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Statement of
Regina M. LaBelle
Acting Director
Office of National Drug Control Policy

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Chairman Whitehouse, Co-Chairman Grassley, and members of the Caucus on International Narcotics Control, it is my pleasure to join you today to talk about the Office of National Drug Control Policy's (ONDCP) role in the Federal response to the changing drug overdose epidemic. I am honored to testify as the Acting Director of the agency where I served for eight years under the Obama Administration.

ONDCP coordinates drug policy through the development and oversight of the *National Drug Control Strategy* and the National Drug Control Budget. We develop, evaluate, coordinate, measure, and oversee the international and domestic drug-related efforts of Executive Branch agencies and, to the extent possible, ensure that those efforts complement State, local, and Tribal drug policy activities. As Acting Director, I act on critical current and emerging drug issues affecting our Nation by facilitating close coordination of Federal agency partners on drug interdiction and public health efforts; and by overseeing our budget authorities, through which I ensure that adequate resources are provided to our drug policy priorities.

The work of ONDCP is critically important at this moment in time. Provisional overdose deaths reported by the Centers for Disease Control and Prevention (CDC) show that an estimated 93,331 people died of an overdose in the 12-month period ending in December 2020.[1] Synthetic opioids other than methadone, a category that includes illicitly manufactured fentanyl and its analogues, were specifically involved in 62 percent of these overdose deaths. In addition, overdose deaths involving psychostimulants, including methamphetamine, have increased 46 percent from 2019 to 2020. Cocaine-involved overdose deaths also increased 21 percent in the same period, likely driven by an increase in cocaine overdose deaths where synthetic opioids other than methadone were also involved.

President Biden has made it clear that addressing addiction and the overdose epidemic is an urgent priority for his Administration. In the first six months of his Administration, he has taken immediate steps to expand access to critical services for people with substance use disorders.

1) The American Rescue Plan invested nearly $4 billion to allow the Department of Health and Human Services' (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) and Health Resources and Services Administration to expand access to vital mental health and substance use disorder services. The funding also included $30 million in supports for harm reduction services—a historic amount that will enhance interventions like syringe services programs that build trust and engagement with people who use drugs, and serve as a connection to care.

[1] Centers for Disease Control and Prevention, National Center for Health Statistics. *Vital Statistics Rapid Release: Provisional Drug Overdose Death Counts* through the 12-month period ending in December 2020. Available at https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm#source, accessed on July 14, 2021.

2) HHS released the *Practice Guidelines for the Administration of Buprenorphine for Treating Opioid Use Disorder*, which exempt eligible physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists and certified nurse midwives from Federal certification requirements related to training, counseling and other ancillary services that are part of the process for obtaining a waiver to treat up to 30 patients with buprenorphine. Submission and approval of a notification of intent to HHS remains necessary in order to use buprenorphine in the treatment of patients with opioid use disorder. This action expands access to evidence-based treatment by removing a critical barrier to buprenorphine prescribing.

3) The Drug Enforcement Administration (DEA) announced a new rule, effective July 28, to streamline registration requirements for opioid treatment programs that want to include a mobile component. This rule change—which was years in the making—will help provide treatment to rural and other underserved communities, including people in correctional facilities.

4) CDC and SAMHSA announced that Federal funding may now be used to purchase rapid fentanyl test strips in an effort to help curb the dramatic spike in drug overdose deaths largely driven by the use of strong synthetic opioids, including illicitly manufactured fentanyl.

5) And the President's Fiscal Year (FY) 2022 Budget includes an historic $41 billion investment for the National Drug Control Program agencies, with the most significant increases dedicated to treatment and prevention efforts.

This funding and these actions are just the start of the Biden Administration's historic commitment to ensure that the Federal Government promotes evidence-based public health and public safety actions to address this epidemic amidst a changing drug environment.

The drug environment that we currently face is considerably different than it was in the past. For instance: when the overdose epidemic began, the primary concern was prescription opioids. Today, the number of drug overdose deaths involving synthetic opioids other than methadone (which is dominated by illicit fentanyl and fentanyl analogs) has risen more than six-fold since 2014.[2] In addition to facing a different environment, the situation we face today requires an urgent response grounded in evidence and an understanding that addiction and overdoses today are driven by polysubstance use.

The COVID-19 pandemic has exacerbated addiction and the overdose epidemic. Overdose deaths were

[2] Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death, 1999-2019 on CDC WONDER Online Database, released December 2020. Extracted by ONDCP from http://wonder.cdc.gov/mcd-icd10.html on December 22, 2020.

rising prior to COVID-19, but provisional data from the CDC show during the 12-months ending in December 2020 there were 54 percent more overdose deaths involving synthetic opioids other than methadone, like fentanyl, than in the 12-month period ending in December 2019.[3] One of the most dramatic and important innovations implemented during COVID-19 was the temporary lifting of barriers to treatment so that people with substance use disorder could access necessary care. As a result, we have seen the high utilization of telehealth services. For example, a buprenorphine program in Oregon was able to transition over 90 percent of its patients to telephone counseling and remote prescribing because of changes enacted during COVID-19 by the DEA that permitted telephone induction of buprenorphine and, to some extent, changes permitting billing for these services made by the Centers for Medicare & Medicaid Services.[4] Given the increases in patient reliance on these telehealth services, it will be important to find a long term solution after the pandemic emergency declaration formally ends.

As we move forward, the Biden-Harris Administration will use our first-year drug policy priorities,[5] which were released in April, as guiding principles in our policy response while we formulate the *National Drug Control Strategy*, which is due to Congress in February 2022. These first-year drug policy priorities represent a focused approach to reducing overdoses; creating more opportunities to engage people with substance use disorders; targeting and disrupting drug trafficking networks at home and abroad, including through anti-money laundering efforts; and ultimately saving lives. The priorities provide guideposts to ensure that the Federal Government promotes evidence-based public health and public safety interventions, which includes directly addressing racial equity in drug policy and embracing a full continuum of interventions, including harm reduction. The priorities, which I will detail further, are:

- Expanding access to evidence-based treatment;
- Advancing racial equity in our approach to drug policy;
- Enhancing evidence-based harm reduction efforts;
- Supporting evidence-based prevention efforts to reduce youth substance use;
- Advancing recovery-ready workplaces and expanding the addiction workforce;

[3] Ahmad, FB, Rossen, LM, & Sutton P (2021). Provisional drug overdose death counts. National Center for Health Statistics. Available at https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm. Accessed on July 14, 2021.
[4] Buchheit BM, Wheelock H, Lee A, Brandt K, Gregg J. Low-barrier buprenorphine during the COVID-19 pandemic: A rapid transition to on-demand telemedicine with wide-ranging effects [published online ahead of print, 2021 Apr 29]. J Subst Abuse Treat. 2021;131:108444. doi:10.1016/j.jsat.2021.108444
[5] Executive Office of the President of the United States, Office of National Drug Control Policy. (2021). The Biden-Harris Administration's Statement of Drug Policy Priorities for Year One. https://www.whitehouse.gov/wp-content/uploads/2021/03/BidenHarris-Statement-of-Drug-Policy-Priorities-April-1.pdf

- Expanding access to recovery support services; and
- Reducing the supply of illicit substances.

Expanding Access to Evidence-based Treatment

One of the most important steps we can take is ensuring that people with substance use disorders can access evidence-based treatment, which can include medications for opioid use disorder (MOUD) and contingency management services. Substance use disorder is a chronic – not acute – condition that requires long-term solutions, and treatment is a first step in the journey of recovery. Already, the Administration has taken several important strides to increase access to treatment.

- In April, the Administration announced new buprenorphine practice guidelines.[6] The guidelines exempt eligible physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists and certified nurse midwives from Federal certification requirements related to training, counseling and other ancillary services that are part of the process for obtaining a waiver to treat up to 30 patients with buprenorphine. This makes care more accessible.
- In June, the Administration announced a new rule that eases restrictions on opioid treatment programs that seek to operate mobile methadone treatment clinics.[7] I recently traveled to Atlantic County, New Jersey, to see firsthand how a mobile clinic is expanding access to methadone treatment for individuals experiencing incarceration at the Atlantic County Jail.

ONDCP continues to review emergency provisions established under COVID-19 that increased patient access to MOUD treatment. SAMHSA and DEA issued guidance that exempts opioid treatment programs from the requirement to conduct an in-person evaluation to begin treating patients with buprenorphine.[8] SAMHSA also granted state requests for blanket exceptions so that some patients receiving treatment at an opioid treatment program could receive take-home medications for opioid use disorder.[9]

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[6] Practice Guidelines for the Administration of Buprenorphine for Treating Opioid Use Disorder. Department of Health and Human Services. April 28, 2021. Accessed on July 3, 2021. https://www.federalregister.gov/documents/2021/04/28/2021-08961/practice-guidelines-for-the-administration-of-buprenorphine-for-treating-opioid-use-disorder

[7] Registration Requirements for Narcotic Treatment Programs With Mobile Components, 86 FR 36681 (June 28, 2021). https://www.federalregister.gov/documents/2021/06/28/2021-13519/registration-requirements-for-narcotic-treatment-programs-with-mobile-components

[8] FAQs: Provision of methadone and buprenorphine for the treatment of Opioid Use Disorder in the COVID-19 emergency. Substance Abuse and Mental Health Services Administration. April 21, 2020. Accessed on July 3, 2021. https://www.samhsa.gov/sites/default/files/faqs-for-oud-prescribing-and-dispensing.pdf

[9] *Ibid.*

Polysubstance use among persons who use opioids is common,[10] and as previously noted, overdoses involving stimulants have increased in recent years, escalating the urgency to offer access to treatment for stimulant use disorders. Currently, the Food and Drug Administration has not approved a drug for treating stimulant use disorder.

There are psychotherapies and behavioral therapies that can help some people recover from stimulant use disorders, but these require rigorous training, practice, and active supervision to ensure fidelity to the clinical model. One particularly effective treatment for treating stimulant use disorder is contingency management therapy, sometimes called "motivational incentives." Research has shown that, unlike psychotherapy, contingency management is easily learned by community therapists, and it helps them yield better outcomes.[11]

However, despite the promising data that underlie these therapies, the federal anti-kickback statute (AKS), which is a criminal statute, and the civil monetary penalty provision prohibiting inducements to beneficiaries (codified at 42 U.S.C. §§ 1320a-7b(b) and 1320a-7a(a)(5), respectively) may constrain the ability of providers to offer contingency management program incentives to Federal health care program beneficiaries. These statutes, respectively, prohibit offering anything of value to induce a person – including a patient – to purchase or use items or services paid for by a Federal health care program and offering anything of value to influence the patient's selection of a particular provider for Medicare or Medicaid items or services. Because contingency management programs often involve payments to the patient in the form of the opportunity to earn vouchers, gift cards, or even, in some models, salaries, these statutes may be implicated. However, any assessment of the application of these laws requires a case-by-case analysis of the facts specific to the applicable contingency management program.

The HHS Office of Inspector General (OIG) has the authority to issue regulations designating specific "safe harbors" for various payment and business practices that, while potentially prohibited by broad reach of the AKS, would not be unlawful. A number of existing safe harbors could apply to contingency management programs. However, ONDCP intends to begin work with the interagency to explore needed modifications to safe-harbor rules to ensure that providers can offer incentives, in connection with a contingency management program, that do not violate these laws, since providers are unlikely to widely use these

[10] Jones CM, McCance-Katz EF. Co-occurring substance use and mental disorders among adults with opioid use disorder. *Drug Alcohol Depend*. 2019;197:78-82. doi:10.1016/j.drugalcdep.2018.12.030
[11] Petry NM, Alessi SM, Ledgerwood DM. A randomized trial of contingency management delivered by community therapists. *J Consult Clin Psychol*. 2012;80(2):286-298. doi:10.1037/a0026826

interventions without further clarity. ONDCP is also looking at other opportunities to expand access to contingency management interventions and digital therapies that provide care for people with methamphetamine use disorder. These efforts fall within ONDCP's development of a broader framework to address methamphetamine use, in which our efforts are focused on expanding access to the evidence-based treatments we know exist, as well as addressing the supply of methamphetamine.

In addition, ONDCP is focused on reducing barriers for pregnant and postpartum persons with substance use disorders to safely access prenatal care and evidenced-based treatments. Sometimes these barriers may be prior to initiating treatment, as pregnant persons are less likely than nonpregnant persons to get an appointment with a buprenorphine-waived prescriber.[12] Other barriers may exist after treatment is initiated, such as policies that punish pregnant and postpartum persons merely for acknowledging their substance use disorder, sometimes by removing their children or imposing criminal penalties. These actions are unacceptable, discriminatory, and may discourage those who are struggling with substance use from seeking treatment.

Reducing the Supply of Illicit Substances

In addition to our efforts to expand access to treatment, supply reduction is an important part of the United States' drug policy and efforts to bend the curve on the overdose epidemic.

The Biden-Harris Administration is actively taking steps to reduce the supply of illicit substances in the United States. While synthetic opioids, such as illicitly manufactured fentanyl, its analogues, and non-fentanyl synthetic opioids, have driven up overdose deaths since 2015,[13,14,15] the United States is also seeing increased availability and use of methamphetamine and other synthetic drugs. Methamphetamine is available in the Western and Midwest United States, and recently has become more prevalent in the

[12] Patrick SW, Richards MR, Dupont WD, et al. Association of Pregnancy and Insurance Status With Treatment Access for Opioid Use Disorder. *JAMA Netw Open*. 2020;3(8):e2013456. Published 2020 Aug 3. doi:10.1001/jamanetworkopen.2020.13456

[13] Gladden, R. M., Martinez, P., & Seth, P. (2016). Fentanyl Law Enforcement Submissions and Increases in Synthetic Opioid-Involved Overdose Deaths – 27 States, 2013–2014. *Morbidity and Mortality Weekly Report (MMWR)*, *65*(33), 837–843. https://doi.org/10.15585/mmwr.mm6533a2.

[14] Peterson, A. B., Gladden, R. M., Delcher, C., Spies, E., Garcia-Williams, A., Wang, Y., Halpin, J., Zibbell, J., McCarty, C. L., DeFiore-Hyrmer, J., DiOrio, M., & Goldberger, B. A. (2016). Increases in Fentanyl-Related Overdose Deaths – Florida and Ohio, 2013–2015. *Morbidity and Mortality Weekly Report (MMWR)*, 65, 844–849. http://dx.doi.org/10.15585/mmwr.mm6533a3.

[15] O'Donnell, J. K., R. Gladden, R. M., & Seth, P. (2017). Trends in Deaths Involving Heroin and Synthetic Opioids Excluding Methadone, and Law Enforcement Drug Product Reports, by Census Region – United States, 2006–2015. *Morbidity and Mortality Weekly Report (MMWR)*, *66*(34), 897–903 https://doi.org/10.15585/mmwr.mm6634a2.

Northeast.[16] Moreover, the use of cultivated drugs such as heroin and cocaine, often adulterated by synthetic opioids, continues to pose a risk of overdose for people who use drugs.[17]

The majority of illicit drugs that enter the United States are smuggled across the Southwest border. Seizures of illicit drugs on the Southwest border show that the total quantity of all drugs seized by U.S. Customs and Border Protection (CBP) at the Southwest border decreased in April 2020, but rebounded in May to pre-pandemic levels, where it remained until October 2020 when seizures at the Southwest border reached 61,326 pounds. They have since started to decline to 37,677 pounds in May of this year. Specifically, fentanyl seizures on the Southwest border increased, from 245 pounds in March 2020 to a peak of 1,171 pounds in October 2020. Fentanyl seizures on the Southwest border have declined since then to 934 pounds in May of this year, but still remain above pre-pandemic levels.[18]

That's why this Administration has moved quickly to work with key partners in the Western Hemisphere, such as Mexico and Colombia, to shape a collective and comprehensive response to illicit drug production that includes bilateral efforts to stem the flow of illicit substances, expand effective state presence, develop infrastructure, and respect the rule of law. In Mexico, for example, we are working closely with them to improve port security, strengthen their ability to detect and seize synthetic opioids, and counter transnational organized crime groups. We expect to continue collaborating with Mexico, including in the upcoming Cabinet-level security dialogue. Meanwhile, in Colombia, we are working to address historic coca cultivation and potential production numbers through a holistic approach that emphasizes development, rural security, interdiction, and eradication efforts.

We are also engaging with Mexico and Canada through regional forums such as the North American Drug Dialogue to share information and best practices on public health and public safety approaches. Additionally, we are establishing multilateral and bilateral forums to engage with China, India, and other source countries to disrupt the global flow of synthetic drugs and their precursor chemicals.

Further, ONDCP is strengthening the U.S. Government's capacity to disrupt the manufacture, marketing,

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[16] https://www.dea.gov/sites/default/files/2021-02/DIR-008-21%202020%20National%20Drug%20Threat%20Assessment_WEB.pdf

[17] U.S. Department of Justice, Drug Enforcement Administration, Diversion Control Division. (2020). Tracking Fentanyl and Fentanyl-Related Compounds Reported in NFLIS-Drug, by State: 2018–2019. *National Forensic Laboratory Information System, Special Maps Release*. https://www.nflis.deadiversion.usdoj.gov/DesktopModules/ReportDownloads/Reports/NFLISDrugSpecialRelease-Fentanyl-FentanylSubstancesStateMaps-2018-2019.pdf.

[18] U.S. Customs and Border Protection. Drug Seizure Statistics. Department of Homeland Security. Updated June 3, 2021. Accessed July 6, 2021. https://www.cbp.gov/newsroom/stats/drug-seizure-statistics

money, and movement of synthetic drugs by addressing illicit Internet drug sales and the continually evolving techniques in illicit financial transactions. Illicit and diverted drugs enter the United States from global suppliers as the result of a long and complex process involving manufacture, concealment, movement, purchase, and delivery, and are bought and sold in communities across America. The illicit drugs change hands several times during the process, which often necessitates the transfers of money either as payment for services or for delivery of the final product. Traditionally, street-level sales of illegal drugs have been, and for the most part still are, conducted with cash, creating immediately liquid assets that are almost impossible to track. Drug Trafficking Organizations (DTOs) employ various techniques to move and launder drug proceeds into, within, and out of the United States. Preferred methods used by DTOs to launder illicit proceeds are Bulk Cash Smuggling, Trade-Based Money Laundering, unlicensed Money Service Businesses, and through the banking sector. Additional money laundering vulnerabilities DTOs exploit include real estate, casinos, and third-party money launderers.[19]

According to the El Paso Intelligence Center's (EPIC) National Seizure System, in 2019 there were over 3,000 bulk currency seizures in the United States. This represents more than $368 million US seized, a 62 percent increase from 2018. Between 2010 and 2018, the volume of bulk currency seized has steadily dropped, with 2019's increase being an outlier to this trend. The number of seizure events in 2019 (3,454) was a 39 percent increase from the previous year (2,487).[20]

Virtual currencies like Bitcoin have been increasing in popularity, due in part to the ability of virtual currencies to change hands rapidly without limits on the amount being transferred. There are over 2,000 distinct virtual currencies in circulation, with more being developed every year; however, Bitcoin continues to be the most widely used due to its status as one of the original virtual currencies. Bitcoin is sometimes a stand-in term for virtual currency as a whole. In recent years, virtual currency exchangers have emerged to ease the conversion of fiat currency into virtual currency, and vice versa.

ONDCP believes that in order to counter these DTO's illicit financial structures, a whole-of-government approach is needed. Focused initiatives such as the Department of the Treasury's (Treasury) Office of Foreign Assets Control Foreign Narcotics Kingpin Designation Act (Kingpin Act) continue to aggressively target narcotics traffickers, and powerful tools such as Treasury's Financial Crimes Enforcement Network's (FinCENs) use of Geographic Targeting Orders assist law enforcement and FinCEN in gathering information necessary to combat money laundering and other illicit financial activity by DTOs. These

[19] Drug Enforcement Administration, 2020 National Drug Threat Assessment. 2020 National Drug Threat Assessment (NDTA) (dea.gov)
[20] Ibid.

targeted orders under the Bank Secrecy Act (BSA) impose additional recordkeeping or reporting requirements on domestic financial institutions or other businesses in a specific geographic area.

On June 30, 2021, FinCEN announced the first set of government-wide anti-money laundering/countering the finance of terrorism (AML/CFT) priorities, as required by the Anti-Money Laundering Act of 2020. Consistent with the National Strategy for Combating Terrorist and Other Illicit Financing, the AML/CFT priorities reflect a mix of new and long-standing threats to the U.S. financial system and national security. These threats involve attempts to exploit perceived legal, regulatory, supervisory, or enforcement vulnerabilities in the U.S. financial system that may be associated with a particular product, service, activity, or jurisdiction.[21]

Within the next six months, new financial institution regulations will be issued by FinCEN and Federal and state institutions to implement the new AML/CFT priorities. Those regulations will require financial institutions to integrate into their BSA compliance programs the emerging and long-standing threats to the U.S. financial system and national security identified in the AML/CFT priorities.[22]

FinCEN's announcement aligns with President Biden's National Security Study Memorandum, issued on June 3, 2021, making anticorruption efforts a core national security interest, and indicating that domestic and foreign corrupt actors and their financial facilitators seek to take advantage of vulnerabilities in the U.S. financial system to launder their assets and obscure the proceeds of crime.[23]

As for interagency mechanisms, strategically placed coordination centers continue to be great examples of information sharing tools focused on illicit financial activities. For example, High Intensity Drug Trafficking Areas (HIDTAs) supported by ONDCP; the Department of Justice's Organized Crime Drug Enforcement Task Forces (OCDETF); DEA Task Forces; the EPIC, jointly operated by DEAs and CBP; U.S. Immigration and Customs Enforcement's (ICEs) Trade Transparency Units; and ICE's Border Enforcement Security Taskforces (BESTs) allow agencies to pool confidential sources, intelligence, resources, and investigations to use evidence-based approaches to disrupt and dismantle entire organizations which create long-term gain and build a systemic means to longitudinally target DTO's illicit financial activities.

[21] Ledbetter, Lisa M., et al. FinCEN Issues First U.S. Priorities For Anti-Money Laundering And Counter-Terrorism Financing. *Mondaq*. https://www.mondaq.com/unitedstates/money-laundering/1090524/fincen-issues-first-us-priorities-for-anti-money-laundering-and-counter-terrorism-financing.
[22] Ibid.
[23] Ibid.

Advancing Racial Equity in our Approach to Drug Policy

As we work on efforts to expand access to treatment and reduce the supply of illicit substances, an important part of our work is to incorporate the cross-cutting issue of advancing racial equity in our approach to drug policy.[24] We know that existing racial inequalities result in disproportionate rates of arrest, conviction, and incarceration, disparate access to care, differential treatment in health care systems, and overall poorer health outcomes. That's why the Biden-Harris Administration supports the "Eliminating a Quantifiably Unjust Application of the Law (EQUAL) Act" and its complete elimination of the unfair sentencing disparity between crack cocaine and powder cocaine.

Additionally, for many people with substance use disorders, access to quality care in the United States is inadequate, but for Black, Indigenous, and People of Color (BIPOC), the situation is worse. A recent study showed that Black individuals generally entered addiction treatment four to five years later than white individuals, a disparity that remained even when controlling for socioeconomic status.[25] In Latino communities, those who needed treatment for substance use disorders were less likely to access care than non-Latinos.[26] This discrepancy in treatment access is important to address at a time when overdose rates are increasing for some communities of color.[27]

Our first-year actions are focused on acknowledging decades of harms to BIPOC communities and taking the steps necessary to begin correcting them. We are working to establish a research agenda to meet the needs of historically underserved communities which includes identifying data gaps related to drug policy.

ONDCP supports allocating Federal resources to advance fairness and opportunities consistent with Executive Order 13985, "Advancing Racial Equity and Support for Underserved Communities Through the Federal Government." ONDCP's FY 2023 funding guidance will direct agencies to identify opportunities to

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[24] Mendoza, S., Rivera-Cabrero, A., & Hansen, H. (2016). Shifting blame: Buprenorphine prescribers, addiction treatment, and prescription monitoring in middle-class America. *Transcultural Psychiatry*, *53*(4), 465–487. https://doi.org/10.1177/1363461516660884

[25] Lewis, B., Hoffman, L., Garcia, C., & Nixon, S. (2018). Race and socioeconomic status in substance use progression and treatment entry. *Journal of Ethnicity in Substance Abuse*, *17*(2), 150–166. https://doi.org/10.1080/15332640.2017.1336959

[26] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (October 25, 2012). *The NSDUH Report: Need for and Receipt of Substance Use Treatment among Hispanics.* Rockville, MD. https://www.samhsa.gov/data/sites/default/files/NSDUH117/NSDUH117/NSDUHSR117HispanicTreatmentNeeds2012.pdf.

[27] U.S. Centers for Disease Control and Prevention, National Center for Health Statistics. (2020). *Multiple Cause of Death 1999-2019*. CDC WONDER Online Database, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. http://wonder.cdc.gov/mcd-icd10.html

promote equity in their budgets. ONDCP will use the results of the Executive Order and our collaboration with National Drug Control Program agencies for allocating Federal drug control resources in a manner that increases investment in underserved communities.

Enhancing Evidence-based Harm Reduction Efforts

Harm reduction organizations provide an opportunity to build connections between people who use drugs and healthcare systems, often through peer support workers. Regular engagement between harm reduction staff and people who use drugs builds trust,[28] allowing for an ongoing exchange of information, resources, beneficial contact, and the potential to develop connections to healthcare systems.

As previously mentioned, access to quality healthcare is essential, but often inaccessible for people with substance use disorders. For many people who use drugs, their first point of contact may be outside of the mainstream healthcare system and through harm reduction programs. For example, critical services offered at syringe service programs (SSPs) may include providing the overdose reversal drug naloxone, sterile syringes, drug testing strips, and testing for the human immunodeficiency virus (HIV) and viral hepatitis, including hepatitis C. Research has shown that SSPs reduce HIV prevalence in conjunction with other support services.[29,30,31]

ONDCP is integrating and building linkages between funding streams to support SSPs, and is working to find ways to support the use of Federal funds to purchase syringes and other critical harm reduction services. In April, CDC and SAMHSA announced that Federal funds may now be used to purchase rapid fentanyl test strips.[32] In addition to this effort, ONDCP is working to identify opportunities to expand access, awareness, and training in naloxone in communities with the highest rates of overdose.

The Administration is encouraging additional research on the clinical effectiveness of emerging harm reduction practices in real-world settings and test strategies for implementing established evidence-based

[28] Bartlett, R., Brown, L., Shattell, M., Wright, T., & Lewallen, L. (2013). Harm reduction: compassionate care of persons with addictions. *Medsurg nursing: official journal of the Academy of Medical-Surgical Nurses*, *22*(6), 349–358. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4070513/
[29] Hurley, S., Jolley, D., & Kaldor, J. (1997). Effectiveness of needle-exchange programmes for prevention of HIV infection. *The Lancet (British Edition)*, *349*(9068), 1797–1800. https://doi.org/10.1016/S0140-6736(96)11380-5
[30] World Health Organization. (2004). *Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injection drug users.* Geneva, Switzerland. http://www.who.int/hiv/pub/idu/e4a-needle/en/
[31] National Institutes of Health. (1997). *Consensus Development Statement: Interventions to prevent HIV risk behaviors, February 11-13, 1997*:7-8 Rockville, MD. https://consensus.nih.gov/1997/1997PreventHIVRisk104html.htm
[32] Federal Grantees May Now Use Funds to Purchase Fentanyl Test Strips, CDC and SAMHSA Press Release, April 7, 2021. https://www.cdc.gov/media/releases/2021/p0407-Fentanyl-Test-Strips.html

practices. We are developing and evaluating the impact of educational materials featuring evidence- based harm reduction approaches that link people who use drugs with harm reduction, treatment, recovery support, health, and social services and evaluate their effectiveness. It is important to note that this is the first time that strengthening harm reduction activities has been identified by the Executive Branch as a top drug policy priority.

Supporting Evidence-based Prevention Efforts to Reduce Youth Substance Use

Preventing youth substance use, including the use of alcohol, tobacco, and illicit drugs, is essential to young people's healthy growth and development. Delaying substance use until after adolescence also decreases the likelihood of developing a substance use disorder later in life.[33]

Scaling up science-based, community-level interventions to prevent and reduce youth and young adult use through ONDCP's Drug-Free Communities (DFC) Support Program can be an essential element of a comprehensive approach to prevention policy.

In the first year of this Administration, ONDCP is using its budget authorities to call on prevention programs that receive Federal funding to use evidence-based approaches to deliver and monitor the fidelity to and outcomes of those approaches through continuous quality improvement. Connected to this, we will conduct an inventory of prevention programs developed with Federal funding, and identify evaluations and assessments of their outcomes and effectiveness.

In order to advance the adoption of evidence-based prevention models, ONDCP is looking at specific opportunities for its DFC program and CDC to enhance culturally competent prevention programming, specifically to identify opportunities for prevention programming in communities with high rates of adverse childhood experiences. Additionally, we will work to update evidence-based prevention curricula for families of school-aged children, including options that can be administered at home; identify grants or other opportunities to increase substance use disorder/ mental health screenings through school nurses, school-based health centers and back-to-school physicals; encourage more widespread use of interventions and linkage to care and treatment, as clinically appropriate; and support the adoption of evidence-based care approaches for adolescents in juvenile justice programs.

[33] Rioux, C., Castellanos-Ryan, N., Parent, S., Vitaro, F., Tremblay, R., & Séguin, J. (2018). Age of Cannabis Use Onset and Adult Drug Abuse Symptoms: A Prospective Study of Common Risk Factors and Indirect Effects. *Canadian Journal of Psychiatry*, *63*(7), 457–464. https://doi.org/10.1177/0706743718760289

Advancing Recovery-ready Workplaces and Expanding the Addiction Workforce

While the Americans with Disabilities Act of 1990 provides some protections for people with substance use disorders, employers are often reluctant to hire a person with a history of substance use disorder.[34] This reluctance may be based on misconceptions and fears, negative attitudes, and even misplaced beliefs that discrimination against people with substance use disorders (either in recovery or not) is acceptable.[35]

At the same time as people in recovery are being excluded from employment, the Nation's addiction workforce is experiencing staffing shortages,[36] and we need to address future needs for various behavioral health occupations.[37] Hiring diverse practitioners who reflect the communities and cultures they serve is also an important workforce issue.[38] The United States needs skilled addiction care providers to provide the array of services necessary to meet the needs of those with behavioral health conditions, especially in light of the significant Federal Government investments in the addiction treatment infrastructure and belief in both the short-term and long-term benefits of these investments.

ONDCP promotes the adoption of recovery-ready workplace strategies by conducting a landscape review of existing programs, as well as outreach to State, local, and Tribal governments, employers, and members of the workforce, including opportunities that support recovery in the workplace and remove hiring and employment barriers. We also provide recommendations to ensure that all communities (including rural and underserved areas) have access to these programs, as well as identifying a research agenda to examine existing recovery-ready workplace models. We are identifying ways in which the Federal Government can remove barriers to employment and expand employment opportunities for people in recovery from addiction, and we are producing guidelines for Federal managers on hiring and working with people in recovery from a substance use disorder. ONDCP intends to lead by example: several ONDCP employees are people in long-term recovery who are using their experience to improve our policies and make treatment and

[34] See 29 C.F.R. § 1630.3(a) and (b) (regulations implementing Title I of the Americans with Disabilities Act of 1990. https://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title29/29cfr1630_main_02.tpl.
[35] Barry, C., McGinty, E., Pescosolido, B., & Goldman, H. (2014). Stigma, Discrimination, Treatment Effectiveness, and Policy: Public Views about Drug Addiction and Mental Illness. *Psychiatric Services, 65*(10), 1269–1272. https://doi.org/10.1176/appi.ps.201400140
[36] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce, National Center for Health Workforce Analysis. (2018). State-Level Projections of Supply and Demand for Behavioral Health Occupations: 2016-2030. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/state-level-estimates-report-2018.pdf.
[37] U.S. Department of Health and Human Services, Health Resources and Services Administration, Health Workforce. (2020). Behavioral Health Workforce Projections, 2017-2030. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/bh-workforce-projections-fact-sheet.pdf.
[38] Ma, A., Sanchez, A., & Ma, M. (2019). The Impact of Patient-Provider Race/Ethnicity Concordance on Provider Visits: Updated Evidence from the Medical Expenditure Panel Survey. Journal of Racial and Ethnic Health Disparities, 6(5), 1011–1020. https://doi.org/10.1007/s40615-019-00602-y

recovery easier for those who follow. In addition, we continue to engage persons with "lived experience" in the development of all levels of drug policy.

Expand Access to Recovery Support Services

We know that addiction is a chronic condition, and that providing support for people in recovery is an essential part of the continuum of care for substance use disorders. Recovery support services are offered in various institutional- and community-based settings and include peer support services and engagement, recovery housing, recovery community centers, and recovery programs in high schools and colleges. Scaling up the capacity and infrastructure of these programs will create strong resource networks to equip communities to support recovery for everyone. The required infrastructure includes a safe, reliable, and affordable means of transportation to access recovery support services.

ONDCP will work with Federal partners, State, local, and Tribal governments, and recovery housing stakeholders to begin developing sustainability protocols for recovery housing, including certification, payment models, evidence-based practices, and technical assistance.

CONCLUSION

Addressing addiction and the overdose epidemic is an urgent issue facing the Nation that has only been made worse during the COVID-19 pandemic. We have lost close to one million people to overdose since this epidemic began.[39] The Biden-Harris Administration's drug policy priorities look at addiction and overdose broadly, and are designed to bend the curve of overdose deaths by improving our addiction infrastructure and address shortcomings in how our country treats addiction. Critically, these priorities are based on science and evidence. We need to follow the science, because the science will lead us to the right answers. We look forward to working with Congress on these important issues to turn the tide on an epidemic that has lasted far too long and taken too many lives.

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[39] From 1999 through 2019, 840,565 Americans died from drug overdose. [Centers for Disease Control and Prevention. (2020). Multiple Cause of Death, 1999-2019. *CDC WONDER*. Extracted by ONDCP from http://wonder.cdc.gov/mcd-icd10.html on January 22, 2021].