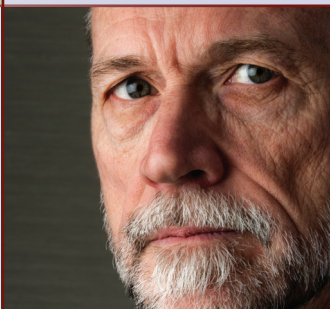


# Lifting the Burden of Addiction:

Philanthropic opportunities to address substance use disorders in the United States



*Cecily Wallman-Stokes, Jacob Appel, Jessica Chiu, Rebecca Hobbie, Jennifer Gable, Götz Bechtolsheimer, and Katherina Rosqueta*



## About This Guide

The purpose of this guide is to help funders make smart investments in lowering the human and economic burden of substance use disorders (SUDs), which currently affect 1 in 12 adolescents and adults in the United States, at a cost of hundreds of billions of dollars annually.<sup>1</sup> In the following pages, we provide:

- Key issues and context to inform philanthropic decision-making
- Specific high-impact opportunities for philanthropists to make a difference, including examples of non-profits implementing those opportunities and, to the extent possible, estimated costs and impacts

In addition, we include an appendix that explains how our team developed the guidance that appears in this document, along with background on our Center's overall work.

This guidance was developed with the generous support of the Mistral Foundation.

## About the Authors

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## About The Center for High Impact Philanthropy

Founded in 2006, the Center for High Impact Philanthropy serves as a unique and trusted authority for funders around the world who are seeking to maximize the social impact of their philanthropic activities. In areas as diverse as closing the achievement gap in the U.S., effective disaster relief, and major global public health issues such as malaria and child mortality, the Center translates the best available information into actionable guidance for those looking to make the greatest difference in the lives of others. The Center also provides cross-cutting guidance to help funders practice high-impact philanthropy no matter what issue, cause, or community they care about. Put simply, success to the Center means moving more money to do more good.

# Substance Abuse Disorder



## Definitions of substance use disorder

### Clinical definition

The 2013 *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* is used by medical professionals across the country to diagnose and describe mental health conditions. The DSM-5 defines a substance use *disorder* as the presence of at least 2 of 11 criteria, which are clustered in four groups:

**Impaired control:** (1) taking more or for longer than intended, (2) unsuccessful efforts to stop or cut down use, (3) spending a great deal of time obtaining, using, or recovering from use, (4) craving for substance.

**Social impairment:** (5) failure to fulfill major obligations due to use, (6) continued use despite problems caused or exacerbated by use, (7) important activities given up or reduced because of substance use.

**Risky use:** (8) recurrent use in hazardous situations, (9) continued use despite physical or psychological problems that are caused or exacerbated by substance use.

**Pharmacologic dependence:** (10) tolerance to effects of the substance, (11) withdrawal symptoms when not using or using less.\*

The *DSM-5* suggests using the number of criteria met as a general measure of severity, from *mild* (2-3 criteria) to *moderate* (4-5 criteria) and *severe* (6 or more criteria).



\*Persons who are prescribed medications such as opioids may exhibit these two criteria, but would not necessarily be considered to have a substance use disorder.

### Working definition for this report

A substance use disorder, in the simplest terms, is **the continued use of drugs or alcohol despite trying to stop and/or causing harm to self or others.**

# Executive Summary



Substance use disorders (SUDs), also known as substance abuse or addiction, affect Americans in all walks of life. An estimated 20 million or more adolescents and adults in the United States—1 in 12—have an SUD, defined as continued use of drugs or alcohol despite trying to stop and/or causing harm to self or others.<sup>2</sup> You probably know someone with an SUD, but most people with an SUD don't talk about it. Stigma and shame keep the disorder hidden, undertreated, and misunderstood.

SUD symptoms can show up in hurtful or even illegal behaviors that can appear to be simply a matter of choice, and it can be difficult to understand why someone can't just stop. We know that people with SUDs experience changes in their brain that make it harder and harder to stop using, but we still have more to learn about why that happens and how to prevent it. What we do know is that bringing evidence-based care to SUD patients gets results: more people get better more quickly, and the pain and damage the disorder can cause to patients and families are reduced.

Lifting the burden of SUDs has another benefit: reduced costs. America spends billions of dollars a year on costs related to SUDs, more than on smoking and obesity combined.<sup>3</sup> Unfortunately, this spending is not always well targeted, and the rate of SUDs remains steady—as does the harm they cause to patients, their families, and communities. The good news is that the context for discussion and treatment of SUDs is changing, and there is a wealth of opportunities for philanthropists to make a difference.

## How to read this guide

In the following pages, we present a portfolio of high-impact opportunities to address the negative impacts of SUDs. The opportunities are divided into four high-level strategies, with potential non-profit partners and implementers highlighted in each:

- **Strategy 1: Save lives and reduce SUD-related illness and homelessness right now.** There are tools that have been shown again and again to save lives and reduce the harm and immediate risk caused by SUDs, as well as save money and open the door to treatment. These include overdose prevention medications, clean syringe programs, supportive housing, and legal assistance to help ensure that patients' basic needs are met, even if recovery remains elusive. Many of these approaches offer a double benefit: they are compassionate, recognizing that those with the most severe SUDs need help; and they save taxpayers money by reducing use of costly emergency services. The evidence shows that these tools work, but they aren't commonly put into practice. Philanthropic support can help change that.
- **Strategy 2: Improve access to evidence-based treatment.** There are opportunities to help extend available treatment options to all SUD patients, including particularly vulnerable groups. For many people, treatment is synonymous with Alcoholics Anonymous or similar programs. In reality, 12-step programs and support groups like AA are just some of the many tools available to help SUD patients recover. Options with good evidence of success include cognitive behavioral therapy, mindfulness training, medication-assisted treatment, and more. Improving treatment often means simply expanding the range of options. For many patients, access to a broader range of treatment options and more comprehensive care can mean the difference between recovery or a continued downward spiral. Philanthropic support can make that access possible.



- **Strategy 3: Improve SUD care by changing systems and policies.** Health care reform has made it possible for hundreds of thousands of Americans to access better mental health and SUD treatment, but broader access requires better implementation. Philanthropists can support organizations working with policymakers and administrators to ensure that access to care continues to improve and that the care itself is informed by the best available evidence.
- **Strategy 4: Fund innovation to improve prevention and treatment.** The sector continues to grapple with big questions about how to prevent SUDs, how to develop and deliver better care, and how to help reduce the stigma that keeps so many SUD patients from accessing the care they need. Philanthropists can support research to learn more about these questions and pilot new programs to help people benefit from that knowledge.

High-impact opportunities in each category are presented in the following pages and summarized in the table on page iv. The format of each opportunity varies slightly, particularly between direct service and research or policy work. In policy and research, the impact on the people you hope to help is more removed from the point of funding, and the chain of cause and effect can be more difficult to see clearly. But those downsides are, for some funders, balanced by the potential to impact large numbers of people in lasting and meaningful ways as a result of a single change—sometimes with the stroke of a pen. Whether in research, policy, or direct service, the common thread across all of the opportunities in this guide is the positive impact they can create.

We present a range of options knowing that not every opportunity will appeal to every funder. We hope the broad scope allows funders of all types to find opportunities that fit within their philanthropic strategies. No matter what you support, the goal is the same: to reduce suffering and harm from substance use disorders, now and in the future. As always, we hope the information and opportunities presented in these pages will help donors move from good intentions to high impact.



## High-Impact Opportunities

<b>STRATEGY 1: Save lives and reduce SUD-related illness and homelessness right now</b>			
Impact and Opportunity	Targeted Populations	Featured Organizations	Find Out More
Prevent deaths from heroin and painkiller overdose through naloxone distribution and training	Heroin and prescription painkiller users at risk of fatal overdose	Prevention Point Pittsburgh; Harm Reduction Coalition	See page 14
Prevent the spread of HIV and Hepatitis C and keep the door to recovery open through clean syringe programs	People who inject drugs, as well as their partners and children at risk of blood-borne infections	Prevention Point Philadelphia	See page 16
Combat SUD-related homelessness through housing support	SUD patients who are chronically homeless	Pathways to Housing (Pennsylvania chapter)	See page 18
Help SUD patients with co-occurring mental health illnesses stay housed & financially stable through legal support	SUD patients who have co-occurring mental health illness	MFY Legal Services	See page 19
<b>STRATEGY 2: Improve access to evidence-based treatment</b>			
Impact and Opportunity	Targeted Populations	Featured Organizations	Find Out More
Help pregnant women, mothers, and their young children get the help they need	Low-income women with SUDs, along with their families	Meta House	See page 26
Break the cycle of substance use and incarceration by connecting inmates to the care they need	Individuals with SUDs within the justice system	Healthy and Safe Communities Initiative (HSCI) of the ACLU	See page 28
Improve screening, prevention, and early intervention for SUDs	Individuals with risky substance use habits or SUDs receiving care from a hospital, primary care clinic, or other non-specialized setting	Institute for Research, Education, and Training (IRETA), National Opinion Research Center (NORC)	See page 30
Integrate mental health care, including SUD treatment, with primary care	Individuals with SUDs who receive care from a hospital, primary care clinic, or other non-specialized setting	Advanced Integrated Mental Health Solutions (AIMS)	See page 32
<b>STRATEGY 3: Improve SUD care by changing systems and policies</b>			
Impact and Opportunity	Targeted Populations	Featured Organizations	Find Out More
Close loopholes and extend insurance coverage to more people by supporting federal policy change	All Americans with SUDs	The Legal Action Center (LAC), Coalition for Whole Health	See page 40
Connect care in the correctional system to care in the community by supporting local policy change	Individuals with SUDs within the justice system	Community Oriented Correctional Health Services (COCHS), Connections Community Support Programs	See page 41
Move towards better care for everyone by creating a more transparent market	All Americans with SUDs	Treatment Research Institute (TRI)	See page 42
<b>STRATEGY 4: Fund innovation to improve prevention and treatment</b>			
Impact and Opportunity	Targeted Populations	Featured Organizations	Find Out More
New research sites for programs that have shown promise in particular settings	Young children and adolescents within the general population	Good Behavior Game (GBG) and the Johns Hopkins Center for Prevention and Early Education; Promoting School-community-university Partnerships to Enhance Resilience (PROSPER)	See page 45
Target risky drinking in adolescents with secondary prevention	Adolescents who drink alcohol	University of Minnesota's Center for Adolescent Substance Abuse Research, NORC at the University of Chicago, Community Catalyst	See page 47
Learn from successful behavior change efforts in related fields	Adolescents among the general population	Partnership for Drug-Free Kids; Penn Annenberg School; behavioral science researchers in schools of public health	See page 48

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*I have absolutely no pleasure in the stimulants in which I sometimes so madly indulge. It has not been in the pursuit of pleasure that I have periled life and reputation and reason. It has been the desperate attempt to escape from torturing memories, from a sense of insupportable loneliness and a dread of some strange impending doom.*

– Edgar Allan Poe<sup>4</sup>



# Section I

## Understanding Substance Use Disorders: Key Issues and Context for Donors



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*The University of Pennsylvania*

# Section 1: Understanding Substance Use Disorders



*I don't take pain pills for pain. I take them to feel normal. I wish I could remember what it felt like NOT to be on pills! I need help to stop. They used to make me feel good. Now they just keep me from being sick. I'm scared to tell my doc ... I just feel like nobody understands. What should I do from here? Who should I talk to?*

— Anonymous user<sup>5</sup>

## INTRODUCTION

### Key Issues and Concepts

Substance use disorders (SUDs) exact a heavy toll on individuals, their families, and society at large. An estimated 20 million adolescents and adults in the United States—approximately 1 in 12—suffer from an SUD.<sup>6</sup> In health care costs, crime, incarceration, and lost productivity, SUDs cost the U.S. hundreds of billions of dollars annually; that's more than the costs of smoking and obesity combined.<sup>7</sup> Although SUDs are a significant problem in many countries, this report focuses on the United States.

The following section introduces donors to information and concepts important to understanding opportunities to lower the social and economic burden of SUDs, including:

- What is a substance use disorder?
- What causes them?
- Who has them?
- What kind of harm and negative outcomes do they cause?
- What's the role of stigma, misinformation, and criminal justice?
- Why is this a particularly opportune time for philanthropic investment?

### What is a substance use disorder?

A substance use disorder, in the simplest terms, is **the continued use of drugs or alcohol despite trying to stop and/or causing harm to self or others**. It's a functional definition: does a person's use negatively impact their happiness, relationships, health, or ability to meet their responsibilities—and do they continue to use anyway?<sup>8</sup> Of course, some substances, such as alcohol and prescription drugs, are legal for adults and not problematic in moderation or as prescribed. "Use" crosses into "disorder" when these substances are regularly consumed despite harm to the user and others. (For a full clinical definition, see page i.)

For many people, their disorder is a chronic condition, like Type 2 diabetes or asthma.<sup>9</sup> Relapse is therefore a symptom of the disorder, just like an episode of low blood sugar or an asthma attack. As with other chronic conditions, good care management can reduce or eliminate these symptoms.

What differentiates SUDs from many other disorders is that there is an undeniable behavioral element: someone who chooses never to try drugs or alcohol will not develop the disorder. The complicating factor is that most people who *do* choose to use drugs or alcohol also will not develop the disorder. For some fraction of those people, however, their use will take them down a slippery slope to physiological and psychological dependence: their brains will physically alter to reinforce the cycle of craving and use, and their behavior will follow. While there is evidence for a genetic component, there is no foolproof way to predict who might become addicted. Any number of biological and environmental factors can interact to make someone more vulnerable to the disorder—or to protect them despite risky personal choices.<sup>10</sup>

Finally, while some in the field include tobacco use as an SUD, we have not included it in this report. We focus on substances with mood-altering effects and other negative consequences consistent with the functional definition outlined above.

**TAKEAWAY:** A substance use disorder (sometimes called addiction or substance abuse) is the continued use of drugs or alcohol despite trying to stop and/or causing harm to self or others. Substance use disorders can include both legal and illegal substances.



## What causes SUDs?

The short answer is: we don't really know. Lots of people regularly consume moderate amounts of alcohol or experiment with drugs without developing SUDs. We do know that adolescents are the highest-risk age group for development of SUDs. Adolescence is a crucial period for brain development. During this time, major shifts in development occur in the prefrontal cortex and limbic regions of the brain. These changes are thought to contribute to increased risk-taking and novelty-seeking behaviors, such as engaging in substance use.<sup>11</sup> Along with these brain developments, social influences such as peer pressure are especially pronounced in the adolescent period, further increasing teens' risk of initiating and continuing substance use.<sup>12</sup>

When it comes to understanding why certain adolescents or adults develop SUDs while others do not, we know much less. Studies of identical twins have shown that genetics plays a role, but environmental factors are important as well. For both reasons, having a parent with an SUD increases the likelihood that a child will develop the disorder.<sup>13-15</sup> A 2008 study of national survey data from over 90,000 adolescents found that the strongest risk factors were *individual risk factors* (favorable attitudes toward illegal activities, low perceived risks of drug use, sensation-seeking, rebelliousness, and others) and *peer risk factors* (friends' delinquent behavior, friends' use of drugs, peer rewards for risky behavior, and gang involvement).<sup>16</sup> Having a mental illness such as depression is also a risk factor.<sup>17</sup> But risk factors are simply associated with a higher likelihood of developing an SUD. The *causal* link is unclear.

We also know that once a person develops an SUD, the brain can change in ways that make it even more difficult to stop using. Recent research has shown that SUDs alter brain structure, and scientists are continuing to learn more about what that means. These changes can be one reason why, for many people, recovery isn't just a simple exercise of willpower.

**TAKEAWAY:** Adolescents are at particular risk for developing SUDs. Certain risk factors such as mental illness, genetic susceptibility, and friends who use can make SUDs more likely. The decision to use or not use before a disorder develops may be a personal choice, but once a person has developed a disorder, that person's brain changes. At that point, stopping use often requires more than a simple exercise of willpower.



*Eventually, the little bags weren't enough to stave off the symptoms of withdrawal, and more and more was required just to get me to work, just to get me to sleep, just to get through this trauma, just to not feel how miserable I was ... and then that little promise you made to yourself – “never ever a needle” – begins to get broken down ... Now the game is in a different league ... it's been 17 years this year since I injected my last hit of heroin which most certainly would have been in my neck, the only veins I could use at that point in my addiction.*

– Vanessa, 17 years clean<sup>18</sup>

## Who are the 1 in 12 Americans suffering from substance use disorder?

Over 20 million adolescents and adults in the United States suffer from an SUD (8.5% of the population over age 12).<sup>20</sup> SUDs affect people from all walks of life and might look different from person to person. Examples might include a recent college graduate who gets drunk every night in order to manage anxiety, a successful professional who is bingeing on cocaine every weekend, or a rural teen who starts with painkillers and begins injecting heroin when the pills become too expensive. SUDs can be found in all socioeconomic groups, among all races and education levels. More than half of adults with an SUD are employed full-time, and adults of all education levels are equally likely to suffer from alcohol dependence. About one in five young adults ages 18-20 uses illicit drugs, whether or not they're in college full-time.<sup>21</sup>

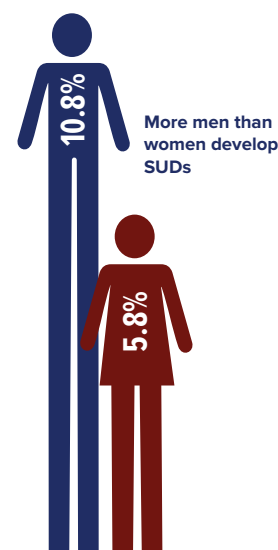
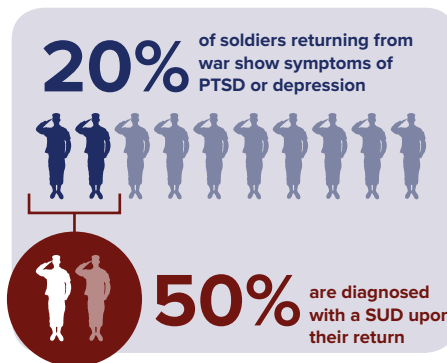
Alcohol is by far the most commonly abused substance. Marijuana use is becoming more common, while cocaine use has decreased.<sup>22</sup> Misuse of prescription medicines has been the fastest growing drug problem; it has been described as an epidemic by multiple agencies such as the FDA, DEA, CDC, and ONDCP. It is a particular issue "among middle class adults, adolescents, and military members and combat veterans who are at risk because of chronic pain."<sup>23</sup> Relatedly, heroin use is rising rapidly as a result of prescription opioid addiction.<sup>24</sup> Evidence has shown that new heroin users often initially abuse prescription opioids before shifting to less-expensive heroin, and the number of heroin users nearly doubled between 2007 and 2013.<sup>25, 26</sup> Regardless of the trends in individual substances, the overall rate of SUDs has remained steady.

**TAKEAWAY:** People with SUDs are found in all walks of life, from those working steady jobs, to celebrities, to the homeless and unemployed. SUD rates are particularly high among young adults, as well as certain populations, such as those in jail. While alcohol-related SUDs are the most common, SUDs related to painkillers and heroin have been rising.

*When I was using heroin, very few people were aware of it. I was ranked in the top 4% of my 1,000+ high school class and a member of the varsity basketball team; not the most likely suspect for heroin addiction ... I can go for months without being tempted to use, but if something happens to trigger my need, the craving comes back as fresh as it was the very first week of sobriety.*

— Jack, former heroin user, nine months clean<sup>19</sup>

## SUDs are a broad category and might look different from person to person.



About one in five young adults ages 18-20 use illicit drugs, whether or not they're in college full-time.

Adults of all education levels are equally likely to suffer from alcohol dependence.



For sources see page 64.

## What kind of pain and damage do SUDs cause?

Those with substance use disorders also face other serious problems, at rates higher than those in the general population. Those problems include:

- Death
- Health conditions including liver failure, HIV/AIDS, and other blood-borne infections such as Hepatitis C
- Homelessness
- Poverty
- Family upheaval
- Repeated incarceration

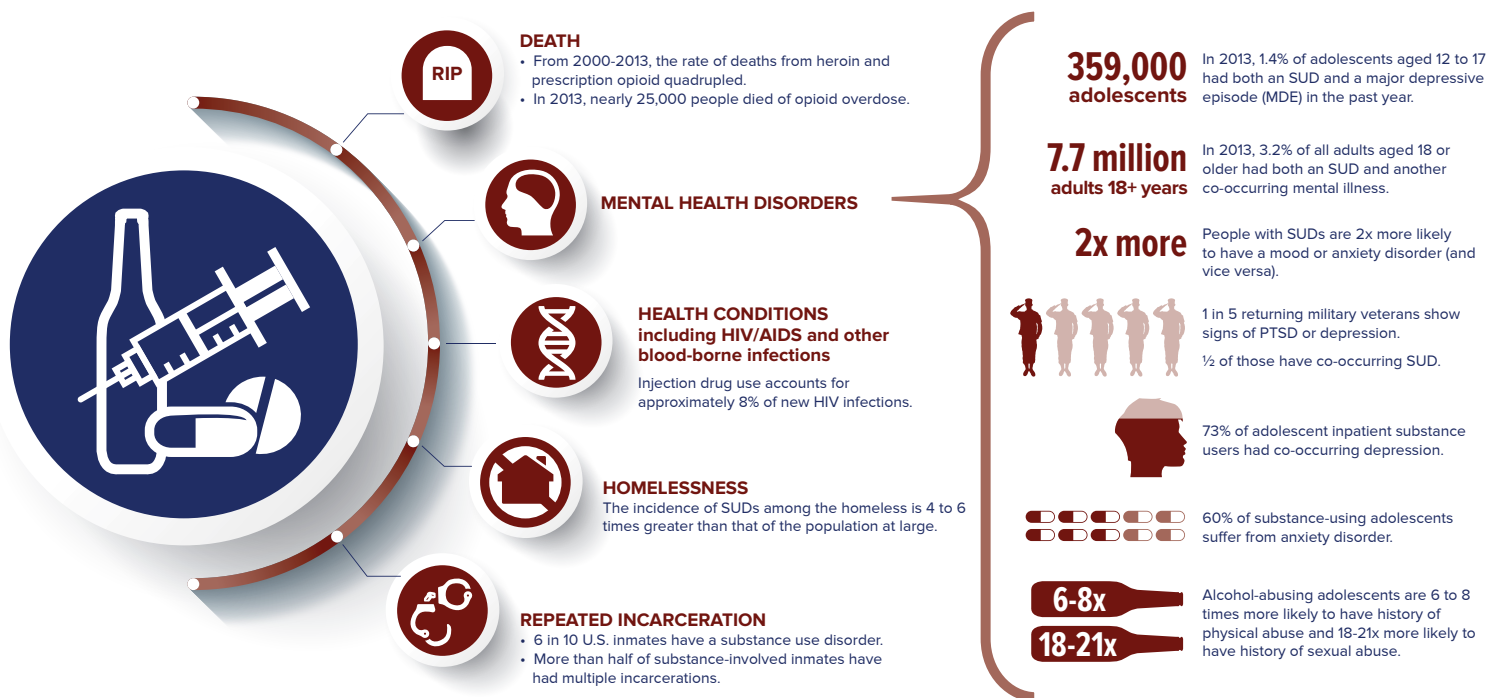
Moreover, individuals with SUDs are not the only people affected. Friends and family suffer as they grapple with their loved one's disorder and its effect on their lives. Damages also occur at the societal level through the spending of public resources, incidence of crime and violence, and the opportunity cost as one-twelfth of the population struggles to function at full capacity. Taxpayers—with or without SUDs—bear that burden, as SUDs are estimated to cost the U.S. over \$400 billion in crime, emergency services, and lost productivity costs each year.<sup>27</sup>

**TAKEAWAY:** People with SUDs suffer in real and acute ways that complicate recovery. The damage and cost of SUDs also extends well beyond individuals with the disorder and includes their families, communities, and society at large.

*I am now 35 and for as long as I can remember my father has been injecting heroin. I wonder when I will get the call to identify my father's body ... I have no words of wisdom [to offer], as a 10-year-old boy or a 35-year-old man watching an addict destroy everything he loves for 30 minutes of nirvana. I can only say, that an addict is never alone in their suffering.*

— Geoffrey, son of a heroin addict<sup>28</sup>

## People with substance use disorders are more likely to experience other illnesses, homelessness, and even death.



For sources see page 64.

*I feel horrible. I look horrible. I hate myself. I am crying writing this because I just don't know where to go or what to do. Everyone thinks I am so strong but I am not. I feel weak and helpless and I feel all alone. I have pushed so many people away and I just don't know how to reach back out again.*

– Anonymous user<sup>29</sup>

## Stigma and misinformation

Stigma has a direct role in the damage caused by SUDs. The factors underlying the stigmatization are complicated. For one thing, while many with SUDs manage to continue meeting the demands of daily life, the most visible symptoms of severe SUDs are, in many cases, behaviors that can hurt loved ones, are socially unacceptable, or even illegal: not meeting commitments, neglecting children, risky sexual behavior, and crimes like theft and violence. The disorder is tied in many people's minds with these behaviors. In addition, empathy can be limited by the fact that many people have personal experience with drugs or alcohol but never develop a disorder. It can be difficult to understand why someone else can't stop if you can.

Stigma, lack of information, and stereotypes complicate attempts to make progress. Stigma makes some SUD patients and their families feel ashamed and afraid to seek help, and it can keep a doctor from providing the best care for fear of offending patients by asking about their substance use. The fact that SUDs are a "taboo" subject also means that information that could be helpful flows less freely. Doctors may be unaware of recent research on more effective treatments and may not know where to send patients for help.<sup>30</sup> What's more, unscrupulous and ineffective SUD "treatment" providers can stay in business because when SUD patients and their families don't even acknowledge being in treatment, there is no word of mouth that might help close down a bad provider. Since addiction is a politically unpopular topic, even known life-saving, cost-saving, evidence-based programs are hard to get funded. Finally, stereotypes and misinformation reinforce the idea that addiction is simply a moral failing, averting questions about the role and quality of care providers. For all of those reasons and more, stigma kills.

**TAKEAWAY:** Stigma around SUDs is a significant and sometimes deadly barrier to effective treatment and recovery.

## Criminal justice and barriers to treatment

The fact that many individuals with SUDs are using illegal substances also complicates diagnosis and treatment. There are lots of questions that could and should be asked about how the justice system treats users of illegal substances. For example, many question the logic or fairness behind the fact that 5 grams of crack cocaine (generally used within poor communities) carries the same legal penalty as approximately 90 grams of powdered cocaine (generally used by wealthier individuals).<sup>31,32</sup> While a broader discussion of the justice system is beyond the scope of this report, what is relevant is this: once an individual with an SUD enters the justice system, there are a host of barriers that make it extremely difficult for that person to access effective treatment. And without treatment, that person is more likely to end up back in jail at an enormous cost to us all.

**TAKEAWAY:** The fact that SUDs can be a criminal issue as well as a health issue is a complicating factor, and those with SUDs who end up in jail face additional barriers to treatment. SUDs, in turn, contribute to recidivism and the high cost of incarceration.

## Right now: A dynamic landscape creating opportunities for change

The good news is that the context for the discussion, prevention, and treatment of SUDs is changing. In part, this change is prompted by recent trends. For example, increases in heroin use across a broader range of socioeconomic groups are challenging the stereotypes many people hold about drug users, and several states have legalized marijuana, changing the context of a criminal drug offense.<sup>33, 34</sup> Relatedly, the high and growing cost of prisons when many inmates are non-violent drug offenders has prompted reconsideration of criminal justice policies.<sup>35</sup>

Health care is also shifting the debate. Recent passage of the federal Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act (MHPAEA) has opened access to treatment for SUDs and may create market incentives for providers to use more effective treatment methods. Several national non-profits working on different aspects of SUD prevention and treatment have also been moving toward closer collaboration.

Finally, this is an area that in many ways is ripe with low-hanging fruit. While there's certainly additional need for research and innovation, there's also enormous opportunity in simply connecting SUD patients with what we already know works and in adjusting policies to align with the knowledge we already have. Philanthropists can make a meaningful difference with the tools and knowledge we have right now.

**TAKEAWAY:** Shifts in conversations around drug policies, changes in health care, new alignments of organizations with experience and capacity in addressing SUDs issues, and the development of new and more effective forms of treatment are changing the SUDs landscape. It is a promising and dynamic time for funders to get involved.

*It is not only your body that screams for the substance. Your brain wants it, too. Without heroin, emotional pain feels unbearable.*

– Katie, 17 years clean<sup>36</sup>







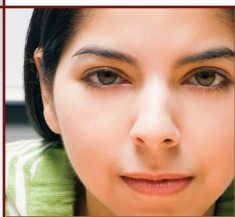
# Section 2

## High-Impact Opportunities: How Funders Can Help



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# Strategies and Opportunities



## THE GOAL

### Reduce immediate harm from substance use disorders, and reduce the burden of the disorder over the long term.

We define social impact as a meaningful and positive change in the lives of others. Here, **the relevant social impact sought is a meaningful and positive reduction in the burden of SUDs. This includes reducing the damage the disorder causes to people with SUDs and their loved ones, reducing the overall incidence of SUDs, and reducing SUD-related costs to society.**

Funders can help move towards this goal in multiple ways, by meeting the immediate needs of people with SUDs or by supporting research and policy work to shift the field over the long term.

This section of the report outlines ways donors can help, with specific examples of programs and organizations that have either proven their ability to reduce the human and economic burden of the SUDs or have strong potential to do so. We present opportunities within four main strategies:

- **Strategy 1:** Save lives and reduce SUD-related illness and homelessness—an approach sometimes known as “harm reduction” (page 11)
- **Strategy 2:** Improve access to evidence-based treatment through improved screening and better integration of mental health and primary care (page 21)
- **Strategy 3:** Improve SUD care by changing systems and policies (page 35)
- **Strategy 4:** Fund innovation to improve prevention and treatment (page 43)

In considering which opportunities to highlight, we used four primary criteria for selection: strength of evidence, expert recommendation and consensus, potential for impact, and whether the opportunity had a clear philanthropic on-ramp for funders, particularly one that allows a funder to play a strategic role in breaking a bottleneck or leveraging public funding.

Because evidence and impact look different in research and policy than in direct service, opportunities are presented slightly differently in those sections. No matter which section they fall into, the common characteristic for each opportunity is the potential for meaningful positive impact.

**The importance of prevention: An opportunity for innovation.** As with many public health issues, prevention is an appealing target for many donors—what better way to reduce suffering and save money than by stopping the disorder before it starts? When it comes to SUDs, the same holds true: prevention is an important and high-impact target for funders. What sets SUDs apart from something like measles, however, is that we don’t yet have proven tools to prevent the disorder from developing. That means that the opportunity for philanthropy to make a difference in prevention is greatest in research and innovation. There are some existing programs that have demonstrated promise within specific populations, but more piloting and research are needed before we can confidently recommend replicating them in schools and communities across the country. Conversely, there are programs that are widely implemented without strong evidence that they work. A better understanding of how these programs may or may not impact substance use will allow for more efficient spending of both public and private dollars. Finally, there are new tools—things like mobile health, genotyping, or even vaccines—that might eventually hold the key to successful prevention efforts. Innovation and information together can move the sector toward more effective prevention, and philanthropy can help make that happen. (For more on how, flip to Strategy 4 on page 44.)

To learn more about these criteria, our methodology, and the resources we consulted, please see the Appendix on page 56.



# Strategy 1

**Save Lives and Reduce  
SUD-related Illness and  
Homelessness Right Now**



## STRATEGY 1 Save lives and reduce SUD-related illness and homelessness right now

In emergency situations, the first priority is to save lives, treat injuries, and meet basic needs (food, water, and shelter). Only then can other issues, such as better disaster prevention or long-term recovery, be addressed. For people with the most clinically severe SUDs, the same logic applies: many of these individuals are in dire circumstances, and measures to protect their lives, alleviate their most immediate physical pain and isolation, and stabilize their surroundings often need to be taken before recovery from the disorder can even be contemplated.

There is a very real opportunity for philanthropy to **save lives by supporting programs that prevent overdoses and the spread of blood-borne viruses such as HIV and Hepatitis C** and to **provide a more stable environment through housing programs and legal support**. These approaches can and often do provide a gateway to care and to a more complete recovery. However, sobriety is not a prerequisite for the strategies outlined in this section. They are notable for their particularly **strong evidence base** and for their **cost savings**, benefitting taxpayers by easing the economic burden of America's substance use epidemic.

Finally, from our conversations with patients and care providers, another benefit emerged: by meeting SUD patients where they are and treating them with dignity *regardless of their recovery status*, these programs can provide links to care and a point of human connection for some of the most vulnerable and isolated people with SUDs.

*By treating clients with respect and dignity, we allow them to keep coming back until they may eventually be ready for treatment.*

— Dr. Brian Work,  
Streetside Health  
Clinic, Prevention  
Point Philadelphia<sup>37</sup>

### Saving lives

While alcohol remains the most commonly abused substance, rates of fatal heroin and prescription opioid overdose are increasing at an alarming rate in what the media has dubbed America's "quiet drug epidemic."<sup>38</sup> Heroin use is on the rise among young adults aged 18-25 and in rural areas. Evidence indicates that this trend is a consequence of prescription pain medication users developing an addiction and shifting to injected heroin as a cheaper alternative.<sup>39-43</sup> In addition to the risk of fatal overdose, injection-drug users expose themselves and others to additional health risks, including infection by viruses such as HIV and Hepatitis C. We highlight two opportunities to target fatal overdose and the spread of blood-borne viruses. There is strong evidence for the efficacy of these cost-saving strategies. Each of these opportunities offers a setting to engage the hardest-to-reach populations, keeping the door open for recovery while easing the most immediate risks and suffering:

- **High-Impact Opportunity: Prevent deaths from heroin & painkiller overdose**

Naloxone is a proven and effective medication to reverse overdose, either through injection or nasal spray. A single kit can cost as little as \$12, and an average of 50-100 kits distributed will save a life. However, funding gaps and restrictive policies keep naloxone out of the hands of many who would benefit from it. Philanthropy can fill a much-needed gap in funding direct service and advocacy for community naloxone distribution programs. *For more details on overdose prevention programs and on how you can help, see page 14.*

- **High-Impact Opportunity: Prevent the transmission of HIV and Hepatitis C and keep the door open for recovery**

Re-using needles facilitates the spread of blood-borne viruses such as HIV and Hepatitis C. To reduce needle re-use, clean syringe programs collect used syringes and dispense clean ones in a non-judgmental setting, often alongside other services such as wound treatment, general health care, or simply the use of the site as a mailing address. The provision of these services, based on requests from drug users themselves, ensures

client retention while keeping the door open to a fuller recovery. Many sites also offer case management services and referrals to treatment for their clients. Contrary to popular myth, extensive research from the Centers for Disease Control, the World Health Organization, and numerous other sources has definitively concluded that clean syringe programs do not increase drug use or crime.<sup>44-46</sup> In addition, every dollar spent on clean syringe programs is estimated to save three dollars in future HIV treatment costs, which are often borne by taxpayers.<sup>47</sup> Philanthropy can fill the gap in funding for such programs, which, despite their efficacy, are currently prohibited from receiving federal funds. *For more details on clean syringe programs and how you can help, see page 16.*

### Providing a stable environment

Substance use disorder and homelessness are deeply intertwined.<sup>48</sup> The incidence of SUDs among the homeless is four to six times greater than that of the population at large.<sup>49</sup> The instability of homeless life makes recovery more difficult, and many who seek help face a catch-22, as access to housing programs and other support services is often contingent on sobriety. As a result, many remain on the streets, their SUDs largely untreated, relying on costly public services like shelters and emergency rooms.<sup>50-51</sup> Problems of homelessness and instability are particularly difficult for patients with co-occurring mental health illnesses. Legal aid can help these patients avoid illegal evictions and catastrophic financial hardships.

- **High-Impact Opportunity: Combat SUD-related homelessness**

Supportive housing programs provide housing and case management to chronically homeless individuals, many of whom suffer from SUDs and other mental illnesses. A subset of these programs known as “Housing First” provides these services permanently whether or not clients are maintaining sobriety.<sup>52</sup> These programs work to reduce homelessness among people with SUDs. For example, a New York City implementation where 90% of participants had an SUD (often with another co-occurring mental health issue) was still able to keep over 80% of participants stably housed after two years,<sup>53</sup> a clear and meaningful improvement in quality of life. In addition, supportive housing is associated with other indicators of reduced SUD severity (see clinical definition on page i) such as lower use of detox and emergency medicine services. From a societal perspective, the cost of providing permanent housing can be offset by the reduction in use of other public services like shelters, emergency rooms, and jails.<sup>54</sup> *For more information on supportive housing programs and how you can help, turn to page 18.*

- **High-Impact Opportunity: Help SUD patients with co-occurring mental illnesses stay housed and financially stable**

Tasks like negotiating with health insurance providers, overturning wrongful denial of public benefits, or contesting an unlawful eviction can be daunting for anyone. It’s even more difficult for people with SUDs and co-occurring mental health issues, and the consequences of failing to manage those tasks can be severe. Unmet need for health care, loss of housing, and financial difficulties can together cause stress and instability that exacerbate mental health issues and create barriers to recovery. Collaborative models called “Medical-Legal Partnerships” use civil legal services to address these and other concerns for patients whose medical progress might be undermined by legal circumstances.<sup>55-59</sup> Once again, such assistance is compelling given the resulting savings from the reduced costs of emergency services.<sup>60</sup> *For more information on medical-legal partnerships and how you can help, turn to page 19.*

*If you would have asked me last year if I was for a needle exchange program, I would have said you're nuts ... I thought, just like a lot of people do, that it's enabling —that you're just giving needles out and assisting them in their drug habit. But then I did the research on it, and there's 28 years of research to prove that it actually works.*

– Public health nurse for Scott County, Indiana, site of a 2015 injection-related HIV outbreak<sup>61</sup>



# High-impact opportunity 1.1



*Street crime is no longer the clearest barometer of our drug problem; corpses are.*

– Sam Quinones, researcher & journalist<sup>62</sup>

*Overdose work is simple and concrete. It leads to lives saved ... you give people a tool and they use it.*

–Eliza Wheeler, overdose prevention specialist<sup>63</sup>

*A guy on the street, a stranger to me, had taken some of that strong gunpowder... and overdosed. His friends asked me if I had narcan and I did, so I saved him.*

–Anonymous user<sup>64</sup>

## Prevent deaths from heroin & painkiller overdose

Fatal overdoses from heroin and painkillers are increasing at an alarming pace; in 2013 alone, **nearly 25,000 people died of an opioid overdose, a 400% increase in fatal overdose rates** in just over a decade.<sup>65</sup> For \$40-\$55 per kit distributed with appropriate training, naloxone kits reverse overdoses and save lives,<sup>66</sup> but barriers to access remain. The cost of the medicine itself, along with training costs, can be hard for a small program to afford. In many cities and states, drug paraphernalia laws can make naloxone kits illegal, and there are no legal protections for doctors who prescribe naloxone or members of the public who administer it. At the time of this writing, there are still 18 states that have yet to pass a single key protection for naloxone distribution, and only 11 that have passed all of the protections suggested by experts.<sup>67</sup>

**CORE PRACTICE:** Community programs distribute naloxone kits and provide training on how to use them so that drug users, their loved ones, and first responders such as police can reverse overdoses and save lives. Advocacy and training groups help create a supportive policy environment and provide the information and coaching direct service programs need to succeed.

**Target Beneficiaries:** Heroin and painkiller users at risk of fatal overdose

**Impact:** For every 50-100 kits distributed, approximately one life will be saved. In 2013 alone, naloxone programs distributed naloxone and training to nearly 38,000 participants who went on to reverse over 8,000 overdoses.<sup>68</sup> Put another way, for every five persons trained nationally, approximately one overdose was reversed. Programs that distribute directly to drug users can be especially efficient. For example, about half the kits distributed by Prevention Point Pittsburgh (see following page) are used to prevent an overdose, a rate twice the national average. Experts estimate that nationally, 5-10% of reversed overdoses would have been fatal.<sup>69</sup> On the ground, communities implementing naloxone distribution programs have seen overdose deaths decrease by up to 70%.<sup>70</sup>

**Cost-per-impact profile:** Based on the cost and impact ranges reported above, a back-of-the-envelope estimate indicates that it costs \$800 - \$5500 to save a life through naloxone distribution programs. That's a wide range, as costs vary due to factors such as the cost of the drug itself, which comes in multiple formulations and is currently in the midst of a price increase, and costs of training and related program expenses. The population targeted also affects that number. While distributing to parents, police, and other groups is important, programs that distribute directly to drug users see more kits used when and where they are needed and therefore lower costs per life saved.<sup>71</sup>

**HOW PHILANTHROPY CAN HELP:** Philanthropists who want to prevent deaths from overdose can fund community naloxone distribution centers directly. At the time of this writing, these programs receive some public support, but training and advocacy are rarely covered by public dollars. Philanthropy can support training and advocacy to make it easier for all naloxone centers to operate in areas where they are needed.



## OPPORTUNITY IN PRACTICE

### Prevention Point Pittsburgh

Prevention Point Pittsburgh (PP Pittsburgh, unaffiliated with Prevention Point Philadelphia) distributes naloxone directly to drug users in the community and trains them to reduce overdose risk, recognize overdose signs, and reverse overdoses. These trainings are offered in several community settings, including the Allegheny County jail, methadone clinics, and other treatment facilities. In addition to serving drug users directly, PP Pittsburgh trains health care providers to provide naloxone to their patients as needed. PP Pittsburgh also engages in advocacy work, including active involvement in the 2014 passage of Pennsylvania's naloxone access law.

In just under a decade, PP Pittsburgh dispensed 2,298 kits to 1,175 individuals, leading to a reported 1,167 successful overdose reversals; roughly 1 in 15 of those would have been fatal.<sup>69</sup> A back-of-the-envelope estimate indicates that for **every 29 kits distributed by Prevention Point Pittsburgh, a life is saved**. PP Pittsburgh estimates the cost of training and providing naloxone to one individual ranges from \$40-55. **It therefore costs PP Pittsburgh approximately \$1,200-\$1,600 to save a life.**

This estimate suggests that PP Pittsburgh is more cost-effective than the national average. This is, in part, because, while they do distribute to family members and others likely to be first on the scene of an overdose, their primary target is people who inject drugs. **Going straight to the users makes it more likely that the kits will be in the right place at the right time, leading to more kits used when they are needed and more lives saved.**

### The Harm Reduction Coalition

The Harm Reduction Coalition (HRC) works in states and at the federal level to advance support of overdose prevention and clean syringe access. They also provide capacity-building services to state agencies and non-profits seeking to implement programs in their own communities.

For example, HRC began work in Colorado in 2010. Through a combination of assistance to care providers and advocacy to the state legislature, **HRC enabled the formation of three new naloxone distribution sites**. The programs are small and still relatively new, but one site reports 400 kits distributed and 155 overdose reversals reported since its start in May 2012.

HRC also piloted overdose prevention within the San Francisco County Jail, placing naloxone kits in trained inmate's property for access upon release. By July 2014, **almost 200 inmates had opted to receive naloxone kits in their property**. HRC also collaborated with The California Coalition of Women Prisoners to develop overdose prevention materials and programming for women in California state prisons.

## TAKE ACTION

To support an existing program like Prevention Point Pittsburgh directly, visit South Boston Hope & Recovery Coalition's national database at [www.hopeandrecovery.org](http://www.hopeandrecovery.org) to find a naloxone distribution program in your community.

To help train and support communities looking to expand access to life-saving naloxone kits, visit the Harm Reduction Coalition's website at <http://harmreduction.org>. Their site also provides fact sheets and materials for those interested in advocating for better overdose prevention.



## TIPS

For the greatest bang for buck, funders should seek out:

- **Centers that distribute directly to drug users** as well as to family members and first responders. The evidence shows that distributing to users results in more lives saved per kit.
- **Advocates with strong ties to state-level decision-makers**. Much of the law and policy around naloxone distribution is decided at the state level. Groups with close connections to state-level decision-makers understand the local context and can advocate more effectively.

# High-impact opportunity 1.2



*It does not result in an increase in drug abuse, and it does decrease the incidence of HIV ... The idea that kids are going to walk out of school and start using drugs because clean needles are available is ridiculous.*

– Dr. Anthony Fauci, National Institutes of Health (NIH)<sup>72</sup>

*Needle exchange offered us a way to say that drug addicts are people and they have an illness that merits concern and love... Until we get people into treatment, this is a way to take care of them.*

– Father Errol Harvey, formerly of Manhattan's St. Augustine Church<sup>73</sup>

## Prevent the transmission of HIV and Hepatitis C and keep the door open for recovery

Lack of access to clean syringes and health care poses a serious health risk to users and to the wider public, as reusing needles facilitates the spread of blood-borne viruses such as HIV and Hepatitis C. **For less than \$1/syringe, clean syringe programs are a cost-effective way to prevent the spread of HIV.** Despite widespread misconceptions, researchers from the Centers for Disease Control, the World Health Organization, and other research centers have repeatedly found that they *don't* increase drug use.<sup>74,75</sup> Clean syringe programs are used widely and receive public funding in nearly 80 countries around the world,<sup>76</sup> but the politics surrounding these programs in the United States are divisive and a ban on federal funding for syringe exchanges remains in place to date.<sup>77</sup>

**CORE PRACTICE:** In areas with a high number of people who inject drugs, used syringes are collected and clean paraphernalia is dispensed. Many clean syringe programs will also offer other services such as wound care, contraceptives, or the use of the clinic as a mailing address.

**Target Beneficiaries:** People who inject drugs, as well as their partners or children at risk of blood-borne infection

**Impact:** Eight different reports commissioned on behalf of U.S. government agencies and the World Health Organization found that clean syringe programs reduced the spread of HIV.<sup>78,79</sup> In the late 1980s, 30-50% of HIV infections in the U.S. arose from injection drug use. Today, this is down to approximately 8%, and evidence shows that clean syringe programs are at the heart of this trend.<sup>80</sup> In Philadelphia, for example, the cumulative average of new HIV infections occurring through injection drug use was estimated at 5.4% of all new infections diagnosed for 2013 (down from an average of over 30% for 1980-2010).<sup>81</sup>

Despite common misconceptions, researchers have repeatedly found that these programs do not increase drug use or crime and can actually make for cleaner neighborhoods as discarded syringes are returned to exchanges.<sup>82,83</sup> In addition, a number of studies have shown a positive correlation between clean syringe programs and reduced drug use, greater treatment entry, and improved treatment outcomes.<sup>84,85</sup>

**Cost-per-impact profile:** A panel of experts convened at the International AIDS Conference in Washington, D.C., in July 2012 gave a conservative estimate that **every dollar spent on clean syringe programs would save three dollars in future HIV treatment costs** averted.<sup>86</sup>

**HOW PHILANTHROPY CAN HELP:** Because of the federal funding ban, lack of capital is a major problem for clean syringe programs. Philanthropists can fund clean syringe programs directly or can support advocacy to encourage increased public funding for this cost-effective intervention.

## OPPORTUNITY IN PRACTICE

### Prevention Point Philadelphia

Prevention Point Philadelphia (PP Philly, unaffiliated with Prevention Point Pittsburgh) began as an underground operation by local AIDS activists in 1991. It was officially sanctioned a year later when the Board of Health declared a public health emergency in response to the HIV/AIDS epidemic sweeping the city.<sup>87</sup> In the years since, PP Philly has become part of Philadelphia's broader medical community, with links to teaching hospitals at the University of Pennsylvania, Thomas Jefferson University, Temple University, and Drexel University.

With an annual operating budget of under \$400,000 for its syringe program, PP Philly **serves over 4,500 regular clients (many of whom are also exchanging for friends, bringing PP Philly's services to over 40,000 individuals overall) and distributes some 1.5 million syringes each year.** In addition, PP Philly provides HIV and Hepatitis C testing services, rudimentary health care (including a wound clinic requested by their clients), naloxone overdose prevention training, case management, and referrals to social services and drug treatment. In-house, PP Philly provides 60 slots in a suboxone opiate substitution program (known to be an effective treatment for heroin and painkiller addiction) and 44 places in HIV Antiretroviral Therapy (ART).

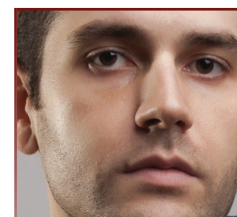
They also offer auxiliary services. For example, in 2015, the organization partnered with a local shelter organization to provide 25 emergency beds for homeless men. Clients can also use PP Philly as a mailing address.

The organization has a team of 15 paid staff and approximately 750 volunteers operating out of a fixed site in Philadelphia's North Kensington neighborhood and from six designated locations via its mobile van.

### TAKE ACTION

Visit Prevention Point Philadelphia's website at <http://harmreduction.org/connect-locally/pennsylvania/prevention-point-philadelphia>, or find similar programs in your area by visiting the mapping tool and database offered by the North American Syringe Exchange Network at <https://nasen.org/directory/>.

Funders can also support advocacy to increase access to clean syringes, such as the Harm Reduction Coalition's campaign to reverse the ban on federal funding for clean syringe programs. (For more about the Harm Reduction Coalition, see page 15.)



### TIPS

To achieve the highest impact, look for programs adhering to accepted best practices, including:

- No limitations on number of syringes a user can obtain;
- No requirements for identification or other legal documents; and
- Provision of other health services tailored to the needs of the local community, such as wound care and contraception.

# High-impact opportunity 1.3



## TIPS

Not all housing programs are the same:

- Housing First programs provide housing and case management, whether or not residents are maintaining sobriety. They are most often “scattered site,” which means that clients aren’t all housed in a single building but rent apartments through private landlords just like any other leaseholder.
- Sober housing programs provide housing only as a reward for sobriety—and withdraw it as a consequence for drinking or drug use.

Both programs can be helpful, depending on the population served. While some with SUDs see sobriety requirements as a barrier to entry, others may welcome them as a needed incentive.

## Combat SUD-related homelessness

The incidence of SUDs among the homeless is four to six times greater than that of the population at large.<sup>88, 89</sup> The instability of homeless life makes recovery more difficult, and many housing programs and other support services require sobriety as a condition of participation. As a result, homeless SUD patients who can’t maintain sobriety remain on the streets, largely untreated, relying on costly public services like shelters and emergency rooms.<sup>90</sup> Stable, supportive housing can make an immediate positive impact in quality of life for a person with an SUD, while improving access to treatment, decreasing the use of emergency services, and ultimately saving public dollars.<sup>91-95</sup>

**CORE PRACTICE: Provide stable housing with supportive services—including options that don’t require sobriety.**

**Target Beneficiaries:** People with SUDs who are chronically homeless; these are often individuals with co-occurring mental health disorders.<sup>96</sup>

**Impact:** In New York City, over 80% of participants in supportive housing without sobriety requirements remained housed after two years.<sup>97</sup> In a similar program in Philadelphia, 90% of clients remained stably housed at the two-year mark. In that program, clients with severe alcohol use disorders decreased their nights in jail, hospitals, and emergency shelters by over 90%, from an average of 88 to 8 nights per year.<sup>98</sup> Sober housing has shown increased use of SUD treatment services (often required for residents) and improved housing stability.<sup>99</sup>

**Cost-per-impact profile:** In Philadelphia, Pathways to Housing PA (see below) pays about \$20 per day to provide permanent housing to a chronically homeless person. When administration and supportive services such as primary care and SUD treatment are included, the total cost is \$77 per day.<sup>100</sup> For comparison, short-term emergency housing costs the City of Philadelphia \$34 per day, a night in prison costs about \$90 per day, and SUD treatment or mental health hospitals average nearly \$600-800 per night.<sup>101</sup> A back-of-the-envelope estimate indicates that the above-mentioned drop from 88 to 8 nights of public service use helped the city avoid costs of about \$30 per client per day, or over \$10,000 per client per year.<sup>102</sup>

**HOW PHILANTHROPY CAN HELP: Philanthropists can help combat homelessness among people with SUDs by funding supportive housing programs in their community. Public dollars fund some of these programs, but services are not available to everyone who needs them.**

## OPPORTUNITY IN PRACTICE

### Pathways to Housing PA

Pathways to Housing PA implements the Housing First model, housing clients regardless of their substance use. According to a 2011 evaluation, 89% of Pathways to Housing PA participants remained stably housed five years after entering the program.<sup>103</sup> Clients can access services like primary care, SUD treatment, and coaching on daily activities such as shopping for groceries. Housing is used as a foundation for stability, rather than an incentive for sobriety. Pathways to Housing PA partners with the Philadelphia Department of Behavioral Health on a special effort targeting chronically homeless SUD patients.

*Note: Pathways to Housing was originally a national network, but local chapters now operate independently. A Pathways chapter in New York was closed following financial and legal difficulties, but other implementations remain highly recommended by experts in homelessness, including the federal agency tasked with homelessness prevention (United States Interagency Council on Homelessness).<sup>104</sup>*

## TAKE ACTION

Several options exist for the kind of supportive housing that keeps SUD sufferers safe, keeps the door open for recovery, and saves societal costs. The 100,000 Homes campaign lists programs across the country at [100khomes.org](http://100khomes.org). For more information about Pathways to Housing PA and the Housing First model, see [pathwaystohousingPA.org](http://pathwaystohousingPA.org).

# High-impact opportunity 1.4



## Help SUD patients with co-occurring mental illnesses stay housed and financially stable

SUDs and other mental health issues are often co-occurring, and the combination can make it particularly difficult for patients to navigate unexpected issues such as a drop in income or an illegal eviction notice. These bumps in the road can then spiral into a worsening situation, creating obstacles to stability and recovery.

**CORE PRACTICE:** In medical-legal partnerships, attorneys train health care providers to recognize when a legal issue such as improper denial of treatment is impeding recovery. Attorneys also work directly with mental health patients to help resolve issues that patients have difficulty managing on their own.

**Target beneficiaries:** SUD patients with co-occurring mental health illness

**Impact:** Medical-legal partnerships can keep patients in their homes and out of financial crisis. For example, MFY Legal Services (highlighted below) served 1,600 clients in 2014, preventing 200 illegal evictions and helping their clients access needed public supports for which they are eligible.

**Cost-per-impact profile:** Medical-legal partnerships save taxpayer dollars. For example, the average cost to shelter a homeless family in New York City is over \$37,000 per year, while it costs MFY one-tenth that amount to prevent that family's eviction.<sup>105</sup> A Virginia study found that every \$1 spent on legal aid yielded over \$5 in cost savings from reduced use of emergency services, increased tax dollars paid to the state, and other benefits; a New York evaluation found similar results.<sup>106-108</sup>

**HOW PHILANTHROPY CAN HELP:** Donors can fund medical-legal partnerships directly to serve the unmet need for such support. They can also work with national groups to support new local partnerships or strengthen training and awareness-building within the medical and legal communities.

### TIPS

Some organizations may also provide legal help outside of the medical-legal partnership model. For instance, MFY runs a project targeting unscrupulous “three-quarter house” operators, who recruit graduates of SUD treatment programs with promises of supportive housing—but in reality provide coerced sham treatment as part of a Medicaid fraud scheme. Patients who request different treatment are summarily (and illegally) evicted.

## OPPORTUNITY IN PRACTICE

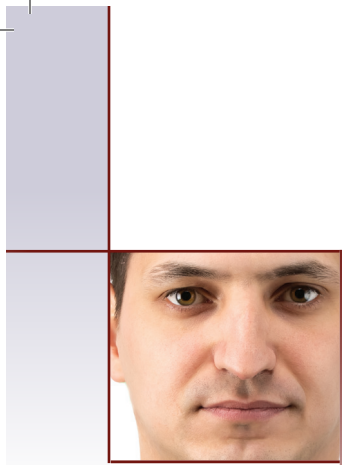
### MFY Legal Services

Through a medical-legal partnership called the “Mental Health Law Project,” MFY Legal Services serves the particular needs of mental health patients, including those with co-occurring substance use disorders (about 40% of their client population). The Mental Health Law Project has relationships with all 11 public hospitals in New York City and receives referrals from mental health care providers who have identified a legal need affecting a patient's health. The major civil legal needs of this community include preventing unlawful eviction, wrongful termination, and improper denial of health care or public benefits.

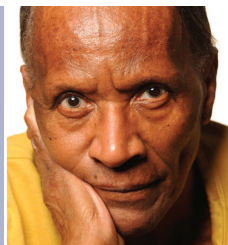
For approximately \$100,000 yearly (including benefits and supervision), an MFY attorney can serve about 200 clients. Their legal support reduces the need for costly emergency services by preventing approximately 30 illegal evictions and helping clients access \$180,000 in public assistance for which they are eligible, a return of up to \$1.80 on the dollar.

### TAKE ACTION

For more information about MFY and how to support its work, see their website at [mfy.org](http://mfy.org). To identify similar medical-legal partnerships in your community, explore the mapping tool provided by the National Center for Medical-Legal Partnerships at [www.medical-legalpartnership.org](http://www.medical-legalpartnership.org). For those interested in supporting the development of a new partnership, the National Center also provides toolkits and other guidance.







# Strategy 2

**Improve Access to  
Evidence-Based Treatment**



## STRATEGY 2 Improve access to evidence-based treatment

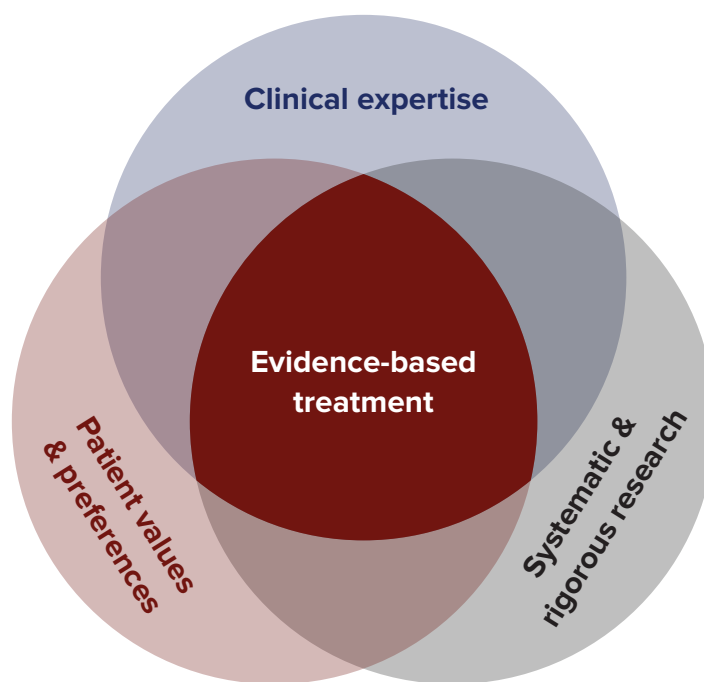
*It's like getting the same antibiotic for a [drug]-resistant infection—eight times.*

– SUD patient who cycled in and out of 12-step-based treatment programs without being offered other treatment options<sup>109</sup>

Substance use disorders can look very different from one person to another, and there is no single silver bullet treatment that works for everyone. As the science behind treatment continues to improve, however, there are two things we can say with certainty.

First of all, **there is a basic need to extend access to evidence-based care.** The treatment most substance use disorder patients receive today is simply ... nothing. Only 1 in 10 SUD patients receives care at a specialized treatment facility.<sup>110</sup> Most individuals with SUDs are never referred to treatment, and for those 1 in 10 who are referred, many find that they are not offered a full range of treatment options. For certain vulnerable or institutionalized groups, such as pregnant women and prison inmates, access to treatment of any kind is particularly difficult.

Second, the need for an individualized and adaptable approach provides the common thread for interventions that effectively treat SUDs. Funders should be wary of any single approach that claims to have cornered the market on effective treatment, eschews all other interventions, and places the burden of failure solely on the “readiness” (or lack thereof) of a patient. **High-quality, evidence-based treatment is not any single therapy, but the practice of drawing upon the full spectrum of what we know works.** In practice, that means integrating clinical expertise, patient values and preferences, and research evidence into the decision-making process for patient care.<sup>111-112</sup> Evidence-based tools (sometimes called *treatment modalities*) include different types of talk therapy, incentives for reduced use, medications to reduce cravings, versions of 12-step therapy, and many more. In addition, many of these can be combined for a more-tailored fit. Case managers, for instance, can help patients access and balance the treatments that are right for them. Availability of a particular treatment is often unrelated to the strength of evidence for that treatment. For example, while evidence for the effectiveness of medication-assisted treatment is much stronger than that for the effectiveness of 12-step programs, the latter are much more widely available within treatment centers.





This section outlines four opportunities to change this situation, getting more people access to the treatment they need. The first two strategies focus on breaking the cycle of substance use by extending care to populations with particularly high barriers to care. The second two strategies work to ensure greater access to specialized treatment for the general population.

### **Breaking the cycle for high-risk groups**

Drug and alcohol use during pregnancy can put a woman at risk of potentially fatal complications,<sup>113</sup> and can increase the risk that a baby is born too soon or with a health complication.<sup>114-118</sup> Many women are afraid to seek prenatal care or admit their substance use, fearing that they will be judged by care providers, faced with criminal charges,<sup>119</sup> or even separated from their existing children.<sup>120</sup> Once children are born, parental substance use increases the risk of child abuse and neglect,<sup>121</sup> as well as the risk that the child will go on to develop an SUD.<sup>122, 123</sup>

While many would not think of inmates as a vulnerable population, incarceration makes it difficult to access treatment—not just within the prison, but in the community after release. This is a population with high need; approximately 6 in 10 U.S. inmates have a substance use disorder, exacerbating the challenges they face upon release and making recidivism and its accompanying costs to society all the more likely.<sup>124</sup> Recently released individuals with SUDs are also at elevated risk of fatal overdose, as they may return to substance use without realizing that abstaining during incarceration has lowered their tolerance. For those individuals, the dose that used to get them high is now deadly.<sup>125</sup>

- **High-impact opportunity: Help pregnant women, mothers, and their young children get the help they need**

The most effective programs for women are residential, offer gender-specific programming, involve children and families, and provide housing and comprehensive support services.<sup>126</sup> Such interventions can help women recover from their SUDs, gain parenting skills to strengthen their family, and retain/obtain custody of their children. They also ensure that newborns get the care they need to minimize harm from substance exposure and that young children receive specialized support. However, such intensive programming is expensive to provide and, therefore, rarely available to low-income women. *To find out more and learn how philanthropy can help low-income mothers and families move toward recovery, turn to page 26.*

- **High-impact opportunity: Break the cycle of substance use and incarceration by connecting inmates with the care they need**

Low-income individuals in many states rely on Medicaid, which in most states is terminated during incarceration but can be renewed upon release. However, the difficulty in re-enrolling can present a major barrier to care. Connecting pre-trial detainees, current inmates, and formerly incarcerated individuals with Medicaid allows them to access mental health care, including SUD treatment, seamlessly upon re-entry into the community. This care can keep them alive and on track to recovery and a fresh start. Moreover, the concurrent reduced recidivism and lower health care costs can result in cost-savings to taxpayers. *To find out more and learn how philanthropy can support increased treatment enrollment and reduced recidivism, turn to page 28.*



## Improve screening, early intervention, and access to mental health care for the general population

Primary care and the emergency department are the most common points of care for most Americans, but physicians are often underequipped to identify, treat, or manage substance use disorders.<sup>127</sup> There are two simple strategies that can help. Health care providers can check early-onset SUDs before a full-blown condition develops through effective **Screening and Brief Intervention** and can deliver specialized evidence-based treatment through **Collaborative Care** models.

- **High-impact opportunity: Improve screening and early intervention for SUDs**

There is a simple protocol that allows health care providers to quickly identify risky or problematic substance use, intervene briefly if appropriate, and refer patients to more intensive treatments when warranted. Patients answer a few screening questions about use. For those who report risky use, the care provider follows up with a brief discussion about the risks of use and the options for cutting back. Finally, the provider gives a referral to treatment for those whose use is severe enough to warrant treatment. This is known as SBIRT (**S**creening, **B**rief Intervention, and **R**eferral to **T**reatment), and it has shown promise in reducing alcohol use and related negative outcomes such as drunk driving and sexually transmitted infections. Moreover, studies have shown that every dollar spent on SBIRT can generate cost savings in health care of between \$3.80 and \$5.60. Excitingly, it's also a promising avenue for research into SUD prevention among adolescents, a particularly high-risk group for new SUDs.<sup>128</sup> *To find out more about how philanthropy can improve screening and early intervention through SBIRT, turn to page 30.*

- **High-impact opportunity: Integrate mental health care, including SUD treatment, with primary care**

Originally developed for treating depression and mental health conditions, the Collaborative Care model is characterized by the following: care teams deliver evidence-based, patient-centered care; health care providers track outcomes for their entire patient population; and care providers are reimbursed for patient outcomes rather than volume of services provided.<sup>129, 130</sup> Collaborative Care can improve mental health and other risk factors for SUDs and, in some implementations, can directly improve access to quality SUD care. There is also a high potential for cost savings. In one study, every \$1 spent on this strategy generated \$6.44 in health care savings.<sup>131-133</sup> *To find out more and learn how philanthropy can help capacity-building efforts in Collaborative Care, turn to page 32.*

All of the opportunities in this section offer innovative approaches to improve access to effective SUD treatment. They extend much-needed care to population groups often unable to access quality care or improve the screening and treatment processes currently offered by mainstream health care providers. These strategies benefit individuals in need of better treatment and also provide savings to taxpayers by reducing associated health care costs.



# High-impact opportunity 2.1

## Help pregnant women, mothers, and their young children get the help they need

Among pregnant women aged 15 to 44 in the U.S., 1 in 20 are current illicit drug users<sup>136</sup> and 1 in 13 report using alcohol.<sup>137</sup> Children of mothers who abuse drugs and alcohol are at increased risk for a variety of problems, and the mothers themselves have a higher likelihood of experiencing trauma or abuse.<sup>138</sup> Drug and alcohol use during pregnancy can lead to negative effects on the baby, including congenital anomalies and an increased risk of developing an SUD in the future.<sup>139, 140</sup>

**CORE PRACTICE:** Residential programs specifically designed for pregnant women and their children offer gender-specific and trauma-informed treatments, providing comprehensive support services for the entire family.

**Target Beneficiaries:** Low-income pregnant women and mothers with SUDs, along with their young children

**Impact:** Participants in these comprehensive, tailored programs showed reductions in substance use and improved birth outcomes, with increases of 20-30 percentage points in the rate of babies born full term or at healthy weights.<sup>141</sup> There can also be impacts on important related factors, such as parenting skills and whether or not a child is placed in state custody. Compared with mothers in regular treatment programs, mothers treated in these tailored, family-based programs are twice as likely to be reunited with their child.<sup>142</sup> While the available data are not sufficient to yield a confident prediction about second-generation prevention, these improvements have the potential to reduce the biological and environmental factors that increase a child's risk of developing a future substance use disorder.

**Cost-per-impact profile:** Costs vary by location, but implementer Meta House (see following page) requires \$6,750 in philanthropic funding (leveraging additional public funding) to provide a pregnant mother, newborn, and additional young child with three months of specialized treatment. Potential impacts include a threefold increase in the mother's likelihood of remaining abstinent from drugs and alcohol for at least six months after her child's birth (from around 25% to around 80%); a reduced risk of low birth weight and prematurity for babies born to mothers in treatment; and increased likelihood that mothers with children in foster care can be reunited with their children.<sup>143</sup>

**HOW PHILANTHROPY CAN HELP:** Organizations like Meta House rely on philanthropy to fill gaps in public funding, enabling women to access the treatment they need for as long as they need it. For example, Milwaukee County currently covers 75 days of a woman's treatment at Meta House; other sources of funding are often needed to extend treatment until a woman has successfully transitioned out of the program.

*I've learned about how using drugs covered up the hurt I was feeling ... I feel so much more [now], and it's painful but a blessing and a joy. I'll never forget when the baby first kicked. I'm already getting to know her -I know when she's hungry or wants to sleep.*

— Arielle, former cocaine user, mother of 2, graduate of Meta House<sup>134</sup>

*I needed time. I didn't know how long it was going to take. I knew I needed TLC for a longer period than I would get at a traditional rehab. I was sick, I was really, really sick.*

— Katie, former cocaine and heroin user, mother of 1, graduate of Meta House<sup>135</sup>

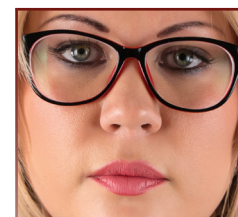
## OPPORTUNITY IN PRACTICE

### Meta House

Meta House has been treating women with SUDs in Milwaukee, WI, since 1963. Women and children at Meta House are a high-risk, high-need population, with disproportionately low education, high unemployment, and frequent homelessness. Over 90% of women at Meta House have suffered trauma or abuse. To serve this population, Meta House's residential program provides a wide range of comprehensive services for up to 35 women and 20 children at a time, including gender-specific and trauma-informed care. For example, while many treatment models emphasize a patient's powerlessness over drugs or alcohol, Meta House women—having experienced powerlessness throughout their lives—often need a sense of empowerment to change their behavior.

Another key component of Meta House's model is the space for children. It was one of the first treatment centers in the country to allow children to stay in treatment with their mothers. They offer child-specific services, such as filial play therapy, in which therapists coach mothers and help support healthy child development through playtime. They also offer parenting education and ways to engage fathers and father figures, such as through a Father Engagement Specialist or Family Nights.

Impacts for mothers at Meta House include increased abstinence from alcohol and illicit drugs and healthier birth outcomes for babies. Women who participated in treatment also reported 33% fewer days of experiencing mental illness symptoms. At intake, approximately 15% of Meta House women with minor children were living with those children. Six months after treatment, however, almost half (48%) of the children of Meta House women had either remained in their mother's care, been reunified with their mothers, or had increased visitation.



### TIPS

Best practices for comprehensive mother and family care include:

- Case management
- Individual, family, and group therapy
- Safe housing for women and children in their care
- Services for children (e.g., play therapy, academic assistance)
- Medical, mental health, and prenatal care
- Parenting education and coaching, including individual instruction about infant care
- Education & support for additional family members

### TAKE ACTION

To support Meta House, visit their website at [www.metahouse.org](http://www.metahouse.org). To find similar programs in your community, see our website for recent grantees from SAMHSA's Services Grant Program for Treatment for Pregnant and Postpartum Women ([www.samhsa.gov/grants/gpra-measurement-tools/csat-gpra/csat-gpra-ppw](http://www.samhsa.gov/grants/gpra-measurement-tools/csat-gpra/csat-gpra-ppw)), which have been recognized as high-quality programs. Or, use the program criteria listed in our tips (at right) to identify a similar program in your community.



# High-impact opportunity 2.2



*Since 1970, the United States prison population has risen 700%. Now, with 5% of the world's population, the U.S. has 25% of the world's prison population. One in 99 adults is living behind bars in the U.S., marking the highest rate of imprisonment in American history—and 60% of those inmates have a substance use disorder.<sup>144</sup>*

— National Center on Addiction and Substance Abuse, Columbia University

## Break the cycle of substance use and incarceration by connecting inmates to the care they need

Approximately 6 in 10 U.S. inmates have a substance use disorder, and those with an SUD are less likely to stay out of prison once their term is over.<sup>145</sup> Access to treatment for this group is important to keep them out of jail, but administrative hurdles can be significant. Low-income individuals in many states rely on Medicaid, which in most states is terminated during incarceration but can be renewed upon release. When individuals lose their Medicaid coverage during incarceration, re-enrolling can be a slow and arduous process, delaying or blocking access to the treatment they need to help them stay sober. The result: high rates of relapse, fatal overdoses, and parole violations leading to repeated incarcerations, with a hefty price tag for individuals and taxpayers. Simplifying the process of Medicaid enrollment can get more care more quickly to this high-need population, saving lives along with taxpayer dollars.

**CORE PRACTICE:** Helping detainees and people on criminal justice supervision enroll or re-enroll in Medicaid allows them to access mental health treatment (including SUD care) immediately upon release, reducing the risk of fatal overdose and facilitating successful re-entry into the community.

**Target Beneficiaries:** Individuals who are involved in the criminal justice system, either as detainees (pre-trial) or inmates. Approximately 60% of this population has a SUD.<sup>146</sup>

**Impact:** Improved access to evidence-based treatment for detainees and inmates, which likely leads to reductions in fatal overdose, recidivism, and their associated costs. Research from the state of Washington found that improving treatment access for justice-involved individuals with a history of substance use disorder can slow health care spending for that population, resulting in overall health care cost savings of \$1,944 per member per year.<sup>147</sup>

**Cost-per-impact profile:** The Healthy & Safe Communities Initiative of the ACLU of San Diego and Imperial Counties (see next page), a leading implementer, operates on a budget of approximately \$120,000 per year. In their first year of operation, they have facilitated Medicaid enrollment for over 2,100 individuals, with approximately 200 more awaiting enrollment decisions. This translates to a philanthropic cost of \$50-\$60 per enrolled individual. That cost per enrollee will continue to decrease with time, as the greatest investment of time and money is in the up-front costs to develop and pilot the enrollment strategy. In addition, as noted above, similar efforts in Washington state returned nearly \$2,000 in health care cost savings per individual.

**HOW PHILANTHROPY CAN HELP:** Funders who want to increase access to care and reduce recidivism can fund capacity-building to help organizations like the ACLU of San Diego and Imperial Counties extend their services and share what they've learned about what works.

## OPPORTUNITY IN PRACTICE

### Healthy & Safe Communities Initiative of the ACLU of San Diego and Imperial Counties

The Healthy and Safe Communities Initiative (HSCI), facilitated by the ACLU of San Diego and Imperial Counties, works to increase Medicaid enrollment among individuals who are incarcerated, formerly incarcerated, or under criminal justice supervision. The HSCI is comprised of local community clinics, reentry service providers, and advocacy organizations. The HSCI collaborates with the local Sheriff's, Probation, and Health and Human Services Departments to identify mechanisms to make Medicaid enrollment smoother for re-entry or release, minimizing dangerous interruptions of care.

From July 2014 to April 2015, the program connected over 2,100 re-entering individuals (approximately 65% of whom have an SUD) with health care coverage through Medicaid. Over 230 additional individuals are currently in the process of enrollment (as of April 2015).<sup>148</sup>

The HSCI operates on a budget of approximately \$120,000 per year, which includes funding for a full-time staff attorney to lead the project and the part-time costs of supporting staff. The project is entirely philanthropically funded; funders have included the Open Society Foundations, the California Endowment, and the Parker Foundation.

In addition to providing technical assistance to the Medicaid enrollment project, HSCI works to reform the systems that influence care within and outside of the correctional system.<sup>149</sup> For example, recent projects include:

- Developing **toolkits** for working with law enforcement on Medicaid enrollment programs
- **Coaching** to other initiatives engaged in similar efforts
- Working with **advocates** across the country to support policies that increase access to care, such as allowing inmates to make an appointment with a community care provider before release

Future work will include impact evaluation to help understand exactly how Medicaid coverage affects the way these populations access care, as well as continued capacity-building efforts around the country. The Initiative plans to work towards systemic change to increase access to care, including advocating for Medicaid-funded supportive housing and specialized Medicaid programs for individuals with SUDs.

### TAKE ACTION

To support the Healthy & Safe Communities Initiative, visit their website at [www.aclusandiego.org](http://www.aclusandiego.org). Other organizations whose work includes SUD treatment access for prison populations are the Legal Action Center and COCHS, profiled on pages 40-41 of this guide.



### TIPS

Funders looking to support changes to criminal justice systems can look for advocates with strong connections to state and local decision-makers. As the HSCI example illustrates, sometimes small, technical changes can be powerful solutions, but it's difficult to identify those opportunities without an inside perspective on the way systems and administrative barriers work.

# High-impact opportunity 2.3



*The idea ... is deceptively simple: What if you could stop drinking and substance abuse problems before they became serious enough to destroy people's lives?*

– SAMHSA (Substance Abuse & Mental Health Services Administration)<sup>150</sup>

## Improve screening, prevention, and early intervention for SUDs

Primary care and the emergency department are the most common points of care for most Americans, but health care providers in both settings are underequipped to identify, treat, or manage substance use disorders.<sup>151</sup> Less than 20% of primary care providers (PCPs) feel “very prepared” to identify the condition, and most patients with SUDs say their PCP did nothing to address their substance abuse.<sup>152</sup> The result? Risky alcohol and drug use goes undiagnosed and unchecked, opening the door to a full-blown disorder and all of the negative impacts that follow.

**CORE PRACTICE:** All patients in hospital emergency departments, primary health clinics, or other health care settings automatically undergo a quick screening to assess their alcohol and drug use. If their use puts them at risk of developing a serious problem, they receive a brief intervention that focuses on raising their awareness of their substance use-related risks and motivating them to change their behavior. Patients who need more extensive treatment receive referrals to specialty care. The entire process is known as SBIRT (screening, brief intervention, and referral to treatment).

**Target Beneficiaries:** Individuals with risky substance use behaviors or SUDs receiving care from a hospital, primary care clinic, or other non-specialized setting

**Impact:** SBIRT can reduce drinking and the risky behaviors that often come along with it. Patients receiving SBIRT have reduced drinking by 13-34% compared with controls.<sup>153</sup> As drinking drops, so do consequences associated with risky drinking. Patients who received SBIRT have shown significant reductions in hospital days and emergency department visits over the four years following the intervention.<sup>154</sup> Of 100 emergency-department patients who screen positive for risky alcohol use, on average 28 will require another emergency-department visit in the following year. But if they receive SBIRT, the likelihood decreases by 38% to about 17.<sup>155</sup> A recent implementation in New York City found that risky drinkers who received SBIRT were 23% less likely to acquire new sexually transmitted infections.<sup>156</sup> There is also some evidence that SBIRT could decrease marijuana use.<sup>157</sup> Finally, proponents of SBIRT point out that simply identifying the disorder is valuable for the provider seeking to manage a patient’s overall care.<sup>158</sup>

**Cost-per-impact profile:** A cost-benefit analysis of a hospital-based program found that each dollar spent on SBIRT would generate \$3.81 in savings from consequent reductions in both emergency department visits and hospital admissions, while other reviews have found savings as high as \$5.60 per dollar spent.<sup>159, 160</sup>

**HOW PHILANTHROPY CAN HELP:** Primary care clinics and hospitals may be willing to implement SBIRT, but making the change isn’t easy. Things like billing systems and patient intake need to be adjusted, and these changes need to occur without disrupting current patient care. Philanthropists can fund the training, technical assistance, and organizational development support needed for an implementation to be successful. They can also fund pilots and new research into SBIRT in non-medical settings such as schools, for high-priority populations such as adolescents, and on less-studied substances such as marijuana.

# OPPORTUNITY IN PRACTICE

## The Institute for Research, Education, and Training in Addictions (IRETA) and NORC at the University of Chicago

The Institute for Research, Education, and Training in Addictions (IRETA) and NORC at the University of Chicago specialize in delivering these capacity-building services, enabling more care providers to offer SBIRT—and allowing more patients to reap the benefits. They provide up-front capacity-building, such as training for health care providers, as well as ongoing support and coaching to ensure that SBIRT is implemented effectively. To successfully implement SBIRT in a hospital or clinic, staff need to be trained and the accompanying systems—e.g., patient intake protocols and medical billing codes—need to be adjusted as well.<sup>161, 162</sup>

For more on SBIRT to prevent SUDs in adolescents, see page 47.

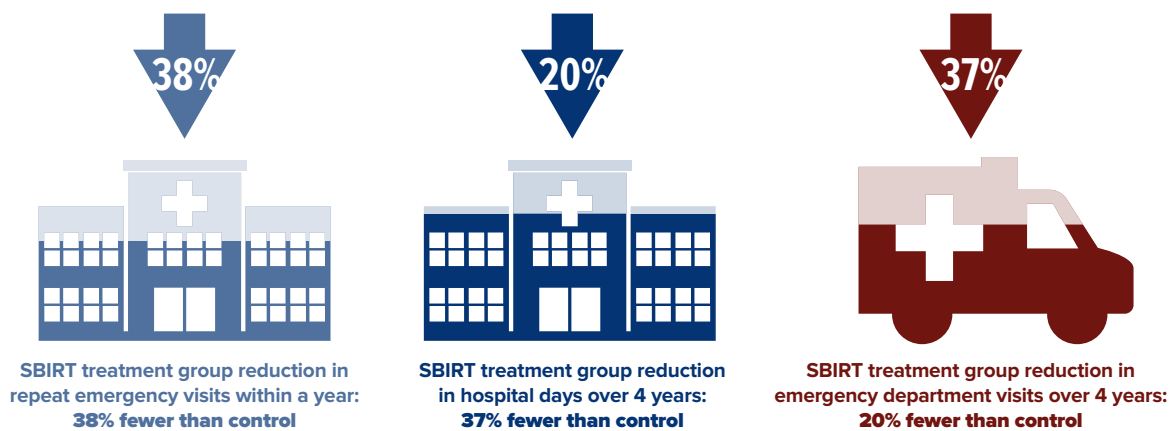


### TIPS

Because capacity-building efforts will be specific to the implementing organization, there is no one-size-fits-all approach. According to IRETA, successful implementations often have an internal “champion,” someone who sees the benefit of SBIRT and is willing to put in the effort required to incorporate it into patient care. Without that internal motivator, the implementation may stall once external funding runs out.

### TAKE ACTION

Donors interested in supporting SBIRT capacity in their communities can work directly with local care providers or can contact IRETA or the NORC via their websites at [www.ireta.org](http://www.ireta.org) and [www.norc.org](http://www.norc.org). IRETA is also a great resource for donors interested in supporting research into new applications of SBIRT, for example, among adolescents.



**Sources:** **Top graphic:** Gentilello, L. M., Ebel, B. E., Wickizer, T. M., Salkever, D. S., & Rivara, F. P. (2005). Alcohol interventions for trauma patients treated in emergency departments and hospitals: a cost-benefit analysis. *Annals of Surgery*. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1357055/>; **Bottom graphic:** Fleming, M. F et al (2002). Brief physician advice for problem drinkers: long-term efficacy and benefit-cost analysis. *Alcoholism, Clinical and Experimental Research*. <http://www.ncbi.nlm.nih.gov/pubmed/11821652>

# High-impact opportunity 2.4



*Collaborative Care has now been convincingly shown to meet the “triple aim” of health reform, including improving quality of care, patient satisfaction, patient symptoms and functional outcomes with either no increase in costs or reduced costs.*

– Wayne Katon, M.D., University of Washington School of Medicine<sup>163</sup>

## Integrate mental health care, including SUD treatment, with primary care

While it is not always clear which illness causes the other, substance users often experience symptoms of another mental illness, and mental illness can increase vulnerability to drug abuse. In 2013, **7.7 million adults—nearly 40% of all SUD sufferers—also had another co-occurring mental disorder.**<sup>164</sup> Treatment for mental health issues, including substance use disorders, has historically been separated from other kinds of medical care. That separation creates barriers for patients and reduces the quality of care, often while increasing health care costs. Health care reform efforts will encourage care providers to integrate SUD treatment and other mental health services into their practice,<sup>165</sup> but many physicians need assistance to effectively implement a more integrated care model.<sup>166</sup>

**CORE PRACTICE:** Mental health and SUD treatment are provided seamlessly alongside primary care and managed by trained care teams, which include primary care providers and behavioral health specialists. This allows a medical practice to reach more patients with the full spectrum of needed care, improving outcomes and reducing medical expenses.

**Target Beneficiaries:** Individuals with mental health issues, including SUDs, who receive care from a hospital, primary care clinic, or other non-specialized setting

**Impact:** Evidence shows that integrated care improves outcomes for mental health disorders such as depression and anxiety, known to be risk factors and common co-diagnoses for SUDs. For example, Collaborative Care is a particular model of integrated care in which care teams deliver evidence-based, patient-centered care; track health outcomes for their entire population; and are reimbursed for patient outcomes rather than volume of services provided.<sup>167</sup> In a randomized controlled trial of 1,801 patients with depression, Collaborative Care patients were three times more likely to have complete remission of their symptoms (25% vs. 8% of control group) and over twice as likely to have their symptoms reduced by 50% or more.<sup>168-171</sup> Collaborative Care’s impact on SUDs is less well-studied, but early evidence is promising. For example, one randomized study of traumatic injury survivors admitted to a hospital found that Collaborative Care was associated with decreases in alcohol consumption.<sup>172</sup> Given that patients with anxiety or depression have double the likelihood of an SUD,<sup>173</sup> Collaborative Care can, at minimum, improve mental health among patients with both conditions and will ideally strengthen mental health care overall and help SUD patients achieve recovery more often and more quickly.<sup>174, 175</sup>

**Cost-per-impact profile:** In the initial trial, researchers found cost-savings of \$3,363 per Collaborative Care patient per four years, compared with treatment as usual. Savings came from reduced expenses on outpatient mental health, pharmaceuticals, other outpatient care, and hospital-based care, generating up to \$6.44 in related health care savings per dollar invested.<sup>176-178</sup>

**HOW PHILANTHROPY CAN HELP:** As with SBIRT (p. 30), health care providers may be willing to make the change to integrated care, but logistics and administrative barriers can be daunting. Philanthropists can fund the training, coaching, and organizational development support needed for a medical practice to successfully implement integrated care. These implementations can also be great research opportunities, improving the field’s understanding of what works in integrated care and what impact it can have on SUDs specifically.

## OPPORTUNITY IN PRACTICE

### AIMS at the University of Washington

The AIMS (Advancing Integrated Mental Health Solutions) Center is a research center at the University of Washington dedicated to helping organizations put the Collaborative Care model into practice. To this end, AIMS engages in three kinds of activity: coaching and support to health care organizations seeking to implement Collaborative Care, workforce training in integrated care, and research on new populations and settings.

An engagement between AIMS and an organization implementing Collaborative Care—a network of health clinics, for example—proceeds as follows:

- **Lay the groundwork:** Help the clinic develop a clear vision and plan for its implementation of Collaborative Care, including hiring plans and necessary changes to relevant protocols.
- **Develop patient-tracking approach:** Population-based care—Collaborative Care team tracks outcomes over the full patient population—is a core principle of Collaborative Care. To do this, providers need a registry that continuously tracks all patients' progress toward clinical outcome goals.
- **Train the workforce:** Effective Collaborative Care creates a team in which all of the providers work together on a single treatment plan for each patient. For example, if a new mother meeting with her primary care provider exhibits signs of post-partum depression, the primary care physician can connect her to a therapist who is part of the care team. The physician and therapist then work together to come up with a plan that addresses the patient's medical needs along with her mental health needs. AIMS provides training for each role and helps the implementer fit these roles into the broader organization.
- **Launch and sustainability:** AIMS provides tailored coaching and support to clinics and organizations post-launch to help them achieve long-term sustainability in terms of team functionality, quality improvement, and finances. A critical component is teaching clinics how to use outcome measures to determine if stated goals are being met and, if not, how to make adjustments.

The full process typically takes 12-36 months.

### TAKE ACTION

Funders interested in improving integrated care capacity can work directly with local care providers or can contact AIMS via their website at [www.aims.uw.edu](http://www.aims.uw.edu) for more information.



### TIPS

Because clinics' needs vary so widely, there is no "typical" case. However, existing projects can provide useful examples of Collaborative Care implementation. For example, an implementation of Collaborative Care in eight rural primary care clinics is expected to provide better mental health care for approximately 8,000 adults at a cost of \$750 per patient. The project is funded by a \$2M Social Innovation Fund grant, which was matched by the John A. Hartford Foundation. Each clinic was then required to match its award.







# Strategy 3

## Improve SUD Care by Changing Systems and Policies



THE CENTER FOR  
HIGH IMPACT PHILANTHROPY  
*The University of Pennsylvania*



## STRATEGY 3 Improve SUD care by changing systems and policies

In the previous section, we presented selected opportunities to improve access to evidence-based treatment within the parameters of current laws and regulations. But **access for all who need care will remain elusive until those rules and regulations reflect the best available evidence.** Philanthropy can help make that happen.

### **Right now: Complicated regulations, opaque markets, reduced access to care**

Currently, a complicated network of rules and regulations determines who gets care and what kind of care they receive. Many policies make good sense in isolation and are enacted with the best of intentions. But policy change is a slow and complicated process, and it's not uncommon for policies to remain in place long after the evidence indicates a different approach. (The federal funding ban on needle exchanges is one example.) Other examples of restrictive policies that don't align with the evidence include:

- **Residential treatment centers with more than 16 beds can't bill Medicaid for services provided to low-income adults.** The original purpose of the law was to reduce institutionalization of mental health patients, but the current impact is a shortage of care for those who would benefit from residential treatment. Treatment centers across the nation are unable to expand to meet demand without cutting off access to Medicaid funds and putting their business model at risk.<sup>179</sup>
- The medication buprenorphine is recommended by physicians as the first-line therapy for opioid use disorder,<sup>180</sup> but **federal regulations make it difficult for this medication to be provided within treatment centers, requiring doctors to obtain a special certification and prohibiting them from prescribing to more than 100 patients** at a time.<sup>181</sup> While safer prescribing of all opioids is a worthy goal, buprenorphine is currently the only one subject to this level of regulation. It is regulated more than opioid painkillers themselves. As a result, for many people, it is easier to get the drug that caused their problem than it is to get a similar drug that might help solve it.
- Common "Fail First" insurance policies mandate that patients be given lower-cost treatments first, regardless of what kind of treatment their doctor recommends.<sup>182</sup> These policies were originally designed as cost-cutting measures and have been put into place with other medical issues, often with some success. **But for SUDs, "failing" comes in the form of relapse, which can be deadly.**<sup>183</sup> The result is that these policies increase the risk of death for SUD patients—even as they try to get the help they need.
- **Many SUD treatment programs don't track patient outcomes, and regulations for SUD treatment professionals are inconsistent and often lax.** For example, a recent review found that only 29 states require treatment facilities to provide clinical supervision by fully credentialed counselors, and only 8 states require a minimum percentage of clinical staff to be licensed or certified. Only 11 states require residential programs to have a physician on staff, only 10 states require any kind of follow-up care, and only 21 states require that patient outcomes be tracked.<sup>184</sup>



Some of these barriers affect broad groups of SUD patients. For example, the limitations on buprenorphine prescriptions are in effect no matter where you live, and federal health care reform affects all insurance plans, making those laws important factors in access to care for anyone not able to pay full costs out of pocket. (For more detail on how these laws affect health care reform, see sidebar on page 40.)

Some specific populations are especially vulnerable, however. Institutionalized groups, primarily prisoners, face additional policy barriers when attempting to access care within the system or after re-entry into their communities. Low-income individuals, such as those covered by Medicaid, are less able to pay out of pocket for better options if their insurance doesn't cover the treatment they need.

Changing these policies is a high-impact opportunity for philanthropists. In the following pages, we present examples of non-profits with the demonstrated ability to make that change happen, with examples such as:

- Closing loopholes and extending insurance coverage to more people through federal policy change (**Legal Action Center**, p. 40);
- Connecting care in the correctional system to care in the community through local policy change (**COCHS**, p. 41);
- Moving toward better care for everyone by using research to enable a more transparent market for treatment. (**Treatment Research Institute**, p. 42).

Funding organizations that work to change these policies is quite different from funding a direct-service organization. The impact on the people you hope to help is more removed from the point of funding, and the chain of cause and effect can be more difficult to see clearly. But those downsides are, for some funders, balanced by the potential to impact large numbers of people in lasting and meaningful ways as a result of a single change—sometimes with the stroke of a pen. This is not a section full of sure bets, but donors who seek game-changing tools for coping with the burden of SUDs will find exciting opportunities and strong organizational partners here.

The examples we present in the following section are only the tip of the iceberg. The featured organizations and others will continue to work toward policy change in new and different ways not captured in these pages. **The key takeaway is that changing the system is a high-impact opportunity, and philanthropy can help make it happen.**

# High-impact opportunity 3.1



## Change systems and policies to reflect the evidence base and increase access to care

**CORE PRACTICE:** System and policy change can happen as a result of direct advocacy, smart partnerships, or the development of a compelling evidence base. What works in any one case might be different from what works in another, but the common factor is a coordinating organization with the knowledge and networks to assess situations as they evolve, identifying solutions and getting the right people on board to implement them.

**Target Beneficiaries:** Populations whose access to care is limited by public or private regulations that are counter-productive or don't reflect the evidence. Examples include participants in a particular insurance plan, residents of a given state or institution, or everyone who needs a particular kind of care (e.g., a federally regulated medication).

**Impact:** More people get access to care now and in the future.

**Cost-per-impact profile:** The successful efforts featured here had upfront costs in the \$50,000-250,000 range, though those costs aren't always covered by a single donor. Costs vary widely because projects can be very different; working for a small policy change at the city level will likely be cheaper than working for sweeping federal reforms. The costs of a single project also don't reflect that success is often collective, with many people and organizations working toward change in slightly different ways. Success can also be cumulative, the product of years of work building the credibility and relationships that make an organization influential. The price of any single effort gives a helpful sense of scale, but it's rarely the whole story.

**HOW PHILANTHROPY CAN HELP:** Philanthropists can support organizations with the demonstrated ability to read and influence the policy landscape. The highest-impact targets and strategies can change rapidly, and effective organizations will anticipate shifts, move quickly to seize opportunities, and course-correct as needed.

## OPPORTUNITY IN PRACTICE

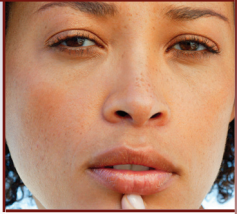
In the following pages, we highlight case examples from the **Legal Action Center**, **COCHS**, and the **Treatment Research Institute**. These organizations have consistently demonstrated the ability to effectively influence systems and policy and are engaged in this work on an ongoing basis. We present these success stories because, while policy change efforts are by necessity tailored to a particular time and place, it can still be helpful to see the way organizations have tackled this work in the past. **With these case examples, we aim to accurately reflect the work that's been done, while providing some insight into what these organizations and their peers might accomplish in the future.**

## TAKE ACTION

Donors interested in supporting policy change can look for organizations with the networks and institutional knowledge to be effective agents for policy change. For example, if the goal is state-level change, do they have the ear of decision-makers in the right agencies? Are they aware of previous efforts so that they can build on what's been done and avoid stepping into a political minefield? Are they connected with other organizations working toward similar change? The non-profits featured in the following pages are examples of implementers that demonstrate that kind of capacity, but funders can also look for similar groups in their own communities.



# Success Story



## TIPS

What policy-changers need to know about health care reform

The *Parity Act* of 2008 requires insurers to keep financial requirements and treatment limitations for mental health and SUD benefits no more restrictive than those for other categories of medical benefits.

The *Affordable Care Act* of 2010 requires all insurance plans sold on Health Insurance Exchanges or provided by Medicaid to include services for SUDs at parity with their other medical and mental health services.

## The Legal Action Center and Health Reform

For policy change that affects everyone, organizations may need to advocate at the federal level—sometimes over the course of years if not decades.. An example of successful federal policy change comes from the passage of key provisions in health care reform (see sidebar) and the role of the Legal Action Center (LAC).

The 2008 Parity Act required large commercial health plans that already provide mental health and substance use disorder benefits to deliver them equally—“at parity”—with other medical benefits. The Parity Act was a significant step forward, but many plans were exempt, and there was a major loophole: insurers that didn’t provide mental health benefits were unaffected by the law. It was therefore simpler for insurers to cut all mental health benefits than to provide SUD treatment coverage that complied with the Act.

This was the backdrop leading up to the 2010 passage of the Affordable Care Act. As that law was in development, LAC and other advocates saw an opportunity to extend parity protections to millions of Americans by closing the loopholes. They advocated for mandates that: 1) required all commercial insurance and expanded Medicaid plans to cover addiction and mental health services, and 2) required that this coverage be at parity with that for other medical conditions. **In combination, these provisions could open up mental health care to tens of millions of Americans who previously would have had to pay out of pocket—or, more likely, go without.**

To make those changes a reality, LAC spent the two years preceding passage of the Affordable Care Act gathering dozens of addiction and mental health organizations and providers into a group that became the Coalition for Whole Health. LAC staffed and led the Coalition for Whole Health, coordinated its agenda, and worked to create field-wide recommendations. On behalf of the Coalition, LAC and some of its other most prominent members circulated these recommendations, educating policymakers in Congress and in federal agencies on the need for the proposed changes and the untapped potential to stem the tide of untreated addiction and mental health problems in the United States.

**Impact:** Health care reform has included expanded coverage for mental health care, including SUD treatment. The federal government estimates that 62 million people will gain coverage for addiction and mental health services once parity is fully implemented.<sup>185</sup>

**Costs:** It cost LAC approximately \$200,000 a year for two years to build the Coalition for Whole Health and lead its advocacy related to the Affordable Care Act. These expenses were largely covered by the Open Society Foundations. Based on the federal estimate of 62 million individuals gaining mental health coverage, **LAC received approximately 6.5 cents in grant money for every person who stands to benefit from parity expansion.** It is important to note, however, that the LAC was able to deliver in part because of its long history and knowledge of the sector. Both of these assets were developed long before the single grant in question.

## TAKE ACTION

To learn more about improving access to health care through federal and state policy change, visit the Legal Action Center’s website at [www.lac.org](http://www.lac.org). The Legal Action Center also conducts SUD-related work in criminal justice, such as advocacy for alternatives to incarceration. Find out more about the Coalition for Whole Health at [CoalitionForWholeHealth.org](http://CoalitionForWholeHealth.org)

# Success Story



## COCHS: Connections, and an evidence-based care system in Delaware

Community Oriented Correctional Health Services (COCHS) works with the public sector to **connect care in the correctional system to care in the community**, as well as to **improve access to substance use and mental health care for the broader population**. They conduct this work through multiple channels, including working directly with government officials at the federal and state level and providing coaching and assistance to organizations facing policy barriers to impact. For example, COCHS conducts regular briefings with leadership of the Office of National Drug Control Policy, helping to identify federal policy changes that could improve access to SUD treatment in jails and prisons. At the state level, they work with criminal justice agencies, health agencies, and other groups. For instance, they are currently working with state policymakers in New Jersey to help them expand their mental health coverage to include residential facilities larger than 16 beds.

In another recent project, **COCHS worked directly with a health care provider to help them expand and improve the quality of their care**. Connections Community Support Programs (Connections) is a non-profit provider of primary and behavioral health care, which includes SUD treatment and other mental health services. Via a contract with the state of Delaware, Connections was providing behavioral health services within the correctional system and in communities, allowing detained individuals to maintain continuity of mental health care when they exited prison. Their primary care services were only available outside of the prison system, however, and the split was causing logistical difficulties and making it harder for patients to maintain access to the full range of care they needed. To address those issues, Connections wanted to provide integrated primary and mental health care within and outside of the correctional system.

To make that integrated care a reality, Connections needed a primary care contract from the state of Delaware, along with their existing contract to provide behavioral health services. For that, they needed increased capacity within their primary care services. COCHS helped Connections manage this process, working with them to secure a loan from the Nonprofit Finance Fund, which enabled the organization to build the capacity they needed. COCHS and Connections also worked together to develop an implementation plan that improved treatment quality within the correctional system.

**Impact:** Connections was able to bid successfully for the state contract, allowing them to **integrate primary care and behavioral health for their detainee patient population, estimated at approximately 1,000 individuals per day**. Their implementation includes expansion of medication-assisted treatment, **making medication for opioid addiction available to anyone within the justice system who needs it**. Prior to these changes, important medications were not available to incarcerated individuals (with the exception of pregnant women) despite physician recommendations.

The impact is meaningful at an individual level to those who struggle with SUDs and are now able to get better care. Though it is too early to say, the improved treatment may also result in cost-savings for the justice system by breaking the cycle of drug use and recidivism.<sup>186</sup>

**Costs:** For its work coordinating the partnership with Connections, the state of Delaware, and the Nonprofit Finance Fund, COCHS spent \$150,000, of which 60% (\$90,000) was philanthropically funded through the Robert Wood Johnson Foundation. The remainder was structured as fee-for-service and paid by Connections. Research on similar approaches indicates that the state will likely save money overall due to reduced costs in medical care and other services. If that holds true, the philanthropic investment in COCHS will have served as the bridge to strategic deployment of public funding for a model that can be sustained over time.

## TAKE ACTION

To learn more about COCHS and their work supporting systems and policy change across the country, visit their website at [www.cochs.org](http://www.cochs.org).

### TIPS

Advocacy often depends on relationships and credibility built over time. Funders looking to support policy change should seek out organizations with demonstrated credibility and sector knowledge, enabling them to bring the right stakeholders to the table and manage the process effectively.



# Success Story



## TIPS

Many of the organizations profiled in these pages are well-known to each other and often work in formal or informal collaboration; this cross-pollination benefits the field, allowing for greater exchange of knowledge and ideas. Funders interested in supporting research or policy change can consider funding a joint effort or working with an organization with the reputation and capacity to mobilize networks effectively.

## Treatment Research Institute (TRI) and the move toward a transparent treatment market

The Treatment Research Institute (TRI) conducts research in substance use treatment, policy, and delivery and works with public and private stakeholders to help translate those findings into practice.

TRI's work is an example of systems change outside of the political setting. Research and the dissemination of new ideas can change systems from the bottom up, for example, when a consumer seeks out a particular evidence-based therapy that they have read about. Research can also make an impact from the top down, such as when an insurance company uses new evidence to decide which treatments to fund. As both of these examples illustrate, when research is available and accessible, it can make an impact by influencing markets. The process is often slow and non-linear, but the change can be both lasting and meaningful.

An early example of this is the **study that showed SUDs to be a chronic mental illness**, published in the *Journal of the American Medical Association* in 2000.<sup>187</sup> This study, led by TRI researchers, has been cited widely to support the need to treat SUDs as a health issue rather than simply a matter of criminal justice.

Recent health care reform offers an illustration of systems change through applied research. Under the Affordable Care Act, insurance coverage, and therefore, demand for treatment services are expected to increase. However, there is no standardized tool to assess whether treatment programs can deliver the level of care necessary to meet patient needs. Without the right information, there are few ways for consumers (individuals or insurers) to choose effective treatment options over less-effective ones. To address this gap, TRI is in the early stages of developing **quality assessment tools and training protocols** to be used by Medicare and Medicaid, among others.

**Impact:** The reconceptualization of SUDs as a chronic medical illness was a key factor enabling SUD treatment's inclusion as an "essential health benefit" under health care reform.<sup>188</sup> (For more on the impact of health care reform, see page 40 for related work by the Legal Action Center.)

The treatment quality assessment tools are expected to improve the overall quality of SUD care, as increased transparency makes it possible for market forces to incentivize good treatment outcomes. Without that transparency, consumers are left to rely on less-relevant but more visible factors such as price, luxury amenities, or size, and treatment centers will continue to direct their resources toward those aspects of their program.

**Costs:** Projects such as the assessment tools may take a year or longer, with typical costs in the range of \$200,000. However, that funding can be a mix of philanthropic and public dollars, as TRI receives government support for some research activities.

## TAKE ACTION

To learn more about TRI and their research into addiction treatment, policy, and health systems improvement, visit their website at [www.tresearch.org](http://www.tresearch.org)

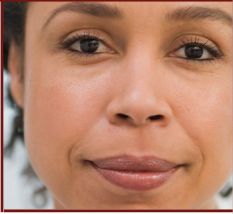


# Strategy 4

## Fund Innovation to Improve Prevention and Treatment



THE CENTER FOR  
HIGH IMPACT PHILANTHROPY  
*The University of Pennsylvania*



## STRATEGY 4 Fund innovation to improve prevention and treatment

In earlier sections, we've presented strategies to lift the burden of SUDs. **But even the best strategies based on the best evidence available are operating without the answers to important questions.** Those big unanswered questions are promising targets for research and innovation and can lead to some of the most exciting opportunities for philanthropy to make a lasting impact. High-impact targets include SUD prevention, better treatment, improved access to treatment, and reduced stigma.

In the following pages, we summarize key findings and highlight promising practices in prevention. We also note promising directions for research and innovation and resources to help funders identify specific opportunities..

### HIGH-IMPACT RESEARCH OPPORTUNITIES IN PREVENTION

The importance of preventing SUDs among adolescents is undisputed. Adolescents are the highest-risk age group for new SUDs, and preventing or delaying substance use can have protective effects. For example, **each year a teen delays alcohol use decreases their chances of developing an alcohol use disorder by 14%.**<sup>189</sup> For that reason, there are hundreds of adolescent substance abuse prevention programs operating within schools and communities across the country. It's a well-studied topic, with an extensive body of academic literature. And it's a well-funded goal: in FY 2015 alone, the federal government allocated \$1.3 billion for substance abuse prevention efforts in schools and communities.<sup>190</sup> However, despite all of those efforts, **much of what's currently done in the name of SUD prevention isn't effective in preventing substance use.**

What does that mean for philanthropy? This is an area with a great deal of room for innovation. Given the potential benefit of effective prevention, even moderate progress can yield major social impact.

Despite the prevention field's limited success to date, funders interested in prevention are by no means flying blind. While the sector has not cracked the code on prevention, there are lessons learned and promising paths to pursue. A common theme is that they need more evidence of impact in different settings and for different populations before donors should consider replicating them widely.

In the following pages, we present promising targets for research and innovation, along with resources to help interested funders learn more about existing efforts they can build upon.

## HIGH-IMPACT RESEARCH OPPORTUNITY:

### Testing the impact of prevention programs that have shown promise in particular settings

Before promising pilot programs can be rolled out on a large scale, they need to be tested within different settings and populations so that researchers and practitioners can understand what the programs really accomplish and for whom. Philanthropy can support that analysis, bridging the gap from a new idea to full-scale implementation. In many ways, this research is a win-win. Learning what works is always the goal, and it's exciting if a new program shows real impact. But even if the results aren't so positive, learning what *doesn't* work is still an important step toward impact.

Donors interested in this opportunity can look for programs with (1) well-supported theories of change, (2) promising evidence of impact, and (3) data limitations that can be addressed with additional research. The examples that follow have strong evidence from well-designed studies, making them among the most promising targets within the over 50 interventions we reviewed. However, one has demonstrated results only in a particular population, while the other has not consistently replicated effects on substance use—but has repeatedly shown other positive impacts.

## PROMISING INNOVATION TARGET:

### Integrate prevention programs at the community level

**The theory:** Taken as a whole, the evidence indicates that any single prevention program is unlikely to deliver major reductions in substance use. However, combining programs to weave a web of support may make a greater difference than the individual programs on their own. The hope is that programs can reinforce each other in a way that's multiplicative rather than additive.

**The model:** Promoting School-community-university Partnerships to Enhance Resilience (PROSPER), a partnership program between local communities and land-grant universities, is a system to deliver a suite of programs within a community. The programs themselves are chosen by community representatives from a list of evidence-based approaches provided by researchers. Community representatives select one family-focused program to deliver in 6th grade and one school-based program to deliver in 7th grade. A team based out of a state university helps the community implement the selected programs.

**What we know:** In a randomized controlled trial of PROSPER implementations in Iowa and Pennsylvania, researchers found that the program decreased use of a number of substances (not including tobacco or alcohol) by approximately 4 to 6 percentage points.<sup>191</sup>

**What we hope to learn:** One important question is whether these results are replicable and generalizable to different populations. The trial was conducted in a population of mostly Caucasian, relatively affluent adolescents in rural areas. Further research is needed to test PROSPER in different settings and better understand the populations for which it can be reliably effective. More research is also needed to understand how much of the effect is due to the delivery system—which is the core of the PROSPER approach—or the specific interventions chosen by the communities.

**Implications for funders:** The idea of integrating different programs to create a supportive community is an exciting one, but still too new to replicate widely. This is a great avenue for further research, whether focused on new populations, new combinations of approaches, new delivery systems, or all of the above.

## LEARN MORE & TAKE ACTION

Dr. Richard Spoth out of Iowa State University developed PROSPER and is currently leading research efforts on the program. (Visit [www.ppsi.iastate.edu](http://www.ppsi.iastate.edu) to learn more.) A similar program with promising results is Communities That Care, currently studied by the University of Washington's Social Development Research Group. (Visit [www.sdrdg.org](http://www.sdrdg.org) to find out more.)





For more on working with grantees to understand their impact, see our guide *Beyond Compliance: Measuring to learn, improve, and create positive change*.

For more on supporting early-childhood efforts, see our early-childhood toolkit for funders, *Invest in a Strong Start for Children*.

## PROMISING INNOVATION TARGET: Focus on healthy child development for positive impacts in adolescence and beyond

**The theory:** Many of the known risk factors for SUDs are also known risk factors for other negative outcomes such as high school drop-out or teen pregnancy. Promising approaches might target those risk factors early, tackling SUD prevention as part of a broader set of healthy development goals.

**The model:** The Good Behavior Game (GBG) is designed to improve first-grade classroom behavior and help children see themselves as members of a classroom community. In GBG classrooms, there are clear, consistent, and transparent rules for behavior. Children are divided into teams of 2-5 students, and the team gains or loses points based on the behavior of its members. The hope is that giving kids tools to manage their behavior early can help them make good choices—such as steering clear of substance use—over the long term.

**What we know:** GBG has demonstrated positive impacts, particularly for boys, but it doesn't always reduce substance use. Substance use is only one of several problem behaviors that GBG targets. In one of the first GBG studies, low-income African American students in Baltimore were randomized into GBG classrooms and tracked from first grade to age 19. The young men in the GBG classrooms showed significant reductions in illicit drug use (excluding alcohol and marijuana) at age 13 and increased academic achievement and reduced behavioral problems at age 19. (The researchers did not report information about substance use at age 19.) The impact was greatest among male children who ranked highest on measures of aggressive and disruptive behavior. There was no effect on female children.<sup>192</sup>

**What we hope to learn:** The biggest question about GBG is whether it can reliably and consistently get results in different settings. The same researchers in the same Baltimore schools mentioned above tried to replicate their results with the next class of first-graders entering school, but they did not see the same impacts. Other studies on GBG have been conducted in Oregon and in Europe. Positive impacts on disruptive and aggressive behavior have been consistently replicated, but impacts on substance use have not.

**Implications for funders:** GBG has been a good and helpful program for children. It's just not clear whether or not it's also a good way to prevent substance use. Philanthropists can support research to understand how, when, and for whom it might impact substance use in particular, knowing that even without an effect on substance use, the program is likely to be a positive influence in children's lives.

## LEARN MORE & TAKE ACTION

The Johns Hopkins Center for Prevention and Early Intervention is researching strategies such as the Good Behavior Game to improve classroom behavior and outcomes and to prevent behavioral problems, including substance abuse, among youth. To contact the Center and support their work, visit their website at <http://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-center-for-prevention-and-early-intervention/>.

## HIGH-IMPACT RESEARCH OPPORTUNITY:

### Target risky drinking in adolescents with secondary prevention

Alcohol is the most commonly used substance, and alcohol use disorders are the most common type of SUD among teens as well as adults. In 2013, for example, the rate of current alcohol use among youths aged 12 to 17 was 12%, and the rate of binge drinking was over 6%.<sup>193</sup> However, even the most promising primary prevention efforts—those that aim to prevent any use of alcohol—have not delivered reductions in teen drinking. While innovation in primary prevention is a worthwhile goal, there may be opportunities to make a difference by focusing on the riskiest users and helping them curb their use. This strategy has been effective in adults, and early research indicates that it may work for adolescents as well.

## PROMISING INNOVATION TARGET: Secondary prevention for adolescents

**The theory:** Secondary prevention efforts, which focus on stopping the progression from risky use to disorder, have been effective among adults and may be a promising approach for adolescents as well.

**The model:** Under the SBIRT protocol (also discussed on page 30), all patients in participating health care settings automatically undergo a quick screening to assess their alcohol and drug use. If their use puts them at risk of developing a serious problem, they receive a brief intervention that focuses on raising their awareness of substance abuse and motivating them to change their behavior. Patients who need more extensive treatment receive referrals to specialty care.

**What we know:** A meta-analysis found that brief alcohol interventions can lead to modest but statistically significant reductions in risky drinking among adolescents and young adults. The effects persisted for up to one year after intervention.<sup>194</sup>

**What we hope to learn:** The evidence base for SBIRT is still much stronger for adults. More research and testing are needed in settings like school health clinics where more adolescent patients can be reached. There may be ways to tailor the content of the brief intervention to make it more effective for a younger population.

**Implications for funders:** SBIRT offers a way to target prevention and early intervention toward the adolescents who need it most, but there are still questions about how best to deliver it and what impact might be possible. Philanthropy can support research into new settings and other adjustments to potentially make this a powerful tool to reach adolescents. In addition, learning more about how it works (or doesn't work) for adolescents might yield insights about how other services, such as SUD treatment, can be tailored for adolescents.

## LEARN MORE & TAKE ACTION

The University of Minnesota's Center for Adolescent Substance Abuse Research ([www.psychiatry.umn.edu](http://www.psychiatry.umn.edu)), in collaboration with Kaiser Permanente, is conducting a study on an SBIRT model for primary care and school settings that is tailored to adolescents experiencing mild to moderate drug involvement.

A partnership led by the research center NORC at the University of Chicago is working to engage social work and nursing schools in a learning collaborative to create an effective SBIRT curriculum to integrate into the students' training. Community Catalyst, a consumer advocacy group, is developing consumer-led advocacy campaigns in five states (Georgia, Massachusetts, New Jersey, Ohio, and Wisconsin) to enact state policy change to increase funding and training for SBIRT. The Conrad N. Hilton foundation is funding SBIRT research and implementations in multiple sites. See [norc.org](http://norc.org), [communitycatalyst.org](http://communitycatalyst.org), and [hiltonfoundation.org](http://hiltonfoundation.org) for more.



### TIPS:

- **Primary Prevention** of SUDs is the prevention or delaying of the start of substance use among a general population of adolescents, such as all teens in a state, county, or school district.
- **Secondary Prevention** of SUDs is preventing risky substance use from progressing to a SUD in individuals.
- **Tertiary Prevention** of SUDs is providing time, cost, and labor-intensive care to patients who are acutely or chronically ill with a SUD.



*Any teenager could explain why [scare tactics don't work]. For them, a cigarette is not a delivery system for nicotine. It's a delivery system for rebellion. Kids take up smoking to be cool, to impress their friends with their recklessness and defiance of adults. They know that smoking is dangerous. ... Danger is part of a cigarette's appeal.*

—Tina Rosenberg, journalist, on why tobacco companies support scare-tactic advertising<sup>202</sup>

## HIGH-IMPACT RESEARCH OPPORTUNITY:

### Learn from successful behavior change efforts in related fields

While the evidence base for successful interventions in SUD prevention is relatively slim, there have been successful behavior change efforts in related fields that can provide a jumping-off point for further research. Anti-tobacco and anti-drunk-driving campaigns have both had successes with efforts focused on changing perceptions of what's normal in one's peer group (see box on following page). Other insights from behavioral science might be relevant as well. Researchers are learning more and more about the way small tweaks to the wording of a message can change people's responses, as well as the importance of choosing the right messenger.<sup>195</sup>

Behavior change research can also tell us a great deal about what doesn't work—and what may even cause harm. It may make intuitive sense that telling kids about the dangers of drug use would keep them away from drugs, but research has demonstrated that it doesn't work. D.A.R.E. (Drug Abuse Resistance Education), a popular school-based program delivered by police officers, was used in 80% of American school districts in 2001.<sup>189</sup> The program was started and delivered by police officers and focused on educating children and teens about the risks of drug use. Somewhat infamously, however, multiple studies have shown that D.A.R.E. had no effect on substance use behavior in teens and may even have increased some participants' curiosity about substance use.<sup>190</sup> Similarly, the much-touted and still publicly funded Meth Project uses graphic and shocking ads to illustrate the dangers of meth, but researchers found that it had no effect on actual meth use.<sup>198</sup>

The same pattern holds in anti-tobacco campaigns. Teens actually overestimate the risk of smoking, but that doesn't translate to any change in their behavior.<sup>199</sup> A related sector, criminal justice, also shows this effect: Scared Straight, the popular program in which prison inmates warn children away from a life of crime, has actually been shown to increase the likelihood of juvenile delinquency.<sup>200</sup>

Avoiding scare tactics does not mean avoiding honest discussion and education. Consider the depiction of teenage pregnancy in the MTV reality series "16 and Pregnant." The show is marketed to adolescents and follows the lives of pregnant teens and their families, exposing youth to information that would otherwise be less visible, particularly in areas that utilize abstinence-only education. Research shows that "16 and Pregnant" led to increased online searches for information regarding birth control and teen pregnancy. Researchers link that increase in knowledge to a marked change in behavior and a decline in teen birth rates during the first 18 months following the show's release. Declining abortion rates during the same time indicate the reduced birth rates were the result of fewer pregnancies.<sup>201</sup>

The line between appropriate information and scare tactics can be difficult to find, making it a potentially valuable area for further investigation.



## PROMISING INNOVATION TARGET: Using social norms to spur behavior change

**The theory:** As the advertising industry has long known, people are influenced by what they perceive as the behavior of their peers. Using media to change the perceptions of what's normal in substance use might help reduce use by removing the powerful incentive to fit in.

**The model:** The 1998 Truth Campaign, a counter-marketing campaign to reduce smoking among Florida teens, used an advertising agency to produce billboards and television ads aimed at exposing the tobacco industry's lies and manipulations toward teens, using teens themselves as the messengers. It worked by creating a new target for teens to rebel against—the tobacco industry rather than the public health establishment—and by creating a visible peer group of teens who weren't taken in by Big Tobacco. That gave kids a new, healthier social norm.

The 1988 Harvard Alcohol Project aimed to spread the concept of the “designated driver” throughout America. With the support of leading television networks and Hollywood studios, writers inserted drunk driving prevention messages (including references to designated drivers) into scripts of popular shows such as “Cheers” and “L.A. Law” over a four-year period.

**What we know:** The anti-tobacco campaign was successful: Florida teen smoking rates were cut in half in less than a decade.<sup>203</sup> The designated driving campaign was also successful: a 1991 poll showed that 9 out of 10 respondents were aware of the designated driver program. Researchers believe that the initiative was a major contributing factor to the 30% decline in alcohol-related traffic fatalities from 1988-1994, a decrease that saved over 50,000 lives.<sup>204</sup>

**What we hope to learn:** Both of these campaigns were launched over a decade ago, when media consumption patterns were different and there were fewer alternate avenues for social norm messages. More work is needed to understand how similar efforts might be adapted to the new media landscape. More research could also illuminate how well these programs can work when there's a strong social norm reinforcing the targeted behavior. For example, can an ad campaign counteract the celebration of drinking on a college campus?

**Implications for funders:** Media campaigns can make a difference, but they're likely to be more effective if they're developed based on what we know about human behavior—in particular, tapping into the powerful drive to fit in with one's peers. Funders should be wary of prevention efforts that are overly focused on highlighting risks, despite the intuitive appeal that many of these programs hold. Better evidence can reduce spending on unsuccessful efforts and help the field get closer to what works.

### LEARN MORE & TAKE ACTION

Many public health schools have departments dedicated to using behavioral science to improve health. Researchers in these departments can be a great place to start. Organizations like the Partnership for Drug-Free Kids ([www.drugfree.org/](http://www.drugfree.org/)) that support ad campaigns and other kinds of outreach can also be partners in this research.

The University of Pennsylvania's Annenberg School ([www.asc.upenn.edu](http://www.asc.upenn.edu)) and other schools of communication are good resources for more information about the role media can play.





## HIGH-IMPACT RESEARCH TARGETS IN SUD TREATMENT AND BEYOND

Few people with SUDs get treatment, and, of those, few achieve recovery the first time they try.<sup>205</sup> Research into treatment improvements can focus on getting more people into treatment or on new treatment tools that will be more effective for more people. Both pieces are needed to make care more effective, more personalized, and perhaps most importantly more available to SUD patients no matter where they live and work.

### New treatment tools

We know that there are treatments that work—for some people, sometimes. But there’s potential to do so much more. Researchers have only just begun to tap the potential of research in genetics, pharmacology, and even immunology. A vaccine against addiction might sound far-fetched, but there’s research into it happening right now. It might never work, but if it does, the potential for impact is enormous. Much of the work in new treatment development is funded by public dollars via research agencies like the National Institutes of Health. However, private philanthropy has the potential to contribute in meaningful ways.

### LEARN MORE & TAKE ACTION

Universities often have research centers dedicated to particular topics or types of research, including those related to substance use. For example, The Perelman School of Medicine at the University of Pennsylvania includes the Center for Studies of Addiction, which conducts research into topics like the genetics of addiction and new medications to treat the disorder. Scripps University hosts the Pearson Center for Alcohol and Addiction Research, where researchers are studying the use of new compounds to control the effect of substances on the brain to prevent relapse during recovery. The National Institute on Drug Abuse (NIDA) maintains research consortia on multiple topics in SUD treatment and delivery.

To learn more about strategic approaches to research funding more generally, see resources from [FasterCures.org](http://FasterCures.org), a non-profit dedicated to investments in medical research.

### Better treatment delivery

Improving treatment delivery is an important goal that can be approached in many different ways. For example, providing care remotely via computer has shown promise in other chronic conditions, such as depression and heart disease, and could open up access to care for those unable to access a specialized facility. The National Institute on Drug Abuse is supporting researchers working toward mobile health (mhealth) solutions to help SUD patients remain on track to recovery and maintain the health of drug users with other medical problems such as HIV. Using mobile technology, this method sends reminder messages about medication and skills learned in treatment. Such technology can also track patients’ progress in real time.

### LEARN MORE & TAKE ACTION

Dartmouth College’s Center for Technology and Behavioral Health (CTBH) conducts research into promising technologies for improving and delivering better SUD treatment. Columbia University’s CASAColumbia research center works on topics in treatment delivery as well as other systemic issues related to SUDs.

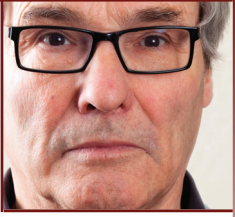
## Reduced stigma and discrimination

Underlying many of the issues outlined in this report is the question of stigma and, relatedly, discrimination. As this report emphasizes, we have tools that can make a difference, but those tools could be even more effective if people could seek help without the fear—or the reality—of being stigmatized. Stigma, misinformation, and stereotypes regarding who has substance use disorders has made addiction a politically unpopular topic. As a result, research funding has been difficult to secure, and innovation has been slow. It's not obvious how to conquer stigma and the discrimination that often accompanies it, but there's a role for philanthropy in helping to figure that out. Research on stigma itself can help us understand how to change hearts along with minds. For example, one thing we do know is that personal contact is the most powerful force against stigma.<sup>206</sup> What we don't yet know is how to harness that to make a difference on a large scale. And, finally, there is a role for philanthropists—and all other advocates for SUD patients—in simply speaking up about the ways SUD patients suffer and the ways we can all help.

### LEARN MORE & TAKE ACTION

The Annenberg Public Policy Center conducts research on the stigma of mental illness. Researchers out of Boston University are exploring language's impact on stigma and how changing the way we speak about substance abuse and addiction can change negative outcomes that often result from stigma. Former House Representative Patrick Kennedy, a recovering addict and founder of the Kennedy Forum, is a dual funder and advocate who openly shares his story of addiction and recovery.







# Conclusion

## Conclusion



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*We must bolster our current approach to addiction with more common sense. We must address it as a public health crisis, providing treatment and support, rather than simply doling out punishment, claiming victory, and moving on to our next conviction.*

— Peter Shumlin,  
Governor of Vermont,  
on the state's heroin  
emergency<sup>207</sup>

The harm caused by substance use disorders is real and widespread. Fatal overdoses from opiates (pills and heroin) alone now surpass traffic fatalities in the U.S.,<sup>208</sup> while nearly a third of traffic fatalities involve drivers under the influence of alcohol.<sup>209</sup> The associated costs of substance abuse disorders in both human and economic terms are enormous. But there are concrete things that donors can do right now to prevent deaths, lower human and economic costs, improve access to effective treatment, and build a stronger foundation for addressing SUDs now and in the future. Some final takeaways:

**Helping people with SUDs with tools we already have isn't just the humane thing to do, it's the smart thing to do.** One of the biggest gaps between current knowledge and practice is in the realm of opportunities to save lives and make life a little bit better for people with SUDs right now, even before they have achieved recovery or sobriety. Overdose prevention, clean syringes, housing, and legal support offer people with SUDs a chance to protect themselves and others. Such treatments also offer people with SUDs the chance to be treated with the respect and care that can be a first step to beginning a process of recovery. From care providers and SUDs sufferers themselves, we heard over and over how much of a difference a safe and respectful environment can make in someone's quality of life and sense of self. From researchers and economists, we heard how much of a difference these tools can make in reducing costs to taxpayers and health risks to the general population.

**Evidence-based treatment works for many patients, but most people never get a chance to try.** The narrative of the SUD patient in popular culture is often a hopeless one, a spiral towards "rock bottom" that ends in abject suffering and death. There's no denying the reality of that story for some, but a more hopeful story is possible. There are many treatment approaches that we know can work, alone or in combination, from mindfulness training, to cognitive behavior therapy, to medication. Most people with SUDs don't get the benefit of those options. Instead they are offered the same narrowly defined treatments again and again—if they get anything at all. Organizations that help build health care providers' capacity to provide personalized, evidence-based care can help get more people to recovery more quickly, often saving money in the process.

**Current laws and care systems aren't working, but there's an exciting opportunity for change.** Among researchers, policymakers, and care providers, there is excitement as well as trepidation about the changes to come from the recent passage of the Affordable Care Act and the Parity Act. The laws have been passed, but the impact will be determined by the implementation. This transitional time creates an unusual opportunity for philanthropists interested in policy and systems change. Often, policy change is a long, slow grind, with change coming incrementally if at all. But right now, change is happening at a comparatively breakneck pace. Organizations like Treatment Research Institute, the Legal Action Center, and others are working across the public and private sectors to help shape implementation and move care providers and policymakers toward what we know works. It's too early to know how all of this will play out, but there are exciting opportunities to help keep it moving in the right direction.

**The various opportunities detailed in this report represent a menu for action.** Not all will appeal to every donor, but all have been chosen as having potentially high impact, evidence of effectiveness, and a clear role for philanthropy. In developing the report, our team spoke with dozens of experts in the field, conducted site visits and reviewed over a hundred studies and reports.

As always, we hope this work helps donors move from good intentions to action and, ultimately, to lifting the burden of SUDs for everyone affected by the disorder.



# Appendix

## Appendix: How We Develop Our Guidance



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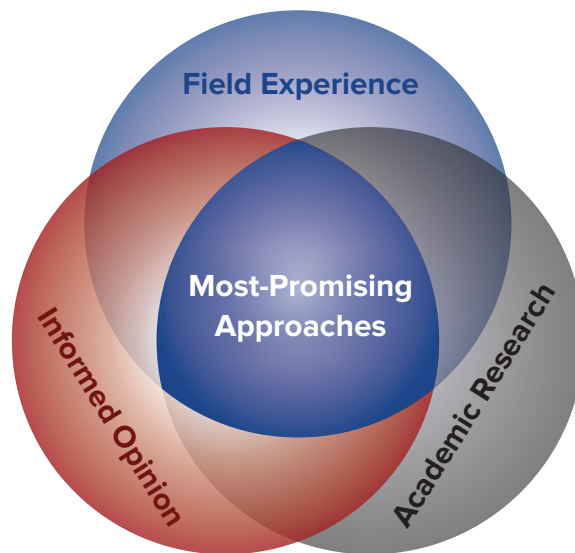


# Broad evidence base, targeted focus on social impact

## Looking for evidence-based solutions

To identify high-impact philanthropic opportunities, our multi-disciplinary team accesses the best available information from three sources: rigorous academic research, informed opinion, and field experience. From all three sources, we seek an empirical understanding of where the unmet needs are, what practices address these needs well, what social impact these practices generate, and how much change costs. By tapping all three sources, we leverage the strengths of each, while mitigating their weaknesses. Where all three sources point to the same practice or model, we see a high-impact opportunity.

## SOURCES OF INFORMATION



### Field Experience

- Practitioner and beneficiary insights
- Performance assessments
- In-depth case studies

### Informed Opinion

- Stakeholder input
- Expert opinion
- Policy analyses

### Academic Research

- Randomized controlled trials and quasi-experimental studies
- Modeled analyses (e.g., cost-effectiveness)

## Sources reviewed

We reviewed over 300 sources and interviewed over 70 experts in academia, policy, philanthropy, health systems, care provision, and more. Our collaboration with the Treatment Research Institute (TRI) is of particular note. TRI is a leading center for substance use disorder research, and TRI staff members served as expert resources throughout the project.

## Criteria for inclusion of opportunities in this report

After conducting our initial scan of the three circles of evidence noted above, we generate a list of potential philanthropic opportunities to highlight. We then analyze each approach to determine how it stacks up against our four criteria:

- **Strength of evidence:** Is there a body of evidence supporting the link between the approach and the targeted social impact? Does that evidence come from each of the three circles. How does the strength of evidence for this approach compare with the evidence for other approaches aiming to achieve the same outcomes?
- **Expert recommendation:** Do experts across the three circles of evidence (including those whose expertise comes from lived experience) see potential for social impact as a result of this approach?
- **Potential for impact:** If the approach is successful, how many people will experience a positive change in their lives, and how meaningful will that change be? Does this approach have the potential to demonstrate a more powerful or efficient way to get to positive impact? If it is not successful, is there potential for negative impact (as compared with the negative impact of doing nothing)?
- **Philanthropic on-ramp:** Are there ways in which philanthropic support could create high impact? Are there credible implementers who could put this approach into practice? Is it clear where funds could be donated to implement this approach? Is it redundant given government programs or market forces?

We seek to highlight opportunities with: strong evidence of a link to the target impact; expert and constituent support; potential for meaningful and potentially game-changing impact; minimal potential for negative impact; and the ability to leverage philanthropic funding. Within opportunities that approach those benchmarks, we analyze and present costs and impacts, facilitating appropriate comparisons and clarifying trade-offs.

As with all of the Center's work, this report summarizes evidence drawn from a range of sources, including academic research, policy experts, and practitioners in the field. As we present a range of opportunities to serve different populations or target different levers for change, some options may have stronger evidence from one dimension than from another. For example, since health service interventions can be replicated and studied in different settings, the academic evidence base in health services is sometimes deeper than the evidence base in policy change. However, since a single policy change can affect large populations for an extended period of time, those interventions can be extremely cost-effective—if they are successful.

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*Impaired control*: (1) taking more or for longer than intended, (2) unsuccessful efforts to stop or cut down use, (3) spending a great deal of time obtaining, using, or recovering from use, (4) craving for substance.  
*Social impairment*: (5) failure to fulfill major obligations due to use, (6) continued use despite problems caused or exacerbated by use, (7) important activities given up or reduced because of substance use.  
*Risky use*: (8) recurrent use in hazardous situations, (9) continued use despite physical or psychological problems that are caused or exacerbated by substance use.  
*Pharmacologic dependence*: (10) tolerance to effects of the substance, (11) withdrawal symptoms when not using or using less.  
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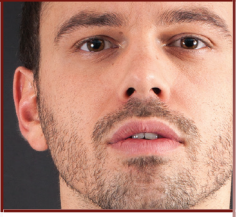
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## ABOUT THE CENTER FOR HIGH IMPACT PHILANTHROPY

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While there are many organizations supplying information and advising services to philanthropists, our approach is uniquely guided by our focus on social impact and the necessity to be both actionable and evidence-based. We start by asking and answering a series of questions:

- What is the positive impact you hope to achieve, and is it meaningful to those you hope to help?
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In deciding to take on a new project, the Center for High Impact Philanthropy weighs two factors: Is there a significant social impact to be achieved? And is it likely that philanthropy can play a role in getting to that impact? When the answer to both questions is yes, we know that our guidance can help move more money to do more good.

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