

**Substance Abuse Policy:  
Simple Actions to Advance Low-Cost,  
Evidence-Based Practices for Population  
Level Effects on Treatment, Intervention and  
Prevention<sup>1</sup>**

*By*

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*ORAL TESTIMONY BEFORE:*

***Join Together's "Blueprint for States:  
Policies to Improve Ways States Organize  
and Deliver Alcohol and Drug Prevention and  
Treatment***

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<sup>1</sup> A series of papers and research studies are available from the author and presenter on details of low-cost, powerful evidence-based treatment and prevention practices.

*No man is an island,  
Entire of itself.  
Each is a piece of the continent,  
A part of the main.  
If a clod be washed away by the sea,  
Europe is the less.  
As well as if a promontory were.  
As well as if a manor of thine own  
Or of thine friend's were.  
Each man's death diminishes me,  
For I am involved in mankind.  
Therefore, send not to know  
For whom the bell tolls,  
It tolls for thee.  
—John Donne, (1572-1631), Devotion 17*

The pains, dangers, disability and deaths of persons who abuse tobacco, alcohol and other drugs diminish us all—just as the poem and devotion of John Donne extoll us. My testimony today is motivated by own life history of exposure to substance abuse endangerment from my family, by my scientific knowledge of what is possible, and my practical experience nationally and internationally with large-scale prevention and treatment efforts.

**Policy Goal for States.** Let us begin with the end in mind, to still the tolling of the bell announcing the pain, suffering and deaths associated with substance abuse and related ills—which no doubt have been well documented before you. The end in mind is bold yet clearly possible: Reduce substance abuse problems by 25% in 5 years and reduce it further to 50% of current prevalence rates of 30-day tobacco, alcohol addiction, and illegal drug addiction in a decade or less. These goals can be achieved by adopting and promoting, by policy and procedures, low-cost evidence based prevention, intervention and treatment practices—strategically implemented statewide and community-wide.

**Low-Cost Prevention and Treatment Practices.** Proven, powerful low-cost prevention, intervention and treatment practices exist, and these can be found in peer-reviewed published literature and other sources such as government reports, which we have enumerated in other documents submitted to the committee. These proven, low cost practices are not widely known because there is

little or no fundamental financial incentive for corporations (for profit or not for profit) to implement them. Perverse economic incentives exist to implement more costly, less effective practices. This should be no surprise to students of economics, politics, or human behavior. Only through the bully pulpit of this committee, actions of state legislators and concerned citizens or groups can these proven practices become as common. The reprinted article from the Arizona Medical Association, “Stop the Methamphetamine Epidemic” supplied to the committee outlines 10 simple evidence-based for short, medium and long-term effects. Other papers details these and related strategies in greater detail. Today, in this testimony, I outline missing coordinating actions by states and localities to make these happen.

**Coordinating Policy Actions.** Research does not immediately translate into wide-spread practice. However, one can easily show that to achieve the goals of our conversation today, one must promote these low-cost practices everywhere in states, not just in pilot projects or political pretends of looking like something is being done. I offer an empirical case to demonstrate the point, shown in Figure 1. My colleagues and I (e.g., Dr. Galloway, who also testified today) launched reward and reminder (a previously proven strategy) statewide in Wyoming and then in Wisconsin to lower illegal sales of tobacco to minors. Dramatic reductions in illegal sales followed, and this is among the first experimental demonstration of any sort of population level effects on substance abuse using an evidence based strategy. If one strips away the content of the intervention per se but focuses on the processes, one can easily see most all the coordinating and policy actions that will be required to achieve the goal of large prevention and treatment effects within 5 and 10 years respectively: 1) the same basic protocol has to be done in every sub-jurisdiction, instead of each doing their own thing; 2) legislation or regulations often need minor changes to support the initiative; 3) contracts for specific evidence-based services have to be let for each jurisdiction; 4) complete protocols, supporting materials, training and technical support for the whole state must be provided; 5) a social marketing

campaign has to be launched to support the strategy, including informing and securing involvement of legislators, the private sector, local governments, and agency or non-profits; and 6) a data dashboard has to be set up so that monthly progress and results can be measured and monitored. This six-point coordinating strategy is represented in Figure 2. How does this Six-Point Star play out in some of the the recommended low-cost prevention and treatments for substance abuse? We offer some examples:

**Strategic Example 1—Incentives and Contingency Management for Sobriety.** A simple “prize-bowl” strategy for wherein persons in treatment for tobacco, alcohol, or illegal drugs including Meth will double, triple or quadruple outcomes of sobriety when given weekly chances to draw cards for prizes for their sobriety measured objectively, and long term outcomes are dramatically improved [1-6]. Figure 3 shows some results from one such study, with a marginal cost of \$150 per client. This cost effective strategy needs the six-point policy star applied for coordinating mechanisms for success:

- (1) Selection — Single State Authorities, Legislative Committees, the State Executive, and advocacy groups need to agree use this powerful evidence-based practice. Some sort of proclamation or public event helps.
- (2) Policy/Legislation — Procedures to pay for the reimbursement of the UA or other biological measures of sobriety must be adopted, plus how to bill or reimburse for the incentives as medical expense must be developed; CEUs might need to be approved. Also, welfare regulations and policies will need to be amended so that the incentives do not count against income or resource limitations, in some cases.
- (3) Contracts – Vouchers or contracts will need to be amended or announced across all localities to achieve population level effects.
- (4) Protocols – With a low-cost protocol applied across the state, one person in state can typically be the technical training manager. This position and materials must be designed or purchased, along with all the training and quality-control protocols.
- (5) Social Marketing – Some kind of media campaign must be organized depicting the approach, its successes, and adoption or spread. This campaign can use what are called guerrilla marketing strategies as well as traditional marketing or PR.
- (6) Data Dashboard – Monthly graphs of

percentages and actual numbers of clients being clean need to be presented to media and policy makers, including stakeholders.

**Strategic Example 2 — Omega 3, Folic Acid and Vitamin Supplementation.** Increasing the intake and supplementation of Omega 3, Folic Acid and/or vitamin supplementation ought to substantially reduce a variety of DSM-IV or ICD-9 conditions associated addictions based on careful studies from the National Institutes of Health and other entities such post-partum depression, bipolar disorder, borderline personality disorder, aggression and violence, addiction cravings, or suicidal ideations. (1) Selection — Single State Authorities, Legislative Committees, the State Executive, and advocacy groups need to agree use this powerful evidence-based practice, which might be done by releasing a lay policy review of the research on Omega 3, Folic Acid and Vitamin Supplementation using research from the National Institutes of Health on a variety of DSM-IV outcomes associations with addictions and related behaviors. (2) Policy/Legislation – The Corrections, Child Protective Services, Behavioral Health and Substance Abuse Authorities must specifically include these in the reimbursable expenses and/or formulary. Further the Department of Education would issue changes in the school lunch program and snack foods policy to include these. All of these policies could be initiated or supported by legislation. (3) Contracts – the state ought to issue amendments to service contracts to provide these supplements. (4) Protocols – Protocols must be published for dose by age, gender, and relevant conditions using available scientific evidence. (5) Social Marketing – A low-cost social marketing needs to be undertaken to explain, reinforce and show successes. This can include “free samples” to opinion leaders. (6) Data Dashboard – Monthly cases of a variety of DSM-IV or ICD-9 codes, graphed provide feedback on progress.

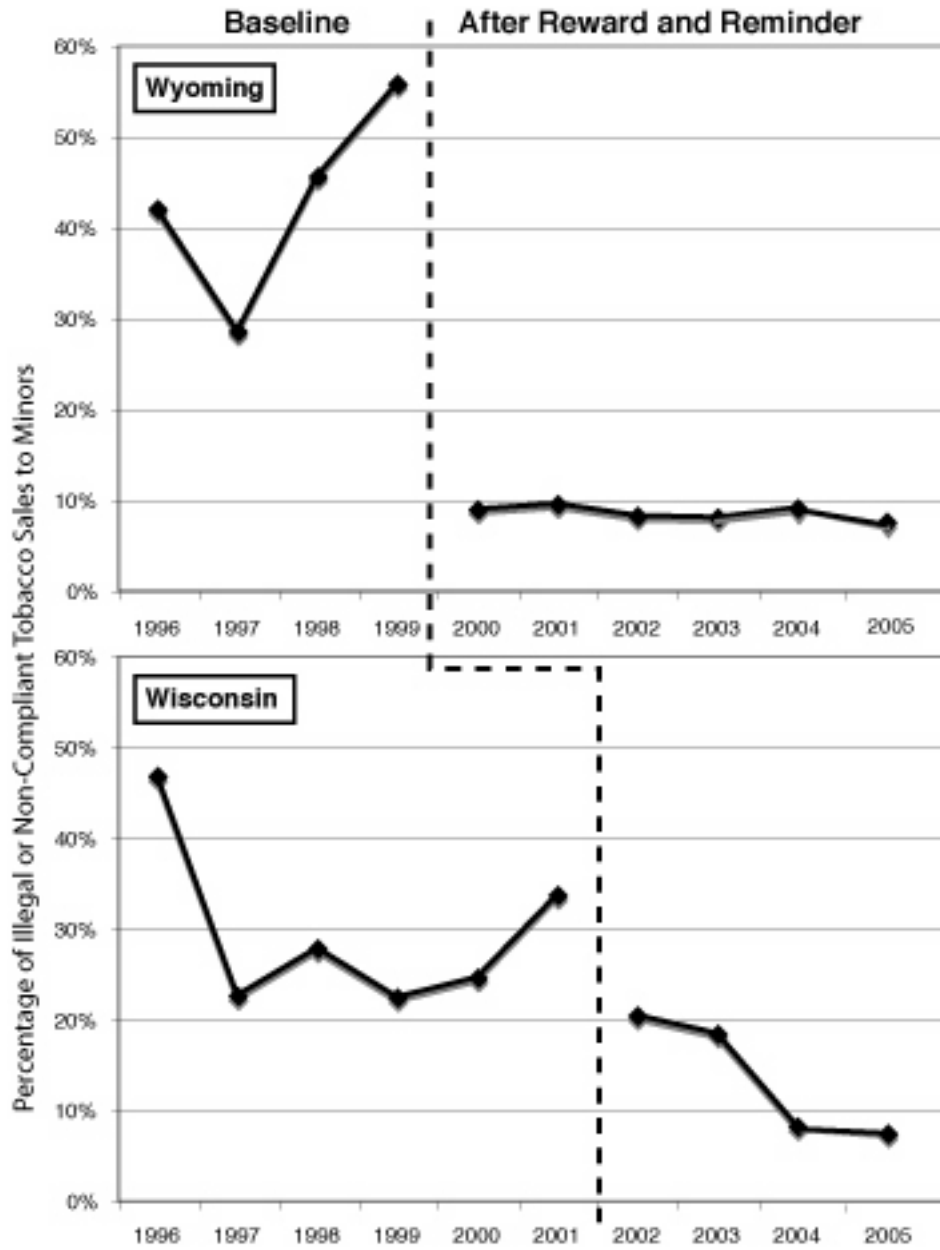
**Strategic Example 3— Good Behavior Game.** A simple evidence-based protocol can cut serious substance abuse (e.g., cocaine and Meth), tobacco use, ADHD, special education, juvenile crime and other problems by 50% . For example, in theory the Good Behavior Game could cut the

numbers of Cocaine and Meth users among adolescents by 15,000 youth. The intervention also increases time for academics. Here is how it might be coordinated: (1) Selection — Single State Authorities, Legislative Committees, the State Executive, and advocacy groups could agree to fund and adopt this “silo busting” protocol across alcohol, tobacco, illegal drugs, child protective services, bullying, behavioral health, special education, character education, and No Child Left Behind. (2) Policy/Legislation The state must change rules to say the programs are selected on outcomes, not content. Even though, this intervention has the largest effects on child to teen tobacco use reduction, the state of California refused to sanction the use of the protocol because it did not teach the children about tobacco, which has almost no experimental effects on tobacco use. Incentives for adoption of silo busting strategies must be adopted. (3) Contracts - Various contracts and awards will have to be amended, such as through behavioral health to support this action. (4) Protocols – Both teacher, school, after-school, faith-based, and mental-health services versions of implementation must be promoted and supported to achieve population level effects. (5) Social Marketing — A campaign of testimonials from teachers and children will dramatically improve uptake of the effort. (6) Data Dashboard – Monthly aggregated observations of disruptive behavior and engaged instruction, which can be collected by community volunteers is the measure for proximal effects.

### **Summary**

A combination of low-cost, evidence-based prevention, intervention and treatment strategies could reduce substance abuse and related ills by 25% in five years, and 50% in less than a decade. With declining Federal resources, low-cost strategies are vital to the public health and safety of states and cities. The key to make this happen is to move to a state-wide public-health model of promoting these strategies, which includes carefully constructed monitoring to show results. We no longer-need to hear the bell toll for the pain, suffering and deaths associated with substance abuse.

**Figure 1: Demonstration of Statewide Effects of Low-Cost, Evidence Based Prevention-Intervention Strategy (From Embry, Biglan, Dahl and Galloway, in submission)**



**Figure 2: Six Point Strategy for Coordinating Low-Cost Strategies for Prevention or Treatment**

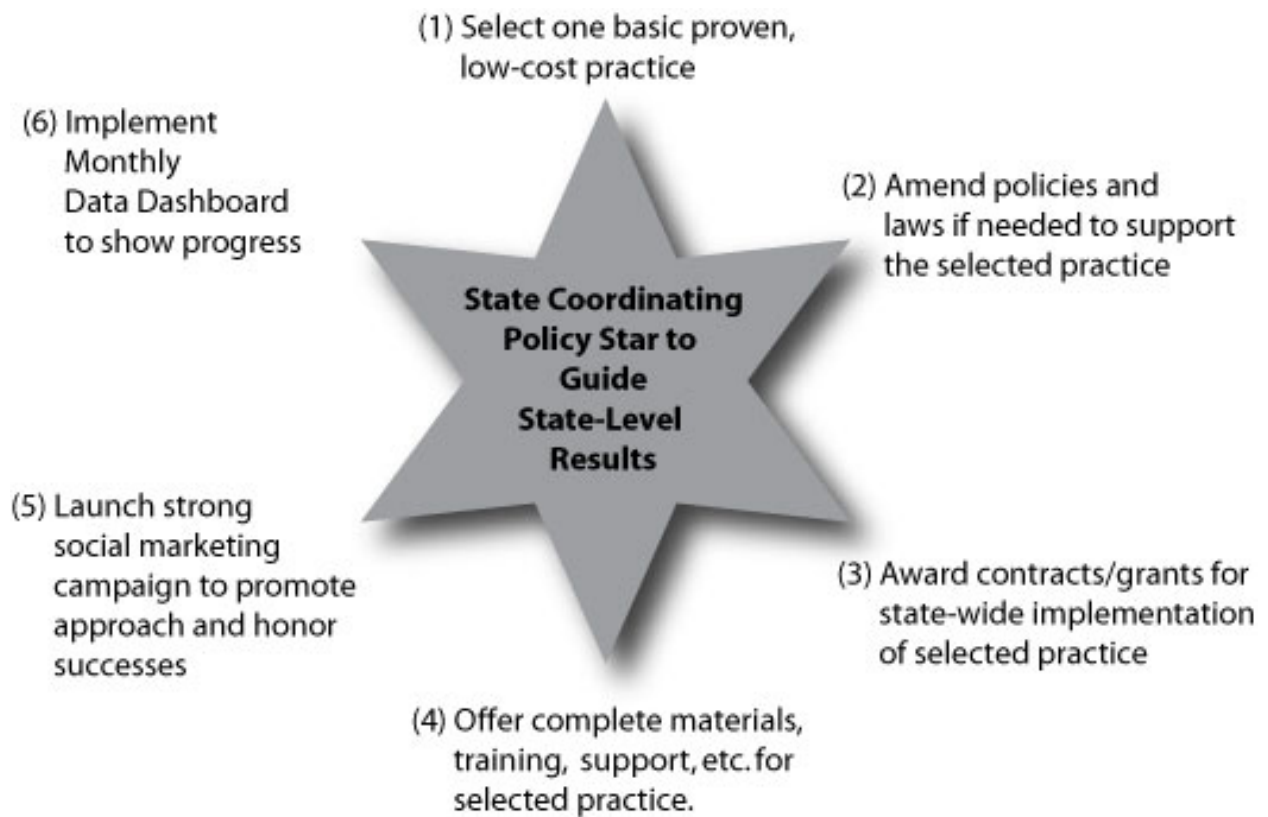
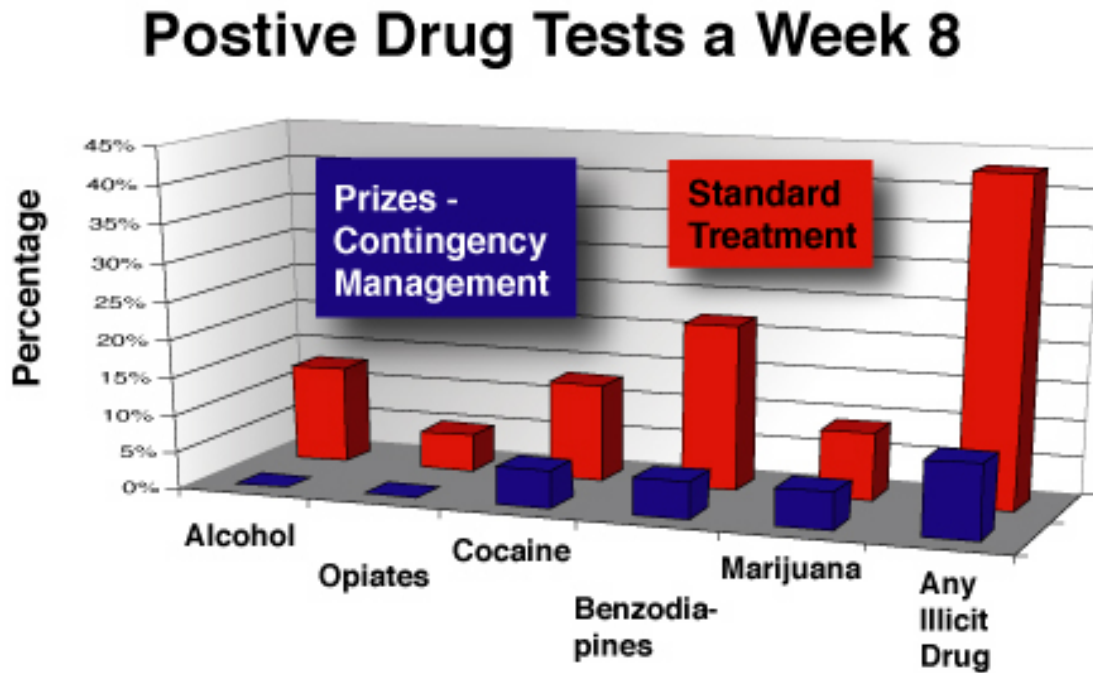
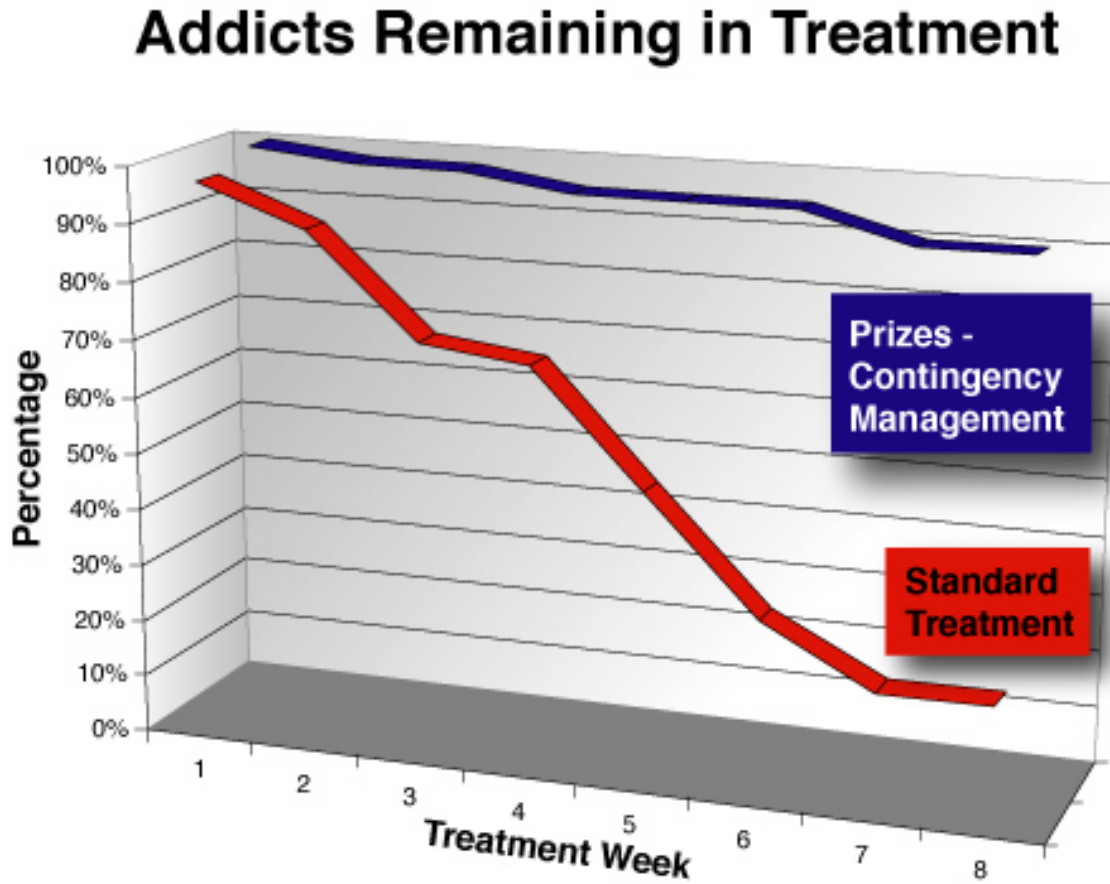


Figure 3: Impact of Prize Bowl on Sobriety Among Poly Drug Users



Source: Petry et al., Journal of Consulting and Clinical Psychology, 2000, 68, 250-257

1. Petry, N.M., et al., *Give them prizes and they will come: Contingency management for treatment of alcohol dependence*. Journal of Consulting & Clinical Psychology, 2000. **68**(2): p. 250-257.
2. Petry, N.M., B. Martin, and C. Finocche, *Contingency management in group treatment: A demonstration project in an HIV drop-in center*. Journal of Substance Abuse Treatment, 2001. **21**(2): p. 89-96.
3. Petry, N.M., et al., *Effect of Prize-Based Incentives on Outcomes in Stimulant Abusers in Outpatient Psychosocial Treatment Programs: A National Drug Abuse Treatment Clinical Trials Network Study*. Arch Gen Psychiatry, 2005. **62**(10): p. 1148-1156.
4. Petry, N.M. and F. Simcic, Jr., *Recent advances in the dissemination of contingency management techniques: Clinical and research perspectives*. Journal of Substance Abuse Treatment, 2002. **23**(2): p. 81-86.
5. Petry, N.M., et al., *Prize reinforcement contingency management for treating cocaine users: How low can we go, and with whom?* Addiction, 2004. **99**(3): p. 349-360.
6. Petry, N.M., J. Tedford, and B. Martin, *Reinforcing compliance with non-drug-related activities*. Journal of Substance Abuse Treatment, 2001. **20**(1): p. 33-44.