**SAMHSA Responses to 2/1/2023**
**Energy & Commerce Health Subcommittee Hearing on Fentanyl**
Questions for the Record

**<u>Honorable Cathy McMorris Rodgers</u>**

**1. Congress relies on agencies such as SAMHSA to collect relevant data to inform our oversight efforts and policy making. What data does SAMHSA collect with regard to mental health conditions in the pediatric population?**

SAMHSA collects data through our grant programs and SAMHSA's Center for Behavioral Health Statistics Quality (CBHSQ), which is the lead Federal government agency for behavioral health data and research. CBHSQ issues reports such as "Mental Health Annual Report 2015–2020 Use of Mental Health Services: National Client-Level Data" which is a compilation of the demographic, clinical, and outcome data of individuals served by the state mental health agencies (SMHAs) within a state-defined 12-month reporting period.[1] SAMHSA's CBHSQ also collects and reports data in the Uniform Reporting System for the pediatric population. SMHAs report annual data as part of their application package for SAMHSA's Community Mental Health Services Block Grant. State reports on how many clients they have served include information about children and adolescents (aged 17 and younger). Data collected for youth include: sociodemographic characteristics of clients served, outcomes of care, use of selected evidence-based practices, client assessment of care, insurance status, living situation, and readmission to state psychiatric hospitals within 30 and 180 days.[2] Additionally, as part of the National Survey on Drug Use and Health (NSDUH), SAMHSA collects information regarding major depressive episodes (MDEs) in adolescents aged 12 to 17, including whether reported MDEs severely impaired adolescents' lives. Finally, SAMHSA collects ICD-10 mental health diagnoses for children that are reported through the Government Performance and Results Act (GPRA) for SAMHSA's Center for Mental Health Services and Center for Substance Abuse Treatment non-formula-based grant programs.

**<u>Grant Programs</u>**

SAMHSA grantees are required to collect and report GPRA data. Categories of data collected from grantees include training, mental health awareness, organizational changes, outreach, partnerships, referrals, screening, access to services, and workforce development. SAMHSA's Center for Mental Health Services (CMHS) grantees comply with GPRA requirements by providing National Outcome Measures, which is client-level data collected by grantees by interviewing their clients and reporting on their behavioral health diagnosis, demographics, functioning, employment, education, housing, and measures specific to the grant program. In addition, CMHS grantees, with the goal of improving the infrastructure of mental health prevention, services and promotion, collect quantitative data on each infrastructure development, prevention and mental health promotion (IPP) indicators as assigned in the grant's Notice of Funding Opportunity or Notice of Award. IPP data is collected quarterly and includes a short narrative description of the results achieved.

Child-serving grant programs that collect both National Outcomes Measures and IPP data include Certified Community Behavioral Health Centers Expansion, Clinical High-Risk for

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[1] https://www.samhsa.gov/data/sites/default/files/reports/rpt38666/2020_MH-CLD%20Annual%20Report-508%20compliant_10212022_final.pdf

[2] Link for 2021 data https://www.samhsa.gov/data/report/2021-uniform-reporting-system-urs-output-tables

Psychosis, Healthy Transitions, Children's Mental Health Initiative (CHMI), and National Child Traumatic Stress Initiative Category III, Community Treatment and Service Centers. Child-serving grant programs that collect IPP data include Project Advancing Wellness and Resiliency in Education (AWARE), Project Linking Actions for Unmet Needs in Children's Health (LAUNCH), Resiliency in Communities After Stress and Trauma (ReCAST), Trauma-Informed Services in Schools, Circles of Care, Mental Health Awareness Training, Garrett Lee Smith Campus Suicide Prevention, Garrett Lee Smith State/Tribal Suicide Prevention, Tribal Behavioral Health/Native Connections, and Infant and Early Childhood Mental Health Consultation.

**2. Among children with mental health conditions, many have co-occurring developmental or other conditions that exacerbate and complicate providing them with the best care. What gaps does SAMHSA see with regard to children with co-occurring conditions?**

Youth and young adults with co-occurring conditions need treatment that addresses the whole person. Such person-centered services may include psychosocial interventions, family behavioral therapy, medication, proactive outreach, and use of specialized applications that can assist or provide an intervention and track symptoms. Youth and young adults experiencing co-occurring conditions commonly face difficulties accessing integrated services or specialty care designed to assess and treat their needs. This is due to a lack of access to health insurance or adequate insurance benefits; provider shortages and/or narrow provider networks; fragmented or uncoordinated care, especially for youth and young adults in foster, juvenile justice, or residential settings, or those experiencing homelessness; limited cross training and education for mental health and substance use professionals; separate and geographically distinct Serious Emotional Disturbance (SED) / Serious Mental Illness (SMI) and Substance Use Disorder (SUD) treatment systems; and different and separate financing and reimbursement policies for each treatment option. Additionally, there are challenges in finding appropriate places of care for children and youth with neurodevelopmental disorders and mental health disorders. These children and youth need higher levels of care, but due to system challenges, including workforce shortages and cross training of specialty services, these children and youth often end up experiencing the longest emergency department boarding times.

However, progress has been made. There has been increased integration of effective and evidence based behavioral health services in primary care and school settings, where youth access treatment and clinical services most often; greater access to telehealth services; and expanded capacity to identify and treat co-occurring issues through more educational training. Implementation of systematic and integrated approaches for this population are critical to increasing the availability of, and access to, services. The following SAMHSA grant programs include a focus on youth and young adults with co-occurring conditions and have helped ameliorate some of the gaps: The Infant and Early Childhood Mental Health program (IECMH), CHMI, the Mental Health Block Grant, the Family Support Technical Assistance Center, and the Statewide Family Network.

**3. What programs and resources are available to working families struggling to navigate complex systems to get help for children with mental health conditions (beyond an online**

**treatment finder, families need help understanding different types of care, what's available, how to access, how to partner with providers in treatment planning, understanding MH conditions, etc.)?**

FindTreatment.gov provides information on location, treatment options, payment and insurance information, and access to over 13,000 state-licensed facilities. A redesigned and improved FindTreatment.gov was launched earlier this year by SAMHSA. FindTreatment.gov uses age-based filters to search for mental health services for the pediatric population aged 17 and under. Additionally, SAMHSA administers several grant programs that assist working families in navigating complex systems to help their children with mental health conditions. Examples include: the Statewide Family Network, ReCAST, the Family Support Technical Assistance Center, Project AWARE, Project LAUNCH, the Children's Mental Health Initiative, and the Clinical High Risk for Psychosis programs.

**4. What percent of SAMHSA staff work in person five days per week? What percentage of meetings are held virtually versus in-person?**

Right now, SAMHSA employees are working onsite, remotely, and on official travel. Our employee responsibilities and roles at SAMHSA vary with regard to whether they must be in person or remote to be able to do their work. Our employees who need to be in person to do their work, are, while those who can do their jobs remotely are generally allowed the flexibility to do so. While COVID-19 is no longer a determining factor for how we do our work, the pandemic has forever changed both the public and private sectors' approaches to the way work is done.

**<u>The Honorable Michael Burgess</u>**

**1. How does SAMHSA currently deal with cybersecurity threats?**

SAMHSA takes several approaches to deal with cybersecurity threats. This includes: (1) establishment of a cybersecurity program that is reviewed annually; (2) deployment of solutions to detect, prevent and respond to cyber threats; (3) conducting risk assessments; (4) use of National Institute of Standards and Technology (NIST) Cybersecurity Framework and other cybersecurity frameworks; (5) establishment of secure baselines for SAMHSA systems, in alignment with OMB Memorandum M-22-09, that allows for architecting toward a Zero Trust model; (6) regularly conducting risk assessments; (7) following HHS and NIST data-protection guidance; (8) regularly monitoring and auditing networks to detect potential threats; (9) enforcement of a strict patching policy for software updates to protect against known vulnerabilities; (10) maintaining awareness on the latest threats and vulnerabilities through multiple partnerships with cybersecurity firms; and (11) involvement with the Department of Homeland Security's Continuous Diagnostics and Mitigation (CDM) Program which provides a dynamic approach to fortifying the cybersecurity of government networks and systems.

**2. Do you believe that SAMHSA, and HHS in general, are ill-equipped to deal with cyber threats?**

HHS possesses a robust ability to identify, protect, detect, respond to, and recover from cyber events. As the threats to HHS and its Divisions continue to evolve, HHS continues to focus on strengthening and modernizing Department information technology systems to bolster our

cybersecurity posture. Increased and consistent funding is critical for HHS to be able to stay current with the necessary tools and technologies to keep the threats at bay.

**3. Aside from implementing H.R. 498, what can SAMHSA do in the future to combat domestic and international cyber threats?**
SAMHSA is actively working to protect the agency from cyber threats, including by:

- Periodically evaluating cybersecurity needs: SAMHSA periodically evaluates cybersecurity needs against emerging cyber threats and adjusts its investment in cybersecurity tools and technologies to adequately protect its data, and systems, in accordance with the Federal Information Technology Acquisition Reform Act and the Federal Information Security Modernization Act.
- Creating a secure hosting environment: SAMHSA is working to leverage a secure hosting environment for all systems that provide security by default, encompassing the latest security practices and frameworks.
- Partnering with cybersecurity experts: SAMHSA is working to partner with cybersecurity experts to ensure that SAMHSA's networks and systems are secure and provide channels to stay up-to-date on emerging cyber threats so SAMHSA can respond quickly and effectively when needed.
- Ensuring oversight and accountability of all new contracts by requiring sign-off from SAMHSA's Chief Information Officer and/or Chief Information Security Officer to ensure that information technology services are expended meaningfully, employing security best practices, avoiding shadow IT and removing duplicative applications and work effort.

**The Honorable Dan Crenshaw**

**1. How important is additional funding for future fentanyl-related research to the work being done by SAMHSA; and, if appropriated, how would they prioritize directing that funding?**
As I mentioned in my testimony, SAMHSA is implementing the HHS Overdose Prevention Strategy, which supports substance use prevention by prioritizing expanded research of new and improved prevention efforts, investment in community resources to help prevent harms related to substance use, increased access to high-quality pain management to reduce preventable suffering, and responsible prescription of medications to protect patient safety.

In addition, SAMHSA is currently working with the National Institutes of Health on the Healing Communities Consortium Stay Safe Study, a multi-site observational study that will assess the effect of fentanyl test strip (FTS) use on overdose risk reduction behaviors among people who use drugs (PWUD) over a 28-day observation period. Simultaneously, the study will examine facilitators and barriers to FTS distribution at individual and organizational levels and how these contextual factors may interact to promote or impede FTS use and overdose risk reduction behaviors among PWUD.

**2. For SAMSHA: how does fentanyl impact families and broader communities.**

As I indicated in my testimony, over the past few years, drug overdose deaths have reached a historic high, devastating families and communities.[3] The 2021 National Survey on Drug Use and Health found that among people who used prescription fentanyl products for any reason in the past year, 20.9 percent misused them.[4] Moreover, findings from SAMHSA's analysis of 2021 data from drug-related emergency department visits show that fentanyl-related emergency department visits rose throughout 2021.[5] Overdose of an individual due to fentanyl, whether fatal or non-fatal has a lasting impact, not just on the individual themselves, but also on their family, friends, and communities. Sadly, data show that of those who are treated for an overdose in the emergency room and survive, about 1 in 20 patients die within one year of their visit, many within two days of discharge.[6] The reverberation of an overdose death of a friend or family member, colleague or neighbor is immense. Provisional data from the Centers for Disease Control and Prevention predicts that more than 107,000 Americans died due to a drug overdose in the 12-month period ending in August 2022. Of these drug overdoses, the same source predicts that 81,231 involved opioids, and approximately 73,102 were attributable to fentanyl and other synthetic opioids (excluding methadone).[7]As fentanyl continues to proliferate, the pain and grief that families and broader communities shoulder with each overdose death continues to grow.

**The Honorable Richard Hudson**

1. **Dr. Gandotra, as you outlined in your testimony, SAMHSA's mission is to "lead public health and service delivery efforts that promote mental health, prevent substance misuse, and provide treatments and supports to foster recovery while ensuring equitable access and better outcomes." As SAMHSA's annual National Surveys on Drug Use and Health have made clear – the country is sadly struggling under a mental health and substance misuse crisis, both of which were heightened by the COVID-19 pandemic lockdowns. According to the 2019 National Survey, 20.4 million people aged 12 or older suffered from a substance use disorder. By 2021, which are the most recent figures we have available, the number for substance use disorders has more than doubled to 46.3 million people. The numbers for mental health are no better. In 2019, 20.6%, or 51.5 million adults over 18 years of age, suffered from any mental health disorder. This number increased to nearly 58 million adults (57.7 million) in 2021, with the rate of serious mental illness also increasing. Over**

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[3] Substance Abuse and Mental Health Services Administration. (2022). Key substance use and mental health indicators in the United States: Results from the 2021 National Survey on Drug Use and Health (HHS Publication No. PEP22-07-01-005, NSDUH Series H-57). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data
[4] Substance Abuse and Mental Health Services Administration. (2021). Key substance use and mental health indicators in the United States: Results from the 2020 National Survey on Drug Use and Health (HHS Publication No. PEP21-07-01-003, NSDUH Series H-56). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data

[5] Substance Abuse and Mental Health Services Administration. (2022). Drug Abuse Warning Network: Findings from Drug-Related Emergency Department Visits, 2021 (HHS Publication No. PEP22-07-03-002). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/
[6] https://nida.nih.gov/news-events/nida-notes/2020/04/many-people-treated-opioid-overdose-in-emergency-departments-die-within-1-year
[7] Id.

**one-fifth of our middle-school and high-school aged youth are suffering from a mental illness. This is unacceptable. It is my opinion the harsh school closures and community lockdowns have only exacerbated this problem, and your data largely reflect that.**

**2. Dr. Gandotra – you have served as the Chief Medical Officer at SAMHSA since July 2019. Could you speak to the role you and your agency, including any specific interactions with other partner agencies such as the CDC, played in the crafting of COVID-19 response policies?**

During the COVID-19 pandemic, agencies across HHS including SAMHSA and the CDC, coordinated on crafting the country's COVID-19 response policies. We worked together, as we always do, to follow the science with regards to prevention, treatment and overall mitigation protocol and policy. As we learned more about COVID-19 through research, we collaborated across HHS to update policies accordingly.

**3. Do you believe the detrimental impact of these lockdowns on mental health and substance use disorders were considered in finalizing and implementing administration recommendations? Should they have been a higher priority, particularly when the policies included mandates?**

Data show that across a broad range of social, emotional, and cognitive outcomes, allowing students to attend school in person is incredibly important. Accordingly, the Biden Administration has prioritized in-person schooling in its COVID-19 response plan. Recommendations, for mask wearing, like those put forth by the Biden Harris Administration[8] were a crucial part of a layered prevention strategy, particularly before adults and children had widespread access to safe and effective COVID-19 vaccines, and wearing masks has been shown to reduce school and day care closures.

**<u>The Honorable Neal Dunn</u>**

1. **Please provide a breakdown of provider type (nonprofit, for profit, health system, independent BHOs, residential vs inpatient) that are subrecipients of the Substance Abuse Prevention and Treatment Block Grant (SABG).**
   Substance Use Prevention, Treatment and Recovery Services (SUPTRS) Block Grant (formally SABG) grantees are required to provide information regarding the subrecipient name, address, and amount of block grant funds received. SAMHSA does not collect information regarding subrecipient's provider type.

   • **What percentage of grant subrecipients serve urban areas? Rural areas?**
   SAMHSA does not collect this information. Grantees are required to report the address and funding amounts received for each subrecipient during the specified fiscal year (three years prior to the current federal fiscal year's award). However, we do not collect information regarding the geographic coverage for each subrecipient. During the FY 2022 reporting

[8] https://www.ed.gov/coronavirus

period, block grant awardees reported that they used a total of 5,413 entities to provide block grant services during federal fiscal year 2019.

**• What percentage of grant subrecipients offer Medication Assisted Treatment or partner with a facility that offers Medication Assisted Treatment services?**

SAMHSA does not collect information regarding the percentage of subrecipients that offer medications for substance use disorder. However, SAMHSA does collect this information at the grantee level. During the latest reporting period, among grantees for which data was available, 77 percent (44 of 57) reported serving a combined total of 279,391 clients with medication treatment for substance use disorder during state fiscal year 2021.

**• Please also provide the percentage of funds dedicated to recovery housing by state.**
SAMHSA does not collect this information. SAMHSA has proposed including this element as part of its 2024-2025 program application and reporting requirements.

**• Please provide the total number of subgrant applications, and what percentage of applications receive funding by state.**
SAMHSA does not collect this information.

**The Honorable Frank Pallone, Jr.**
**Addressing the opioid epidemic, stemming the flow of illicit fentanyl, and ensuring individuals with substance use disorder are connected to services are important issues that deserve thoughtful, bipartisan solutions. This Committee has worked together to tackle these problems under past Republican and Democratic Chairs. I hope that we can continue that tradition at future hearings to find common ground on these and the other issues in our jurisdiction. One bill that would have been a great addition to this hearing today is the Medicaid Reentry Act. This bipartisan legislation would extend Medicaid eligibility to incarcerated individuals 30 days prior to their release. It's my understanding that individuals newly released from incarceration are at a much higher risk of overdose and suicide. Can you describe some of the reasons for that?**

Yes, individuals newly released from incarceration are at much higher risk of overdose and suicide because of many of the challenges they face with re-entry from incarceration to society. Pre and post-release support services and continuity of care are key to help incarcerated individuals re-enter successfully into the community, which often means establishing or re-establishing relationships and support systems, finding work and stable housing, connecting to health care, and finding other needed supports. These challenges, many of which may have existed prior to entering incarceration, are often stressful and can lead to substance misuse and or depression, anxiety, and other mental health challenges, which, without access to services pre and post release, can prove deadly. In addition, newly released individuals often have decreased tolerance for opioids as a result of incarceration-induced abstinence or because they begin treatment for OUD while incarcerated. When individuals are released from incarceration after either abstinence from opioid use or being on tapering managed withdrawal, this population face a higher risk of overdose because of decreased tolerance. These individuals are also more

susceptible to overdose after treatment if they attempt to use the same amount or dose of opioids that they used prior to treatment because of decreased tolerance. In addition, many individuals who began OUD treatment while incarcerated, do not continue treatment once released, leading to relapse and potential overdose.

**2. It sounds like ensuring newly-released individuals have continuity of access is incredibly important, especially for individuals with substance use disorder; would you agree with that?**
Yes.

**3. What are some of the barriers to care that recently-incarcerated individuals may face when reentering society?**
As I mentioned above, there are many challenges that recently-incarcerated individuals face with reentering successfully into the community, and these challenges include finding places to access care, paying for care and prescriptions, obtaining health insurance, etc. In addition to finding and paying for medical care, incarcerated individuals must learn to re-enter their lives outside of incarceration and often that means establishing or re-establishing relationships and support systems, finding work and stable housing, and finding other needed supports. These challenges are often stressful, many of which may have existed prior to entering incarceration, and can lead to substance misuse and or depression, anxiety, and other mental health challenges, which, without access to services pre and post release, can prove deadly.

**4. Medicaid Reentry Act would extend Medicaid eligibility to individuals 30 days prior to their release, promoting continuity of coverage and access to care during their transition into the community. Given the enormous risk of overdose during this time period and the importance of continuity of care, do you think enrolling individuals in health insurance, like Medicaid, prior to their release could help to address some of the issues you identified that make transitioning in the community a challenge?**
Yes, enrolling individuals who are incarcerated in health insurance prior to their release would likely facilitate a more successful transition to the community. SAMHSA is actively engaging individuals who are currently incarcerated and soon to be transitioning back into the community using the Sequential Intercept Model (SIM). The SIM model encourages:

- Transition planning by jail or in-reach providers, starting at intake, that shape reentry outcomes to a person's needs prior to release including resources for behavioral health, physical health, and other related needs;
- States to allow individuals coming back into the community to have access to services and medications;
- Warm handoffs between release and service providers, ideally as a follow-up from in-reach services through the SIM;
- Necessary medication and prescription access for those being released to bridge the gap between their release and their next meeting with a medical provider; and
- Peer support services to help those being released to plan for reentry, identify quality stable housing, and diverting from the criminal justice system.

**5. As you know, the recently passed omnibus addressed many of the gaps in substance use disorder treatment and mental healthcare—one of those being access to treatment, namely medication assisted therapy (MAT). MAT has been shown to keep people in treatment for their substance use disorder for longer periods of time leading to better chances of recovery. I'd like to take a moment to examine the implications of this law and how it will benefit people struggling with opioid use disorder. What is buprenorphine-naloxone and how does it work?**
Buprenorphine is a partial agonist at the mu-opioid receptor, which means that it has similar effects to other opioids, such as pain relief, but it does not produce the same degree of effects as full agonists, such as heroin or fentanyl. Naloxone is an opioid antagonist that blocks the effects of opioids and is added to buprenorphine to deter misuse of the medication. Buprenorphine works by binding to the mu-opioid receptors in the brain, which reduces the craving and withdrawal symptoms associated with opioid use disorder. As a partial agonist, buprenorphine produces weaker effects than full agonists, which reduces the risk of overdose and misuse. Naloxone is included in the medication to discourage misuse by injection, as the antagonist effects of naloxone can precipitate withdrawal symptoms if the medication is injected. Buprenorphine-naloxone is typically taken under the tongue or inside the cheek, where the medication dissolves and is absorbed into the bloodstream. Buprenorphine-naloxone has been found to be an effective treatment for opioid use disorder, and has been shown to reduce illicit opioid use, improve retention in treatment, and decrease overdose deaths. It's an important tool in the treatment of opioid use disorder and can help individuals achieve and maintain long-term recovery.

**6. Is there abuse potential for buprenorphine-naloxone? In other words, could someone use it to achieve a "high?"**
While any opioid can produce euphoric effects, buprenorphine as a partial opioid agonist may not act as strongly as other opioids for its euphoric effects and many individuals do not report experiencing any euphoric effects which with its long half-life, makes it an ideal medication for withdrawal management. Opioids have variable effects on opioid receptors such as 1. pain relief, 2. autonomic nervous effects like heart rate, temperature control, blood pressure, digestive functions, etc., and 3. euphoric effects. Buprenorphine works very well for autonomic regulation, which is why it works for withdrawal, less so for pain management over 4-6 hours, and even less for euphoria. In fact, most individuals do not feel euphoric effects; rather, they simply have withdrawal relief. As buprenorphine still has partial agonist effects on opioid receptors, there is some abuse risk, albeit lower than other full agonist opioids.

**7. Can you explain what the X-waiver was and how its removal makes it easier to deal with the fentanyl crisis and treating OUD overall?**
The X-Waiver (also known as the Data-Waiver) was established under the Drug Addiction Treatment Act of 2000 (DATA 2000) to allow qualified practitioners to prescribe certain opioid treatment medications for the treatment of opioid use disorder (OUD). Under DATA 2000, qualifying practitioners received waivers from the Drug Enforcement Administration (DEA) after SAMHSA determined that they met certain statutory conditions. Qualifying practitioners were permitted to dispense, including prescribe, Schedule III, IV, and V controlled medications approved by the Food and Drug Administration (FDA) specifically for maintenance or

detoxification treatment without being separately registered as a narcotic treatment program by the DEA, otherwise known as an Opioid Treatment Program. "DATA-Waived" practitioners were not permitted to prescribe the Schedule II medication methadone for the treatment of OUD. Qualifying practitioners were subject to certain conditions. For example, practitioners were authorized to prescribe only opioid medications specifically approved by the FDA for the treatment of a use disorder, and that are controlled in Schedules III through V. Also, only practitioners in certain disciplines were eligible for a waiver and they had to be "qualified" by satisfying certain credentialing, training or experience requirements. Practitioners were also subject to limits on how many patients they could treat at any one time.

On December 29, 2022, the President signed the Consolidated Appropriations Act, 2023. Section 1262 of the Act amended the Controlled Substances Act to remove the requirement that practitioners obtain a special waiver to prescribe buprenorphine for the treatment of OUD, and section 1263 added substance use disorder training requirements for all DEA registrants. Section 1262 also made several conforming changes throughout the Controlled Substances Act, the Public Health Service Act, and the Social Security Act. These amendments expand the pool of potential buprenorphine prescribers from 114,000 (the number of practitioners with an X-Waiver in December 2022) to 1.8 million DEA-registered practitioners. Expansion in capacity to prescribe buprenorphine is significant because any practitioner, subject to applicable state law, with a valid medical license and DEA registration can now prescribe buprenorphine, assuming that they have completed requisite substance use disorder training. This means that those with OUD in rural areas and areas previously classified as having low access to treatment for OUD, can receive intervention. This change also has the potential to reduce the stigma associated with prescribing buprenorphine, and to establish OUD as a chronic medical condition that is manageable with treatment.

**8. What do you believe is the next step in addressing the Opioid Crisis?**
In response to the COVID-19 pandemic, in October 2021 the Department of Health and Human Services (HHS) released its Overdose Prevention Strategy (The Strategy). The Strategy aims to combat opioid overdoses by applying the best-available data and evidence to maximize health equity, inform SUD-related policy and actions, integrate SUD into other types of health care and social services, and reduce stigma. The Strategy includes elements from the full continuum of care including prioritization of prevention, harm reduction, expanding evidence-based quality treatment and sustaining recovery through support. Key to supporting those activities and The Strategy are SAMHSA's grant programs such as the Substance Use Prevention, Treatment and Recovery Services (SUPTRS) Block Grant, the State Opioid Response grants, and the Building Communities of Recovery and Partnerships for Success programs, all of which received major investments in the FY 2023 Omnibus. This Administration believes that investing in and expanding elements of the Strategy will ultimately help save lives.

**9. What is SAMHSA doing to reduce disparities in substance use and mental health in the United States?**
SAMHSA is committed to addressing health disparities by supporting culturally and linguistically appropriate mental health, substance misuse prevention, treatment and recovery support programs. This commitment is reinforced through SAMHSA's Behavioral Health

Disparity Impact Statement (DIS), which monitors programs and activities to ensure that access, use, and outcomes are equitable across racial, ethnic, and other under resourced populations. SAMHSA requires all non-formula-based grant recipients to prepare a DIS. In addition, SAMHSA administers information sharing, training and technical assistance towards the goal of promoting behavioral health equity through the National Network to Eliminate Disparities in Behavioral Health, which is a network of community-based organizations focused on the mental health and substance use issues of diverse racial and ethnic communities. Examples of grant programs and technical assistance centers focused on reducing disparities include the Minority Fellowship Program, the Tribal Behavioral Health grant program (also known as Native Connections), the Tribal Opioid Response Grants, and the Circles of Care program.

In addition, SAMHSA's Minority AIDS program supports activities that build a strong foundation for delivering and sustaining high-quality and accessible substance misuse and HIV prevention services. The program aims to engage community-level domestic public and private non-profit entities, tribes, and tribal organizations to prevent and reduce the onset of substance misuse and transmission of HIV/AIDS among at-risk populations, including racial/ethnic minority youth and young adults. SAMHSA also has Technology Transfer Centers that are dedicated to American Indian and Alaska Native and Hispanic and Latino populations. These Centers work with organizations and treatment practitioners involved in the delivery of behavioral health services to American Indian and Alaska Native individuals, families, and tribal and urban Indian communities and Hispanic and Latino communities respectively. SAMHSA also supports three Centers of Excellence, which are dedicated to providing training and technical assistance related to the evidence-based and evidence-informed prevention, treatment and recovery services specific to Black or African Americans, LGBTQI+ and older adult populations respectively. SAMHSA likewise funds the Historically Black Colleges and Universities Center of Excellence in Behavioral Health program, which recruits students to careers in the behavioral health field to address mental and substance use disorders, providing training that can lead to careers in the behavioral health field, and/or preparing students to obtain advanced degrees in the behavioral health field. Finally, SAMHSA administers the Centers of Excellence for Behavioral Health Disparities program. This program funds three Centers of Excellence that develop and disseminate training and technical assistance for healthcare providers related to addressing behavioral health disparities in the Black or African American, LGBTQI+ and aging populations.

**10. How is SAMHSA addressing social determinants of health and their impact on human well-being?**

Some examples of SAMHSA's work related to addressing social determinants of health include: our Office of Behavioral Health Equity, which coordinates SAMHSA's efforts to reduce disparities in mental and/or substance use disorders across populations; our Office of Recovery, which was established to evaluate and initiate policy, programs and services with a recovery focus and ensure that the voices of individuals in recovery are represented. The Office of Recovery addresses key social determinants that support recovery including access to housing, education, social support, and employment. In addition, SAMHSA works collaboratively with the United States Interagency Council on Homelessness and we administer programs like the Projects for Assistance in Transition from Homelessness program, which collaborates with the

Department of Housing and Urban Development as part of local continuums of care to comprehensively address the needs of individuals with serious mental illness and a co-occurring disorder who are experiencing homelessness or are imminently homeless. Finally, SAMHSA also administers the Transforming Lives Through Supported Employment program, which aims to increase evidence-based, supported employment programs for individuals with co-occurring mental and substance use disorders.

**11. What agencies is SAMHSA collaborating with to address health inequities?**
SAMHSA collaborates with several other agencies to address health inequities. Some examples of our collaborative work to promote health equity include: leading the Interdepartmental Serious Mental Illness Coordinating Committee and the Interdepartmental Substance Use Disorders Coordinating Committee, both of which include representatives from a combination of the Department of Justice, the Department of Veterans Affairs, the Department of Defense, the Department of Housing and Urban Development, the Department of Education , the Department of Labor, Centers for Medicare & Medicaid Services , the Administration for Community Living, the Social Security Administration, and the White House Office of National Drug Control Policy. In addition, SAMHSA works with the Office of Refugee Resettlement and National Institute of Mental Health to improve mental health outcomes for refugee and migrant populations. SAMHSA also participates in the Department of Justice's monthly coordinating meeting to discuss ongoing Olmstead[9] cases and issues related to Olmstead implementation for states, as well as Olmstead-related initiatives and resources across agencies. Finally, SAMHSA administers the Asian American, Native Hawaiian, and Pacific Islander Center of Excellence (AANHPI-CoE). The AANHPI-CoE is tasked with developing and disseminating culturally informed, evidence-based behavioral health information and providing technical assistance on training on issues related to addressing behavioral health disparities in the Asian American, Native Hawaiian, and Pacific Islander communities.

[9] *The 1999 Supreme Court's decision in Olmstead v. L.C. requires states to eliminate unnecessary segregation of persons with disabilities and to ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs. The Department of Justice's Civil Rights Division work with state and local governments officials, disability rights groups and attorneys around the country, and with representatives of the HHS, to fashion an effective, nationwide program to enforce the integration mandate of the Department's regulation implementing title II of the Americans with Disabilities Act (ADA). For more information, see [https://archive.ada.gov/olmstead/index.html](https://archive.ada.gov/olmstead/index.html).*