TO: United States Senate Committee on Finance
FROM: Tony Vezina

RE: May 23rd Hearing Written Requested Testimony, Front Lines of the Fentanyl Crisis: Support Communities and Combating Addiction Through Prevention and Treatment

Chairman Wyden, ranking member Crapo, and U.S. Senate Committee on Finance members.

My name is Tony Vezina, and I am a person in long-term Recovery, which for me means I have not used any alcohol or drugs since July 20th, 2012. I serve as the Executive Director of 4D Recovery and participate in various roles on boards and commissions, including Oregon's Alcohol and Drug Policy Commission. My remarks do not represent my titles; they are based solely on my personal and professional experience. I hope to provide this committee with testimony combining personal experiences, academic knowledge, and professional insights that move you to take pragmatic steps to curb addiction in America.

Combatting the fentanyl epidemic is a paramount priority in the United States, and I am humbled to support the Senate Committee on Finance in exploring solutions that will ultimately increase general welfare in America and spare innumerable deaths from unintentional overdose. The fight for recovery isn't new. Americans started advocacy for treating alcoholism as a health issue in the 1840s with America's first large-scale peer recovery movement known as the Washingtonians. They knew then what I know now: people with substance use disorders can recover when they are provided the tools to do so. According to the National Institutes of Health, a survey of recovering people concluded that "Tens of millions of Americans [9.1% of Americans] had successfully resolved an AOD [alcohol or other drug problem] using a variety of traditional and non-traditional means." This demonstrates that people can and do recover, and treatment services work.

<u>Recommendations</u>

Improvements to the substance use service sector are vast and complex, requiring regulatory changes and substantial financial investments. The recommendations below align with Medicaid and target Fentanyl and other opioid use disorders. Prioritizing youth interventions, access to medication for opioid use disorder, expansion of recovery supports, treatment services, and workforce development can take critical steps in addressing the Fentanyl and addiction crises. My passion is for youth and young adults; these recommendations reflect that.

Prioritize Youth Interventions

Adolescents and young adults in America who use substances are underserved despite the incredible benefit to them and our society, investments in substance use services would yield. Emerging research from universities and multiple government and private entities significantly demonstrate that investments in primary prevention and substance use disorder treatment produce substantial economic returns, reducing government

burden spending in other sectors, e.g., the criminal justice system, health care costs, child welfare, etc. U.S. lack of capacity creates vulnerabilities for our youth and our future. The following data illuminate problems American teens face.

- The percentage of people aged 12 or older with an SUD in the past year was highest among young adults aged 18 to 25 (27.8% or 9.7 million people), followed by adults aged 26 or older (16.6% or 36.8 million people), then by adolescents aged 12 to 17 (8.7% or 2.2 million people). (NSDUH, 2023)

- Among the 1.8 million adolescents aged 12 to 17 in 2022 who had an SUD in the past year and did not receive substance use treatment in the past year, 97.5% (or 1.7 million people) did not seek treatment or think they should get it (NSDUH, 2024 and MHA, 2024). An estimated 0.5% of adolescents with an SUD (or 8,000 people) sought treatment, and 2.0% of adolescents with an SUD (or 34,000 people) did not seek treatment but thought they should get it. (NSDUH, 2024)

- New reports from the CDC show that 22 U.S. teens die every week from drug overdose. That is the equivalent of an entire high school classroom dying every week. *Fentanyl has become the leading cause of death among American teens.*

The finance committee can take steps to curb the crisis our youth are experiencing, specifically:

Prevent and Intervene
Use CHIP and Medicaid funds to increase primary prevention, screening, referral tools, and school-based support investments. Despite the evidence of primary prevention, few public resources are allocated, likely because of the lack of tangible outcomes.

Expand Access to Evidence-Based Treatment and Interventions
Expand access to residential treatment, outpatient, and peer recovery services by increasing reimbursement rates, providing one-time capacity-building funds, and allowing peer-based services that do not require assessments. In the United States today, 23 states do not offer adolescents whose families are receiving Medicaid services to access treatment.

According to a National Institutes of Health-supported analysis, teen residential capacity is lacking, and services are expensive. The report found that 46% of facilities contacted had a waitlist, with the average time being 28 days. The study found that between nonprofit and for-profit agencies, for-profit was more likely to have a bed open immediately (77% vs. 39%) but at roughly triple the daily cost ($1,211 vs. $395). Non-profits were four times more likely than for-profits to accept Medicaid.

Outpatient treatment is generally less costly and is used by more individuals than residential treatment. Outpatients can provide various levels of care, from simple education to rigorous interventions based on the individuals' substance use severity. Additionally, outpatient services are an adjunct to residential care as a level of care

titration that supports continued skill development and a reduction of relapse tendencies, much like physical therapy is an adjunct to an acute muscle injury.

Increasing peer support services such as Recovery Drop-In Centers for teens provide them with critical social support that reinforces and normalizes a life without the use of drugs or alcohol. Youth with substance use disorders need positive peer reinforcement to maximize success. Peer support services use the lived experience of people in recovery and provide hope and guidance to those seeking recovery. Peer support can increase a person's motivation to change behavior and improve treatment outcomes.

Lastly, it is a necessity that medications for opioid use disorders are widely available for youth, given the unprecedented increase in deaths from overdoses. Increased education for prescribers will make sure that they know these medications are successfully treating opioid use disorders, and that access to these lifesaving drugs is available.

The fiance committee can take other significant steps for adults in America, such as the following.

Expand Recovery Support Services
Create access to recovery centers and recovery residences (sober living) by creating specific funding models that facilitate service durations aligned with chronic disease conditions and reimburse peer support for pre-treatment and outreach engagement activities. According to Facing Addiction in America, a report by the U.S. Surgeon General, it can take more than five years of remission before the risk of relapse drops below 15 percent. This demonstrates the need for services that provide ongoing support post-treatment or incarceration.

Recovery Centers provide people in recovery with free daily access to essential community-based and peer support services. This service is extremely cost-effective and leverages grassroots recovery supports like 12-step Meetings. This service modality is currently being studied closely by the Recovery Research Institute, a nonprofit organization of Massachusetts General Hospital, an affiliate of Harvard Medical School, dedicated to advancing addiction treatment and recovery. A Recovery Center is typically open daily, offers 12-step and other recovery meetings, organizes events for recovering people, and offers skill-building workshops and one-on-one peer support services. Medicaid could potentially fund or partially fund Recovery Centers on a per-member basis.

Peer support services provide hope and encouragement to people during recovery, and extensive research demonstrates other positive outcomes, including reduced recidivism, lowered healthcare costs, and increased employment. Expanding Medicaid-covered for pre-treatment outreach activities can increase treatment enrollment, especially for those addicted to fentanyl.

Invest in Recovery Residences
In decades past, recovery housing was considered a “Treatment First” model, antithetical to the body of research supporting the “Housing First” model. Today, this is not the case. Recovery housing now operates pre-treatment, post-detox, concurrent with treatment, post-treatment, concurrent with medication-assisted treatment, and in harm reduction practices with “Stabilization Houses” and “Aid & Assist Recovery Housing” as a part of community restoration services.

Recovery housing now operates on a continuum and is supported by over a hundred research studies demonstrating its efficacy in supporting recovery and enhancing treatment outcomes. Currently, NSTARR (the National Study of Treatment and Addiction Recovery Residences) is implementing the U.S.’ most extensive scale series of studies on the efficacy of the Recovery Residence model through the ARG research group. ARG has previously completed over 50 studies demonstrating the efficacy of recovery housing.

SAMHSA's best practices manual summarizes that recovery housing produces “decreased substance use, reduced likelihood of return to use, lower incarceration rates, higher income, increased employment, and improved family relationships”.

Recovery housing is now endorsed by:

- HUD (Recovery Housing Policy Brief, 2015)
- White House ONDCP & LAPPA (Model Recovery Residence Certification Act, 2021)
- NCMW (Building Recovery: State Policy Guide for Supporting Recovery Housing, 2018)
- SAMHSA (Best Practices for Recovery Housing, 2023)

NARR, the National Alliance of Recovery Residences, is the largest accreditor of recovery housing in the U.S., active in 37 states. Like CARF and JCAHO, NARR accreditation implements a credentialing process with 105 research-based standards that recovery housing providers must meet to obtain accreditation.

Increased funding to Recovery Residences will ensure individuals addicted to fentanyl have supportive housing environments free from the temptation of drugs. Medicaid can provide funding to NARR Accredited or State Licenced Recovery Residences to ensure low-income individuals have access.

Increase Access to Medication for Opioid Use Disorders
Increasing access to Medication for Opioid Use Disorders is an expedient option that can create an immediate impact on the fentanyl crisis. The efficacy of this intervention is well-researched, but accessibility is limited, creating significant barriers to care. Providing access in jail settings, through mobile clinics, in emergency rooms, and via

telehealth would drastically reduce overdose rates while increasing engagement and retention in the recovery process.

Expand Substance Use Disorder Treatment
According to the National Survey on Drug Use and Health, people were classified as needing substance use treatment in the past year if they had an SUD or received substance use treatment in the past year. Among people aged 12 or older in 2022 who were classified as needing substance use treatment in the past year, about 1 in 4 (24.0% or 13.1 million people) received substance use treatment in the past year.

Limited access to treatment creates system flow issues where the linkage between complementary care is severed, leaving individuals at high risk for relapse. For example, an individual exiting detoxification services cannot enter residential treatment due to waitlists, so they return to their previous environment and risk using again. This scenario is common, depending on individual states, and perilous for fentanyl users.

Increasing reimbursement rates is a necessary and critical strategy to expand access. Reimbursement rates that do not cover the costs of detoxification and residential treatment disincentivize organizations to establish or expand operations and create workforce barriers due to low wages.

Workforce Development
A summary of research from the National Conference of State Legislatures reveals that burnout rates among behavioral health professionals are higher than among other types of workers.

The U.S. mental health crisis, fueled and synergized by newer synthetic forms of methamphetamine, fentanyl, xylazine, and nitazenes, is leading to extreme and profound psychiatric effects that have also exacerbated the growing Aid & Assist population in the U.S. Court system. These clients are challenging to work with due to growing comorbid psychoses and are leading to increased rates of burnout among staff.

In 2023, the Health Resource Service Administration (HRSA) reported that the shortage of addiction counselors is projected to last until 2036. NSDUH estimated that 44 million people had SUDs in the past year. According to HRSA, there are 86,794 addiction counselors in the U.S., and we need 125,010 additional addiction counselors to fill the need.

Reimbursement rates remain low, and wages remain very low for workers who are being asked to work with individuals with severe addiction and mental health conditions.

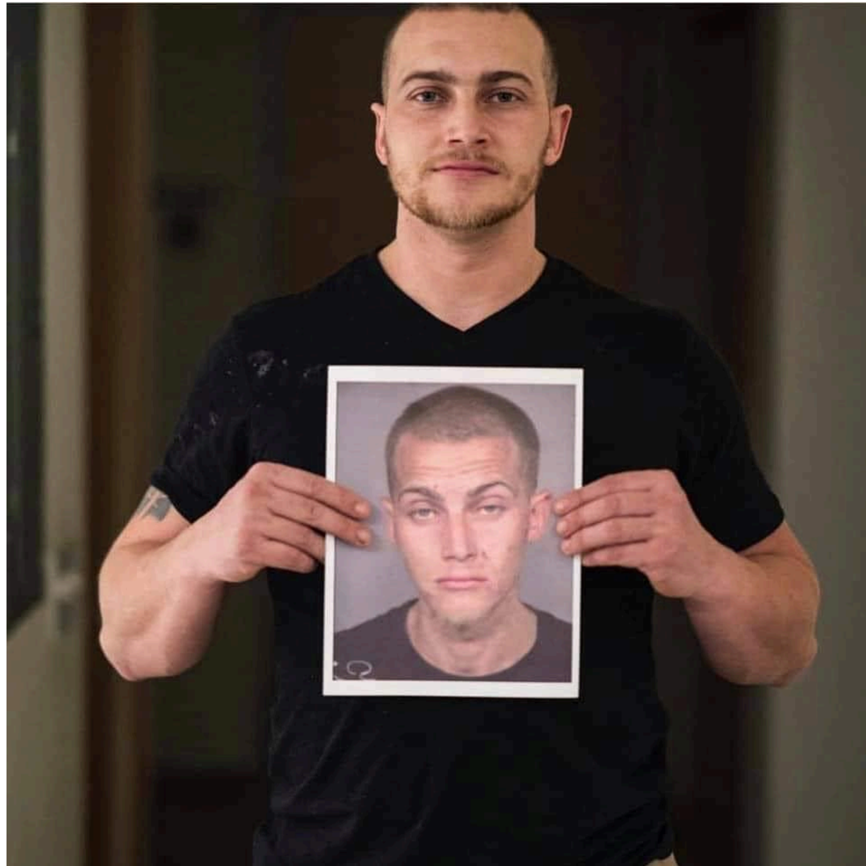
Expanding peer support services can help ameliorate the workforce shortage.

Moreover, the Obama Whitehouse Report on Occupational Licensing warned of the consequences of over-licensing in the United States and called for voluntary certification instead. Licensing is often coupled with irrelevant requirements, rules, and extreme background checks not supported by research. The over-licensing of America has led to extreme difficulties for military families to move from state to state due to the inability to acquire reciprocity for their occupational license in other states and discrimination

that leads to workers of color. For example, in Oregon, about 89% of licensed behavioral health professionals are non-Hispanic white, compared to only 68% of certified behavioral health workers.

The U.S. should support voluntary peer-run certification of peer behavioral health workers with basic or adjustable background check procedures that maximize the workforce while maintaining the safety of those served.

Addiction Recovery Autobiography



Addiction is a reality that I, along with my family, am intimately familiar with. Though I hail from Pocatello, Idaho, my formative years were spent in Camas, Washington. Eventually, I found myself tethered to Portland, Oregon. My numerous relocations were not the result of family military assignments, parental job obligations, or personal academic aspirations. Rather, I moved around a lot because of drugs and alcohol.

My family's history with addiction stretches back as far as I can trace, but I'll begin with my parents. My mother was just 16 when she had me. She left Idaho soon after, seeking to escape the drugs, violence, and poverty that marked her life. She hoped to give me a chance at a better life. Despite the odds, she succeeded, even though her own life was tragically cut short due to her opioid addiction.
Growing up in the affluent town of Camas presented challenges for me. We were not well-off financially, and my stepfather was an alcoholic. Despite these hardships, I enjoyed playing soccer, football, and basketball. I also loved fishing and bike riding. However, around the age of 12, I began experimenting with alcohol and tobacco. Within a few years, this experimentation escalated into regular partying, leading to frequent run-ins with the law.
My drug addiction strengthened in High School, and I eventually dropped out. Around this time (roughly 20023), my mother was diagnosed with fibromyalgia and received a

large prescription for Oxycotin, and I started using them. I want to be frank: this was wrong, and I take full responsibility.

I soon became addicted to Oxycontin, which I realized when I ran out of the pills and thought I had the flu, but my friend told me it was withdrawal. I knew at the time that I was in a tough spot because I was unable to function for weeks without using a pill to "get well." Opioid withdrawal for me was like getting bashed with a baseball bat wrapped in barbwire, and I spent years trying to quit. A couple of years into the Oxycontin rush, my mother's prescriber was shut down due to overprescribing. I later found that this office was referred to as a "pill farm," a location where people could receive large amounts of various addictive medications. When the pill farm shut down, the heroin dealers ramped up, leveraging an opportune moment to capitalize on an emerging consumer base. ***Something strikingly similar to the current Fentanyl crisis, which will be addressed later.***

With a vacuum in the Oxycotin market, many people I knew turned to heroin to avoid the sickness. For many of us, it started with snorting a liquid mixture, something shared by different types of "users." Heroin soon became a viable option for various individuals, including those dependent on pain management and young people like me, who were naive to the supreme addictive nature of pain medication. We became snared in a vicious cycle, and many did not make it out.

At some point, using drugs became a necessity: I've heard it described by recovering addicts as being reduced to almost an animal level, and I felt that way at times. I moved back to Idaho to live with my grandma a few times; this is known as a geographic in the recovery community, but every time, my addiction followed me. In January of 2007, my addiction took a turn for the worse after my mother died in a fatal car accident, something I had long feared as she would regularly fall asleep while driving because of her medication and heroin use. I am not alone in this; a new report from SAMSHA states that 321,566 children in the United States lost a parent to drug overdose from 2011 to 2021, according to a study published in JAMA Psychiatry.

After my mom died, I completely caved to despair and began using drugs intravenously. This was a pivotal moment in my drug use and the beginning of the last chapter. Arriving back in Portland shortly after my mom's death, my girlfriend became pregnant, and I began the long and arduous journey to sobriety. Research estimates that it takes an average of seven attempts to quit using substances, which seems reasonable if you compare how humans struggle with sugar and fatty foods.

My treatment attempts were mostly voluntary, though the one that stuck was via a criminal justice intervention. The last time I used any drugs or alcohol was July 19th, 2012, when I was arrested due to my erratic behavior within a convenience store related to my meth and heroin use. In jail, I was held with early release to treatment. I left jail and went to the Volunteers of America Men's Residential Treatment Center, where I stayed for nearly six months.

While I partially attribute the criminal justice system intervention to saving my life at age 27, I am not advocating for this as a singular solution to the complex issue of addiction and fentanyl. There were many missed intervention opportunities for me that I will highlight for the committee before discussing my post-use recovery journey. I will not dwell on circumstances that have since been rectified but focus on gaps I see persist today.

Healthcare Interventions

I found myself in various healthcare settings and was not effectively engaged despite my obvious addiction symptoms, and I will highlight two. First, I was removed by security guards several times when seeking help, primarily for using heroin in the facility. I think this could have been an opportunity for engagement and rapid medication for opioid use disorder induction or referral to treatment. Second, I was hospitalized for an abscess on my left forearm caused by my attempt to inject Vicodin (apparently, you cannot do that). During my stay at the ER, I begged and pleaded for a prescription of methadone but was denied, although a Priest did visit a couple of times. I was in terrible withdrawal and kept leaving the hospital against medical advice to get well.

Youth Based Care

I now know that I have several vulnerabilities for addiction - genetics, socioeconomic, and family use patterns - but was never taught this in school. I knew that drugs were illegal, but I also loved them the 1st time I tried them. I didn't know about addiction either, at least not as a healthcare disorder; I knew there were drug addicts but thought they were inept people. Primary prevention strategies may have been effective in helping me. Additionally, school-based substance use interventions and recovery services may have intervened on me earlier and helped me avoid a lot of problems.

Criminal Justice Interventions

I started going to jail at 15 years old, all related to my substance use. I do not believe I was ever offered treatment while in prison as an adolescent. I cycled in and out of county jail in multiple states throughout my addiction but was never provided treatment while in jail, including medication for opioid use disorders. The criminal justice system is saturated with substance users who don't have much…except for time. Investing in treatment and recovery services in carceral settings would undoubtedly facilitate the rehabilitation process.

Back to my story. I am 27 years old, exiting county jail to a residential addiction program with no driver's license, no education, no money, and no shoes, but I did have about 65% of my teeth left and warrants in two states (Idaho and Washington). As I sat in the lobby of the treatment center, I had a moment of clarity: instead of leaving and going to get high one more time, I would stay long enough to get as healthy as the men I saw eating in the chow hall.

While in treatment, I was required to do several things I was reluctant towards. One was to attend GED classes on Tuesdays and Thursdays at the Londer Learning Center, a program the criminal justice system funded to help those on probation improve their

education. This ultimately led to me receiving my GED and being awarded a scholarship to Portland Community College for 12 credits. I attended daily therapy groups led by alcohol and drug counselors and met one-on-one with my counselor every other week. Many of the counselors stated they were in recovery, which eased my suspicions and cracked the door for learning. Lastly, I was required to go to recovery meetings and build a support group. While the cognitive therapy was impactful, the integration into the recovery community was essential.

I enrolled in Portland Community College and started my educational journey during my treatment stay. In my first semester, I attended a recovery support group hosted in the women's resource center that gave me one free credit. The allure of saving money kept me engaged, and I met a faculty member who suggested that I start a recovery club. The Recovery 101 Club's mission was to destigmatize addiction by organizing community service events led by recovering students. Club organizing introduced me to student government, where I became the President of the Phi Theta Kappa Honors Society and later the Student Body President. During my tenure at PCC, I also co-founded a non-profit organization called The 4th Dimension Recovery Center. I am still the Executive Director today (I included our most recent annual report). My leadership development at PCC was profound, and I am incredibly grateful to the faculty and staff who shaped my aspirations.

I graduated from PCC and moved to Concordia University for the social work program, discontinuing student government to pursue my dreams at 4th Dimension Recovery Center, now 4D Recovery. 4D Recovery is a non-profit recovery community organization providing a variety of treatment, peer-based recovery, and housing services for adolescents and young adults with substance use disorders. As I attempted to grow 4D Recovery, I realized there needed to be more funding opportunities. I began organizing, engaging in local and state politics, and participating in service opportunities on boards, committees, and commissions.

In 2017, I co-founded Oregon Recovers, a statewide advocacy group charged with increasing services for substance use disorder. After researching the actual gap in services for people who need them, I was astonished by the contradiction that addiction is a treatable disease, but services are lacking. I decided then that I would do everything I could to change that in Oregon. Over the last seven years, I have participated in many great things in advancing recovery, which my resume illustrates in the appendix.

As I grew professionally, I lived in recovery-supportive housing for several years. This housing was inexpensive and right down the street from my treatment center. Living with other sober people provided a sanctuary from the onslaught of addictive substances lingering outside the house and provided accountability and the opportunity to develop financial skills. I exited recovery housing, lived with recovery friends, and then rented a room until I bought my first home.

Fentanyl Considerations

Quitting heroin was nearly impossible for me, but I cannot imagine the difficulties associated with fentanyl, which is changing the illicit drug market and related attempts to tackle it. Heroin and fentanyl are similar to cocaine and crack in many ways. First, crack was cheap and readily available, and the high peaked quickly and evaporated just as fast. This means a person has to use it frequently to maintain the desired effect. Fentanyl is similar in cost, availability, and effect duration, but the fatality risk is much higher, and it is consumed by a broader user market.

Where I once needed to use heroin every 6 - 8 hours to stay well, it is being reported to me that people need to use it every hour. Because of the fatality risk, this results in the frequency of potential overdose increasing exponentially. The consumption frequency also reduces the "window of opportunity" for intervention. Most people I know in recovery describe stories of fleeting ambition to quit and even sustained use despite knowing they need to quit. To be successful in treating fentanyl addiction, we need rapid access to effective tools – and one of the most effective tools in Medication for Opioid Use Disorder.

We cannot treat people who die from overdose, and Medications for Opioid Use Disorder curb the necessity to use and provide opportunities to engage in service interventions. Access to MOUDs should be widely available and accessible in multiple settings, including jails, hospitals, and via telehealth.

Tackling the Fentanyl Crisis requires investments in prevention and education, treatment, and recovery support services—the U.S. Senate Finance Committee has the opportunity to expand critical access via Medicaid and CHIP authority.

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