipt of substance use screening and early intervention for Medicaid-enrolled youth,^{161,162} including 1) enacting billing codes to ensure coverage of services; 2) satisfying the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit;^{‡163} 3) providing incentives to ensure that pediatricians, SBHCs, and primary care and allied healthcare professionals effectively screen children and youth; 4) improving guidance, training, and oversight of primary care and school-based healthcare professionals to screen for, provide early interventions and appropriate follow-up for, and bill for such services; 5) increasing reimbursement rates for such services to boost system capacity; 6) establishing performance, quality, and outcome measures that can be tied to reimbursement and incentive payments for high-quality care; and 7) updating state plans to reimburse for covered services provided in schools to Medicaid-enrolled students, even if there is no charge for the service.¹⁶⁴

Strengthening substance-specific measures

15. In the absence of a legal ability to ban direct-to-consumer pharmaceutical advertising, the federal government should advance policies that limit pharmaceutical companies’ marketing of scheduled medications to healthcare professionals and patients, including ending related tax deductions.¹¹²
16. States should promote system-level measures and policies to optimize opioid prescribing, expand patients’ access to multimodal (including non-opioid) pain management, and support clinicians in responsible opioid prescribing (when opioids are medically indicated) to reduce inappropriate prescribing and exposure to pharmaceutical opioids, especially among opioid-naïve patients.
17. States should require prescribers and dispensers to participate in and query prescription drug monitoring programs (PDMPs) to prevent related harms.^{108,165} States should include

‡ The EPSDT requires that Medicaid and many CHIP enrollees under age 21 be periodically screened for SUD as a regular component of comprehensive medical assessments.

such personnel working at opioid treatment programs (OTPs) in mandated PDMP reporting, to support safer controlled medication prescribing and dispensing practices.

18. States should enact policies that facilitate the safe disposal of scheduled medications, such as through mandating prescription drug take-back drop boxes at community pharmacies.¹⁶⁶
19. The federal government should increase federal tobacco and alcohol excise taxes as an efficient means to reduce tobacco and harmful alcohol use, increase federal revenues, and save lives. State and localities governments should increase or maintain significant alcohol and tobacco taxes, reduce alcohol retail outlet density and days of hours of sale, and enforce 1) commercial host liability policies;¹⁶⁷ 2) the Minimum Legal Drinking Age, through compliance check surveys, and 3) laws to suspend drivers' licenses for underage alcohol violations, as well as take other cost-effective measures to reduce harmful alcohol use and tobacco use.¹⁰²
20. States should enact policies that reduce youth access and exposure to cannabis products, including restrictions on manufacturing, marketing, and retail operations, age limits, and opposing commercialization.¹²⁷ States should implement science-based campaigns that provide public education on potential and demonstrated risks (particularly for youth) of using cannabis products, and correct misinformation that minimizes youth perception of risk, or conflates the important differences between decriminalization, legalizing possession, state-controlled or other public health-based regulation of legalized sales, and full commercialization.¹⁶⁸ In states where cannabis products are legally available, states should identify minimum distances from schools and residential zones for retailers and enforce measures that prevent diversion to minors.

Capitalizing on future prevention opportunities

21. The federal government should provide planning grants to state governments that support efforts to launch public-private partnerships established to address the long-term health-related social needs of children and their families. States should establish such funds as mechanisms for blending and braiding federal, state, and/or private funding streams to improve the implementation of interventions that support children's development, growth, and ability to thrive.¹⁴⁹
22. The federal government should assist states and localities with optimizing spending from opioid litigation settlements.¹⁶⁹ States should codify measures to ensure that opioid litigation settlement funds are spent on evidence-based substance use, misuse, and SUD prevention and treatment programs.¹⁷⁰

Adopted by the ASAM Board of Directors July 27, 2023.

© Copyright 2023. American Society of Addiction Medicine, Inc. All rights reserved. Permission to make digital or hard copies of this work for personal or classroom use is granted without fee provided that copies are not made or distributed for commercial, advertising or promotional purposes, and that copies bear this notice and the full citation on the first page. Republication, systematic reproduction, posting in electronic form on servers, redistribution to lists, or other uses

of this material require prior specific written permission or license from the Society. ASAM Public Policy Statements normally may be referenced in their entirety only without editing or paraphrasing, and with proper attribution to the society. Excerpting any statement for any purpose requires specific written permission from the Society. Public Policy statements of ASAM are revised on a regular basis; therefore, those wishing to utilize this document must ensure that it is the most current position of ASAM on the topic addressed.

American Society of Addiction Medicine

11400 Rockville Pike, Suite 200, Rockville, MD 20852
Phone: 301.656.3920 | Fax: 301.656.3815

www.ASAM.org

References

1. Lochman JE, Wells KC. Effectiveness of the coping power program and of classroom intervention with aggressive children: Outcomes at a 1-year follow-up. *Behav Ther.* 2003;34(4):493-515. doi:10.1016/S0005-7894(03)80032-1
2. Nelson LF, Weitzman ER, Levy S. Prevention of Substance Use Disorders. *Med Clin North Am.* 2022;106(1):153-168. doi:10.1016/j.mcna.2021.08.005
3. Das JK, Salam RA, Arshad A, Finkelstein Y, Bhutta ZA. Interventions for Adolescent Substance Abuse: An Overview of Systematic Reviews. *J Adolesc Health.* 2016;59(4, Supplement):S61-S75. doi:10.1016/j.jadohealth.2016.06.021
4. Mihalic SF, Elliott DS. Evidence-based programs registry: Blueprints for Healthy Youth Development. *Eval Program Plann.* 2015;48:124-131. doi:10.1016/j.evalprogplan.2014.08.004
5. Hawkins JD, Jenson JM, Catalano R, et al. Unleashing the Power of Prevention. *Natl Acad Med Perspect.* Published online June 22, 2015. doi:10.31478/201506c
6. Saitz R, Miller SC, Fiellin DA, Rosenthal RN. Recommended Use of Terminology in Addiction Medicine. *J Addict Med.* 2021;15(1):3-7. doi:10.1097/ADM.0000000000000673
7. Alinsky RH, Hadland SE, Quigley J, Patrick SW, COMMITTEE ON SUBSTANCE USE AND PREVENTION. Recommended Terminology for Substance Use Disorders in the Care of Children, Adolescents, Young Adults, and Families. *Pediatrics.* 2022;149(6):e2022057529. doi:10.1542/peds.2022-057529
8. McLellan AT. Substance Misuse and Substance use Disorders: Why do they Matter in Healthcare? *Trans Am Clin Climatol Assoc.* 2017;128:112-130.
9. Charlson FJ, Baxter AJ, Dua T, Degenhardt L, Whiteford HA, Vos T. Excess mortality from mental, neurological and substance use disorders in the Global Burden of Disease Study 2010. *Epidemiol Psychiatr Sci.* 2015;24(2):121-140. doi:10.1017/S2045796014000687
10. Plana-Ripoll O, Pedersen CB, Agerbo E, et al. A comprehensive analysis of mortality-related health metrics associated with mental disorders: a nationwide, register-based cohort study. *The Lancet.* 2019;394(10211):1827-1835. doi:10.1016/S0140-6736(19)32316-5
11. Ropero-Miller JD, Speaker PJ. The hidden costs of the opioid crisis and the implications for financial management in the public sector. *Forensic Sci Int Synergy.* 2019;1:227-238. doi:10.1016/j.fsisyn.2019.09.003
12. The Joint Economic Committee Democrats. The Economic Toll of the Opioid Crisis Reached Nearly \$1.5 Trillion in 2020. Published online October 2022. https://www.jec.senate.gov/public/_cache/files/67bcd7f-4232-40ea-9263-f033d280c567/jec-cost-of-opioids-issue-brief.pdf
13. Centers for Disease Control and Injury Prevention. Excessive Drinking is Draining the U.S. Economy. Published April 14, 2022. Accessed March 22, 2023. <https://www.cdc.gov/alcohol/features/excessive-drinking.html>
14. Winters KC, Arria A. Adolescent Brain Development and Drugs. *Prev Res.* 2011;18(2):21-24.

15. Squeglia LM, Jacobus J, Tapert SF. The Influence of Substance Use on Adolescent Brain Development. *Clin EEG Neurosci Off J EEG Clin Neurosci Soc ENCS*. 2009;40(1):31-38.
16. National Institute on Drug Abuse. Drug Misuse and Addiction. National Institute on Drug Abuse. Accessed April 11, 2023. <http://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/drug-misuse-addiction>
17. Gray KM, Squeglia LM. Research Review: What Have We Learned About Adolescent Substance Use? *J Child Psychol Psychiatry*. 2018;59(6):618-627. doi:10.1111/jcpp.12783
18. McCabe SE, Schulenberg JE, Schepis TS, McCabe VV, Veliz PT. Longitudinal Analysis of Substance Use Disorder Symptom Severity at Age 18 Years and Substance Use Disorder in Adulthood. *JAMA Netw Open*. 2022;5(4):e225324. doi:10.1001/jamanetworkopen.2022.5324
19. McLellan AT, Koob GF, Volkow ND. Preadiction-A Missing Concept for Treating Substance Use Disorders. *JAMA Psychiatry*. Published online July 6, 2022. doi:10.1001/jamapsychiatry.2022.1652
20. Marel C, Sunderland M, Mills KL, Slade T, Teesson M, Chapman C. Conditional probabilities of substance use disorders and associated risk factors: Progression from first use to use disorder on alcohol, cannabis, stimulants, sedatives and opioids. *Drug Alcohol Depend*. 2019;194:136-142. doi:10.1016/j.drugalcdep.2018.10.010
21. Grummitt L, Barrett E, Kelly E, Newton N. An Umbrella Review of the Links Between Adverse Childhood Experiences and Substance Misuse: What, Why, and Where Do We Go from Here? *Subst Abuse Rehabil*. 2022;13:83-100. doi:10.2147/SAR.S341818
22. Gerra G, Somaini L, Manfredini M, et al. Dysregulated responses to emotions among abstinent heroin users: Correlation with childhood neglect and addiction severity. *Prog Neuropsychopharmacol Biol Psychiatry*. 2014;48:220-228. doi:10.1016/j.pnpbp.2013.10.011
23. Stein MD, Conti MT, Kenney S, et al. Adverse childhood experience effects on opioid use initiation, injection drug use, and overdose among persons with opioid use disorder. *Drug Alcohol Depend*. 2017;179:325-329. doi:10.1016/j.drugalcdep.2017.07.007
24. Leza L, Siria S, López-Goñi JJ, Fernández-Montalvo J. Adverse childhood experiences (ACEs) and substance use disorder (SUD): A scoping review. *Drug Alcohol Depend*. 2021;221:108563. doi:10.1016/j.drugalcdep.2021.108563
25. Adverse childhood experiences: What we know, what we don't know, and what should happen next. Early Intervention Foundation. Published January 28, 2020. Accessed July 3, 2023. <https://www.eif.org.uk/report/adverse-childhood-experiences-what-we-know-what-we-dont-know-and-what-should-happen-next>
26. Jones CM, Merrick MT, Houry DE. Identifying and Preventing Adverse Childhood Experiences. *JAMA*. 2020;323(1):25-26. doi:10.1001/jama.2019.18499
27. National Institute on Drug Abuse. Genetics and Epigenetics of Addiction DrugFacts. Published August 5, 2019. Accessed July 5, 2023. <https://nida.nih.gov/publications/drugfacts/genetics-epigenetics-addiction>
28. Potenza MN. Biological Contributions to Addictions in Adolescents and Adults: Prevention, Treatment, and Policy Implications. *J Adolesc Health*. 2013;52(2, Supplement 2):S22-S32. doi:10.1016/j.jadohealth.2012.05.007

29. Vinkers CH, Kalafateli AL, Rutten BP, et al. Traumatic stress and human DNA methylation: a critical review. *Epigenomics*. 2015;7(4):593-608. doi:10.2217/epi.15.11
30. Hinton, Elizabeth. Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. Kaiser Family Foundation. Published May 10, 2018. Accessed April 27, 2023. <https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>
31. Braveman P, Gottlieb L. The Social Determinants of Health: It's Time to Consider the Causes of the Causes. *Public Health Rep*. 2014;129(1_suppl2):19-31. doi:10.1177/003335491412915206
32. Alegria M, Carson NJ, Goncalves M, Keefe K. Disparities in treatment for substance use disorders and co-occurring disorders for ethnic/racial minority youth. *J Am Acad Child Adolesc Psychiatry*. 2011;50(1):22-31. doi:10.1016/j.jaac.2010.10.005
33. Marotta PL, Tolou-Shams M, Cunningham-Williams RM, Washington DM, Voisin D. Racial and Ethnic Disparities, Referral Source and Attrition From Outpatient Substance Use Disorder Treatment Among Adolescents in the United States. *Youth Soc*. 2022;54(1):148-173. doi:10.1177/0044118X20960635
34. American Society of Addiction Medicine. Racial Justice Beyond Health Care: Addressing the Broader Structural Issues at the Intersection of Racism, Drug Use, and Addiction. Default. Published February 9, 2023. Accessed March 19, 2023. <https://www.asam.org/advocacy/public-policy-statements/details/public-policy-statements/2023/02/09/racial-justice-beyond-health-care-addressing-the-broader-structural-issues-at-the-intersection-of-racism-drug-use-and-addiction>
35. American Society of Addiction Medicine. Advancing Racial Justice in Health Care through Addiction Medicine. Default. Published July 28, 2022. Accessed August 1, 2022. <https://www.asam.org/advocacy/public-policy-statements/details/public-policy-statements/2022/07/29/public-policy-statement-on-advancing-racial-justice-in-health-care-through-addiction-medicine>
36. Heitzeg NA. Education or Incarceration: Zero Tolerance Policies and the School to Prison Pipeline. *Forum Public Policy Online*. 2009;2009(2). Accessed April 23, 2023. <https://eric.ed.gov/?id=EJ870076>
37. Hawkins JD, Catalano RF, Miller JY. Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychol Bull*. 1992;112(1):64-105. doi:10.1037/0033-2909.112.1.64
38. SAMHSA & Office of the Surgeon General, Office of the Surgeon General (US). *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. US Department of Health and Human Services; 2016. Accessed January 25, 2022. <http://www.ncbi.nlm.nih.gov/books/NBK424857/>
39. Compton WM, Jones CM, Baldwin GT, Harding FM, Blanco C, Wargo EM. Targeting Youth to Prevent Later Substance Use Disorder: An Underutilized Response to the US Opioid Crisis. *Am J Public Health*. 2019;109(S3):S185-S189. doi:10.2105/AJPH.2019.305020
40. Catalano RF, Fagan AA, Gavin LE, et al. Worldwide application of prevention science in adolescent health. *The Lancet*. 2012;379(9826):1653-1664. doi:10.1016/S0140-6736(12)60238-4
41. Principles of Substance Abuse Prevention for Early Childhood: A Research-Based Guide | NIDA Archives. Published March 1, 2016. Accessed March 23, 2023.

<http://archives.nida.nih.gov/publications/principles-substance-abuse-prevention-early-childhood-research-based-guide>

42. International Standards on Drug Use Prevention. United Nations : Office on Drugs and Crime. Accessed March 22, 2023. [//www.unodc.org/unodc/en/prevention/prevention-standards.html](http://www.unodc.org/unodc/en/prevention/prevention-standards.html)
43. Nelson A. Unequal treatment: confronting racial and ethnic disparities in health care. *J Natl Med Assoc.* 2002;94(8):666-668.
44. Turnbull JE, George LK, Landerman R, Swartz MS, Blazer DG. Social outcomes related to age of onset among psychiatric disorders. *J Consult Clin Psychol.* 1990;58:832-839. doi:10.1037/0022-006X.58.6.832
45. Kessler C, Saunders B. Social Consequences of Psychiatric Disorders, I: Educational Attainment. Published online July 1995. <https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&doi=e853576b82f90408b358deda473a839f2dc45333>
46. Barlow A, Mullany B, Neault N, et al. Paraprofessional-delivered home-visiting intervention for American Indian teen mothers and children: 3-year outcomes from a randomized controlled trial. *Am J Psychiatry.* 2015;172(2):154-162. doi:10.1176/appi.ajp.2014.14030332
47. Barlow A, Mullany B, Neault N, et al. Effect of a paraprofessional home-visiting intervention on American Indian teen mothers' and infants' behavioral risks: a randomized controlled trial. *Am J Psychiatry.* 2013;170(1):83-93. doi:10.1176/appi.ajp.2012.12010121
48. Kitzman HJ, Olds DL, Cole RE, et al. Enduring Effects of Prenatal and Infancy Home Visiting by Nurses on Children: Follow-up of a Randomized Trial Among Children at Age 12 Years. *Arch Pediatr Adolesc Med.* 2010;164(5):412-418. doi:10.1001/archpediatrics.2010.76
49. LeCroy CW, Krysik J. Randomized trial of the healthy families Arizona home visiting program. *Child Youth Serv Rev.* 2011;33(10):1761-1766. doi:10.1016/j.chilcyouth.2011.04.036
50. Green BL, Tarte J, Sanders MB, Waller MS. Testing the Effectiveness of Healthy Start-Healthy Families Oregon: Outcomes and Cost-Benefits. Published online January 2016.
51. Hawks L, Lopoo E, Puglisi L, et al. Community investment interventions as a means for decarceration: A scoping review. *Lancet Reg Health – Am.* 2022;8. doi:10.1016/j.lana.2021.100150
52. Hanson JL, Gillmore AD, Yu T, et al. A Family Focused Intervention Influences Hippocampal-Prefrontal Connectivity Through Gains in Self-Regulation. *Child Dev.* 2019;90(4):1389-1401. doi:10.1111/cdev.13154
53. Kumpfer KL, Whiteside HO, Greene JA, Allen KC. Effectiveness outcomes of four age versions of the Strengthening Families Program in statewide field sites. *Group Dyn Theory Res Pract.* 2010;14:211-229. doi:10.1037/a0020602
54. Biallas RL, Rehfuess E, Stratil JM. Adverse and other unintended consequences of setting-based interventions to prevent illicit drug use: A systematic review of reviews. *J Public Health Res.* 2022;11(2):22799036221103360. doi:10.1177/22799036221103362
55. American Society of Addiction Medicine. Substance Use and Substance Use Disorder Among Pregnant and Postpartum People. Default. Published October 2, 2022. Accessed January 12, 2023.

<https://www.asam.org/advocacy/public-policy-statements/details/public-policy-statements/2022/10/12/substance-use-and-substance-use-disorder-among-pregnant-and-postpartum-people>

56. Stewart KM. Re-Envisioning Child Well-Being: Dismantling the Inequitable Intersections among Child Welfare, Juvenile Justice, and Education. *Columbia J Race Law*. 2022;12:630.
57. Edwards F, Wakefield S, Healy K, Wildeman C. Contact with Child Protective Services is pervasive but unequally distributed by race and ethnicity in large US counties. *Proc Natl Acad Sci*. 2021;118(30):e2106272118. doi:10.1073/pnas.2106272118
58. Diliberti RMP and MK. Survey: Understanding how U.S. public schools approach school discipline. Brookings. Published January 19, 2023. Accessed May 12, 2023. <https://www.brookings.edu/blog/brown-center-chalkboard/2023/01/19/survey-understanding-how-us-public-schools-approach-school-discipline/>
59. Council on School Health and Committee on Substance Abuse. The Role of Schools in Combating Illicit Substance Abuse. *Pediatrics*. 2007;120(6):1379-1384. doi:10.1542/peds.2007-2905
60. Committee on Substance Abuse and Council on School Health. Testing for Drugs of Abuse in Children and Adolescents: Addendum—Testing in Schools and at Home. *Pediatrics*. 2007;119(3):627-630. doi:10.1542/peds.2006-3688
61. Legislative Analysis and Public Policy Association. Model School Response to Drugs and Drug-related Incidents Act • LAPP. LAPP. Published May 3, 2023. Accessed May 19, 2023. <https://legislativeanalysis.org/model-school-response-to-drugs-and-drug-related-incidents-act/>
62. Levy S, Schizer M, COMMITTEE ON SUBSTANCE ABUSE, et al. Adolescent Drug Testing Policies in Schools. *Pediatrics*. 2015;135(4):782-783. doi:10.1542/peds.2015-0054
63. Cuellar AE, Markowitz S. School suspension and the school-to-prison pipeline. *Int Rev Law Econ*. 2015;43(C):98-106.
64. Roche A, Bywood P, Pidd K, Freeman T, Steenson T. Drug testing in Australian schools: Policy implications and considerations of punitive, deterrence and/or prevention measures. *Int J Drug Policy*. 2009;20:521-528. doi:10.1016/j.drugpo.2009.04.002
65. Yamaguchi R, Johnston LD, O'Malley PM. Relationship Between Student Illicit Drug Use and School Drug-Testing Policies. *J Sch Health*. 2003;73(4):159-164. doi:10.1111/j.1746-1561.2003.tb03596.x
66. Terry-McElrath YM, O'Malley PM, Johnston LD. Middle and High School Drug Testing and Student Illicit Drug Use: A National Study 1998–2011. *J Adolesc Health Off Publ Soc Adolesc Med*. 2013;52(6):707-715. doi:10.1016/j.jadohealth.2012.11.020
67. Gilman AB. *Incarceration and the Life Course: Predictors, Correlates, and Consequences of Juvenile Incarceration*. Thesis. 2014. Accessed April 12, 2023. <https://digital.lib.washington.edu:443/researchworks/handle/1773/27584>
68. Western B, Pettit B. Incarceration & social inequality. American Academy of Arts & Sciences. Published July 1, 2010. Accessed April 12, 2023. <https://www.amacad.org/publication/incarceration-social-inequality>

69. Hill KG, Bailey JA, Steeger CM, et al. Outcomes of Childhood Preventive Intervention Across 2 Generations: A Nonrandomized Controlled Trial. *JAMA Pediatr.* 2020;174(8):764-771. doi:10.1001/jamapediatrics.2020.1310
70. U.S. Government Publishing Office. Federal Drug Control Funding FY 2018 - FY 2020. <https://www.govinfo.gov/content/pkg/BUDGET-2020-PER/pdf/BUDGET-2020-PER-5-9.pdf>
71. Office of National Drug Control Strategy. National Drug Control Budget FY 2024 Funding Highlights. Published online March 2023. <https://www.niaaa.nih.gov/about-niaaa/our-funding>
72. National Institute on Drug Abuse. Fiscal Year 2024 Budget Information - Congressional Justification for National Institute on Drugs and Addiction. National Institute on Drug Abuse. Published March 13, 2023. Accessed March 22, 2023. <https://nida.nih.gov/about-nida/legislative-activities/budget-information/fiscal-year-2024-budget-information-congressional-justification-national-institute-drug-abuse>
73. Our Funding | National Institute on Alcohol Abuse and Alcoholism (NIAAA). Accessed April 2, 2023. <https://www.niaaa.nih.gov/about-niaaa/our-funding>
74. Substance Abuse and Mental Health Administration. Grants. Published May 13, 2013. Accessed April 12, 2023. <https://www.samhsa.gov/grants>
75. Villani J, Ganoza L, Sims BE, et al. Substance use prevention research funded by the NIH. *Drug Alcohol Depend.* 2020;206:107724. doi:10.1016/j.drugalcdep.2019.107724
76. Bipartisan Policy Center. Tracking Federal Funding to Combat the Opioid Crisis. Published March 2019. Accessed April 20, 2023. <https://bipartisanpolicy.org/wp-content/uploads/2019/03/Tracking-Federal-Funding-to-Combat-the-Opioid-Crisis.pdf>
77. National Association of State Alcohol and Drug Abuse Directors. Substance Use Prevention, Treatment and Recovery Services (SUPTRS) Block Grant. NASADAD. Published February 14, 2023. Accessed April 24, 2023. <https://nasadad.org/substance-use-prevention-treatment-and-recovery-services-suptrs-block-grant/>
78. School Safety Policies and Programs Administered by the U.S. Federal Government: 1990-2016. Office of Justice Programs. Accessed April 12, 2023. <https://www.ojp.gov/library/publications/school-safety-policies-and-programs-administered-us-federal-government-1990>
79. Ringwalt C, Vincus AA, Hanley S, Ennett ST, Bowling JM, Rohrbach LA. The prevalence of evidence-based drug use prevention curricula in U.S. middle schools in 2005. *Prev Sci Off J Soc Prev Res.* 2009;10(1):33-40. doi:10.1007/s11121-008-0112-y
80. Ringwalt C, Vincus AA, Hanley S, Ennett ST, Bowling JM, Haws S. The Prevalence of Evidence-based Drug Use Prevention Curricula in U.S. Middle Schools in 2008. *Prev Sci Off J Soc Prev Res.* 2011;12(1):63-69. doi:10.1007/s11121-010-0184-3
81. Rollison J, Banks D, Martin AJ, et al. Improving School-Justice Partnerships: Lessons Learned from the Safe Schools/Healthy Students Initiative. *Fam Court Rev.* 2013;51(3):445-451. doi:10.1111/fcre.12041
82. Matson PA, Ridenour T, Jalongo N, et al. State of the Art in Substance Use Prevention and Early Intervention: Applications to Pediatric Primary Care Settings. *Prev Sci.* 2022;23(2):204-211. doi:10.1007/s11121-021-01299-4

83. Levy SJL, Williams JF, COMMITTEE ON SUBSTANCE USE AND PREVENTION, et al. Substance Use Screening, Brief Intervention, and Referral to Treatment. *Pediatrics*. 2016;138(1):e20161211. doi:10.1542/peds.2016-1211
84. Babor TF, McRee BG, Kassebaum PA, Grimaldi PL, Ahmed K, Bray J. Screening, Brief Intervention, and Referral to Treatment (SBIRT): toward a public health approach to the management of substance abuse. *Subst Abuse*. 2007;28(3):7-30. doi:10.1300/J465v28n03_03
85. O'Connor EA, Perdue LA, Senger CA, et al. Screening and Behavioral Counseling Interventions to Reduce Unhealthy Alcohol Use in Adolescents and Adults: Updated Evidence Report and Systematic Review for the US Preventive Services Task Force. *JAMA*. 2018;320(18):1910. doi:10.1001/jama.2018.12086
86. US Preventive Services Task Force. Screening and Behavioral Counseling Interventions to Reduce Unhealthy Alcohol Use in Adolescents and Adults: US Preventive Services Task Force Recommendation Statement. *JAMA*. 2018;320(18):1899-1909. doi:10.1001/jama.2018.16789
87. Rombouts SA, Conigrave JH, Saitz R, Louie E, Haber P, Morley KC. Evidence based models of care for the treatment of alcohol use disorder in primary health care settings: a systematic review. *BMC Fam Pract*. 2020;21(1):260. doi:10.1186/s12875-020-01288-6
88. Rubin A, Livingston NA, Brady J, et al. Computerized Relational Agent to Deliver Alcohol Brief Intervention and Referral to Treatment in Primary Care: a Randomized Clinical Trial. *J Gen Intern Med*. 2022;37(1):70-77. doi:10.1007/s11606-021-06945-9
89. Kaiser Permanente Research Affiliates Evidence-based Practice Center. Screening for Illicit Drug Use, Including Nonmedical Use of Prescription Drugs: An Updated Systematic Review for the U.S. Preventive Services Task Force. Published online August 2019. <https://www.uspreventiveservicestaskforce.org/Home/GetFile/1/17049/drug-use-screening-draft-evidence-review/pdf>
90. US Preventive Services Task Force. Screening for Unhealthy Drug Use: US Preventive Services Task Force Recommendation Statement. *JAMA*. 2020;323(22):2301-2309. doi:10.1001/jama.2020.8020
91. Hadland SE. Filling in the Gaps: Building the Evidence Base for Screening, Brief Intervention, and Referral to Treatment in Adolescents. *J Adolesc Health*. 2022;71(4):S1-S4. doi:10.1016/j.jadohealth.2022.06.023
92. COMMITTEE ON SUBSTANCE USE AND PREVENTION, Levy SJL, Williams JF, et al. Substance Use Screening, Brief Intervention, and Referral to Treatment. *Pediatrics*. 2016;138(1):e20161210. doi:10.1542/peds.2016-1210
93. Aldridge A, Linford R, Bray J. Substance use outcomes of patients served by a large US implementation of Screening, Brief Intervention and Referral to Treatment (SBIRT). *Addict Abingdon Engl*. 2017;112 Suppl 2:43-53. doi:10.1111/add.13651
94. Chan YF, Lu SE, Howe B, Tieben H, Hoeft T, Unützer J. Screening and Follow-Up Monitoring for Substance Use in Primary Care: An Exploration of Rural–Urban Variations. *J Gen Intern Med*. 2016;31(2):215-222. doi:10.1007/s11606-015-3488-y
95. Marks KR, Leukefeld CG, Dennis ML, Scott CK, Funk R. Geographic differences in substance use screening for justice-involved youth. *J Subst Abuse Treat*. 2019;102:40-46. doi:10.1016/j.jsat.2019.04.005

96. Ridenour TA, Murray DW, Hinde J, et al. Addressing Barriers to Primary Care Screening and Referral to Prevention for Youth Risky Health Behaviors: Evidence Regarding Potential Cost-Savings and Provider Concerns. *Prev Sci.* 2022;23(2):212-223. doi:10.1007/s11121-021-01321-9
97. Hinde J, Bray J, Kaiser D, Mallonee E. The influence of state-level policy environments on the activation of the Medicaid SBIRT reimbursement codes. *Addict Abingdon Engl.* 2017;112 Suppl 2:82-91. doi:10.1111/add.13655
98. Leslie LK, Mehus CJ, Hawkins JD, et al. Primary Health Care: Potential Home for Family-Focused Preventive Interventions. *Am J Prev Med.* 2016;51(4):S106-S118. doi:10.1016/j.amepre.2016.05.014
99. Press KR, Zornberg GZ, Geller G, Carrese J, Fingerhood MI. What patients with addiction disorders need from their primary care physicians: A qualitative study. *Subst Abuse.* 2016;37(2):349-355. doi:10.1080/08897077.2015.1080785
100. Samet JM. Tobacco Smoking: The Leading Cause of Preventable Disease Worldwide. *Thorac Surg Clin.* 2013;23(2):103-112. doi:10.1016/j.thorsurg.2013.01.009
101. Understanding Alcohol's Impact on Health | National Institute on Alcohol Abuse and Alcoholism (NIAAA). Accessed April 23, 2023. <https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/understanding-alcohol-impact-health>
102. World Health Organization. *Tackling NCDs: "Best Buys" and Other Recommended Interventions for the Prevention and Control of Noncommunicable Diseases.* World Health Organization; 2017. Accessed April 23, 2023. <https://apps.who.int/iris/handle/10665/259232>
103. Casswell S, Callinan S, Chaiyasong S, et al. How the alcohol industry relies on harmful use of alcohol and works to protect its profits. *Drug Alcohol Rev.* 2016;35(6):661-664. doi:10.1111/dar.12460
104. Humphreys K. Opinion | Why raising this tax could save lives. NBC News. Published January 2, 2023. Accessed April 30, 2023. <https://www.nbcnews.com/think/opinion/2023-new-year-dry-january-can-cut-alcohol-consumption-even-taxes-rcna63732>
105. Increase Excise Taxes on Tobacco Products | Congressional Budget Office. Accessed April 30, 2023. <https://www.cbo.gov/budget-options/58706>
106. Increase All Taxes on Alcoholic Beverages to \$16 per Proof Gallon and Index Them for Inflation | Congressional Budget Office. Accessed April 30, 2023. <https://www.cbo.gov/budget-options/58705>
107. Haegerich TM, Jones CM, Cote PO, Robinson A, Ross L. Evidence for state, community and systems-level prevention strategies to address the opioid crisis. *Drug Alcohol Depend.* 2019;204:107563. doi:10.1016/j.drugalcdep.2019.107563
108. Ansari B, Tote KM, Rosenberg ES, Martin EG. A Rapid Review of the Impact of Systems-Level Policies and Interventions on Population-Level Outcomes Related to the Opioid Epidemic, United States and Canada, 2014-2018. *Public Health Rep.* 2020;135(1_suppl):100S-127S. doi:10.1177/0033354920922975
109. Dowell D. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. *MMWR Recomm Rep.* 2022;71. doi:10.15585/mmwr.rr7103a1

110. Jones MR, Viswanath O, Peck J, Kaye AD, Gill JS, Simopoulos TT. A Brief History of the Opioid Epidemic and Strategies for Pain Medicine. *Pain Ther.* 2018;7(1):13. doi:10.1007/s40122-018-0097-6
111. Centers for Disease Control and Injury Prevention. Understanding the Opioid Overdose Epidemic | Opioids | CDC. Published October 7, 2022. Accessed May 20, 2023. <https://www.cdc.gov/opioids/basics/epidemic.html>
112. Humphreys K, Shover CL, Andrews CM, et al. Responding to the opioid crisis in North America and beyond: recommendations of the Stanford–Lancet Commission. *The Lancet.* 2022;399(10324):555-604. doi:10.1016/S0140-6736(21)02252-2
113. Ford JA, Pomykacz C, Szalewski A, McCabe SE, Schepis TS. Friends and relatives as sources of prescription opioids for misuse among young adults: The significance of physician source and race/ethnic differences. *Subst Abuse.* 2020;41(1):93-100. doi:10.1080/08897077.2019.1635955
114. Brummett CM, Waljee J, Goesling J, et al. New Persistent Opioid Use After Minor and Major Surgery in U.S. Adults. *JAMA Surg.* 2017;152(6):e170504. doi:10.1001/jamasurg.2017.0504
115. Howard R, Waljee J, Brummett C, Englesbe M, Lee J. Reduction in Opioid Prescribing Through Evidence-Based Prescribing Guidelines. *JAMA Surg.* 2018;153(3):285-287. doi:10.1001/jamasurg.2017.4436
116. Chou R, Hartung D, Turner J, et al. *Opioid Treatments for Chronic Pain.* Agency for Healthcare Research and Quality (US); 2020. Accessed June 8, 2023. <http://www.ncbi.nlm.nih.gov/books/NBK556253/>
117. Wu CL, King AB, Geiger TM, et al. American Society for Enhanced Recovery and Perioperative Quality Initiative Joint Consensus Statement on Perioperative Opioid Minimization in Opioid-Naive Patients. *Anesth Analg.* 2019;129(2):567-577. doi:10.1213/ANE.0000000000004194
118. Stringfellow EJ, Lim TY, Humphreys K, et al. Reducing opioid use disorder and overdose deaths in the United States: A dynamic modeling analysis. *Sci Adv.* 8(25):eabm8147. doi:10.1126/sciadv.abm8147
119. Shover CL, Falasinnu TO, Dwyer CL, et al. Steep increases in fentanyl-related mortality west of the Mississippi River: Recent evidence from county and state surveillance. *Drug Alcohol Depend.* 2020;216:108314. doi:10.1016/j.drugalcdep.2020.108314
120. O'Donnell J, Tanz LJ, Gladden RM, Davis NL, Bitting J. Trends in and Characteristics of Drug Overdose Deaths Involving Illicitly Manufactured Fentanyls — United States, 2019–2020. *Morb Mortal Wkly Rep.* 2021;70(50):1740-1746. doi:10.15585/mmwr.mm7050e3
121. Arya S, Nagappala S, Krawczyk N, Gu Y, Meacham MC, Bunting AM. Fentanyl in Pressed Oxycodone Pills: A Qualitative Analysis of Online Community Experiences with an Emerging Drug Trend. *Subst Use Misuse.* 2022;57(13):1940-1945. doi:10.1080/10826084.2022.2120365
122. Daniulaityte R, Sweeney K, Ki S, Doebbeling BN, Mendoza N. “They say it’s fentanyl, but they honestly look like Perc 30s”: Initiation and use of counterfeit fentanyl pills. *Harm Reduct J.* 2022;19(1):52. doi:10.1186/s12954-022-00634-4
123. Legislative Analysis and Public Policy Association. Pill Press Laws: A Forgotten Aspect of Counterfeit Drug-Making • LAPP. LAPP. Published March 21, 2021. Accessed May 21, 2023. <https://legislativeanalysis.org/pill-press-laws-a-forgotten-aspect-of-counterfeit-drug-making/>

124. Health (OASH) O of the AS for. Surgeon General Issues New Advisory About Effects Social Media Use Has on Youth Mental Health. HHS.gov. Published May 23, 2023. Accessed June 1, 2023. <https://www.hhs.gov/about/news/2023/05/23/surgeon-general-issues-new-advisory-about-effects-social-media-use-has-youth-mental-health.html>
125. Braymiller JL, Riehm KE, Meier M, et al. Associations of alternative cannabis product use and poly-use with subsequent illicit drug use initiation during adolescence. *Psychopharmacology (Berl)*. Published online March 3, 2023. doi:10.1007/s00213-023-06330-w
126. Reboussin BA, Rabinowitz JA, Thrul J, Maher B, Green KM, Ialongo NS. Trajectories of cannabis use and risk for opioid misuse in a young adult urban cohort. *Drug Alcohol Depend*. 2020;215:108182. doi:10.1016/j.drugalcdep.2020.108182
127. American Society of Addiction Medicine. Public Policy Statement on Cannabis. Default. Published October 20, 2020. Accessed March 28, 2023. <https://www.asam.org/advocacy/public-policy-statements/details/public-policy-statements/2020/10/10/cannabis>
128. Shanahan L, Steinhoff A, Bechtiger L, et al. Frequent teenage cannabis use: Prevalence across adolescence and associations with young adult psychopathology and functional well-being in an urban cohort. *Drug Alcohol Depend*. 2021;228:109063. doi:10.1016/j.drugalcdep.2021.109063
129. Lorenzetti V, Solowij N, Yücel M. The Role of Cannabinoids in Neuroanatomic Alterations in Cannabis Users. *Biol Psychiatry*. 2016;79(7):e17-e31. doi:10.1016/j.biopsych.2015.11.013
130. Albaugh MD, Ottino-Gonzalez J, Sidwell A, et al. Association of Cannabis Use During Adolescence With Neurodevelopment. *JAMA Psychiatry*. 2021;78(9):1031-1040. doi:10.1001/jamapsychiatry.2021.1258
131. Young men at highest risk of schizophrenia linked with cannabis use disorder. National Institute on Drug Abuse. Published May 4, 2023. Accessed June 23, 2023. <https://nida.nih.gov/news-events/news-releases/2023/05/young-men-at-highest-risk-schizophrenia-linked-with-cannabis-use-disorder>
132. Moreno MA, Jenkins M, Binger K, et al. A Content Analysis of Cannabis Company Adherence to Marketing Requirements in Four States. *J Stud Alcohol Drugs*. 2022;83(1):27-36. doi:10.15288/jsad.2022.83.27
133. Hust SJT, Willoughby JF, Li J, Couto L. Youth's Proximity to Marijuana Retailers and Advertisements: Factors Associated with Washington State Adolescents' Intentions to Use Marijuana. *J Health Commun*. 2020;25(7):594-603. doi:10.1080/10810730.2020.1825568
134. Pedersen ER, Firth CL, Rodriguez A, et al. Examining Associations Between Licensed and Unlicensed Outlet Density and Cannabis Outcomes From Preopening to Postopening of Recreational Cannabis Outlets. *Am J Addict*. 2021;30(2):122-130. doi:10.1111/ajad.13132
135. Rhew IC, Guttmanova K, Kilmer JR, et al. Associations of cannabis retail outlet availability and neighborhood disadvantage with cannabis use and related risk factors among young adults in Washington State. *Drug Alcohol Depend*. 2022;232:109332. doi:10.1016/j.drugalcdep.2022.109332
136. Manthey J, Jacobsen B, Hayer T, et al. The impact of legal cannabis availability on cannabis use and health outcomes: A systematic review. *Int J Drug Policy*. 2023;116:104039. doi:10.1016/j.drugpo.2023.104039

137. Babor TF. Big Alcohol Meets Big Science at NIAAA: What Could Go Wrong? *J Stud Alcohol Drugs*. 2023;84(1):5-10. doi:10.15288/jsad.2023.84.5
138. Hoffman SJ, Creatore MI, Klassen A, Lay AM, Fafard P. Building the political case for investing in public health and public health research. *Can J Public Health Rev Can Santé Publique*. 2019;110(3):270-274. doi:10.17269/s41997-019-00214-3
139. Castro FG, Barrera, Jr. M, Martinez, Jr. CR. The Cultural Adaptation of Prevention Interventions: Resolving Tensions Between Fidelity and Fit. *Prev Sci*. 2004;5(1):41-45. doi:10.1023/B:PREV.0000013980.12412.cd
140. Elliott D, Mihalic S. Issues in Disseminating and Replicating Effective Prevention Programs: Blending Prevention Research and Practice in Schools. *Prev Sci*. 2004;5. doi:10.1023/B:PREV.0000013981.28071.52
141. Durlak J, DuPre E. Implementation Matters: A Review of Research on the Influence of Implementation on Program Outcomes and the Factors Affecting Implementation. *Am J Community Psychol*. 2008;41:327-350. doi:10.1007/s10464-008-9165-0
142. Valentine JC, Biglan A, Boruch RF, et al. Replication in prevention science. *Prev Sci Off J Soc Prev Res*. 2011;12(2):103-117. doi:10.1007/s11121-011-0217-6
143. Williams DR, Mohammed SA. Discrimination and racial disparities in health: evidence and needed research. *J Behav Med*. 2009;32(1):20-47. doi:10.1007/s10865-008-9185-0
144. Williams DR, Lawrence JA, Davis BA, Vu C. Understanding how discrimination can affect health. *Health Serv Res*. 2019;54(S2):1374-1388. doi:10.1111/1475-6773.13222
145. Snyder JE, Upton RD, Hassett TC, Lee H, Nouri Z, Dill M. Black Representation in the Primary Care Physician Workforce and Its Association With Population Life Expectancy and Mortality Rates in the US. *JAMA Netw Open*. 2023;6(4):e236687. doi:10.1001/jamanetworkopen.2023.6687
146. Wilkins V, Elliott MN, Richardson A, Lozano P, Mangione-Smith R. The Association between Care Experiences and Parent Ratings of Care for Different Racial, Ethnic, and Language Groups in a Medicaid Population. *Health Serv Res*. 2011;46(3):821-839. doi:10.1111/j.1475-6773.2010.01234.x
147. Weech-Maldonado R, Fongwa MN, Gutierrez P, Hays RD. Language and Regional Differences in Evaluations of Medicare Managed Care by Hispanics. *Health Serv Res*. 2008;43(2):552-568. doi:10.1111/j.1475-6773.2007.00796.x
148. Weech-Maldonado R, Hall A, Bryant T, Jenkins KA, Elliott MN. The Relationship Between Perceived Discrimination and Patient Experiences With Health Care. *Med Care*. 2012;50:S62. doi:10.1097/MLR.0b013e31825fb235
149. Manatt. Caring for the Whole Child: A New Way to Finance Initiatives to Improve Children's Health and Well-being Issue Brief. Published online December 2020. https://www.manatt.com/Manatt/media/Documents/Articles/RWJF-Manatt-Caring-for-the-Whole-Child-Issue-Brief_12-1-20.pdf
150. Maximizing the Impact of Opioid Litigation Settlements. O'Neill. Accessed April 23, 2023. <https://oneill.law.georgetown.edu/projects/maximizing-the-impact-of-opioid-litigation-settlements/>

151. Gilbert M. What History's Big Tobacco Settlement Means for Today's 'Opioid Remediation' | Bipartisan Policy Center. Published August 19, 2021. Accessed April 24, 2023. <https://bipartisanpolicy.org/blog/big-tobacco-opioids/>
152. Volkow DN. Social Determinants of Health Can't Be Extricated from Addiction Science. National Institute on Drug Abuse. Published April 27, 2023. Accessed May 14, 2023. <https://nida.nih.gov/about-nida/noras-blog/2023/04/social-determinants-health-cant-be-extricated-addiction-science>
153. Consortium to Advance Prevention Solutions to the Opioid Crisis. Letter to Dr. Volkow, Director of the National Institute on Drug Abuse (NIDA). Proposal to increase NIDA funding for prevention focusing on health disparities. Consortium to Advance Prevention Solutions to the Opioid Crisis (CAPSOC). Published 2023. Accessed April 23, 2023. https://www.npscoalition.org/_files/ugd/773dc1_49ac28c66d58466abdcdf86bb2e982257.pdf
154. University of Washington, School of Social Work, Social Development Research Group. The Center for Communities That Care. Published June 17, 2020. Accessed March 22, 2023. <https://www.communitiesthatcare.net/>
155. Kuklinski MR, Briney JS, Hawkins JD, Catalano RF. Cost-Benefit Analysis of Communities That Care Outcomes at Eighth Grade. *Prev Sci.* 2012;13(2):150. doi:10.1007/s11121-011-0259-9
156. Blueprints for Healthy Youth Development – Committed to Healthy Youth, Families and Communities. Accessed March 29, 2023. <https://www.blueprintsprograms.org/>
157. Dishion T, Kavanagh K, Schneiger A, Nelson S, Kaufman N. Preventing Early Adolescent Substance Use: A Family-Centered Strategy for the Public Middle School. *Prev Sci Off J Soc Prev Res.* 2002;3:191-201. doi:10.1023/A:1019994500301
158. Smith VC, Wilson CR, COMMITTEE ON SUBSTANCE USE AND PREVENTION, et al. Families Affected by Parental Substance Use. *Pediatrics.* 2016;138(2):e20161575. doi:10.1542/peds.2016-1575
159. Camenga DR, Hammer LD, the Committee on Substance Use and Prevention and C on CHF. Improving Substance Use Prevention, Assessment, and Treatment Financing to Enhance Equity and Improve Outcomes Among Children, Adolescents, and Young Adults. *Pediatrics.* 2022;150(1):e2022057992. doi:10.1542/peds.2022-057992
160. Hargraves D, White C, Frederick R, et al. Implementing SBIRT (Screening, Brief Intervention and Referral to Treatment) in primary care: lessons learned from a multi-practice evaluation portfolio. *Public Health Rev.* 2017;38:31. doi:10.1186/s40985-017-0077-0
161. Clemans-Cope L, Lynch V, Winiski E, Epstein M, Payton M. Characteristics of Medicaid-Enrolled Adolescents with Unhealthy Opioid or Other Substance Use. Urban Institute. Published January 27, 2022. Accessed May 1, 2023. <https://www.urban.org/research/publication/characteristics-medicaid-enrolled-adolescents-unhealthy-opioid-or-other-substance-use>
162. Ramos C, Allen EH, Eggleston A, Coquillat S, Clemans-Cope L, Taylor KJ. Improving Substance Use Services for Youth: Policy Opportunities for State Medicaid/CHIP Programs. Published online January 2022. https://www.urban.org/sites/default/files/publication/105388/improving-substance-use-services-for-youth_1.pdf

163. Centers for Medicare and Medicaid Services. Leveraging Medicaid, CHIP, and Other Federal Programs in the Delivery of Behavioral health Services for Children and Youth. Published online August 18, 2022. <https://www.medicaid.gov/federal-policy-guidance/downloads/bhccib08182022.pdf>
164. Centers for Medicare and Medicaid Services. CMS Guidance to State Medicaid Directors RE: Medicaid Payment for Services Provided Without Charge (Free Care). Published online December 15, 2014. <https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf>
165. Haffajee RL, Mello MM, Zhang F, Zaslavsky AM, Larochelle MR, Wharam JF. Four States With Robust Prescription Drug Monitoring Programs Reduced Opioid Dosages. *Health Aff (Millwood)*. 2018;37(6):964-27. doi:<http://dx.doi.org.proxy.library.georgetown.edu/10.1377/hlthaff.2017.1321>
166. Ehrhart AL, Granek EF, Nielsen-Pincus M, Horn DA. Leftover drug disposal: Customer behavior, pharmacist recommendations, and obstacles to drug take-back box implementation. *Waste Manag*. 2020;118:416-425. doi:10.1016/j.wasman.2020.08.038
167. Mosher JF, Cohen EN, Jernigan DH. Commercial host (dram shop) liability: current status and trends. *Am J Prev Med*. 2013;45(3):347-353. doi:10.1016/j.amepre.2013.04.013
168. Consortium to Advance Prevention Solutions to the Opioid Crisis. Synopsis: Protections for Youth are Needed to Meet the Challenges Presented by Increasing Trends to Legalize Marijuana. Published online February 12, 2023. https://www.npscoalition.org/_files/ugd/773dc1_62d5527493574de393ac6cd10ac9b2ee.docx
169. Pattani A. Biden promised a watchdog for opioid settlement billions, but feds are quiet so far. *NPR*. <https://www.npr.org/sections/health-shots/2023/04/20/1170921912/opioid-settlement-billions-federal-watchdog-missing>. Published April 20, 2023. Accessed April 30, 2023.
170. Legislative Analysis and Public Policy Association. Model Opioid Litigation Proceeds Act • LAPP. LAPP. Published October 21, 2021. Accessed April 23, 2023. <https://legislativeanalysis.org/model-opioid-litigation-proceeds-act/>