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News for policy and program decision-makers

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In This Issue...

Methadone or buprenorphine preferred over naltrexone by inmates

When CODAC Behavioral Healthcare, the main provider of treatment services for corrections in Rhode Island, looks at its clientele with opioid use disorder (OUD), Vivitrol (depot naltrexone) is preferred by no one. The patients want either methadone or buprenorphine, CODAC CEO Linda Hurley explained in a webinar this month (for the first part of this two-part article, see *ADAW* (https://onlinelibrary.wiley.com/doi/10.1002/adaw.34254).

Brown University manages all of the data and outcomes for CODAC, which bid on the $2 million contract from the state's Department of Corrections to provide treatment. Brown is a subcontractor. So, the evidence is being gathered on a regular basis.

Recent incarceration is a well-known risk factor for overdosing — twice as many overdose death victims were recently incarcerated, Hurley explained. Their tolerance had gone down during incarceration if they had not received medications during treatment; when

See **CODAC** page 2

Bottom Line...

People in jail or prison with opioid use disorder do not want naltrexone; they want methadone or buprenorphine, CODAC has confirmed.

Survey: Jails still fall short in offering medications for OUD

Despite policy guidance suggesting the critical importance of making medications for opioid use disorder (MOUD) widely available in correctional settings, newly published data suggest that uptake of these treatments in local jails continues to be slow.

A survey with responses from 1,028 county jails across the country, published Sept. 24 in *JAMA Network Open*, reported that only 43.8% of jails offered any MOUD treatment. Still fewer, 12.8%, made medication treatment available to anyone with an OUD, generally restricting the treatment only to pregnant individuals or inmates who already had been using a medication when they were booked into jail.

The research team for the National Institute on Drug Abuse (NIDA)-supported study stated that local correctional systems are not taking advantage of a critical chance to make a difference for many of the close to two-thirds of jail inmates who are estimated to have an active substance use disorder.

"Given the association between opioid use and involvement with the legal system, these findings

See **Jails** page 7

Bottom Line...

Just over 1 in 10 jails in the U.S. offer wide availability of medications for opioid use disorder to any inmate who could benefit, according to a newly published survey covering a 2022–2023 time frame.

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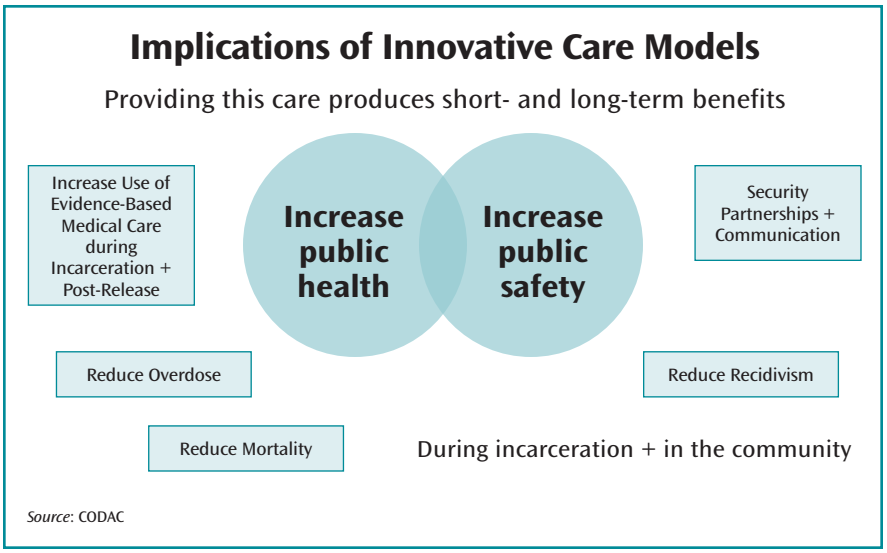
they get out of prison, they go back to their regular dose on the street, not recognizing that they need less, and also not recognizing that the illicit fentanyl supply on the street is deadly.

In Rhode Island, 50% of inmates awaiting trial are released within six days. This means that in order to be an effective intervention, treatment needs to be started immediately. Methadone for severely addicted patients should be started, said Hurley; for those with less severe OUD, buprenorphine will be effective. The goal is not only to prevent withdrawal, but to treat OUD with maintenance agonist medication that lasts during and after incarceration.

But it's essential to help inmates as soon as they are committed, by having methadone and buprenorphine available. "Time is of the essence," says Hurley.

Few prisons and jails provide treatment (see bottom lead). Hurley said she doesn't understand it. "You could get sued if you don't do this," she warns corrections departments.

"This is going to happen anyway," she said. Some sheriffs have been unwillingly forced into it. Inmates have died under their watch, from withdrawal symptoms — dehydration from vomiting and diarrhea (see *ADAW* https://onlinelibrary.wiley.com/doi/10.1002/adaw.30666).



But it doesn't need to be such a momentous decision. "We can say this over and over, it's just more medicine for a disease that many of us have," said Hurley. "It's also a medical decision."

For people in prison and jail, CODAC provides treatment until release and referral to a community treatment provider.

Some corrections officials prefer the Sublocade version of buprenorphine, an injectable long-term medication, which means that diversion is not possible (unlike oral buprenorphine). But cost is a factor. "If everyone wanted Sublocade, we wouldn't be able to afford it," said Hurley.

Vivitrol (depot naltrexone) is also expensive. But it's not something anyone wants, said Hurley. The reason may be that detoxification is required first — there can be no opioids in the body when treatment starts or the medication will provoke severe withdrawal symptoms. "We don't have anyone on depot naltrexone. It's not a medication that when people are left to choose, they will request," said Hurley.

Treatment gap

Hurley detailed the need for medications for OUD in prisons and jails.

- Between 15% and 25% of incarcerated individuals nationwide screen positive for OUD;

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Cost

1 Program Director
1 Program Administrator
1 Clinical Supervisor
1.40 Assessment clinicians
5 Counselor/Discharge Planners
.30 Medical Director (physician)
.60 APRN
3 Dispensing Nurses
1 Nurse Care Manager
1 Community Integration Specialist
2 Peer Recovery Support Specialists
Dr on call 7 days/wk

Medicine and supplies
Administrative oversight

$2,600,000

Source: CODAC

- Of current CODAC participants in medication assisted treatment (MAT), 16% are in the Rhode Island Department of Corrections jail and prison facilities population;
- For women, the percentage is even higher: 27% of the RIDOC Women's Facility individuals are on MAT; and
- At the RIDOC Men's Intake Center, 22% of the population is on MAT.

Currently, 56% of CODAC patients take methadone, 32% take sublingual (oral) buprenorphine, and 12% take Sublocade (injectable buprenorphine). No one takes naltrexone.

How to reach patients

It's important to have culturally appropriate treatment, said Hurley. At CODAC, peers are important. The key is to provide MAT services without stopping or interrupting treatment due to the length of treatment. For this, CODAC with RIDOC has built a Recovery-Oriented System of Care with the following utilization of peer recovery specialists:

- Hired a year ago, peer recovery specialists meet with about 57 individuals each month;
- The second round of peer recovery specialists are now meeting with at least one-third of program participants; and
- Nobody has to meet with peer recovery specialists unless they want to; only self-referrals are accepted.

Of CODAC program staff, one-third are bilingual/bicultural.

And outside volunteers host Alcoholics Anonymous and Narcotics Anonymous meetings inside RIDOC facilities.

Lessons learned

The CODAC RIDOC program has provided important lessons that can be share with other providers in the criminal justice and treatment communities:

- Corrections MAT is not the same as community MAT — consider the nuances including budget, staffing, program demographics, and the environment;
- Relationship building is essential — this includes communication, consistency, and culture; and
- Time and resource constraints — access to individuals is limited by the daily schedule of the corrections facility and the induction dosing process differs from the community.

The basic rule to remember is to be practical: "Start where you can and focus on program sustainability."

The essentials for success of MAT for incarcerated individuals are:

- History of understanding your state's environment;
- Flexibility;
- Understanding system change;
- Competence is respected in the communities served;
- Can commit to comprehensive re-entry services;
- Ability to meet workforce demands; and
- Understanding the challenges in mission integration: safety and rehabilitation as opposed to safety vs. rehabilitation.

These essentials apply to corrections staff as well as treatment staff. And Hurley stressed that flexibility is key. •

CODAC provides all FDA approved medications for the treatment of Opioid Use Disorder

Sublocade: The Bipartisan MAT Medication

Sublocade End-of-Year-Report		
	2022	**2023**
At least 1 injection received for the year	49	103 (increase of 110%)
On Sublocade d/t diversion	14 (28.6%)	14 (13.5%)
New induction for the year	38	90 (increase of 137%)
Started Sublocade d/t diversion	10 (26.3%)	11 (12%)
Total # diversions	51	52
# Unique Patients	41	44
Changed medication to Sublocaade	10 (24.3%)	11 (25%)

1 in 4 individuals on Buprenorphine now receive Sublocade-up from 1 in 5 individuals one year ago

Source: CODAC

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SAMHSA publishes proposal for new draft data collection tool

Last month, the Substance Abuse and Mental Health Services Administration (SAMHSA) published a document in the Federal Register announcing specifications for comments on a new document: the SAMHSA Unified Client-level Performance Reporting Tool (SUPRT). The Aug. 15 Federal Register notice, however, was missing the website to view the proposed draft tool. In a correction published last week, SAMHSA included the web address. Comments on the tool are due Oct. 15.

For the Aug. 15 notice, which now includes the website, go to https://www.federalregister.gov/citation/89-FR-66429.

About SPARS

Currently, more than 7,500 grantees across a range of prevention, harm reduction, treatment and recovery support discretionary grant programs report program performance data into SAMHSA's Performance Accountability and Reporting System (SPARS) that serves as a central data repository. Historically, SAMHSA has required grantees to collect much of the client-level information in SPARS using a prescribed series of questions in long complex instruments. Now, SAMHSA plans to "develop and implement a new streamlined client-level performance tool that will allow SAMHSA to continue to meet the Government Performance and Results Modernization Act (GPRAMA)," as well as to reduce the burden of questions requiring responses from individual clients of these programs. There have been complaints that the requests delved way too far into personal lives, including questions about sex (see *ADAW* https://onlinelibrary.wiley.com/doi/10.1002/adaw.33387. The current 2010 reporting requirements would be replaced by this new tool.

According to SAMHSA, the proposed new tool "will involve streamlining questions from the currently used client-level performance reporting tools, as well as incorporating select new measures/questions into a multi-component client-level tool." The tool will also clarify to grantees what questions they are expected to ask specifically of clients, and those for which "alternative data sources" may be used.

"…data from the new client-level performance tool…can be used to delineate who is served, how they are served, what services they receive and how the program impacts the progress of clients…"

SAMHSA

"This tool also reflects diverse stakeholder feedback SAMHSA obtained through multiple listening sessions conducted with key stakeholders and will incorporate findings of cognitive testing to improve clarity of the measures," according to the Federal Register announcement. "SAMHSA will use the data collected through the new streamlined client-level performance tool for both annual reporting required by GPRAMA, grantee monitoring, and continuous improvement of its discretionary grant programs. The information collected through this process will allow SAMHSA to: (1) monitor and report on implementation and overall performance of the associated grant programs; (2) advance SAMHSA's proposed performance goals; and (3) assess the accountability and performance of its discretionary grant programs, focused on efforts that promote mental health, prevent substance use, and provide treatments and supports to foster recovery."

SAMHSA also seeks to align its reporting requirements with those of other agencies, such as the Centers for Medicare & Medicaid Services, the Centers for Disease Control and Prevention, the U.S. Census Bureau and the federal Office of Management and Budget. "To meet these goals, data from the new client-level performance tool for SAMHSA's discretionary grants can be used to delineate who is served, how they are served, what services they receive and how the program impacts the progress of clients in terms of mental health and substance use issues. The tool reflects SAMHSA's goals to elicit pertinent program data that can be used to inform current and future programs and practices and respond to stakeholders, congressional and other agency inquiries."

Components

Below are the components of the proposed new tool:

- The first component will be composed of standardized questions about demographic information (asked directly of clients at baseline only) and social determinants of health (asked directly of clients at baseline and annually as instructed by SAMHSA);
- The second component will contain standardized recovery, quality of life, and client goal measures as impacted by services received (also asked of clients at baseline and reassessment during the first year of a grant, then annually as instructed by SAMHSA); and
- The third component will consist of a streamlined set of questions describing clients' behavioral health history, screening and diagnosis items, and services provided to clients (as reported at the client-level by the grantee using alternate data sources that already may be in use for other purposes, for

example an electronic health or medical record).

Question(s) about services provided to the client will only be required at reassessment and annually for some programs as instructed by SAMHSA.

Reassessments

SAMHSA is also finalizing a revised policy on when reassessments are expected to occur, recognizing that a one-size-fits-all approach may not be appropriate for all client-focused grant programs. SAMHSA is conducting testing to establish a better estimate of the time it will take to complete the information collection given the varying degree of direct client involvement across the new tool's components and grantee use of alternate data sources for a portion of the tool. At this point, SAMHSA estimates that approximately 1,500 client-focused grantees annually will use the tool and with a burden hour estimate per assessment that ranges from 0.13 to 0.27 for each of the three tool components. SAMHSA's goal is to develop a new performance tool that is streamlined and will significantly reduce burden compared to the current performance tools.

Send comments to the SAMHSA Reports Clearance Officer, 5600 Fishers Lane, Room 15E45, Rockville, Maryland, 20857, OR email a copy to samhsapra@samhsa.hhs.gov. Written comments should be received by Oct. 15, 2024.

Comments are invited on: (a) whether the proposed collections of information are necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. •

FROM THE FIELD

The DEA should focus!

By Rob Kent, JD

I watched the segment this past weekend on [CBS TV's] *60 Minutes* about fentanyl and have some thoughts.

First, my heart breaks for parents Mike O'Kelley and Angela King who lost their 20-year-old son, Jack O'Kelley, to an accidental fentanyl overdose and for all the other parents who have lost their children because they were exposed to fentanyl without their knowledge. My heart also breaks for those who die because [they] are unable or unwilling to access help.

While the story focused primarily on the Drug Enforcement Administration's (DEA) efforts to stop the flow of fentanyl across the Southern border, I wish they had also focused on the other side of the DEA and their interference with efforts to treat those who use drugs. The DEA controls the rules that allow for the use of telemedicine to offer buprenorphine, a medicine that treats opioid use disorder. It appears that they want to roll back the current rule and make it much more difficult to access this lifesaving medicine. They constantly cite concerns about diversion but have NEVER offered any data or evidence to support that concern.

The DEA also partly controls the rules related to access to methadone. Thankfully, [the Substance Abuse and Mental Health Services Administration] SAMHSA, which also regulates access to methadone, has updated their rules and made it easier for opioid treatment programs to operate in a more patient friendly manner. While current law limits access to this medicine to these opioid treatment programs; it also contains language that would allow the DEA to develop rules that allow these programs to write prescriptions for their patients to pick up their medicine at a pharmacy just like other medicines. However, the DEA refuses to enact that regulatory change.

The story also briefly touched on naloxone, the opioid overdose reversal medicine. A few points here: first, Narcan is not the only naloxone, it is one version of the medicine. There are many others available that have been approved by the Food and Drug Administration, however, government, the manufacturer, and one segment of those who help people who use drugs have this mysterious relationship that seeks to limit access to only Narcan. Your readers should know that government, which purchases and distributes most of the naloxone in this country, is not buying as much as it could because they work with only one company. It is time for governments across the country to issue procurements that would absolutely reduce the price per product and allow more naloxone to be made available.

A few closing thoughts — to those who believe that losing more than 100,000 annually to overdose is success, please find another line of work! The DEA should be allowed to focus on intervention and supply reduction, and they should have no role in regulating access to medicines to treat addiction! •

Rob Kent, J.D., is president of Kent Strategic Advisors, LLC. Reach him at (518) 669-8596 or go to www.Kentstrategicadvisors.com. He was formerly general counsel for the federal Office of National Drug Control Policy, and before that, general counsel for the New York Office of Addiction Services and Supports.

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Lethal fentanyl analog shows increase across U.S.

According to urine drug tests, carfentanil, a lethal illegal analog of fentanyl, is surging across the United States. A Sept. 24 Millennium Health *Signals Alert* reported an uptick in detections since the substance reemerged in 2023.

Carfentanil was detect 134 times urine drug tests (UDT) in 21 states from July 2023 to June 2024, compared to only 11 times in six states during the preceding three years.

The analysis of more than 158,000 fentanyl-positive UDT specimens also showed that carfentanil use is associated with significantly higher rates of other drug use, including methamphetamine, xylazine, cocaine, benzodiazepines, and other fentanyl analogues.

"Because carfentanil is 100-times more potent than fentanyl and appearing in so many states, public health authorities are right to be worried," said Millennium Health Chief Clinical Officer Angela Huskey, PharmD.

"Given its history of contributing to overdose outbreaks and the volatility of these trends, we are monitoring carfentanil closely and will provide timely updates to raise awareness of its presence in our communities," said Huskey

"Carfentanil differs from fentanyl in potency — or strength — and clinical use," Eric Dawson, PharmD, vice president for clinical affairs of Millennium Health, told *ADAW* last week. "Carfentanil is a fentanyl analogue, meaning it's like fentanyl, but it's 100-times more potent than fentanyl, making it one of, if not the most potent opioid available. This makes it too dangerous for use in humans. Carfentanil is instead used in veterinary medicine to sedate very large animals like moose, elk and elephants."

Hence the common reference to "elephant tranquilizer" when carfentanil comes up.

Importantly, there needs to be a distinction between fentanyl used in therapeutic settings — it is a legal medication — and the fentanyl found on the street, which, according to Dawson, is "nearly all illicitly manufactured fentanyl."

According to the Dawson, the increase, including the geographic spread, will "further increase overdose risk and complicate treatment efforts," Dawson told *ADAW*. •

U.S. officials speak out on fentanyl crisis at U.N. General Assembly

Speaking at last week's Summit of the Global Coalition to Address Synthetic Drug Threats, part of the United Nations General Assembly meeting in New York City last week, United States Secretary of State Antony Blinken praised the gathering of foreign officials to take time to address this issue. Fentanyl is a synthetic drug which is causing a crisis internally, said Blinken. "Now, for years, the threat of synthetic drugs has been rising around the world: methamphetamines in the East, in Southeast Asia; Captagon in the Middle East, tramadol in Africa; and here in the United States fentanyl, the number-one killer of Americans aged 18-49," said Blinken September 24, according to remarks released by the Department of Justice. "This is by definition a global challenge: people ship precursor chemicals, the ingredients that go into fentanyl from one country to another; criminals make them into synthetic drugs, and then sell them in a third country. Every country needs to take steps at home to address this challenge. But no single government can solve it alone.

"So last year, in July, the United States and our partners launched this global coalition to mobilize a coordinated response to the threat of synthetic drugs. We started out with 80 countries; today, nearly 160 countries and 15 international organizations."

The coalition has taken "concrete steps" over the past year, said Blinken, by:

- Creating an international network for legislators to share best practices and create laws,
- Making it harder for drug traffickers to buy the precursor chemicals needed to make fentanyl, or to smuggle drugs across borders,
- Warning law enforcement and health professionals about new trends in drug use, and
- Training officials on how to use "a new tool that scrapes the internet "to find people illegally selling substances, including precursor chemicals.

In addition to law enforcement and detection, the coalition is working to develop public health measures to fight the epidemic, including:

- Expanding access to naloxone,
- Sharing school curriculums, and
- Creating resources for addiction treatment centers.

"Together, all of our countries' efforts add up to a stronger global network, a more effective response to synthetic drug threats," said Blinken, whose remarks introduced President Biden, who went on to praise countries for helping to fight the fentanyl crisis, but said more needs to be done – here and internationally.

President Biden's remarks

Below are excerpts from President Biden's remarks, also made September 24.

"A couple of years ago, a father who I got to meet from a small town here in the United States wrote me a letter about his daughter. Her name was Courtney. She was bright

and smart, she had a laugh that was contagious, and wanted to travel the world. But in high school, she became addicted to pills.

"Her father eventually brought her to a treatment facility, but his insurance company wouldn't cover the cost. They said, quote, 'It wasn't a matter of life and death.'

"A month later, Courtney died from a fentanyl overdose. She was just 20 years old — 20 years old.

"In his letter that he wrote to me, he described life without his child. He said, and I quote, 'There is no greater pain.' 'There is no greater pain.'

"I told him I know what it's like, having lost several children myself — two children. There is no greater pain. They still live in your heart, but there's no greater pain." (President Biden lost one child in a car accident, and another to brain cancer.)

President Biden went on to say that as president, he "made beating the opioid epidemic a cen tral part of the Unity Agenda." For the past year, this agenda, according to the White House, has included:

- Making naloxone available over the counter (for purchase),
- Investing more than $80 billion to expand access to addiction treatment and support,
- Issuing an executive order cutting cartel leaders off from U.S. financial system, and
- Deploying hundreds of advanced X-ray machines to stop the threat of drugs coming across the border.

Ultimately, however, President Biden pointed to the pain people are going through. "These aren't just facts and figures. They're families — families who don't have to bear the loss of a child, a parent, a spouse — families who are kept whole. But there are too many that are still dying. There's so much more that needs to be done." •

Jails from page 1

highlight a missed opportunity for reducing the impact of the opioid crisis on communities," wrote the study's authors, led by Elizabeth Flanagan Balawajder, senior research associate at NORC (National Opinion Research Center) at the University of Chicago.

The survey's results also illustrate the potentially important role of access to MOUD in jails' surrounding communities. The researchers found that jails located in counties with shorter mean distances to the nearest facility providing MOUD were more likely to offer MOUD as well.

Details of survey

The research team used phone, mail and internet formats in conducting the survey between June 6, 2022, and April 30, 2023. Participating jail staff were asked whether their facility offered any type of substance use treatment or recovery support, whether MOUD (surveyors actually used the term "medication-assisted treatment," more recognizable to jail staff) was available in the past year, and which type of medication was available and to whom.

The survey also collected information on jail size, the jail's health care delivery model (direct services, contracted services or a combination) and county-level factors such as access to treatment for OUD and socioeconomic variables.

The most commonly cited reason for not offering MOUD was a lack of adequate licensed staff to administer the medication.

A total of 927 respondent jails in the researchers' analysis were representative of 3,157 jails nationally after weighting. In this weighted analysis, only 43.8% of jails were found to offer some type of MOUD. Among those offering MOUD, 69.9% offered buprenorphine, 54.5% offered naltrexone and 46.6% offered methadone. By comparison, a larger proportion of jail staff, 70.1%, reported offering some type of substance use treatment or recovery support in their facility.

The most commonly cited reason for not offering MOUD was a lack of adequate licensed staff to administer the medication. The survey also found that jails located in counties with higher fatal overdose rates were more likely to offer some type of SUD treatment but had no greater likelihood of offering MOUD.

Greater community vulnerability to social factors such as poverty and unemployment was associated with decreased odds of offering any SUD treatment or offering MOUD, either at all or more broadly. Communities with greater driving distances for MOUD were less likely to have a jail facility offering MOUD or any SUD treatment.

Larger jails were generally more likely to offer SUD treatment than smaller jails, a finding that the researchers attributed to the larger facilities being located in more highly resourced communities.

"MOUD services require ready access to licensed health care clinicians; these staff present added cost and logistical barriers for many jails," the study's authors wrote. They added, "Although logistically challenging, partnering with local facilities providing MOUD may help jails make treatment available for their detainees."

The research team cited several limitations, including a survey response rate of just over one-third, possible underreporting of the perceived undesirable response of not offering MOUD, and the fact that the survey's time frame might

Continues on page 8

Continued from page 7

not translate to other time periods affected by other policies enacted to combat the opioid crisis.

Importance of partnership

The researchers emphasized the importance of looking at jail policies through the broader lens of factors present in the local community. They wrote that "our findings underscore that efforts to improve access to treatment are dependent on shared resources and relationships across public safety and public health contexts."

Balawajder added, "Our findings suggest that supporting areas such as staff training, infrastructure improvements and partnerships with community treatment providers are key areas to improve substance use disorder treatment for people in jail."

The researchers pointed out that even though the methodology of their survey differed considerably from those of surveys conducted a few years earlier, their results were generally consistent with past research reporting that few jails make MOUD available to anyone who could benefit. The American Society of Addiction Medicine and the National Institute of Corrections both recommend that MOUD be made available to all jailed individuals with an OUD.

"Though someone may be in jail for only a short time, connecting them to addiction treatment while they are there is critical to reduce risk of relapse and overdose, and to help them achieve long-term recovery," NIDA Director Nora D. Volkow, M.D., said in a news release announcing the survey results.

The study, titled "Factors Associated with the Availability of Medications for Opioid Use Disorder in US Jails," was conducted by researchers in the NIDA-funded Justice Community Opioid Innovation Network, which is supported through the National Institutes of Health's Helping to End Addiction Long-term (HEAL) Initiative. •

Coming up...

The **Addiction Health Services Research Conference** will be held **October 16-18** in San Francisco. For more information, go to **https://www.ahsrconference.org/2024/**

The **NAADAC Annual Conference and Hill Day** will be held **October 18-23** in Washington, DC. For more information, go to **https://www.naadac.org/annualconference**

The annual **AMERSA Conference** (Association for Multidisciplinary Education and Research in Substance use and Addiction) will be held **November 14-16** in Chicago. For more information, go to **https://amersa.org/**

The annual meeting of the **American Academy of Addiction Psychiatry** (AAAP) will be held **November 14-17** in Naples, Florida. For more information, go to **https://www.aaap.org/training-events/annual-meeting/2024-annual-meeting-and-scientific-symposium/**

The **American Society of Addiction Medicine annual conference** will be held **April 24-27, 2025** in Denver, Colorado. For more information, go to **https://www.asam.org/education/signature-courses/live-conference-events**

Briefly Noted

STAR Plus Scholarship Act announced

On Sept. 12, U.S. Representatives Andrea Salinas (D-Oregon) and Marc Molinaro (R-New York) introduced the Substance Use Disorder Treatment and Recovery (STAR) Plus Scholarship Act. This bill aims to establish a new scholarship program for students studying in the fields of mental health, behavioral health, or substance use disorder treatment. The STAR Loan Repayment Program, administered by the Health Resources and Services Administration, has consistently advocated for the creation of a scholarship program to accompany the loan repayment program.

"NAADAC is excited and proud to support the STAR Plus Scholarship Act, as creation of these scholarship opportunities is an essential step towards building a more robust and well-trained addiction workforce," said Terrence Walton, MSW, NAADAC's executive director. "NAADAC applauds Representatives Salinas and Molinaro for their leadership and recognition of the meaningful difference this policy solution will make in countless lives." •

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In case you haven't heard...

Most people have probably heard by now that alcohol is a major risk factor for cancer, one of the top preventable risk factors, in fact. According to the 2024 edition of the *American Association for Cancer Research's Cancer Progress Report*, while cancer has gone down, preventable causes such as excessive alcohol use will results in more than two million new cases being diagnosed in the U.S. this year. The tobacco lesson has been well-learned. Now it's time for alcohol — excessive use is now the top modifiable risk factor for cancer. In 2019, 5.4% of all cancer cases diagnosed in the U.S. in 2019 were attributable to alcohol use.