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Statement of
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Chairwoman Eshoo, Ranking Member Guthrie, and Members of the Subcommittee, it is my pleasure to discuss the Biden-Harris Administration's drug policy priorities and the activities of the Office of National Drug Control Policy (ONDCP). I am honored to testify as the Acting Director of the agency where I served for eight years under the Obama Administration. I do not take this honor lightly – the issues of addiction and overdose are personal to me. Like many of you, and like millions of your constituents, my family has lived experience with substance use disorders. So in addition to my role as the President's acting chief advisor on drug policy matters, I also understand that my responsibility is to advocate for people with substance use disorders, for balanced approaches to drug policy that include public health and public safety, and for greater inclusion, equity, and civil rights in our efforts to tackle an addiction and overdose epidemic that has been exacerbated by the COVID-19 pandemic.

While the origins of the overdose epidemic began with prescription opioids, it has not remained static. The issues and the drug environment we face today have changed considerably, and so too must the strategies that we pursue to address the addiction epidemic.

Our plan, therefore, does three things. First, it approaches substance use disorders as chronic – not acute – conditions that require long-term solutions. Second, the policy priorities look at the lifecycle of today's addiction epidemic by incorporating actions across the continuum of prevention, treatment and recovery. Beyond preventing substance use disorders, the policy priorities identify how to treat these chronic conditions, reduce the harms associated with illicit substance use and prescription drug misuse, and help people with substance use disorders sustain their recovery. Lastly, we look at disrupting drug trafficking networks that provide the substances that are misused and put our families and communities in harm's way.

The latest provisional data from the Centers for Disease Control and Prevention (CDC) show that an estimated 88,000 people died of an overdose in the 12-month period ending in August 2020, a 26.8 percent increase, from the past 12 months.[1] In the period from 2015 to 2019, drug overdose

[1] Ahmad, F. B., Rossen, L. M., & Sutton P. (2021). Provisional drug overdose death counts. *Centers for Disease Control and Prevention*. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

deaths rose by 35 percent.[2] This is a greater rate of increase than for any other type of injury death in the United States.[3] The CDC data also show us who is the most affected: people 35-44 years old are dying at the highest rate, and people 25-34 are not far behind.[4] It is also important to note that age-adjusted drug overdose deaths involving synthetic opioids other than methadone (which includes fentanyl analogs) continue to increase.[5] What's more, data also suggest that recent increases in overdose mortality[6] have underscored systemic inequities in our Nation's approach to criminal justice and prevention, treatment, and recovery support.

President Biden has made it clear that addressing the overdose and addiction epidemic is an urgent priority for his Administration, and I deeply appreciate the support Congress has already provided on this important priority. The American Rescue Plan Act of 2021, which President Biden signed into law last month, appropriated nearly $4 billion to the Substance Abuse and Mental Health Services Administration and the Health Resources and Services Administration to expand access to vital behavioral health services. This funding is necessary. We need to make sure that the money we are spending is effectively coordinated across the Federal Government and State, local, and Tribal communities, and that it creates more opportunities for people with substance use disorders to access evidence-based services when and where they need them. It is only through building these connections that we can engage people in treatment, and support them through their recovery.

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[2] In 2018, drug overdose death declined (by four percent) for the first time since at least 1999, but resumed their ascent to unprecedented levels in 2019 [Hedegaard, H., Miniño, A.M., Wagner, M. (2020). Drug Overdose Deaths in the United States, 1999-2019. *NCHS Data Brief No. 304*. https://www.cdc.gov/nchs/products/databriefs/db394.htm].

[3] From 2015 to 2019, the numbers of U.S. injury deaths by firearms increased by ten percent, those by suicide increased by eight percent, those by homicide by eight percent, and those by motor vehicle crash by four percent. Injury death categories are not mutually exclusive. For example, 4,777 suicides in 2019 were by drug overdose [U.S. Centers for Disease Control and Prevention, National Center for Health Statistics. (2020). *Underlying Cause of Death 1999-2019*. CDC WONDER Online Database. http://wonder.cdc.gov/mcd-icd10.html.

[4] Hedegaard, H., Miniño, A. M., & Wagner, M. (2020). Drug Overdose Deaths in the United States, 1999-2019. *NCHS Data Brief, 394*. Figure 2: Drug overdose death rates among those aged 15 and over, by selected age group. Centers for Disease Control and Prevention, National Center for Health Statistics. https://www.cdc.gov/nchs/products/databriefs/db394.htm.

[5] *Ibid*.

[6] U.S. Centers for Disease Control and Prevention, National Center for Health Statistics. (2020). *Underlying Cause of Death 1999-2019* on CDC WONDER Online Database, released 2020. Extracted by ONDCP from http://wonder.cdc.gov/mcd-icd10.html on January 22, 2021.

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.

As I mentioned, a lot of this work is done in the formulation and implementation of the Administration's *National Drug Control Strategy*, the blueprint for addressing drug use and its consequences. During an inauguration year, to give a new Administration sufficient time to develop a *National Drug Control Strategy*, ONDCP is required by statute to issue a new Administration's drug policy priorities by April 1, which ONDCP has done, with a complete *Strategy* due February 1 the following year.[7]

Understanding our statutory responsibilities and the critical urgency of the addiction and overdose epidemic, ONDCP issued the Biden-Harris Administration's Statement of Drug Policy Priorities[8] on April 1. These drug policy priorities represent a focused approach to reducing overdoses, creating more opportunities to engage with people with substance use disorders, and ultimately save lives. The priorities provide guideposts to ensure that the Federal Government promotes evidence-based public health and public safety interventions. They also directly address racial equity in drug policy and the need to embrace a full continuum on interventions, including harm reduction. The priorities are:

- Expanding access to evidence-based treatment;
- Advancing racial equity in our approach to drug policy;

[7] Section 706(a) of the Office of National Drug Control Policy Authorization Act of 1998, as amended (21 U.S.C. § 1705(a)). *See* https://www.law.cornell.edu/uscode/text/21/1705

[8] 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

- Enhancing evidence-based harm reduction efforts;
- Supporting evidence-based prevention efforts to reduce youth substance use;
- Reducing the supply of illicit substances;
- Advancing recovery-ready workplaces and expanding the addiction workforce; and
- Expanding access to recovery support services.

In the first year, the Biden-Harris Administration will work through ONDCP to coordinate with other White House components and its Federal agency partners – as well as with Congress – to begin addressing these priorities.[9] I will discuss each of them in more detail below.

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. For far too long, people with substance use disorders and those in recovery from them have faced stigma, judgment, and exclusion in healthcare, housing, employment, and other sectors.[10] President Biden has emphasized that ensuring that Americans have access to affordable, high-quality healthcare and achieving universal healthcare is the most crucial step in addressing substance use disorders, and I could not agree more. That's why our policy priorities emphasize the importance of expanding access to evidence-based treatment through a number of different channels.

In our first year, the Biden-Harris Administration will take steps to ensure that health insurers and group health plans that offer mental health and substance use treatment and services provide the same level of benefits for those services that they do for other medical care. We will evaluate progress made since the 2016 Mental Health and Substance Use Disorder Parity Task Force

[9] U.S. Government Accountability Office (March 2020). *Drug Misuse: Sustained National Efforts Are Necessary for Prevention, Response, and Recovery*. GAO-20-474. Washington, DC. https://www.gao.gov/assets/gao-20-474.pdf
[10] van Boekel, L., Brouwers, E., van Weeghel, J., & Garretsen, H. (2013). Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review. *Drug and Alcohol Dependence*, *131*(1), 23–35. https://doi.org/10.1016/j.drugalcdep.2013.02.018

issued its recommendations[11] and identify additional actions necessary to complete these recommendations. This will include developing and establishing a working group with healthcare insurers and employers to promote full compliance of the Mental Health Parity and Addiction Equity Act to eliminate discriminatory barriers to mental health and substance use disorder services.

There are also several action items the Biden Harris Administration will pursue that address lifting barriers to MOUD and making medications more accessible, including removing unnecessary barriers to prescribing buprenorphine and identifying opportunities to expand low-barrier treatment services; reviewing policies relating to methadone treatment and developing recommendations to modernize it; expanding access to evidence-based treatment for incarcerated individuals; and publishing final rules regarding telemedicine special registration and mobile opioid treatment units that provide methadone.

ONDCP will review evaluations and explore making permanent the actions implemented during the COVID-19 pandemic national emergency, as well as evaluating the continuation of Medicaid and Medicare reimbursements for these telehealth services.

We understand that polysubstance use is common, and overdoses involving stimulants have increased in recent years, escalating the urgency to offer access to treatment for stimulant use disorders. Evidence-based treatments for stimulant use disorders exist – Contingency Management (Motivational Incentives) is the one supported by the best evidence. Our policy priorities include identifying and exploring options to addressing policy and reimbursement barriers to providing evidence-based treatment for stimulant use disorder.

In addition, we will explore the existing landscape, identify barriers, and establish policy to help pregnant women with substance use disorder get the prenatal care and addiction treatment they need, without fearing that they will lose custody of their child or face criminal sanctions.

[11] Executive Office of the President of the United States. (2016). *The Mental Health and Substance Use Disorder Parity Task Force Final Report.* Washington, DC. https://www.hhs.gov/sites/default/files/mental-health-substance-use-disorder-parity-task-force-final-report.PDF

Advancing Racial Equity in our Approach to Drug Policy

Underlying our work on treatment access and other priorities is a clear and discernable need to take steps that advance racial equity [12] in our approach to drug policy. 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 poorer health outcomes. For many people with substance use disorders, access to 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 4-5 years later than White individuals, a disparity that remained even when controlling for socioeconomic status.[13] In Latino communities, those who need treatment for substance use disorders were less likely to access care than non-Latinos.[14] This discrepancy in treatment access is important to address at a time when overdose rates are increasing for some communities of color.[15]

Our first-year actions are focused on, first, acknowledging decades of harms to BIPOC communities, and then taking the steps necessary to begin to correct them. We will focus on establishing a research agenda to meet the needs of historically underserved communities. This will include identifying data gaps related to drug policy to target unmet needs in diverse communities. ONDCP will participate in an interagency working group to agree on specific policy priorities for criminal justice reform, in collaboration with the Domestic Policy Council and other White House components.

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[12] 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

[13] 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

[14] 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

[15] 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

We will also develop a drug budget that includes an accounting and analysis of how Federal dollars meet the needs of diverse populations. We will shape drug budget recommendations to target resources to address equity issues and direct agencies to develop ways to collect budget data, when presently unavailable, that is disaggregated by demographic categories.

Further, we will identify culturally competent and evidence-based practices for serving BIPOC across the continuum of care that includes prevention, harm reduction, treatment, and recovery services. As part of this, we will promote integration of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Healthcare for providers of substance use disorder prevention, treatment, and recovery support services**,** starting with a review of CLAS standards by Executive departments and agencies with healthcare roles.[16]

Enhancing Evidence-based Harm Reduction Efforts

Harm-reduction organizations provide an opportunity for connections between people who use drugs and healthcare systems, often with peer support workers. Regular engagement between harm reduction staff and people who use drugs builds trust,[17] allowing for an ongoing exchange of information, resources, and contact. Harm reduction staff can build trust over time with patients, making them trusted messengers, and placing them in a position where they can effectively encourage people who use drugs to request services.

As we have mentioned previously, access to quality healthcare, treatment, and recovery support services is essential, but largely inaccessible for many people with substance use disorders. For many people who use drugs, their first point of contact may be outside of the mainstream

[16] Office of Minority Health, U.S. Department of Health and Human Services. (2013). *National standards for culturally and linguistically appropriate services in health and health care: A blueprint for advancing and sustaining CLAS policy and practice*. Washington, DC. Office of Minority Health, U.S. Department of Health and Human Services. https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf

[17] 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/

healthcare system and through harm reduction programs. Services offered at Syringe Services Programs (SSPs) may include providing the overdose reversal drug naloxone, sterile syringes, fentanyl test strips, and testing for human immunodeficiency virus (HIV) and hepatitis C virus. Research has shown that SSPs reduce HIV prevalence.[18,19,20]

ONDCP will focus on integrating and building linkages between funding streams to support SSPs. This will include identifying state laws that limit access to SSPs, naloxone, and other services. We will also highlight and advance best practices for distribution and use of fentanyl test strip services, standards for fentanyl test strip kits, and the use of fentanyl test strips as part of a strategy to engage individuals into healthcare systems. Further, we will examine naloxone availability in counties that have high rates of overdose and identify opportunities to expand access, awareness, and training in targeted areas among pharmacists, clinicians, peer support workers, family and community members, and people who use drugs.

ONDCP will also support research on the clinical effectiveness of emerging harm reduction practices in real-world settings and test strategies for implementing established evidence-based practices. We will develop and evaluate 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. These approaches will involve a diverse range of community members, including first responders and law enforcement, in evidence-based approaches that address overdose and provide police-assisted access to harm reduction, treatment, recovery support, and other services.

[18] 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
[19] 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/
[20] 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

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.[21]

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 will use its budget authorities to ensure that prevention programs that receive Federal funding 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 will look at specific areas, including actions to identify opportunities for its DFC program and CDC to enhance culturally competent prevention programming; identify opportunities for prevention programming in communities with high rates of adverse childhood experiences; 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.

[21] 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

Reducing the Supply of Illicit Substances

The Biden-Harris Administration will take steps to reduce the supply of illicit substances in the United States. Along with prevention, harm reduction, treatment, and recovery efforts, preventing illicit drug trafficking into the United States is part of a comprehensive approach to reducing overdose deaths. While synthetic opioids, such as illicitly manufactured fentanyl, its analogues, and non-fentanyl synthetic opioids, have driven up overdose deaths since 2015,[22, 23,24] the United States is also seeing increased availability and use of methamphetamine and other synthetic drugs. Moreover, the increasing availability and use of cultivated drugs such as heroin and cocaine, often adulterated by synthetic opioids, continue to pose challenges.[25]

The Nation's ports of entry provide an entry point for illicit substances that harm Americans. These substances can be marketed and sold on the dark web using cryptocurrency, and are delivered to the purchaser through the mail and commercial carriers, or brought across the Nation's geographic borders by multiple conveyances.[26] The availability of drugs with historically high purity and low price, along with the increased lethality of synthetic opioids, helps drive the overdose and addiction epidemic.

In this Administration's first year, ONDCP will work with key partners in the Western Hemisphere, such as Mexico and Colombia, to shape a collective and comprehensive response to

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[22] 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.

[23] 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.

[24] 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.

[25] 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.

[26] U.S. Department of Justice, Drug Enforcement Administration. (2020). National Drug Threat Assessment. https://www.dea.gov/sites/default/files/2021-02/DIR-008-21%202020%20National%20Drug%20Threat%20Assessment_WEB.pdf.

illicit drug production and use by deepening bilateral collaboration on public health approaches, expanding effective state presence, and developing infrastructure. This will help ensure that activities to curb the unlawful production and trafficking of drugs nonetheless adhere to the rule of law and respect for human rights.

We will also exercise leadership in regional and multilateral forums such as the North American Drug Dialogue to advance evidence-based public health responses to substance use, and prevent the proliferation of counterfeit medicines and the diversion of licitly produced substances to the illicit market. Additionally, we will use established 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 will work to strengthen the U.S. Government's capacity to disrupt the manufacture, marketing, sale, and shipment of synthetic drugs by addressing illicit Internet drug sales and the continually evolving techniques in illicit financial transactions. This includes engaging commercial carriers to disrupt the movement of synthetic drugs through postal and parcel systems. On the home front, we will support law enforcement efforts through ONDCP's High Intensity Drug Trafficking Areas (HIDTA) program to disrupt and dismantle domestic drug trafficking networks and support initiatives to advance coordinated responses; and support multi-jurisdictional task forces and other law enforcement efforts to disrupt and dismantle transnational drug trafficking and money laundering organizations that provide the funding for the drug trafficking organizations through the use of the U.S. financial system.

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.[27] This reluctance is often based on misconceptions and fears, negative attitudes, and

[27] 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.

even misplaced beliefs that discrimination against people with substance use disorders (either in recovery or not) is acceptable.[28] Our current economic crisis, coupled with the overdose epidemic, requires the public and private sectors to work together to develop a workforce prepared to meet today's challenges.

At the same time, the Nation's addiction workforce is experiencing staffing shortages,[29] and we need to address future needs for various behavioral health occupations.[30] Hiring diverse practitioners who reflect the communities and cultures they serve is also an important workforce issue.[31] The United States needs skilled behavioral health providers to provide the array of services necessary to meet the needs of those with behavioral health conditions, especially important 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 will promote 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, and 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 will identify ways in which the Federal Government can remove barriers to employment and expand employment opportunities for people in recovery from addiction, and we will produce guidelines for Federal managers on hiring and working with

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[28] 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

[29] 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.

[30] 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.

[31] 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

people in recovery from a substance use disorder. ONDCP intends to lead by example: several new ONDCP employees are people in long-term recovery who are using their experience to improve our policies and make treatment and recovery easier for those who follow.

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.

In the Administration's first year, 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. In addition, we will develop interagency support for Recovery Month activities in September and engage persons with "lived experience" in the development of drug policy.

CONCLUSION

Addressing the overdose and addiction epidemic is an urgent issue facing the Nation that has only been made worse by the COVID-19 pandemic. We have lost close to one million people since this epidemic began.[32] The Biden-Harris Administration's drug policy priorities are designed to bend the curve of this epidemic. The multi-faceted and evidence-based approach

[32] 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].

reflected in these priorities will take on this challenge by expanding access to prevention, harm reduction, treatment, and recovery support services, and by reducing the supply of illicit substances. This work will also include long-overdue efforts to address racial equity issues in drug policy and healthcare. Working with our partners, including Members of Congress, ONDCP will take quick action to implement the Administration's drug policy priorities with the aim of turning the tide on an epidemic that has lasted far too long and taken too many lives.