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FIGHTING FENTANYL: THE FEDERAL RESPONSE TO A GROWING CRISIS

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED SEVENTEENTH CONGRESS

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ON

EXAMINING FIGHTING FENTANYL, FOCUSING ON THE FEDERAL RESPONSE TO A GROWING CRISIS

JULY 26, 2022

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C O N T E N T S

STATEMENTS

TUESDAY, JULY 26, 2022

FIGHTING FENTANYL: THE FEDERAL RESPONSE TO A GROWING CRISIS

Tuesday, July 26, 2022

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The Committee met, pursuant to notice, at 10 a.m., in room 216, Hart Senate Office Building, Hon. Patty Murray, Chair of the Committee, presiding.

Present: Senators Murray [presiding], Casey, Baldwin, Murphy, Kaine, Hassan, Lujan, Hickenlooper, Collins, Cassidy, Braun, Marshall, Scott, and Moran.

OPENING STATEMENT OF SENATOR MURRAY

The CHAIR. Good morning. The Senate Health, Education, Labor, and Pensions Committee will please come to order. Today we are having a hearing on the fentanyl crisis that is devastating our communities. I will have an opening statement followed by Senator Cassidy. He will—and then we will introduce our witnesses.

After they give their testimony, Senators will each have 5 minutes for a round of questions. And again, while we are unable to have this hearing fully open to the public or media for in-person attendance, live video is available on the Committee website at *help.senate.gov*.

If you are in need of accommodations including closed captioning, please reach out to the Committee or the Office of Congressional Accessibility Services. Last week, back in Washington State, King County declared fentanyl a public health crisis and it is painfully obvious why. This year King County alone has lost over 270 people to fentanyl overdoses. That is an increase of nearly 50 percent from last year.

That is more than one fentanyl death every day, and that is just one county in my state, one corner of our Country, which lost over 100,000 people to drug overdoses last year. That is an all-time high. And that number doesn't just represent a grim record, it represents so many personal tragedies, so many families that are shattered by the loss of a loved one, parents, caregivers, and increasingly teenagers.

Now, there is no question we had a mental health and substance use disorder crisis on our hands before the COVID pandemic. But there is also no doubt things have gotten so much worse due to the

trauma of this pandemic and so much more deadly with the sharp rise of illicit fentanyl in recent years.

That is because fentanyl is up to 50 times stronger than heroin and 100 times stronger than morphine. Two milligrams can be a lethal dose. From April 2020 to 2021, synthetic opioids, mostly illicit fentanyl, were responsible for nearly two-thirds of all overdose deaths. And the recent rise in fentanyl overdose deaths has also reflected the painful, systemic health inequities we still need to do so much to address.

Black communities as well as American Indian and Alaskan Native communities have suffered a higher increase in overdose deaths than other demographics. There has also been a deeply alarming rise in young people dying from overdoses. In 2019, over 250 teens died from illicit fentanyl. Last year, we lost almost 900. Think about that. Fentanyl deaths for teenagers more than tripled in 2 years.

My heart goes out to every family touched by this crisis, and I have heard from many of them, people who lost a loved one after a long, hard struggle with addiction and those who lost a loved one suddenly to a counterfeit pill laced with a lethal dose of fentanyl.

Our communities are doing everything they can to fight this, but they need help from the Federal Government to stop these dangerous drugs at the source, cutoff supply lines, and importantly, get these kids and their families the help they need. And the way we do that is to support families on the ground through robust public health efforts and better access to mental health and substance use disorder care.

When it comes to cutting off the supply of fentanyl, FDA has been working to crack down on counterfeit drugs being sold online. Something I want to see them continue making progress on to protect our youth. And the DEA is working to seize fentanyl laced pills before they can end up in our kids hands.

I have been pressing President Biden on this the same way I pressed the Trump administration. And we are seizing more fentanyl laced pills than ever before, and I appreciate the hard work that is going into that.

Our law enforcement and first responders on the ground are really working to rise to this challenge, to stop these deadly pills and save lives, and ensure people can get the care they need.

But when I talk to police officers or fire chiefs and first responders back in Washington State, it is clear we have a lot more to do to build on the progress that we are making, cutoff the supply lines that produce these dangerous drugs, and prevent them from ever reaching our communities.

Drug trafficking is a serious problem, and that is why Democrats continue to work with Republicans to provide significant funding for border security and drug interdiction.

But let's get one thing clear, we need to be taking this seriously and having real conversations about how we address the national threat of fentanyl use and supply, not playing politics, not scapegoating, not fear mongering, not attacking refugees and immi-

grants with proposals that are based more on xenophobia than on what will actually work to keep people safe.

That is not to say we cannot talk about accountability, especially for opioid manufacturers who fueled this crisis to line their pockets.

There are enormous corporations that knew just how dangerous and addictive these products were and yet decided to ignore the risk for patients, market these pills aggressively, and flood our communities with opioids. We absolutely must hold these companies accountable for padding their profits at the expense of countless lives.

Of course, stopping the supply of illicit fentanyl and holding companies accountable, which fueled the opioid crisis, is critical. But we really have to tackle this challenge from every angle possible. And with that in mind, we have a lot more work to do to help our communities get people the mental health and substance use disorder care they need.

Right now, less than 10 percent of people who need substance use disorder treatment can get it, and care is even harder if you are Black, or Hispanic, or American Indian, or Alaskan Native.

The painful reality is that most people who die by overdose didn't get any substance use disorder treatment before they passed away. That is unacceptable. We need to do better. A big part of the problem is our mental health and substance use disorder workforce has been woefully overstretched and understaffed.

I said this before, but it is so important to understand if we are going to get our arms around this. Almost 130 million Americans live in areas with a mental health care provider shortage. Essentially, they don't even have one mental health care provider per thousand people—per 30,000 people.

In Washington, our mental health care workforce is only able to meet 17 percent of our state's needs. If we are going to turn the tide in the fight against fentanyl, that is going to have to change. We cannot lose sight of the fact that a strong public health system and easy access to treatment for everyone are some of the most powerful tools in our arsenal.

We need to make sure every community has a robust public health department with the data needed to track overdoses, stop spikes, and the ability to raise public awareness about rising threats like counterfeit drugs laced with fentanyl. And we need to support programs on the front lines in our communities that are focused on prevention, treatment, and recovery support.

I have fought hard to invest in our communities to expand mental health and substance use disorder care through HRSA, which is helping build our mental health and substance use disorder workforce in our rural communities, through Federal grants, which have helped set up dozens of new treatment centers across our states, and in the American Rescue Plan, which included critical funds for this work.

But to talk to anyone on the front lines of this for 2 seconds and you will understand we have a lot more to do. I talked to the fire chief in Seattle who told me a few months ago they respond to four overdoses every day.

I talked with a University of Washington researcher who told me how 80 percent of people who could benefit from services to keep them alive can't access them. Talked with a nurse in Everett who told Secretary Becerra about how there are just not enough beds to get people treatment.

The mom who told him about how she lost her job, her house, and her child while she was struggling with fentanyl addiction. Talked to Jason Cockburn at the Second Chance Foundation in Everett, who is spoken about the challenge of trying to get kids the treatment they need, or the many people who desperately tried to help him find an open treatment bed for a 15 year old earlier this year, calling contacts, posting to Facebook, no—all, to no avail.

It is so clear that leaders like Jason, who are on the front lines of this crisis, need so much more from our Federal agencies and from this Congress. More when it comes to getting fentanyl off the streets and more when it comes to getting people the health care they need.

Which is why I am as determined as ever to continue the progress Senator Burr and I are making on a bipartisan package on mental health and substance use disorder. We need to support the programs on the ground in our communities that are already doing lifesaving work to identify people who are at risk and prevent substance use disorders in the first place, to get people treatment, and to support people in recovery.

We need new programs, especially when it comes to addressing the new challenges we are seeing with fentanyl and with heart breaking increases in overdoses among young people. So I am going to continue to press for us to advance as expansive a package as possible, as quickly as possible.

I believe that we can do it because we have done it before. In 2016 and again in 2018, Democrats and Republicans worked together to pass some of the most comprehensive legislation to respond to the opioid crisis in our Country's history. That has made a big difference.

That legislation has undoubtedly saved lives. But I have traveled to just about every part of Washington State to talk about this crisis. From Everett, to Seattle, to Longview, to the Tri-Cities, to Spokane, and more.

The challenges that we are dealing with today are not the same challenges we faced in 2018. So now it is on all of us to build on the bipartisan progress we have made. And it is painfully clear our communities cannot wait.

They need us to meet this moment with serious action and lifesaving support for families. With that, I will turn it over to Senator Cassidy for his opening remarks.

OPENING STATEMENT OF SENATOR CASSIDY

Senator CASSIDY. Thank you, Madam Chair. And I thank Ranking Member Burr who allows me to lead this meeting. As a physician, I took care of patients with addiction. But it doesn't take a physician taking care of those with addiction to know that we have a fentanyl crisis. Everyone here and everyone watching knows of

someone who has died or who has suffered from addiction related to opioids.

If you read of the young person who dies, the teenager or in college, most often it is related to a drug overdose. And you think about the tragedy of that child whose whole future was before she or he, and now it has ended, affecting not just their life, but all those generations that would come after them from that wonderful person. It is incumbent upon us to address this issue.

Now the statistics. Fentanyl is killing over 200 Americans a day. In 2021, we saw the largest annual increase in opioid deaths in 50 years. In the 35 years between 1979 and 2016, 600,000 Americans died to overdose and a 100,000 died last year.

I will speak of my own state. Louisiana's drug overdose deaths hit a record high of 2,100 in the 12 months leading up to March of 2021. Overdose mortality increased statewide by over 56 percent through 2020 to 2021.

New Orleans was up 51 percent in 2020, with 365 overdose deaths. Jefferson Parish up 69 percent. Saint Tammany up 35. And Saint Bernard up 64 percent. And we know the cause of this, it is fentanyl.

Illegal fentanyl and fentanyl related substances are flooding into our market from our Southern border in unprecedented amounts, with the bulk of this ultimately originating from a handful of manufacturers in Wuhan, China.

Fentanyl accounted for 64 percent of the 100,000 overdose deaths last year. Two out of every three people who die from opioids it is from fentanyl or fentanyl like drugs. Now, Congress has to continue to pass tools to fight this from multiple fronts.

First, we need to make the classification of fentanyl analogs as Schedule 1 drugs permanent. Several of my colleagues and I introduced to Halt Lethal Traffic of Fentanyl Act last year to do just that. Second, we need to educate Americans just how deadly fentanyl is. Two milligrams is enough to kill someone.

I was proud to join Senator Marshall and other doctors in the Congress to record a PSA informing Americans about the risk of fentanyl. Health experts and public officials need to continue such efforts.

Third, the border. Last year, the DEA seized 20 million fake pills and 50,000 pounds of fentanyl, enough for 440 million lethal doses. When I went to the border, I saw this big cage of illegal drugs. I said, how much do you think you are getting? They think, we probably think we are getting about a third of it.

If we seize this much, that much more went through. We have to recognize that a policy at the border which has been feckless and ineffective as this Administration has had, not just allows people to come here who are not—who are illegal, illegal immigrants, it allows drugs to come across as well.

We have got to control that border. If there is a message I wish the Administration to get, use your tools to control. Fourth, we need to combat the drug cartels' ability to finance the production and smuggling of illicit fentanyl into the United States. Selling synthetic opioids laced with fentanyl is a major source of revenue

for cartels, drugs—excuse me, gangs, criminal organizations, and for organizations such as Hezbollah.

They use a financial process, including one known as trade based money laundering, to disguise their activities and illegally move in and out of the country. It is the use of financial exchanges that look like legitimate trade to serve as cover for illicit flows of money. If we can stop the financing of the drug trade, we can stop the trade of drugs.

Finally, we need to look at loopholes in our customs system. For example, cartels will ship Chinese made fentanyl into our Country by mail, claiming the contents of the packages worth less than $800, which is the threshold for paying tariffs. Because it is declared as less than $800, Customs and Border Protection does not inspect the package and it passes through. It is a glaring loophole in our customs system.

I look forward to discussing these solutions and more in todays hearing. Congress failing to address this crisis threatens our national security and risks the safety of the individual who does not know that one pill laced with fentanyl can kill, which means that there will be one more obituary of an 18 year old child whose life is gone forever. With that, I yield.

The CHAIR. Thank you, Senator Cassidy. I will now introduce today's witnesses. Mr. Kemp Chester is the Senior Policy Adviser for Supply Reduction and International Relations at the Office of National Drug Control Policy, ONDCP.

Dr. Miriam Dephin-Rittmon is the Assistant Secretary for Mental Health and Substance Use and Head of the Substance Abuse and Mental Health Service Administration, known as SAMHSA. Ms. Carole Johnson is the Administrator of the Health Resources and Services Administrator, HRSA.

Dr. Christopher Jones is Acting Director of the National Center for Injury Prevention and Control at Centers for Disease Control and Prevention. Thank you to all of you for joining us today for this really urgent crisis—discussion on this really urgent crisis.

I really do appreciate all of your sharing your time and your expertise. We look forward to your testimony. And Mr. Chester, we will begin with you.

STATEMENT OF KEMP CHESTER, SENIOR POLICY ADVISOR FOR SUPPLY REDUCTION AND INTERNATIONAL RELATIONS, OFFICE OF NATIONAL DRUG CONTROL POLICY, THE WHITE HOUSE, WASHINGTON, DC

Mr. CHESTER. Thank you, Chair Murray, Ranking Member Cassidy, and Members of the Committee. Thank you for inviting me to testify today on the dynamic, illicit drug environment we face in the United States and the Administration's approach to addressing it. Drug poisonings and overdoses claimed 108,809 lives in 2021 alone, which represents in American life lost every 5 minutes around the clock.

Behind these fatal overdoses or millions of individuals experiencing non-fatal overdoses that are overwhelming our first responders and taxing our health care system. And while these fatali-

ties and non-fatal overdoses are the most visible manifestations of our crisis, along with them are tens of millions of Americans suffering from a substance use disorder.

Underlying these heartbreaking numbers is the impact on our economic prosperity. The cost of this epidemic is estimated to be $1 trillion a year, and up to 26 percent of the loss in our labor force participation can be attributed to people suffering from addiction.

The Administration is approaching this crisis with a keen sense of urgency and with action that is bold, far reaching, and innovative. The President's National Drug Control Strategy is an evidence based blueprint designed to save as many lives as possible in the near term, while building our capacity to deal with untreated addiction and the profit driven trafficking of illicit drugs in the long term.

The Director of National Drug Control Policy has further identified four immediate priorities that cut across the strategy's goals to achieve these outcomes. First is to have naloxone, the opioid reversal medication, in the hands of everyone who needs it, especially now when three out of every four overdose deaths involve an opioid like fentanyl.

Second is tackling the enduring issue of Americans with substance use disorder not getting the treatment they need. Fewer than 1 out of 10 people in the United States who need treatment are able to get it. We simply cannot accept that, and we are committed to ensuring universal access to medication for opioid use disorder by 2025.

Third, we must disrupt and dismantle the transnational criminal organizations who produce and traffic illicit drugs like fentanyl, by commercially disrupting the entire global illicit business of drug production and trafficking, including its illicit financial networks, supply chains, and a holistic and coordinated fashion.

Finally, we need to close our existing gaps in data collection and analysis we need to drive and evaluate drug policy decisions, especially for non-fatal overdoses, which are the most accurate predictors of a fatal overdose in the future. Taken together, this represents a new era of drug policy that is precisely what we need now to address an environment of drug trafficking and use that is more dynamic than at any time in history.

This is the first time the Federal Government is embracing high impact harm reduction to reduce overdoses and deaths. Commercial disruption is a new approach that brings together our efforts in illicit finance, supply chain targeting, and international engagement to target drug traffickers, their operating capital, and their profits.

This strategy is the first in which we focused on improving data to deliver lifesaving resources to the people who need it, particularly those who interact with the criminal justice system and those who are incarcerated. This is the first time we have emphasized adverse childhood experiences and social determinants of health as key elements of our prevention efforts.

This is the first time we have called for making access to substance use disorder treatment universal, removing outdated bar-

riers to prescribing medications for opioid use disorder, and providing workforce opportunities for people in recovery.

In today's environment, dominated by opioids like illicit fentanyl, we must reduce overdose deaths, ensure people can get access to the help they need, and disrupt the flow of illicit drugs across our borders and into our communities.

On behalf of Dr. Gupta and the men and women of the Office of National Drug Control Policy, I want to thank this Committee and your colleagues in Congress for your leadership on this critical issue.

We look forward to working with you to address this complex national security, law enforcement, and public health challenge with the urgency that it so desperately demands. Thank you, and I look forward to your questions.

[The prepared statement of Mr. Chester follows:]

PREPARED STATEMENT OF KEMP CHESTER

Chair Murray, Ranking Member Burr, and Members of the Committee, thank you for inviting me to testify today on the dynamic illicit drug trafficking and use environment we face in the United States, and the Administration's approach to addressing it with the urgency it demands.

Introduction

Since 2015, provisional data shows that annual overdose deaths in America have more than doubled.[1] Additionally, the COVID–19 pandemic has increased the strain on our health care system and amplified the existing difficulties in accessing treatment for substance use disorder, which has exacerbated an overdose epidemic that was already getting worse prior to the pandemic.

The Centers for Disease Control and Prevention (CDC) estimates that drug poisoning and overdoses claimed 108,809 lives in 2021 alone, which represents an American life lost every 5 minutes around the clock. These are our family members, co-workers, neighbors, and friends. Over the past two decades, nearly a million Americans have lost their lives to drug poisonings and overdoses, devastating their families, our communities, and our Nation as a whole. Beyond these fatal overdoses over the past two decades are millions of individuals experiencing nonfatal overdoses that are overwhelming our first responders and taxing our healthcare system. And while these fatalities and nonfatal overdoses are the most visible manifestation of our crisis, underneath them are tens of millions of Americans suffering from addiction to opioids.

While this crisis has been accelerating at an unprecedented rate over the years, the impact on our economic prosperity goes even further. Research estimates the economic costs of this epidemic to be a staggering $1 trillion a year,[2] and up to 26 percent of the loss in U.S. labor force participation can be attributed to people suffering from addiction.[3]

This is a nonpartisan issue that touches everyone, regardless of where they live or how they vote, and it is why ending the opioid epidemic is a key part of President Biden's Unity Agenda for the Nation, which he announced during his State of the Union address. The strong support we see across our country, and across political parties, for comprehensive and meaningful solutions to the overdose crisis underscores the nonpartisan nature of this issue and the need for immediate action.

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[1] Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999–2020 on CDC WONDER Online Data base, released in 2021. Available at *http://wonder.cdc.gov/mcd-icd10.html*. Extracted by ONDCP on December 22, 2021.

[2] Ahmad FB, Cisewski JA, Rossen LM, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. 2022.

[3] Federal Reserve Bank of Atlanta researcher Karen Kopecky, Jeremy Greenwood of the University of Pennsylvania and Nezih Guner of the Universitat Autonoma de Barcelona. National Bureau of Economic Research Working Paper. *https://www.nber.org/system/files/working—papers/w29932/w29932.pdf*.

The Administration's National Drug Control Strategy

The Administration is approaching this crisis with a keen sense of urgency, prioritizing saving lives as our fundamental task. Our actions must be bold, far-reaching, and innovative while also being evidence-based, compassionate, equitable, safe, and effective. The President's inaugural *National Drug Control Strategy* is an evidence-based blueprint designed to save lives immediately, build the infrastructure our Nation desperately needs to treat the enduring problem of addiction, and disrupt drug trafficking and the illicit profits that fuel it, enhancing public safety for us all. The implementation of President Biden's *Strategy* will save as many lives as possible in the near term while building our capacity to deal with untreated addiction and the global production of illicit drugs in a long-term and sustainable fashion.

As the Office of National Drug Control Policy developed this Strategy, the Director focused on the two fundamental drivers of this epidemic: untreated addiction, and the profit-driven production and trafficking of illicit drugs.

In the SUPPORT Act of 2018, Congress laid out key requirements for the President's *National Drug Control Strategy* that includes issuing a comprehensive, evidence-based plan to reduce both the supply of, and demand for, illicit drugs, and for illicit synthetic opioids more specifically.

The *Strategy* does precisely this while outlining a bold and innovative approach to reduce overdoses that includes measures at both the strategic and program levels to hold government accountable under the requirements of the SUPPORT Act.

The Director has identified four immediate priorities that cut across the *Strategy's* goals, which if advanced will help us save lives both in the short term while building our capacity to address this challenge in the long term:

First, the most important action we can take right now is to have naloxone, the opioid overdose reversal medication, in the hands of all those who need it without fear or judgment—especially now when three out of every four overdose deaths involve opioids.[4] Harm reduction interventions like fentanyl test strips, naloxone, and syringe services programs that enable us to work with people who use drugs to build trust, engagement, and, most importantly, keep them alive, are proven to work and enjoy broad bipartisan support.

Expanding access to naloxone is a simple and cost-effective tool supported by strong evidence: in addition to saving lives, every dollar we spend on naloxone provides $2,769 in benefits according to one cost-benefit analysis.[5]

Second, the President's *Strategy* lays out actions to tackle a long-standing issue: the majority of people with a substance use disorder are not getting the treatment they need. Fewer than one out of ten people in the United States who need treatment get it[6] and we cannot accept that.

When people lack the coverage and support they need for treating and managing their substance use disorders they lose their jobs, their families, they disengage from their communities, and far too often, they lose their lives. Treatment saves lives, and everyone who needs treatment should be able to access it. Through the President's *Strategy*, we will ensure universal access to medications for opioid use disorder by 2025.

Third, the Director believes we must disrupt and dismantle the Transnational Criminal Organizations (TCOs) who produce and traffic illicit drugs by targeting their operations, illicit financial networks, and supply chains in a comprehensive and sophisticated way.

The drug production and trafficking environment we see today is vastly different than it was just a few years ago. The TCOs that sustain and perpetuate the multi-billion-dollar illicit drug business operate seamlessly across borders and cooperate with remarkable efficiency to obtain raw materials, move and launder their proceeds, and to ship their illicit products to the United States and destinations around the world. Therefore, we must commercially disrupt[7] the global drug trafficking en-

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[4] Ahmad FB, Cisewski JA, Rossen LM, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. 2022.

[5] Naumann et al. Drug Alcohol Depend 2019;204:107536.

[6] 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 Rockville*, MD: Center for Behavioral Health Statistics and Quality.

[7] The 21st century global economy depends upon the constant movement of money, ideas, people, and goods across international borders with incredible speed and efficiency. Drug producers

Continued

terprise, first by raising a sophisticated awareness of this environment, especially among private sector entities, so we can focus our resources on the malign actors in a more precise way. Moreover, we must expand the number of tools we apply to include not only financial sanctions, but also a range of other actions to disrupt and degrade drug production and trafficking operations at best, or at the very least make it incredibly difficult and much more costly.

It is also vitally important that we maintain close and cooperative relationships with other countries where these illicit drugs and their precursors are manufactured, and do so from a perspective of common and shared responsibility. While the people of the United States see the effects of global drug trafficking in the heartbreaking realities of fatal and non-fatal overdoses, shattered families, and broken communities, we must also bear in mind that many of the dollars used to purchase those drugs—in addition from seeking to profit from harmful and addictive psychoactive substances—often plays a role in destabilizing that country, corrupting its officials, and victimizing its most vulnerable citizens.

Mexico has become the locus of illicit fentanyl production since late 2019 and remains the country of origin for the majority of heroin and methamphetamine found in the United States.

In September 2021, the United States marked a new era in security cooperation with Mexico by establishing the U.S.-Mexico Bicentennial Framework for Security, Public Health, and Safe Communities. This comprehensive, long-term, and holistic approach to improve the safety and security of both nations has three overarching goals: Protecting Our People, Preventing Transborder Crime, and Pursuing the Criminal Networks who threaten both countries.[8] Earlier this month, the Office of National Drug Control Policy and its partners from the Department of State traveled to Mexico, where the United States and Mexico formally committed to strengthening our work against the manufacture, trafficking, distribution, and consumption of illicit fentanyl and other synthetic drugs. Further, President Biden and Mexican President López Obrador met recently and the two heads of state reemphasized the importance of our two nations working together to address these challenges.

The United States routinely engages with the People's Republic of China to address shipments of PRC-origin precursor chemicals bound for North America, as well as to cooperatively address the numerous money laundering and illicit finance facilitators with ties to Chinese criminal organizations that enable drug trafficking.

In the past, the PRC government has been responsive to the United States' concerns about the shipment of fentanyl and its analogues directly to the United States, and PRC's actions in that regard have had a direct and positive impact. We must buildupon those actions, and addressing illicit drugs precursor chemicals and associated money laundering are areas where U.S. and PRC interests align. We look forward to continuing our cooperation with the PRC government in holding respon-

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and traffickers exploit this to sustain and enhance their illicit business: the provision of precursor chemicals, some of which are unregulated chemicals that can be shipped in plain sight; physically dislocated payments that include the movement of funds across borders; the internet-based sales of raw materials and finished drugs using both fiat and cryptocurrency; and the physical movement of chemicals and their finished products around the world. The vast majority of the physical and virtual terrain on which drug producers and traffickers operate such as the dark web, open social media platforms, eCommerce sites, express consignment shippers and freight forwarders, banks, cryptocurrency vendors, legitimate chemical suppliers, and pill press and die mold manufacturers, are private sector entities who likely have little to no idea they are a constituent part of an illicit business enterprise. We must commercially disrupt what has become a global illicit business enterprise that enjoys huge capital resources, routine collaboration with raw material suppliers across international borders, advanced technology to fund and conduct business, product innovation and strategies to expand markets, and in many cases centralized control and decision-making. Actions include: Raising a sophisticated awareness of this environment with government and commercial sector partners around the world, so we can sift out the unwitting from the deliberately malignant; increasing the visibility of the legal goods such as unregulated chemicals, high capacity pill presses, die molds, and pill press replacement parts, that can be diverted for illicit use; using financial tools such as sanctions to disrupt the flow of illicit proceeds to drug producers and traffickers, and deny them the operating capital they need to sustain their business; disrupt illicit drug production capacity by focusing on the chemical precursors used to make them; and expanding the tools we apply to the entire complex of drug production and trafficking, to disrupt drug production and trafficking or, at the very least, make it incredibly difficult and more costly. We must also apply those tools in a sophisticated and surgical manner, and make deliberate government-wide decisions about the long-term consequences of our short-term actions, better synchronizing the full range of tools to gain strategic results and avoid potentially negative downstream effects.

[8] *https://www.whitehouse.gov/briefing-room/statements-releases/2021/10/08/fact-sheet-u-s-mexico-high-level-security-dialog/*.

sible those individuals, anywhere in the world, who engage in this criminal enterprise.

India, another global producer and exporter of chemicals and pharmaceuticals, similarly suffers from the presence of criminal elements who traffic precursor chemicals for the manufacture of synthetic opioids and other drugs, as well as finished opioids such as tramadol and tapentadol. The United States has been working closely with India over the last several years to develop a long-term counternarcotics relationship, and earlier this month the Office of National Drug Control Policy, along with the Departments of State and Justice, headed the third, and first in-person, United States-India Counternarcotics Working Group (CNWG) in New Delhi. The United States made it clear it is in both countries' interest to establish and maintain a relationship based upon mutual respect, shared interests, and a common desire to partner as leaders on the global issue of illicit drug production, trafficking, and use. During 2 days of meetings both parties reached agreement on major issues to address together and adopted a written framework to guide their collective work going forward.

The Director firmly believes we must bring the international community together to control fentanyl precursor chemicals. Earlier this year, in response to a request by the United States, the United Nations Commission on Narcotic Drugs (CND) voted to take international action and internationally control the acquisition, production, and export of three precursors used to illicitly manufacture illicit fentanyl and its analogues: 4-anilinopiperidine (4-AP), 1-(tert-butoxy carbonyl)-4-phenylaminopiperidine (boc-4-AP), and N-phenyl-N-(piperidin-4-yl) propionamide (norfentanyl). The CND also voted to schedule brorphine and metonitazene, two synthetic opioids, under Schedule I of the 1961 Convention on Narcotic Drugs, and eutylone, a synthetic stimulant, under Schedule II of the 1971 Convention on Psychotropic Substances. This action obligates the signatories to these conventions to establish national laws to control these substances. At the same meeting, the CND also adopted a U.S.-sponsored resolution that calls for greater cooperation among member states to prevent the diversion of chemicals not subject to international control that are diverted to illicit drug production, including so-called designer precursor chemicals.

President Biden's budget proposal includes substantial increased investments for border security and supply reduction approaches. The women and men who work every day to stop illicit drugs from coming into our country perform extraordinary work protecting our public safety and public health in challenging circumstances, and President Biden is committed to ensuring they have the tools and technology they need to get the job done.

This *National Drug Control Strategy* directs agencies to uncover financial networks and obstruct and disrupt the illicit financial activities that fund the TCOs that produce and traffic illicit drugs into the United States by strengthening every available tool, seeking new ones that will provide tangible results, and better synchronizing our efforts across the Federal Government to commercially disrupt this global illicit enterprise.

In support of this effort, this past December President Biden issued two Executive Orders that provide the executive branch enhanced architecture to better counter TCOs in this dynamic environment, and to increase our ability to negatively impact foreign persons involved in the global illicit drug trade from a financial perspective. When issuing those executive orders, the President declared that "international drug trafficking, including the illicit production, global sale, and widespread distribution of illegal drugs; the rise of extremely potent drugs such as fentanyl and other synthetic opioids; as well as the growing role of Internet-based drug sales, constitutes *an unusual and extraordinary threat to the national security, foreign policy, and economy of the United States*."[9] These carefully chosen words not only speak to the high priority the President places upon this issue, but also open doors to new authorities and capabilities for the United States to address this threat in a comprehensive and sustainable fashion.

Additionally, law enforcement task forces such as Organized Crime Drug Enforcement Task Forces (OCDETF) and High Intensity Drug Trafficking Areas programs (HIDTAs) work diligently with the Nation's 94 U.S. Attorney's Offices to disrupt and dismantle transnational organized crime by prosecuting those individuals responsible for manufacturing and distributing these deadly substances in our communities.

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[9] *https://www.whitehouse.gov/briefing-room/Presidential-actions/2021/12/15/executive-order-on-imposing-sanctions-on-foreign-persons-involved-in-the-global-illicit-drug-trade/*.

Through this *Strategy*, the Director and ONDCP will continue to work, both unilaterally and with other nations, to make it more difficult and more costly, in every way, for drug trafficking organizations to continue their business. This work is critical because if it is easier to get illicit drugs in America than it is to get treatment, we will never bend the curve on overdoses.

Finally, the *Strategy* ramps up our work on data and research at a time when the Federal Government faces important gaps in data collection and analysis related to drug policy.

We know that a past non-fatal overdose is one of the most accurate predictors of whether someone will experience a fatal overdose in the future.[10] However, we currently lack consistent and timely measures of non-fatal overdoses in all jurisdictions in the United States, and this constrains our ability to identify emerging trends and act before it is too late. Building on gains already made in the timeliness and accuracy of our data will greatly increase our ability to drive and evaluate policy decisions. With this *Strategy*, the Administration is working to develop a near real-time national estimate for non-fatal overdose occurrences, along with a system to rapidly surge substance use prevention and treatment resources to those communities experiencing the greatest burdens.

In addition to these four areas, the President's *Strategy* also directs Federal agencies to take actions to prevent youth substance use, support people in recovery, and advance racial equity in our drug policies across the board. The *Strategy* also expands the scope of our work to address many of the factors that affect substance use disorder including child poverty, employment, and economic opportunity, so people can reach their full potential.

A New Era for Drug Policy

Taken together, these goals, priorities, and objectives usher in a new era of drug policy that is evidence-based comprehensive, holistic, and targeted at saving lives.

This is the first time the Federal Government is embracing high-impact harm reduction as a tool to reduce overdoses and overdose deaths, an effort that has broad bipartisan congressional support.

Commercial disruption is a new approach that brings together our efforts in illicit finance, supply chain targeting, and international engagement as a comprehensive and sophisticated means to target TCOs, their operating capital, and their profits.

This *Strategy* is the first in which we have delivered extensive chapters dedicated to data and criminal justice that will help us better understand our environment and deliver life-saving resources to people who interact with the criminal justice system, including evidence-based treatment for people who are incarcerated, so we can improve public health and public safety outcomes.

This is the first time we have emphasized Adverse Childhood Experiences (ACEs) and the Social Determinants of Health (SDOH) as key elements of our prevention efforts.

This is the first time we have called for making access to substance use disorder treatment universal.

Finally, we are placing a new emphasis on getting naloxone to everyone who needs it, removing outdated barriers to prescribing medications for opioid use disorder, and providing workforce opportunities for people in recovery.

This *Strategy* represents exactly what we need to do to reduce overdose deaths, ensure people can access the help they need, and disrupt the flow of illicit drugs across our borders and into our communities.

Action Now

While we are taking action now to implement the President's inaugural *Strategy*, since the beginning of this Administration, our office has led a number of efforts designed to advance administration priorities and deal with America's opioid and overdose epidemic head on:

- CDC and SAMHSA established a $3 million partnership to leverage CDC's National Harm Reduction Technical Assistance Center to support

[10] Krawczyk N, Eisenberg M, Schneider KE, et al. Predictors of overdose death among high-risk emergency department patients with substance-related encounters: A data linkage cohort study. Annal of Emergency Medicine 2020;75(1):1–12.

implementation of effective, evidence-based harm reduction programs, practices, and policies in diverse settings and decrease health disparities.

- ONDCP announced the release of the Model Law Enforcement and Other First Responders Deflection Act, a resource for states that encourages the development and use of deflection programs across the country. First responders, including law enforcement, often do not have good options when encountering people with substance use and mental health disorders, and this Model Law deflects people with these disorders away from traditional criminal justice programs when appropriate and connects them to evidence-based treatment, harm reduction, and recovery and prevention services, changing lives and reducing a burden on first responders.
- SAMHSA announced the extension of the methadone take-home flexibilities for 1 year, effective upon the eventual expiration of the COVID–19 Public Health Emergency. The flexibility promotes individualized, recovery-oriented care by allowing greater access for people who reside farther away from an Opioid Treatment Program or who lack reliable transportation, such as those in rural and tribal communities.
- CDC has provided $300M+ per year through Overdose Data to Action to support 47 states, Washington, DC, two territories and 16 high burden cities and counties in collecting high quality, comprehensive, and timely data on nonfatal and fatal overdoses and in using those data to inform prevention and response efforts, such as ensuring people are connected with the care they need, supporting health care providers and systems with overdose response efforts, and developing partnerships with public safety and first responders to improve data sharing and response.
- CDC expanded its investment in Public Health Analysts participating in the High Intensity Drug Trafficking Areas (HIDTA) program's Overdose Response Strategy. This collaboration is helping communities reduce fatal and non-fatal drug overdoses by connecting public health and public safety agencies, sharing information, and supporting evidence-based interventions. CDC is funding public health analysts in all 50 states, the District of Columbia, the U.S. Virgin Islands, and Puerto Rico.
- The Department of Justice's Office of Justice Programs (OJP) has provided more than $110.7 million to reduce recidivism and support adults and youth returning to their communities after confinement. OJP also awarded more than $300 million to help address the needs of individuals with substance use disorders, including treatment and recovery services.
- CDC and ONDCP invested in communities by expanding our investment in the Combating Opioid Overdoses through Community Level Intervention (COCLI) initiative to fund eight new projects to implement innovative, evidence-based, and scalable solutions—like the Merrimack Valley, Massachusetts "Wheels of Hope" program for persons with substance use disorder to receive rides to treatment appointments.
- Earlier this month ONDCP announced fiscal year 2022 Drug Free Communities (DFC) Continuation funds to 646 coalitions, representing an investment by the Biden-Harris administration of approximately $81 million in youth substance use prevention in communities across the country. Later this summer, ONDCP anticipates awarding fiscal year 2022 DFC new grant awards.

CONCLUSION

There is no doubt that the environment of illicit drug production, trafficking, and use, particularly as it relates to synthetic opioids, presents a daunting challenge. However, as difficult as it may be, it is not insurmountable. The Biden-Harris administration is focused on meeting this complex national security, public safety, and public health challenge head on in a comprehensive and sophisticated way. This will not only reduce the number of drug deaths and save American lives in the short term, but also shape our approach to addressing the broader and more enduring challenge of illicit drug use and its consequences in the years to come.

The Administration's leadership on this critical issue, the close collaboration among Federal departments and agencies, and the work the members of this Committee and your colleagues in Congress have done to keep this issue at the forefront of our national consciousness are changing the trajectory of the challenge we face.

On behalf of Dr. Gupta and the men and women of the Office of National Drug Control policy, I would like to thank the subcommittee for your foresight and leadership on this critical issue, and on behalf of the Administration, ONDCP looks forward to continuing to work with you to reduce illicit drug availability, use, and the many harms they bring to American families and their communities.

[SUMMARY STATEMENT OF KEMP CHESTER]

- The Centers for Disease Control and Prevention (CDC) estimates that drug poisoning and overdoses claimed 108,809 lives in 2021, and research estimates the economic costs of this epidemic to be $1 trillion a year. Up to 26 percent of the loss in U.S. labor force participation can be attributed to people suffering from addiction.
- The National Drug Control Strategy's approach is saving lives now while prioritizing innovative, evidence-based, compassionate, and equitable actions. The Strategy focuses on the two fundamental drivers of this epidemic: untreated addiction and the profit-driven production and trafficking of illicit drugs.
- The Director identified four key priorities as crucial components of the Strategy's goals:
    - Ensuring everyone can access naloxone. With 3 out of 4 overdose deaths involving opioids, access to this overdose reversal medication will save lives immediately.
    - Expanding access to substance use disorder treatment and provide universal access to medication for opioid use disorder by 2025.
    - Dismantling Transnational Criminal Organizations (TCOs) by targeting their operations, illicit financial networks, and supply chains.
    - Improving research and near-real time data, particularly in tracking nonfatal overdoses, one of the most accurate predictors of whether someone will experience a fatal overdose in the future.
- We maintain close and cooperative relationships with countries where these illicit drugs are produced and trafficked, and do so from this principal of shared responsibility.
    - The 2021 the U.S.-Mexico Bicentennial Framework for Security, Public Health, and Safe Communities is designed to improve the safety and security of both nations.
    - The United States routinely engages with the People's Republic of China to address the ever-increasing number of precursor chemical shipments originating in China.
    - The United States is now working with India in a long-term counternarcotics relationship to address the shipment of precursor chemicals and drugs such as tramadol and tapentadol.
- The Administration's leadership on this critical issue, the close collaboration among Federal departments and agencies, and the work the Members of this Committee and your colleagues in Congress have done to keep this issue at the forefront of our national consciousness are changing the trajectory of the challenge we face.

The CHAIR. Thank you.

Dr. Delphin-Rittmon.

STATEMENT OF MIRIAM E. DELPHIN-RITTMON, PH.D., ASSISTANT SECRETARY FOR MENTAL HEALTH AND SUBSTANCE USE, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, ROCKVILLE, MD

Ms. DELPHIN-RITTMON. Good morning and thank you, Chair Murray, Ranking Member Cassidy, and Members of the Committee for inviting me to testify during this hearing focused on fentanyl and its impact on the overdoses across the Nation.

I am pleased to be here, along with my colleagues from the White House Office of Drug Control Policy, the Health Resources and Services Administration, and the Center for Disease Control and Prevention to discuss SAMHSA's efforts.

The overdose crisis continues to be a challenge across the country. Synthetic opioids, like illicitly manufactured fentanyl, and the use of other substances, particularly stimulants such as cocaine and methamphetamines, have led to significant increases in overdose deaths.

The COVID–19 pandemic exacerbated an already tragic situation, with drug overdose deaths reaching a historic high, devastating families and communities. Provisional data from CDC reported that more than 107,000 Americans died due to drug overdose in the 12 month period ending January 2022.

Moreover, preliminary findings from SAMHSA's analysis of 2021 data from the Drug Related Emergency Department visits show that fentanyl related emergency department visits rose throughout 2021. That is why addressing addiction and the overdose epidemic is one of the four pillars of the unity agenda the President outlined in the State of the Union address.

Additionally, last year, Secretary Becerra released a comprehensive HHS overdose prevention strategy, which is designed to increase access to a full range of care and services for individuals who use substances that cause overdoses and their families. The strategy prioritizes four key areas, primary prevention, harm reduction, evidence based treatment, and recovery support.

SAMHSA has several efforts underway across this continuum. For example, SAMHSA's First Responder Comprehensive Addiction Recovery Act Program trains and equips first responders and other volunteer organizations on how to respond to overdose related incidents, including how to administer overdose reversal medication, naloxone.

During the program's recent project period, each state developed a strategic action plan for combating opioid misuse and deaths related to heroin and illicit fentanyl. This year, SAMHSA launched the first ever harm reduction grant program and issued $30 million in grant awards.

This opportunity, authorized and funded by the American Rescue Plan Act, is increasing access to a range of community harm reduction services and supports harm reduction service providers as they work to help to prevent overdose deaths and reduce the health risks associated with drug use.

We are increasing access to evidence based treatments to more Americans by allowing practitioners to treat more patients with buprenorphine through the revised buprenorphine practice guidelines. This policy has given over 17,000 more providers the ability to provide this lifesaving treatment.

SAMHSA's programs like the Substance Abuse Prevention Treatment Block Grant and the State Opioid Response Grant Programs are critical resources for states to fight this epidemic. States can use these funds to purchase fentanyl test strips, which are dispos-

able, single use tests to detect the presence of fentanyl in a substance.

Finally, SAMHSA's Office of Recovery is promoting the involvement of people with lived experience throughout the agency and stakeholder activities and fostering relationships with internal and external organizations with mental health and addiction recovery field. On behalf of my colleagues at SAMHSA, I want to thank you for your interest and support of our programs and for supporting the Nation's behavioral health.

I would be pleased to answer any questions and look forward to our discussion. Thank you.

[The prepared statement of Ms. Delphin-Rittmon follows:]

PREPARED STATEMENT OF MIRIAM E. DELPHIN-RITTMON

Good morning. Thank you, Chair Murray, Ranking Member Burr, and Members of the Committee for inviting me to testify during this hearing focused on fentanyl and its impact on overdoses across the Nation.

My name is Miriam Delphin-Rittmon, and I am the Assistant Secretary for Mental Health and Substance Use at the U.S. Department of Health and Human Services (HHS). In this role, I lead the Substance Abuse and Mental Health Services Administration, also known as SAMHSA. SAMHSA leads public health efforts to advance the behavioral health of the Nation and improve the lives of individuals living with mental and substance use disorders, as well as their families.

I am pleased to be here, along with my colleagues from the White House Office of National Drug Control Policy, Health Resources and Services Administration, and the Centers for Disease Control and Prevention (CDC) to discuss SAMHSA's response to the overdose crisis.

The overdose crisis continues to be a challenge for this country. Synthetic opioids like illicitly manufactured fentanyl and the use of other substances, particularly stimulants such as cocaine and methamphetamine, have led to significant increases in overdose deaths. [1]

As President Biden has noted, our Country faces an unprecedented crisis among people of all ages and backgrounds. The COVID–19 pandemic exacerbated an already tragic situation, with drug overdose deaths reaching a historic high, devastating families and communities. [2] Provisional data from the CDC reported that more than 107,000 Americans died due to a drug overdose in the 12-month period ending in January 2022. Moreover, preliminary findings from SAMHSA's analysis of 2021 data from drug-related emergency department visits show that fentanyl-related emergency department visits rose throughout 2021. [3]

That is why addressing addiction and the overdose epidemic is one of the four pillars of the unity agenda the President outlined in the State of the Union Address.

Last year Secretary Becerra released the comprehensive the HHS Overdose Prevention Strategy (Strategy), which is designed to increase access to the full range of care and services for individuals who use substances that cause overdose, and their families. The Strategy prioritizes four key areas: primary prevention, harm reduction, evidence-based treatment, and recovery support.

Though this testimony, I will expand on how SAMHSA is working to implement the Strategy and advancing the goals of the President.

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[1] O'Donnell J, Tanz LJ, Gladden RM, Davis NL, Bitting J. Trends in and Characteristics of Drug Overdose Deaths Involving Illicitly Manufactured Fentanyls—United States, 2019–2020. MMWR Morb Mortal Wkly Rep 2021;70:1740–1746. DOI: *http://dx.doi.org/10.15585/mmwr.mm7050e3*.

[2] 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*.

[3] Substance Abuse and Mental Health Services Administration. (2022). Preliminary Findings from Drug-Related. Emergency Department Visits, 2021; Drug Abuse Warning Network (HHS Publication No. PEP22–07–03–001). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from *https://www.samhsa.gov/data/*.

SUPPORTING THE SUBSTANCE USE CARE CONTINUUM

Primary Prevention

Prevention is critical to reducing overdoses and overdose deaths. SAMHSA's activities in this area are designed to invest in community infrastructure necessary to prevent harms related to substance use. Examples of SAMHSA's activities in support of the Strategy's primary prevention goal are below.

First Responder Training for Opioid Overdose-Related Drugs

SAMHSA's First Responders—Comprehensive Addiction and Recovery Act (FR-CARA) program is an important part of our response to the overdose crisis. The FR-CARA program trains and equips firefighters, law enforcement officers, paramedics, emergency medical technicians, and volunteers in other organizations to respond to adverse overdose-related incidents, including to administer naloxone. This program also establishes processes, protocols, and mechanisms for referral to appropriate treatment and recovery communities. FR-CARA's broader eligibility and rural-set asides ensure that much needed services reach rural and tribal areas. During the program's recent project period, each state developed a strategic action plan for combating opioid misuse and deaths related to heroin and illicit fentanyl.

Strategic Prevention Framework for Prescription Drugs Grant Program

The Strategic Prevention Framework for Prescription Drugs (SPF-Rx) assists grantees in developing capacity and expertise in the use of data from state run prescription drug monitoring programs (PDMP). Grantees have also raised awareness about the dangers of sharing medications and worked with pharmaceutical and medical communities on the risks of overprescribing to young adults. SAMHSA's program focuses on bringing prescription drug use prevention activities and education to schools, communities, parents, prescribers, and their patients. SAMHSA tracks reductions in opioid overdoses and the incorporation of prescription drug monitoring data into needs assessments and strategic plans as indicators of program success.

Harm Reduction

Evidence-based harm reduction strategies minimize the negative consequences of drug use to both the individual and the community. Therefore, providing funding and support for innovative harm reduction services is a key pillar of the Strategy. The activities below highlight the substantial strides that SAMHSA has made to advance the adoption and use of evidence-based harm reduction approaches.

Harm Reduction Grant Programs

This year, SAMHSA launched its first-ever Harm Reduction grant program and issued $30 million in grant awards. This opportunity, authorized and funded by the American Rescue Plan Act, will help increase access to a range of community harm reduction services and support harm reduction service providers as they work to help prevent overdose deaths and reduce health risks often associated with drug use. This funding is allowing organizations to expand their distribution of overdose-reversal medications and fentanyl test strips, provide overdose education and counseling, and manage or expand syringe services programs (SSP), which help control the spread of infectious diseases like HIV and hepatitis C. For example, in Maine, "Project DHARMA (Distribution of Harm Reduction Access in Rural Maine Areas)" will involve the delivery of evidence-based harm reduction strategies across the state, with a focus on utilizing Peer Support Workers embedded in SSPs to facilitate the distribution of harm reduction supplies, such as naloxone and fentanyl test strips, and linkage to care for infectious disease prevention and treatment, wound care, and substance use.

Fentanyl Test Strips

HHS announced in April 2021 that grantees in certain programs, such as State Opioid Response (SOR) grants and the Substance Abuse Prevention and Treatment Block Grant program, may use grant funds to purchase rapid fentanyl test strips

to help curb the dramatic spike in drug overdose deaths largely driven by strong synthetic opioids, including illicitly manufactured fentanyl.[4, 5]

Reports from states such as California, Arizona, Nevada, and Alaska note that fentanyl test strips funded through SOR have become an important component of syringe service programs; education and awareness building toolkits; and innovative, low-threshold, on-demand treatment programs. These 4 states report distributing approximately 15,000 fentanyl test strips collectively since April 2021.

Evidence-based Treatment

Evidence-based treatments for substance use disorder can reduce substance use, related health harms, and overdose deaths, and increase odds for long-term recovery. Below are examples of SAMHSA efforts and programs that support evidence-based treatment.

Flexibilities to Increase Access to Medications for Opioid Use Disorder

In an effort to get evidenced-based treatment to more Americans with opioid use disorder (OUD), in April 2021 SAMHSA and HHS announced buprenorphine practice guidelines that remove certain training and certification requirements which some practitioners have cited as a barrier to treating more people.[6] We know that treatment with buprenorphine decreases opioid-related overdose mortality by over 50 percent.[7, 8] The Practice Guidelines for the Administration of Buprenorphine for Treating Opioid Use Disorder (Practice Guidelines) provides an exemption from certain statutory certification requirements for eligible physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives who are state licensed and registered by the Drug Enforcement Administration to prescribe controlled substances. Specifically, the exemption allows these practitioners to treat up to 30 patients with OUD using buprenorphine without taking the previously required training so long as a practitioner submits a Notice of Intent. This exemption also allows practitioners to treat patients with buprenorphine without certifying to their capacity to provide counseling and ancillary services. As of July 1, 2022, a total of 126,286 providers have obtained a waiver; of these, 17,633 were specifically related to the revised Practice Guidelines.

During the COVID–19 pandemic, we have seen how telehealth can expand access to care, overcome geographic inequality in the provision of services, and reduce stigma associated with accessing life-saving medications such as buprenorphine.[9] Providers and patients have overwhelmingly supported integration of telehealth into the care of those with OUD, since it offers: flexibility in delivery and receipt of treatment; a means for those living in rural or remote areas to better engage in care; improvement in the provider-client relationship through flexible scheduling; greater care coordination activities; maximization of workforce productivity; reduction in burnout; and a reduction in service delivery costs by allowing remote work and care provision.[10]

The COVID pandemic also necessitated flexibilities in how patients accessed methadone for unsupervised administration. SAMHSA's relaxation of the strict regulations related to methadone take home medication has been met with positive feedback and reports from patients, providers, and researchers. Allowing patients to take home 14–28 days of methadone medication as long as this has been deemed

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[4] Centers for Disease Control and Prevention, "Federal Grantees May Now Use Funds to Purchase Fentanyl Test Strips", (April 7, 2021).

[5] SAMHSA 2021 Report to Congress on the State Opioid Response Grants (SOR). *https://www.samhsa.gov/sites/default/files/2021-state-opioid-response-grants-report.pdf*.

[6] Substance Abuse and Mental Health Services Administration, "HHS Releases New Buprenorphine Practice Guidelines, Expanding Access to Treatment for Opioid Use Disorder" (April 27, 2021). *https://www.samhsa.gov/newsroom/press-announcements/202104270930*.

[7] Substance Abuse and Mental Health Services Administration Results From the 2018 National Survey on Drug Use and Health (2019) *https://www.samhsa.gov/data/*.

[8] Sordo, Barrio, Bravo, Indave, Degenhardt, Wiessing, Ferri, Pastor-Barriuso, Mortality Risk During and After Opioid Substitution Treatment: Systematic Review and Meta-analysis of Cohort Studies (Apr. 2017), available at: *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5421454/*.

[9] Guille, C., Simpson, A. N., Douglas, E., Boyars, L., Cristaldi, K., McElligott, J., Johnson, D., & Brady, K. (2020). *Treatment of opioid use disorder in pregnant women via telemedicine: A nonrandomized controlled trial*. JAMA Network Open, 3(1), e1920177-e1920177.

[10] King, V. L., Brooner, R. K., Peirce, J. M., Kolodner, K., & Kidorf, M. S. (2014). *A randomized trial of web-based videoconferencing for substance abuse counseling*. Journal of Substance Abuse Treatment, 46(1), 36–42.

safe and appropriate by the treating practitioner at the Opioid Treatment Program has proven safe and effective. It has allowed patients to work, go to school, and take care of their families without the restrictions previously imposed by SAMHSA's regulations—many of which have been criticized for years as being overly restrictive. Recent research has found that these increases in methadone take home doses have not been associated with increases in overdoses or other negative impacts. For these reasons, SAMHSA has announced that it intends to propose making these flexibilities permanent through rulemaking.

In 2021, SAMHSA certified 113 new opioid treatment programs, new brick and mortar medication units, as well as new mobile units to expand treatment across the Nation. As of July 2021, there are 1,950 active opioid treatment programs (OTPs) with 65 brick and mortar medication units, and 19 mobile locations. Additionally, SAMHSA assisted the Federal Bureau of Prisons (BOP) with establishing OTPs for its hub and spoke model for providing treatment across their system.

State and Tribal Opioid Response Grants

To assist states, territories, Tribes and Tribal Nations in addressing the Nation's overdose crisis, SAMHSA manages the State Opioid Response (SOR) and Tribal Opioid Response (TOR) grant programs. Recognizing that illicitly manufactured fentanyl is driving overdose deaths across much of the country, often in combination with stimulants, both programs focus on opioids and as selected by grantees, stimulants. As such, the core aims of SOR and TOR continue to involve increasing access to the three FDA-approved medications for the treatment of opioid use disorder, reducing unmet treatment need, and reducing opioid-related overdose deaths by supporting the full continuum of prevention, harm reduction, treatment, and recovery support services. These programs also support the continuum of care for those states and communities across the country who are dealing with rising rates of stimulant use in addition to opioids and the associated negative health, social, and economic consequences. Like the SOR program, the Tribal Opioid Response TOR grants program provides dedicated resources for these activities to Tribes and Tribal Nations.

As an example, in partnership with the Seattle Indian Health Board, Washington State provided low barrier treatment with medications for opioid use disorder and related services to urban American Indian and Alaskan Native individuals who are experiencing homelessness with OUD. In Alaska, in collaboration with the University of Alaska and with the assistance of SAMHSA-funded opioid technical assistance and training resources (i.e. Addiction Technology Transfer Center and the Opioid Response Network), Alaska has provided co-occurring behavioral health, opioid and stimulant use disorder trainings with SOR grant resources.

Substance Abuse Prevention and Treatment Block Grant

The Substance Abuse Prevention and Treatment Block Grant (SABG) helps all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, 6 Pacific jurisdictions, and 1 tribal entity in addressing substance use disorder treatment and prevention needs through support of prevention, treatment, and other services not covered by public or private insurance and non-clinical activities and services that address the critical needs of state substance use service systems. The SABG supports state prevention, treatment, and recovery systems' infrastructure and capacity, thereby increasing availability of services and development and implementation of evidence-based practices.

Medication-Assisted Treatment for Prescription Drug and Opioid Addiction

The Medication-Assisted Treatment for Prescription Drug and Opioid Addiction (MAT-PDOA) program addresses treatment needs of individuals who have an OUD by expanding/enhancing treatment system capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based Medications for Opioid Use Disorder (MOUD) and recovery support services.

Comprehensive Opioid Recovery Centers

The Comprehensive Opioid Recovery Center (CORC) program provides grants to nonprofit substance use disorder treatment organizations to operate comprehensive centers which provide a full spectrum of treatment and recovery support services for opioid use disorders. Grantees are required to provide outreach and the full continuum of treatment services including MOUD; counseling; treatment for mental disorders; testing for infectious diseases, residential treatment, and intensive outpatient services; recovery housing; peer recovery support services; job training, job

placement assistance, and continuing education; and family support services such as childcare, family counseling, and parenting interventions. The CORC Grantees have been utilizing funding to expand access to comprehensive services in a variety of ways, from improving the system of comprehensive MOUD care at the county level; improving follow-up with clients who have experienced overdose reversals; and removing barriers to MOUD in residential treatment to engaging special populations, such as homeless persons, people on probation, and LGBTQ+persons , and meeting the needs of underserved areas.

Certified Community Behavioral Health Clinics Expansion Grants

The Certified Community Behavioral Health Clinics (CCBHC) Expansion program is designed to increase access to and improve the quality of community mental and substance use disorder treatment services. CCBHCs funded under this program must provide access to services for individuals with serious mental illness or SUD, including OUD; children and adolescents with serious emotional disturbance; and individuals with co-occurring mental and substance use disorders. This program improves the mental health of individuals by providing comprehensive community-based mental and substance use disorder services; improving treatment of co-occurring disorders; advancing the integration of mental/substance use disorder treatment with physical health care; utilizing evidence-based practices on a more consistent basis; and promoting improved access to high quality care.

Data from intake to most recent reassessment for individuals served in the CCBHC program demonstrate that as of March 2022, enrollees have achieved a 72 percent reduction in hospitalization and a 69 percent reduction in Emergency Department visits, as well as a 25 percent increase in mental health functioning in everyday life. Additionally, the data demonstrated a 12 percent increase in employment or school enrollment. SAMHSA appreciates Congress including support for CCBHC planning grants and technical assistance in the Bipartisan Safer Communities Act.

Pregnant and Postpartum Women Program

The Pregnant and Postpartum Women program (PPW) uses a family centered approach to provide comprehensive residential substance use disorder treatment, prevention, and recovery support services for pregnant and postpartum individuals, their minor children, and for other family members. The family centered approach includes partnering with others to leverage diverse funding streams, encouraging the use of evidence-based practices, supporting innovation, and developing workforce capacity to meet the needs of these families. The PPW program provides services not covered under most public and private insurance. SAMHSA continues to prioritize states that support best-practice collaborative models for treatment, as well as provide support to pregnant individuals with OUD. The Comprehensive Addiction and Recovery Act increased accessibility and availability of services for pregnant individuals by expanding the authorized purposes of the program to include the provision of outpatient and intensive outpatient services.

Recovery

SAMHSA has a long history of advancing recovery supports dating back to the 1980's with the Community Support Program and the 1990's, when the first Recovery Community Support Programs were funded. SAMHSA defines recovery as a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.

Establishing an Office of Recovery and Advancing Peer Supports

Recovery is a key pillar of the HHS Overdose Prevention Strategy. That is why during Recovery Month last fall, SAMHSA announced it would be establishing a new Office of Recovery. This office promotes the involvement of people with lived experience throughout agency and stakeholder activities, fosters relationships with internal and external organizations in the mental health and addiction recovery fields, and identifies health disparities in high-risk and vulnerable populations to ensure equity for support services across the Nation.

We know that recovery is enhanced by peer-delivered support services. These services have proven to be effective in sustaining recovery over the long term. Investing in peer services is critical, given the significant workforce shortages in behavioral health. That is why, as part of the President's Strategy to Address Our National Mental Health Crisis, SAMHSA is updating and expanding existing com-

pendia [11] of state-by-state peer specialist certifications and is convening stakeholders to create a new set of model national standards for peer specialist certification.

SABG Recovery Set-Aside

The Administration supports the addition of a 10 percent set-aside within the SABG for recovery support services aimed at significantly expanding the continuum of care both upstream and downstream. This proposed set-aside would support the development of local recovery community support institutions (i.e., recovery community centers, recovery homes, recovery schools); develop strategies and educational campaigns, trainings, and events to reduce addiction/recovery-related stigma and discrimination at the local level; provide addiction recovery resources and support system navigation; make accessible peer recovery support services that support diverse populations and are inclusive of all pathways to recovery; and collaborate and coordinate with local private and non-profit clinical health care providers, the faith community, city, county, state, and Federal public health agencies, and criminal justice response efforts.

CONCLUSION

On behalf of my colleagues at SAMHSA, thank you for your interest in, and support for, our programs, and for supporting the Nation's behavioral health. I would be pleased to answer any questions you may have.

The CHAIR. Thank you.

Ms. Johnson.

STATEMENT OF CAROLE JOHNSON, ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION, ROCKVILLE, MD

Ms. JOHNSON. Chair Murray, Senator Cassidy, and Members of the Committee, thank you for the opportunity to speak with you today about the work of the Health Resources and Services Administration to address the opioid crisis, which, as this hearing demonstrates, is increasingly a fentanyl crisis.

I am Carole Johnson, Administrator of the Health Resources and Services Administration, the agency in the Department of Health and Human Services that is home to the Federal Office of Rural Health Policy, community health centers, the Ryan White HIV AIDS Program, Federal behavioral health workforce training programs, and our Federal investments in maternal and child health.

Across our work, we are seeing the impact of fentanyl use in the historically underserved communities that we serve, including urban, rural, and tribal communities. And we are committed to improving access to mental health and substance use disorder treatment and growing the behavioral health workforce.

I want to focus my remarks today on three key issues related to the crisis that HRSA's work aims to respond to. First, as the Chair mentioned, our investments in training and growing the mental health and substance use disorder workforce.

This includes psychiatrists and psychiatric nurses, social workers, substance use disorder counselors, psychologists, and peer support specialists with lived experience who are trained and funded through programs like our Behavioral Health Workforce Training

[11] Peer Recovery Center of Excellence, Comparative Analysis of State Requirements for Peer Support Specialist Training and Certification in the United States, January 2022 *https://www.peerrecoverynow.org/documents/Comparative%20Analysis-Jan.31.2022520(003).pdf.*

Program that supports direct training and stipends to build the next generation of mental health and substance use disorder providers.

The National Health Service Corps, where we offer loan repayment and scholarships to behavioral health students and providers in return for practicing in high need areas. And our other dedicated substance use disorder workforce programs like the Substance Use Disorder Treatment and Recovery Loan Repayment Program, our Addiction Medicine Fellowship Program, and our Opioid Impacted Families Support Program.

We believe that is critical to expand our investment in this training and deployment of a mental health and substance use disorder workforce that can respond to the prevention, treatment, and recovery needs of individuals struggling with fentanyl use.

That is why the President's budget includes a nearly $400 million investment in growing the number of mental health and substance use disorder providers. It is also why the American Rescue Plan's unprecedented investment in the National Health Service Corps has allowed us to see the largest cohort in the program's 50 year history, including thousands of behavioral health providers.

Second, I want to speak to our work to expand access to substance use disorder services in rural communities across the country. HRSA's Rural Communities Opioid Response Program reaches over 1,500 rural communities in 47 states. And we are funding what rural communities tell us they need, including more access to treatment for individuals using fentanyl.

In fact, in June, we announced a new $10 million rural investment to tackle synthetic opioid overdoses, including fentanyl and fentanyl laced drug overdoses, with the goal of creating new treatment access points in rural communities.

In June, we also announced a new $50 million rural investment focused on stimulants like methamphetamine, particularly as rural communities have reached out to us for help with their critical needs as they see drugs like meth and cocaine becoming even more dangerous due to contamination with highly potent fentanyl.

We also fund other tailored support programs in rural communities, such as grants to reduce the incidence and impact of neonatal abstinence syndrome and our Rural Centers of Excellence on Substance Use Disorder. And we are continuing, and we are committed to continuing to help rural communities respond to this crisis.

For a third and final point I want to emphasize HRSA's work to help ensure that there is no wrong door for getting mental health and substance use disorder help. And we want to do that by integrating behavioral health into primary care. And with this Committee's leadership, two important steps on that path were included in the bipartisan Safer Communities Act.

The bill gave us new tools and resources to expand mental health training of primary care providers, and the funding needed to grow our pediatric mental health access program to expand our work with pediatricians, as well as reach beyond pediatricians' offices and into schools in emergency departments.

We want there to be no wrong door for those seeking mental health and substance use disorder care, which is why we aim to expand the capacity of the primary care workforce to respond to the mental health and substance use disorder needs of the community, including family medicine, pediatrics, maternal care, internal medicine, and others.

We are committed to building on the primary care footprint of the 1,400 community health centers we fund in communities across the country to help reach this goal. We know there is much more work to do and are grateful to the Committee for the opportunity to work with you on the next steps.

Thank you for the opportunity to discuss HRSA's work, and I look forward to your questions.

[The prepared statement of Ms. Johnson follows:]

PREPARED STATEMENT OF CAROLE JOHNSON

Chair Murray, Ranking Member Burr, and Members of the Committee:

Thank you for the opportunity to speak with you today about the work of the Health Resources and Services Administration (HRSA) to address the opioid crisis, which is increasingly a fentanyl crisis, in communities across the country. I am Carole Johnson, Administrator of HRSA, the agency of the Department of Health and Human Services that is home to the Federal Office of Rural Health Policy, community health centers, the Ryan White HIV/AIDS Program, Federal behavioral health workforce training programs, and our Federal investments in maternal and child health programs. Across our work, we are seeing the impact of fentanyl use in the historically underserved and rural communities that we serve, and are committed to improving access to services and growing the behavioral health workforce to address these critical needs.

In October 2021, the Department of Health and Human Services released the HHS Overdose Prevention Strategy (Strategy), which is focused on saving lives, reducing risk, and removing barriers to effective interventions. As the Strategy notes, the epidemiology of drug overdose deaths has shifted from primarily involving prescription opioids in the late 1990's and early 2000's to the current poly drug landscape, where synthetic opioids like fentanyl and stimulants like methamphetamine are the major drivers of overdose.

Also, in recent years, there have been marked increases in overdose deaths among racial and ethnic minority populations, who are more likely to face barriers in accessing equitable treatment and recovery services. The rate of overdose deaths among non-Hispanic Black Americans more than tripled between 2010 and 2019, but Black Americans are still less likely to receive substance use disorder treatment than White Americans. At the same time, research also has shown regional variation in the types of drugs most commonly consumed and in access to services, with rural areas experiencing more challenges in treatment access compared to urban areas.

Today's testimony will review our work in rural and underserved communities to expand access to services as well as our focus on training and building the behavioral health workforce.

Overdose Prevention and Treatment in Rural Communities

Rural communities are on the frontline of the surge in synthetic opioid overdoses, including fentanyl and fentanyl-laced drug overdoses. HRSA funds the Rural Communities Opioid Response Program (RCORP), a multi-year initiative aimed at reducing opioid use in rural communities that reaches over 1,500 rural communities in 47 states and has supported the provision of direct services to over two million rural residents. The RCORP initiative is aimed at meeting community needs and programs are designed through feedback received directly from rural stakeholders. Through RCORP, HRSA funds five major lines of work in rural communities addressing opioid use disorder, including:

- **Planning grants** to help rural communities conduct needs assessments, build partnerships, and develop workforce plans and otherwise build their community framework for prevention, treatment and recovery;

- **Implementation grants** to support rural communities in strengthening and expanding opioid use disorder prevention, treatment, and recovery services in rural areas;
- **Medication-Assisted Treatment expansion grants** to support the establishment and/or expansion of medication-assisted treatment in eligible rural hospitals, clinics, and tribal organizations;
- **Neonatal Abstinence Syndrome** grants to reduce the incidence and impact of Neonatal Abstinence Syndrome in rural communities by improving systems of care, family supports, and social determinants of health; and
- **Psychostimulant Program grants** to strengthen and expand prevention, treatment, and recovery services for individuals in rural areas who misuse psychostimulants and enhance their ability to access treatment and move toward recovery.

HRSA also supports three Rural Centers of Excellence on Substance Use Disorders to identify and share evidence-based programs and best practices for substance use disorder treatment, including as it relates to fentanyl and prevention in rural communities. They are: (1) the University of Rochester in New York, which focuses on addressing synthetic opioid-related overdose mortality in the Appalachian region, particularly high-need rural Appalachian counties in Kentucky, New York, Ohio, and West Virginia; (2) the Center on Rural Addiction at the University of Vermont, which focuses on treatment interventions and supports in rural communities in Maine, New Hampshire, and Vermont; and (3) the Fletcher Group in Stockbridge, Georgia in partnership with the University of Kentucky, which focuses on recovery housing in rural counties in Kentucky, Georgia, West Virginia, Ohio, Idaho, Montana, Oregon, and Washington. In addition, in partnership with the Northern Border Regional Commission, a Federal-state partnership to assist the most distressed counties of Maine, New Hampshire, Vermont, and New York, HRSA supports Rural Behavioral Health Workforce Centers to train health workers and community members to support individuals with substance use disorders. HRSA also supports an online technical assistance portal to help our rural behavioral health grantees request technical assistance, find nearby grantees or grantees with a similar focus, and access a repository of resources tailored to support RCORP grantees.

In fiscal year 2020, HRSA rural grantees trained over 44,000 providers, paraprofessional staff, and community members to administer naloxone and between September 1, 2021 and February 28, 2022, over 60 percent of award recipients reported actively distributing fentanyl test strips in their rural service area.[1] Yet, with almost 30 percent of rural Americans compared to 2.2 percent of urban Americans living in a county without a buprenorphine provider, HRSA believes it is critical to continually focus on expanding access to the evidence-based tools that we know work, including medication to treat opioid use disorder. To that end, HRSA recently announced the availability of $10 million in grant funding through a new RCORP program called Medication-Assisted Treatment Access. This funding will help rural communities establish new treatment access points to connect individuals to medication, counseling, and behavioral therapies to treat opioid use disorder, with a particular emphasis on supporting new buprenorphine providers to help reach more individuals in need.

Last month, HRSA announced nearly $15 million in funding to address psychostimulant misuse and related overdose deaths in rural communities. Psychostimulants include methamphetamine and other illegal drugs, such as cocaine and ecstasy. The overdose crisis has evolved over time and is now largely characterized by deaths involving illicitly manufactured synthetic opioids, including fentanyl, and, increasingly, psychostimulants. Overdose deaths involving methamphetamine nearly tripled from 2015 to 2019 among people ages 18–64 in the United States, according to a study by the National Institutes of Health, which also noted that methamphetamine and cocaine are becoming more dangerous due to contamination with highly potent fentanyl, and increases in higher risk use patterns such as multiple substance use and regular use. Rural communities have made their concerns about what they are seeing with stimulant use known to us, and given the flexibility of the RCORP program, we were able to respond with these timely investments.

Looking ahead, HRSA will continues to provide critical resources to address the drug overdose crisis and remain responsive to rural community needs. We anticipate awarding more than $90 million in additional community-based funding to help

[1] RCORP-awardee performance data.

rural communities address substance use disorder and broader behavioral health care needs before the end of this fiscal year.[2] In fiscal year 2023, our proposed budget focuses on expanding access to substance use prevention and treatment across rural communities.

Health Centers and Opioid Use Disorder

As you know, HRSA supports 1,400 community health centers in high need, underserved communities across the country, where services are available regardless of an individual's ability to pay. The Health Center Program supports health centers that provide primary care in underserved communities across the country and health centers are increasingly focused on integrating behavioral health into primary care services. We also fund the Health Care for the Homeless Program, which supports coordinated, comprehensive, integrated primary care including substance use and mental health services for individuals experiencing homelessness. While many health centers offer a range of integrated primary care services, HRSA is committed to increasing the capacity of health centers to deliver mental health and substance use disorder services. HRSA also provides all health centers with access to technical assistance resources to promote the integration of behavioral health and substance use disorder services in primary care.

To further improve access and raise the quality of substance use disorder services, the availability of services onsite is essential. HRSA is supporting this goal by training health center clinicians to provide high quality and expanded services for those with substance use disorders. Because many communities served by health centers have a high need for substance use disorder treatment and services, many health centers have chosen to co-locate and integrate substance use disorder services reflecting efficient and effective approaches in meeting patient needs. The integration of these services can include the provision of enhanced services, such as medication-assisted treatment by primary care clinicians. Going forward, HRSA is committed to continuing to grow this footprint and expand access to opioid use disorder treatment in high need communities across the country. Further support is provided to clinicians through the Substance Use Warmline, which provides free, real-time clinician-to-clinician telephone consultation to health centers, focusing on substance use evaluation and management for integrated primary care and behavioral health clinicians.

HRSA also supports health centers to improve their care and delivery of services by making a variety of technical assistance available. The Health Center Program Care Integration of Behavioral Health and Substance Use Disorder Services Technical Assistance focuses on integrating behavioral health services through the dissemination of evidence-based practices for health care delivery, as well as quality improvement recommendations to improve access to health care for medically underserved and vulnerable populations. Health centers receive one-on-one support, directed to the health center's specific needs and goals. Additionally, the National Training and Technical Assistance Partners provides training and technical assistance to existing and potential health center grantees and look-alikes.

Ryan White HIV/AIDS Program and Opioid Use Disorder

The Ryan White HIV/AIDS Program provides critical health care and support services for people with HIV to help them get into and stay in HIV care. This includes a range of behavioral health-focused services, including mental health services, case management, inpatient and outpatient substance use disorder treatment, and psychosocial support services. The program plays a critical role in addressing the public health crisis of opioid use disorder, including fentanyl, for people with HIV, especially within rural communities. In consideration of the opioid crisis, Ryan White HIV/AIDS Program grantees are facing the need to redouble their efforts to provide a range of needed services to the most vulnerable populations, including those who are uninsured or underinsured, meeting clients where they are and working to improve individual-level and overall public health.

HRSA supports Ryan White HIV/AIDS Program providers in addressing opioid use disorder through training, technical assistance, and funding innovative projects, including targeted projects to strengthen networks of care to respond to the opioid epidemic and ensure people with HIV and an opioid use disorder have access to behavioral health care, treatment, and recovery services. Further, HRSA also funds an initiative focused on implementing effective and culturally appropriate evidence-

[2] RCORP-Implementation (HRSA–22–057); RCORP-Behavioral Health Care Support (HRSA–22–061).

informed interventions for integrating behavioral health in primary care settings and identifying and addressing trauma among people with HIV. Services include recently diagnosed patients being screened for referrals to substance use treatment, mental health supports, and other services, as well as facilitating rapid institution of prophylactic medications when necessary; taking action to ensure that mental health conditions, substance use, history of trauma, low health literacy, and lack of support services among individuals living with HIV can be addressed; and cognitive-behavioral group therapy program designed to address co-occurring substance use and PTSD.

Health Workforce and Behavioral Health

HRSA programs play a critical role in growing and training the behavioral health workforce, which are integral to building the capacity to improve access to mental health and substance use disorder treatment. HRSA funds:

- Scholarships and loan repayment through the National Health Services Corps where behavioral health providers receive support for committing to practice in a high need community;
- Training programs focused on recruiting and training mental health and substance use disorder clinicians such as psychiatrists, psychologists, psychiatric nurses, social workers, and marriage and family therapists;
- Training programs that help engage and retain people in mental health and substance use disorder treatment, including community health workers and peer support specialists;
- The Addiction Medicine Fellowship Program that focuses on increasing the number of board certified addiction medicine and addiction psychiatry specialists trained in providing behavioral health services, including prevention, treatment, and recovery services;
- Graduate Medical Education, including the Children's Hospitals Graduate Medical Education Program, which supports the training of pediatric residents, including pediatric psychiatry residents, in freestanding children's teaching hospitals, and the Teaching Health Center Graduate Medical Education Program, which supports primary care residency training, including for psychiatry, in community-based ambulatory patient care centers.

Thanks to the Bipartisan Safer Communities Act, HRSA is also working to implement new funding to support integrating behavioral health training in pediatric primary care training.

To strengthen the mental health and substance use disorder workforce, the fiscal year 2023 budget proposes an investment of $397 million for HRSA's Behavioral Health Workforce Development Programs, which is $235 million above fiscal year 2022 enacted level. This funding will increase training of new behavioral health providers, including a track for health support workers like peers and community health workers, and place an emphasis on team-based care. To promote inclusive and equitable behavioral health care for youth, this investment will support a special focus on the knowledge and understanding of children, adolescents, and youth at risk for a mental health disorder, serious emotional disturbance, or substance use disorder.

National Health Service Corps:

HRSA's largest workforce program is the **National Health Service Corps**, which has also played a significant role in combatting the overdose epidemic by growing and retaining a skilled workforce of behavioral health professionals and increasing access to opioid and SUD treatment and mental and behavioral health services in underserved communities. Thousands of behavioral health clinicians have and are serving in underserved communities through the support of the NHSC. The NHSC provides scholarships and loan repayment for clinicians, including mental health and substance use disorder providers, who commit to practice in underserved communities. In 2021, thanks to the American Rescue Plan Act of 2021, nearly 20,000 clinicians were practicing in underserved communities through the National Health Service Corps, the largest number in the 50-year history of the program.

The National Health Service Corps also received a dedicated appropriation to expand and improve access to quality opioid and substance use disorder treatment in rural and underserved areas in settings such as opioid treatment programs, office-

based opioid treatment facilities, and non-opioid outpatient SUD facilities. Funding for this **National Health Service Corps Substance Use Disorder Workforce Loan Repayment Program** supports the recruitment and retention of health professionals needed in underserved areas to provide evidence-based substance use disorder treatment and to help prevent overdose deaths. Providers receive loan repayment assistance to reduce their educational financial debt in exchange for service at substance use disorder treatment facilities. More than 3,000 clinicians are practicing in the field thanks to the National Health Service Corps Substance Use Disorder Workforce Loan Repayment Program.

HRSA also support the **National Health Service Corps Rural Community Loan Repayment Program**, a program for providers working to combat the opioid epidemic in the Nation's rural communities. This program has made loan repayment awards in coordination with the Rural Communities Opioid Response Program initiative to provide evidence-based substance use treatment, assist in recovery, and to prevent overdose deaths in rural communities. More than 1,200 clinicians are practicing in rural communities thanks to the National Health Service Corps' Rural Community Loan Repayment Program.

The **Substance Use Disorder Treatment and Recovery (STAR) Loan Repayment Program** focuses on recruiting and retaining medical, nursing, and behavioral health clinicians and paraprofessionals who provide direct treatment or recovery support of patients with or in recovery from a substance use disorder through loan repayment in return for providing services in high need areas. Participation in this new program is open to a number of provider disciplines and specialties, including bachelor's-level SUD counselors, behavioral health paraprofessionals, and clinical support staff, that previously have not been eligible to participate in other HRSA-administered opioid-related loan repayment programs. The STAR Loan Repayment Program's first application cycle in fiscal year 2021 made 255 awards.

Behavioral Health Workforce Training Programs:

The **Behavioral Health Workforce Education and Training Programs** (BHWET) for Professionals and Paraprofessionals are HRSA's primary grant program to support the training of social workers, psychologists, school and clinical counselors, psychiatric nurse practitioners, marriage and family therapists, community health workers, outreach workers, social services aides, mental health workers, substance use disorder workers, youth workers, and peers. In Academic Year 2020–2021, the BHWET Program supported training for nearly 6,500 individuals. The program aims to increase the supply of behavioral health professionals and paraprofessionals while also improving distribution of a quality behavioral health workforce and thereby increasing access to behavioral health services. The President's Budget for Fiscal Year 2023 would significantly expand investment in this critical training program.

The **HRSA Addiction Medicine Fellowship Program** focuses on increasing the number of board certified addiction medicine and addiction psychiatry specialists trained in providing behavioral health services, including prevention, treatment, and recovery services in underserved, community-based settings. In Academic Year 2020–2021, awardees trained 98 fellows in addiction medicine, including 63 graduates. Throughout the year, the fellows recorded over 61,000 hours of training and nearly 80,000 patient encounters in medically underserved communities. The **HRSA Integrated Substance Use Disorder Training Program** supports training and expansion of the number of nurse practitioners, physician assistants, health service psychologists, and social workers trained to provide mental health and substance use disorder services in underserved community-based settings that integrate primary care and mental health and substance use disorder services, and the **HRSA Opioid-Impacted Family Support Program** trains paraprofessionals to support children and families living in underserved areas who are impacted by opioid use disorder and other substance use disorders. The **HRSA Graduate Psychology Education Program** supports innovative doctoral level health psychology programs that foster a collaborative approach to providing mental health and substance use disorder prevention and treatment services in high need and high demand areas through academic and community partnerships. In addition, HRSA recently issued a funding opportunity announcement for community health worker and other health support worker training, including peer specialists, which aims to build the workforce supporting community connections to care.

Additionally, HRSA supports the **Children's Hospitals Graduate Medical Education Program** which supports the training of pediatric residents, including pediatric psychiatry residents, in freestanding children's teaching hospitals, and the

Teaching Health Center Graduate Medical Education Program, which supports primary care residency training, including for psychiatry, in community-based ambulatory patient care centers.

HRSA continues to take innovative steps to grow the behavioral health workforce and support the recruitment and retention of health professionals needed in underserved areas to expand access to substance use disorder treatment and prevent overdose deaths, particularly given the increasing challenges communities are facing as a result of fentanyl.

Conclusion

Thank you for the opportunity to discuss HRSA's work on this critical public health issue and our commitment to continuing to take all steps that we can to combat is epidemic. We look forward to continuing to work with the Committee on solutions to the Nation's overdose crisis.

The CHAIR. Thank you.

Dr. Jones.

STATEMENT OF CHRISTOPHER JONES, PHARM.D, DR.PH, MPH, ACTING DIRECTOR, NATIONAL CENTER FOR INJURY PREVENTION AND CONTROL, UNITED STATES CENTERS FOR DISEASE CONTROL AND PREVENTION ATLANTA, GA

Dr. JONES. Chair Murray, Senator Cassidy, and distinguished Members of the Committee, it is an honor to appear before you today to discuss the Centers for Disease Control and Prevention's efforts to address the overdose crisis. Thank you to the Committee for your attention to this important public health challenge.

This is a complex issue that requires a coordinated approach, and I am pleased to be here with my colleagues from SAMHSA, HRSA, and ONDCP. The overdose crisis continues to escalate due to the proliferation of highly potent synthetic opioids like illicit fentanyl and the resurgence of stimulants like methamphetamine.

In fact, we have never seen an illicit drug supply that is so potent, unpredictable, or lethal. According to the latest CDC provisional data, of the more than 100,000 overdose deaths in 2021, 75 percent involved at least one opioid, with 66 percent specifically involving synthetic opioids and 50 percent involving stimulants, often in combination with synthetic opioids.

These statistics reflect the urgent need for action, and CDC is confronting this crisis through five key strategies that complement the work of our sister agencies in HHS and across the Federal Government. Our first strategy focuses on data which are foundational to prevention efforts.

CDC uses data to stay on the leading edge of overdose trends to ensure that communities have the information they need to respond to the evolving crisis. Through our Overdose Data to Action or OD2A program, CDC administers two key data systems to improve the timeliness and comprehensiveness of both nonfatal and fatal overdose data.

The drug overdose surveillance and epidemiology or DOSE system collects near real time data on non-fatal overdoses in emergency departments. States participating in DOSE have immediate access to their data and can quickly mobilize a community response to surges in overdose.

The State Unintentional Drug Overdose Reporting System, or SUDORS, provides detailed contextual information on the circumstances of overdose deaths and the specific substances involved in deaths to inform prevention strategies. To make these data more readily available for decision-making, we recently launched public facing dashboards for both DOSE and SUDORS.

Our second strategy is building state, tribal, local, and territorial capacity. In addition to 47 states and DC, CDC's OD2A program funds in 19 cities, counties, and territories, and we fund 26 tribal entities through other cooperative agreements.

Under these programs, funding is used to build public health capacity, leverage data to drive action, and support the implementation of evidence based strategies to reduce overdose. Our third strategy is supporting providers, health systems, payers, and employers.

Under this strategy, CDC supports efforts to increase safer prescribing and improve pain care, maximize the use of prescription drug monitoring programs, advance insurer and health system interventions, and link people to care and services across health care, community, and criminal justice settings.

Our fourth strategy focuses on partnering with public safety and community organizations. For example, the Overdose Response Strategy, a unique collaboration between CDC and ONDCP's HIDTA program helps communities reduce overdose by connecting public health and public safety agencies in all 50 states.

CDC also partners with ONDCP on the Drug-Free Communities Program to provide grants and supports to hundreds of community coalitions across the country to advance youth substance use prevention. Our fifth strategy is raising public awareness and reducing stigma.

To advance this strategy, we recently launched a campaign called Stop Overdose, which focuses on raising awareness about fentanyl, naloxone, polysubstance use, and decreasing stigma. To date, Stop Overdose has reached over 1 billion views.

Finally, CDC recognizes the importance of preventing adverse childhood experiences or ACEs as a key part of the prevention strategy. ACEs are potentially traumatic events that happen during childhood, and decades of research show ACEs are strongly linked to risk for substance use addiction and overdose, as well as risk for mental health challenges and suicide, among other leading causes of death.

By focusing on upstream ACEs prevention, we can make substantial progress in preventing substance use and overdose and addressing the behavioral health challenges facing our Nation. As a person in long term recovery, I know firsthand the pain and devastation that addiction can inflict on individuals, families, and communities. But I have also seen the transformative power of recovery.

I am grateful to be one of the millions of Americans in recovery that can serve as a beacon of hope to others struggling with substance use. This work is very personal to me, and at CDC, we are committed to advancing a comprehensive, community driven ap-

proach to save lives today, get ahead of the crisis by identifying emerging threats, and supporting upstream prevention so the next generation doesn't have to experience this overdose crisis.

Thank you for the opportunity to be here. I look forward to your questions.

[The prepared statement of Dr. Jones follows:]

PREPARED STATEMENT OF CHRISTOPHER JONES

Introduction

Chair Murray, Ranking Member Burr, and distinguished Members of the Committee, thank you for the opportunity to be here today to discuss the Centers for Disease Control and Prevention's efforts to address of our Nation's drug overdose crisis. I appreciate the Committee's dedicated support and attention to this pressing public health issue and we at CDC are committed to continuing our work to tackle the growing crisis.

Over the past two decades, drug overdose deaths have claimed far too many lives, with more than 250 Americans now dying each day from an overdose.[1] These sobering statistics represent individuals, families, and communities that have been deeply and forever impacted by this crisis. However, there is hope in knowing that we can alter this trajectory. Drug overdoses can be prevented and people with substance use disorders can recover. At CDC, we are working tirelessly to prevent overdose and substance-use related harms so that we can save lives and all people can achieve optimal health and well-being.

The drug overdose crisis is complex and requires a multi-sector, multi-pronged response. That is why I am pleased and privileged to be joined by colleagues from the Office of National Drug Control Policy (ONDCP), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Health Resources and Services Administration (HRSA) to discuss the Federal Government's comprehensive response to curtail substance use and overdose, particularly from illicitly made fentanyl. Together we can stop drug overdoses and save lives.

The latest provisional mortality data from CDC indicate that more than 107,000 Americans died from a drug overdose in the 12-months ending in January 2022. Of these deaths, it is estimated that 80,590 of these deaths, or 75 percent, involved at least one opioid, with 71,450 (66.5 percent) involving synthetic opioids, primarily illicitly manufactured fentanyl or fentanyl analogs.[2] Stimulant overdose deaths are also on the rise, with approximately 33,128 (30.8 percent) deaths involving methamphetamine and 24,751 (23 percent) involving cocaine.[3] The increases in overdose deaths have been experienced across the nation. The overdose crisis cuts across socioeconomics, demographics, political and religious affiliation, and geography. This is a crisis that impacts both large cities and rural communities. Particularly noteworthy are the recent unprecedented increases in overdoses among communities of color, including Black persons and American Indian and Alaska Native persons, with disparities in overdose deaths among these populations compared to White persons worsening during the COVID-19 pandemic.[4]

Driving the historic increases in overdose deaths, particularly since 2013, is the continued proliferation of a highly potent and unpredictable illicit drug market saturated with synthetic opioids, especially illicitly manufactured fentanyl and fentanyl analogs (IMFs), which are easier and less costly to make, distribute, and sell. Introduced primarily as adulterants in, or replacements for white powder heroin in drug markets east of the Mississippi River, IMFs are now widespread in these white pow-

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[1] Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2021. Available at *http://wonder.cdc.gov*.

[2] Centers for Disease Control and Prevention. State Unintentional Drug Overdose Reporting System (SUDORS). Atlanta, GA: US Department of Health and Human Services, CDC; [2022, July, 11]. Access at: *https://www.cdc.gov/drugoverdose/fatal/dashboard*.

[3] Centers for Disease Control and Prevention. State Unintentional Drug Overdose Reporting System (SUDORS). Atlanta, GA: US Department of Health and Human Services, CDC; [2022, July, 11]. Access at: *https://www.cdc.gov/drugoverdose/fatal/dashboard*.

[4] Vital Signs: Drug Overdose Deaths, by Selected Sociodemographic and Social Determinants of Health Characteristics—25 States and the District of Columbia, 2019—20Mbabazi Kariisa, PhD1; Nicole L. Davis, PhD1; Sagar Kumar, MPH1; Puja Seth, PhD1; Christine L. Mattson, PhD1; Farnaz Chowdhury; Christopher M. Jones, PharmD, DrPH3 *Vital Signs: Drug Overdose Deaths, by Selected Sociodemographic and Social Determinants of Health Characteristics—25 States and the District of Columbia, 2019–2020 MMWR (cdc.gov)*.

der heroin markets, increasingly expanding into drug markets in the western United States, and readily available as pressed counterfeit pills that resemble commonly misused prescription drugs such as oxycodone and alprazolam throughout the U.S.[5] Data from the Drug Enforcement Administration and other law enforcement partners also indicate that IMFs are found in some illicit supplies of other drugs such as methamphetamine and cocaine, adding an additional concern about unintentional exposure to these highly potent drugs among individuals who may have little prior exposure to opioids—exponentially raising their risk for overdose. Illicitly manufactured fentanyl is highly potent, and CDC data shows that over half of decedents with an IMF-related overdose had no pulse when first responders arrived at the scene.[6], [7]

The recent increases in overdose deaths highlight the need to ensure people most at risk of overdose can access care, as well as the urgent need to expand prevention and response activities with a focus on health equity. As the nation's public health and prevention agency, CDC is leading the public health approach in collaboration with our state, local, territorial, and tribal partners. Our top priority is to address the overdose crisis by rapidly tracking the evolving epidemic and using this information to equip people on the ground to save lives in their community. We work to ensure that data is driving decision making and planning so that the response to the overdose crisis meets local needs, particularly in communities hardest hit by IMFs. Communities use this information to inform where they should focus their efforts including activities such as providing naloxone, decreasing stigma, increasing linkage to care, and improving bystander education and response.

CDC prioritizes *five key strategies that align with the HHS-wide Overdose Prevention Strategy* to address the evolving drug overdose crisis and reduce substance use related harms: (1) monitoring, analyzing, and communicating trends; (2) building state, tribal, local, and territorial capacity; (3) supporting providers, health systems, payors, and employers; (4) partnering with public safety and community organizations; and (5) raising public awareness and reducing stigma. CDC's mission is to end this crisis by using data to drive innovation, tailoring prevention in local communities, partnering broadly, and addressing underlying factors, including a central focus on health inequities, and preventing or reducing adverse childhood experiences, which are key risk factors for substance use and overdose.

CDC's Efforts to Use Data for Overdose Prevention

Data are essential for informing a public health response to the overdose crisis. CDC uses data to understand drivers of both nonfatal and fatal overdose, including its scope and magnitude, who is most impacted, and to track trends over time to inform prevention and response efforts. CDC's National Center for Health Statistics (NCHS) maintains strong working relationships with state vital records offices and has made great strides in improving the timeliness and completeness of drug overdose death certificates in recent years. In fact, the improvements in the timeliness of these data have now made it possible to provide provisional drug overdose death data on a monthly basis, allowing for the identification of trends in overdose counts by drug class within 4–5 months as opposed to within 2 years. NCHS has also now released provisional drug overdose death data on CDC's online analysis system **WONDER**, enabling for the first time, detailed analyses of overdose death counts and rates by demographic and geographic characteristics. These improvements allow us to assess overdose death trends at a national level and adjust our use of resources in a timelier manner. In addition, the completeness of drug overdose death certificates has greatly improved in recent years, with approximately 95 percent of drug overdose death certificates listing specific drugs contributing to the overdose, up from approximately 75 percent a decade ago. To continue to advance improvements in the death certification process, CDC has recently established a Coordinating Office for Medical Examiners and Coroners that will continue to seek improvements in the speed, accuracy, and completeness of data received.

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[5] Shover CL, Falasinnu TO, Dwyer CL, et al. Steep increases in fentanyl-related mortality west of the Mississippi River: recent evidence from county and state surveillance. Drug Alcohol Depend 2020;216:108314. *https://doi.org/10.1016/j.drugalcdep.2020.108314*.

[6] O'Donnell J, Tanz LJ, Gladden RM, Davis NL, Bitting J. Trends in and Characteristics of Drug Overdose Deaths Involving Illicitly Manufactured Fentanyls—United States, 2019–2020. MMWR Morb Mortal Wkly Rep 2021;70:1740–1746. DOI: *http://dx.doi.org/10.15585/mmwr.mm7050e3*.

[7] Gill H, Kelly E, Henderson G. How the complex pharmacology of the fentanyls contributes to their lethality. Addiction 2019;114:1524–5. *https://doi.org/10.1111/add.14614*.

CDC's National Center for Injury Prevention and Control has developed two key data systems to improve the timeliness and comprehensiveness of both nonfatal and fatal overdose data as part of the Overdose Data to Action (OD2A) cooperative agreement. These two systems provide more information about substances contributing to nonfatal overdoses and contextual information about what led to an overdose death. CDC's *Drug Overdose Surveillance and Epidemiology (DOSE) System* was developed to analyze data from electronic health records to rapidly identify outbreaks and provide situational awareness of changes in suspected drug overdose-related emergency department visits at the local, state, and regional levels ensuring consistent and accurate reporting across all entities that make it easier to compare data across states. DOSE captures timely data on emergency department visits involving all suspected drug overdoses, including demographic characteristics of those who overdose such as sex, age, and county of patient residence. Since 2019, forty-one states and the District of Columbia have provided data to CDC on a monthly basis which is publicly accessible through an *Interactive dashboard*. This data improves coordination and strategic planning for intervention and response efforts among health departments, community members, healthcare providers, public health, law enforcement, and government agencies.

CDC's State Unintentional Drug Overdose Reporting System (SUDORS) collects comprehensive information on drug overdose deaths in 47 states and the District of Columbia. The data are collected from death certificates and medical examiner/coroner reports (including scene findings, autopsy reports, and full postmortem toxicology findings) to help inform overdose prevention and response efforts by (1) lending a better understanding of the circumstances that surround overdose deaths, (2) identifying specific substances causing or contributing to overdose deaths as well as emerging and polysubstance overdose trends, and (3) improving the timeliness and accuracy of overdose data. In 2016, SUDORS began as part of CDC's Enhanced State Opioid Overdose Surveillance (ESOOS) program, to provide comprehensive data on opioid-involved overdose deaths. In 2019, SUDORS expanded to collect data on all unintentional and undetermined intent drug overdose deaths. Through this data, we have gleaned integral information that can help inform prevention in communities. For example, recent SUDORS data indicated that more than 3 in 5 people who died from a drug overdose had an identified opportunity for linkage to care or life-saving actions.[8] In addition, 40 percent of overdose deaths occurred while a bystander was present.[9] CDC disseminates both DOSE and SUDORS data through *interactive data dashboards* accessible via CDC's website.

In addition to DOSE and SUDORS investments in states, localities, and territories, CDC continues to use other proprietary data sets to gain a holistic understanding of the factors that contribute to drug overdose and substance use related harms so communities know what interventions to choose and when to make adjustments based on the evolving crisis. This includes leveraging data sets within CDC and from our Federal partners, including data related to substance use disorder and treatment, prescribing data, and using innovative data science tools, methods, and techniques, and advance modeling efforts to help communities allocate resources and interventions. CDC is also supporting medical examiners and coroners with increased toxicology testing as well as supporting labs to identify synthetic opioids through the provision of Traceable Opioid Material Kits that provide reference materials for fentanyl compounds and other synthetic opioids. In coming months, CDC will expand this portfolio to include stimulant reference materials. Finally, CDC works collaboratively with other Federal partners to conduct research and leverage available data sources that help identify key information about emerging substance use patterns, prevalence, treatment availability, and the changing drug supply.

CDC's Comprehensive Public Health Approach to Preventing Overdose and Substance Use Related Harms

CDC's National Center for Injury Prevention and Control has funded state health departments for overdose prevention activities since 2015, beginning with a small subset of high-burden states. This program has since scaled to a national program

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[8] O'Donnell J, Gladden RM, Mattson CL, Hunter CT, Davis NL. Vital Signs: Characteristics of Drug Overdose Deaths Involving Opioids and Stimulants—24 States and the District of Columbia, January—June 2019. MMWR Morb Mortal Wkly Rep 2020;69:1189–1197. DOI: *http://dx.doi.org/10.15585/mmwr.mm6935a1*.

[9] O'Donnell J, Gladden RM, Mattson CL, Hunter CT, Davis NL. Vital Signs: Characteristics of Drug Overdose Deaths Involving Opioids and Stimulants—24 States and the District of Columbia, January—June 2019. MMWR Morb Mortal Wkly Rep 2020;69:1189–1197. DOI: http://dx.doi.org/10.15585/mmwr.mm6935a1.

that has not only provided support to every state that applies for funding but adapted as the overdose crisis evolved. Under the Overdose Data to Action (OD2A) program, CDC now funds 47 states, Washington DC, and 16 city and county health departments to advance surveillance efforts, which allows the departments to tailor the implementation of prevention efforts with a menu of strategies that support jurisdictions in addressing the primary drivers of overdose in their states and communities.

As the overdose crisis has broadened, CDC has expanded the initial scope of its overdose prevention activities to address new challenges along with opioids misuse and overdose. This flexibility allows funded jurisdictions to meet the needs of today's crisis, including investing in populations with a high percentage of individuals using stimulants like methamphetamine and cocaine, which we know are increasingly intertwined with illicit fentanyl and opioid overdose. CDC has also scaled investments in activities to link people to care and treatment across health care, community, and criminal justice settings. These activities include peer navigation, quick response teams, and harm reduction and represent an important compliment to the work of other agencies focused on funding substance use treatment and service delivery. The insights we have gained from OD2A have informed two new funding opportunities that were recently announced, including an announcement specifically to support state and territorial health departments (OD2A-S) and another to support local health departments (OD2A-Local). CDC is also partnering with other Federal agencies to coordinate and leverage all resources to increase uptake of these important strategies. For example, The National Harm Reduction Technical Assistance Center (NHRTAC) is a joint project funded by CDC and SAMHSA. This program provides critical technical assistance to harm reduction programs, including syringe services programs (SSPs) to prevent the spread of infectious diseases, and other community-based programs and organizations that provide treatment, prevention, recovery, and harm reduction services including increasing access to fentanyl test strips (FTS) by allowing Federal funds to be used to purchase FTS in an effort to curb the spike in drug overdose deaths.

In addition to the Overdose Data to Action program, CDC, in partnership with the National Association of City and County Health Officials, supports local county health departments through the Implementing Overdose Prevention Strategies at the Local Level (IOPSLL) program. This program focuses on establishing linkages to care; supporting providers and health systems; enhancing surveillance and data sharing capabilities; improving partnerships with public safety and first responders; implementing harm reduction activities such as providing fentanyl test strips and educating about the use of naloxone; developing communications campaigns; and implementing innovative prevention projects. This program enables the implementation of innovations and promising strategies at the local level and is an essential source of funding for capacity-building that can increase readiness to participate in future funding opportunities aimed at local health departments.

CDC also funds 11 Tribal Epidemiology Centers and 15 tribes or tribal-serving organizations for overdose prevention activities. These collaborations support efforts to improve data quality, completeness, accuracy, and timeliness among a high-risk population. Funding also supports regional strategic planning to address opioid overdose prevention so that strategies appropriate to tribal communities are developed by the communities impacted and the strengths inherent to tribal organizations are built upon and scaled across the country.

In addition to supporting states, localities, territories, and tribes, CDC continues to advance partnerships through multiple public health and public safety collaborations that aim to strengthen and improve efforts to reduce drug overdoses. These partnerships allow for effective implementation of programs and help advance promising strategies that address rising overdoses in communities. The *Overdose Response Strategy (ORS)* is a unique collaboration between CDC and the *High Intensity Drug Trafficking Areas (HIDTA)* program at ONDCP designed to enhance public health and public safety partnerships. The mission of the ORS is to help communities reduce fatal and non-fatal drug overdoses by connecting public health and public safety agencies, sharing information, and supporting evidence-based interventions. More specifically, under the program, drug intelligence officers and public health analysts collaborate and leverage supply and overdose data to problem-solve and address local and regional issues, including spikes in overdoses related to illicit fentanyl. Given the potential impact of this program, CDC has expanded its investment in this partnership to support the public health component in all 50 states, Puerto Rico and the U.S. Virgin Islands.

The ORS also supports the *Combatting Overdose through Community-level Intervention program*, to implement innovative strategies within a targeted geographic

area to build the evidence base for response activities that other communities can employ. Projects include efforts on post-overdose strategies to link people to care using patient navigators and recovery coaches; justice-involved populations and access to medications for opioid use disorder (MOUD); buprenorphine induction in emergency departments; and training and provision of trauma-informed care.

One example from the program is the Martinsburg Initiative in West Virginia. The Initiative is an innovative, police-school-community partnership focused on opioid overdose prevention that can act as a model for other communities. Through a partnership between the Martinsburg Police Department, Berkeley County Schools, and Shepherd University, this project expands community resources and links law enforcement, schools, communities, and families in a dynamic partnership that assesses participants' ACE scores and subsequently links them to necessary resources and supports. Through a strategic focus that targets at-risk children and families experiencing challenges, this initiative aims to assess, identify, and reduce the root cause families experiencing challenges, this initiative aims to assess, identify, and reduce the root cause of substance use through a trauma-informed and collaborative approach.

CDC also partners with the *Office of Justice Programs, Bureau of Justice Assistance's Comprehensive Opioid, Stimulant, and Substance Abuse Program* (COSSAP) to support effective state, local, and tribal responses to illicit substance use. These demonstration projects promote public safety, and support access to treatment and recovery services in the criminal justice system in order to reduce overdose deaths. This partnership has focused on rural responses, expanding use of the *Overdose Detection Mapping Application Program (ODMAP)* in states and tribes, harm reduction education and training for law enforcement, building bridges between jail and community-based treatment, and *overdose fatality review (OFR)* implementation.

In an epidemic of this scale, public education and empowerment to combat stigma has never been more important. This is true not only for individuals who use drugs, but also anyone—friend, parent, caregiver, or community member—who may encounter someone experiencing an overdose. CDC's public messages and campaigns have evolved along with the epidemic. For example, CDC's Rx Awareness campaign initially focused on increasing awareness of the risks associated with prescription opioids when prescription opioids were the primary driver of overdose deaths. As the crisis evolved, the campaign shifted to focus on messages of hope in recovery with a focus on equity and inclusion. Most recently, CDC's latest messaging includes four mini-campaigns, entitled "Stop Overdose," and focuses on raising awareness of fentanyl, naloxone, polysubstance use, and decreasing stigma with a particular focus on 18–34 year olds—a group experiencing some of the highest rates of overdose in recent years. Launched in late 2021, these new mini campaigns have reached over 1 billion views, showing not only the importance of these messages, but the need for messages in reaching all populations, especially young adults.

We cannot reverse current trends without a holistic effort that fully leverages the health system and health care providers to address substance use disorder and overdose. Recent research shows that touch points with the health system present an important opportunity to engage at-risk patients in care for substance use-related challenges and overdose prevention. This includes advancing efforts for prevention, screening, linkage to care, and retention in treatment toward long-term recovery. In particular, CDC's work in health systems and funding to jurisdictions a focus on improving upstream prescribing and pain care, enhancing linkage to care and treatment across various health care settings, from primary care to emergency departments, utilizing peer navigators to help individuals seek and connect to recovery options, and reducing stigma among clinicians and providers so that people feel safe seeking the care they need. Pain, particularly chronic pain, can lead to impaired physical functioning, poor mental health, and a reduced quality of life. A key aim of pain management is the provision of individualized, patient-centered care that focuses on optimizing function and supporting activities of daily living. CDC provides guidance to clinicians, as well as tools and resources for patients and clinicians, to help advance comprehensive pain care. One important way CDC promotes patient-centered pain care is through recommendations in its 2016 CDC Guideline for Prescribing Opioids for Chronic Pain and accompanying training and ancillary resources.

Since release of the Guideline in 2016, CDC has stayed at the forefront of new research and collaborated with the Agency for Healthcare Research and Quality to conduct five formal systematic reviews of new available evidence on noninvasive, nonpharmacological treatment and nonopioid pharmacological treatment of chronic pain. As a result of these reviews and the new scientific evidence that has accrued since 2016, CDC determined that an update of the Guideline, and an expansion to

certain acute conditions, was warranted. The draft 2022 CDC Clinical Practice Guideline for Prescribing Opioids was posted for a 60-day public comment period from February 10, 2022, to April 11, 2022. Release of a final updated Guideline is anticipated in late 2022, along with a suite of translation and communication resources to facilitate effective implementation.

Finally, focusing on preventing substance use in the first place is a core component of CDC's work and the long-term solution to reversing the decades-long overdose crisis. A key element of this work is advancing upstream prevention strategies to prevent Adverse Childhood Experiences, or ACEs—potential traumatic events like experiencing abuse or neglect, witnessing violence in the home or community, and growing up in a household with mental health or substance use problems. Research shows that ACEs are strongly linked to increased risk for substance use, including increased risk for prescription opioid misuse, opioid injection, cocaine and amphetamine use and use disorder, and earlier age of initiation for these substances. Additionally, losing a loved one to overdose or suicide are themselves ACEs that can increase the risk of overdose or suicide in the future. Thus, preventing exposure to these early adversities is an important step in reducing the risk for overdose and suicide, and many other health risk behaviors and health outcomes throughout the lifespan. Focusing on shared risk and protective factors at the individual, family, and community levels helps to create safe, supportive, and nurturing relationships and environments and reduces these risks. Upstream prevention of ACEs and other violence and adversity among children and youth can have a profound impact on the trajectory of substance use, overdose, and mental health in the United States. CDC appreciates the support of Congress to address these intertwined crises through an integrated public health approach.

CDC also partners with ONDCP on youth prevention efforts through the Drug Free Communities (DFC) Support Program. DFC, the Nation's leading effort to mobilize communities to prevent and reduce substance use among youth is administered by ONDCP and managed by CDC. The DFC Program funds community-based coalitions to strengthen the infrastructure among local partners to create and sustain a reduction in local youth substance use. The DFC coalitions focus efforts on youth and in many instances, promote health equity and aim to reduce disparities that impact youth substance use, and address the risk and protective factors that negatively impact health outcomes in communities. More than 700 community coalitions across the country receive funding of up to $125,000 per year to strengthen collaboration among local partners and create an infrastructure that reduces youth substance use.

Closing

The drug overdose crisis continues to evolve, and our response must be nimble and flexible to the changing situations in communities throughout our country. We know that public health thrives when the approach is comprehensive, coordinated, and can quickly adapt and respond to current and emerging needs. Data are foundational to this effort. This is especially true with an overdose crisis driven by an extremely potent illicit substance, like fentanyl. CDC is continuously using data to drive prevention action in states, territories, tribes, and local communities. We are continuing to make vital strides in accelerating data collection, analysis, and dissemination of nonfatal and fatal overdoses and increasing the use of innovative data science and modeling efforts to fight the current crisis and predict where it will go next.

For far too long the tragic consequences of overdose have devasted families and communities across the country, and the continued proliferation of illicitly made fentanyl has only exacerbated the challenges we face. CDC is committed to using data, science, innovation, and collaboration as part of a whole-of-government approach to save lives and bring an end to our Nation's overdose crisis.

The CHAIR. Thank you very much to all of our witnesses today and for sharing your expertise. We will now have opening rounds of questions from Senators. Please again, if you can keep your remarks to, or your questioning to 5 minutes.

Mr. Chester, let me start with you. As you know, fentanyl has been devastating for all of our communities, including in my home

State of Washington. Over 2,000 people died from a drug overdose in Washington State in 2021.

That is an increase of nearly 70 percent over 2019. And half of those deaths involve fentanyl. So those numbers are really heartbreaking. And in King County, we saw record high fentanyl deaths in 2021.

Spokane County reported out 186 percent increase in fentanyl overdose. That is devastating. And because of the transnational criminal networks that traffic fentanyl, it is only becoming more prevalent. The Drug Enforcement Administration recently reported a 264 percent increase in counterfeit pill seizures in Washington State alone.

Law enforcement officials and first responders are working hard to intercept and seize fentanyl before it reaches our communities and respond to the increased use, but the Federal Government really has to do more.

Mr. Chester, share with us what steps ONDCP is taking to coordinate the activities of the Federal law enforcement agencies, Department of Justice, DEA to make sure that our efforts to disrupt fentanyl trafficking is as effective as possible.

Mr. CHESTER. Thank you for the question, Senator. And in your question was a great deal of the answer, and that is going after the transnational criminal organizations before the drugs can even get across our borders and into our communities. And it is what we refer to as commercial disruption.

What we are dealing with is a global illicit business that has all of the hallmarks of a transnational business organization. They have access to resources. They do product development. They have the ability to move money, products, raw materials across borders with incredible efficiency. They are free riders on the back of the legitimate commercial network that keeps the international economy alive.

But it has critical vulnerabilities. And so what we are focused on, and this is across the interagency and across the Federal Government, is focusing our efforts on those critical vulnerabilities where we can get the greatest amount of effect. And one of them, obviously, as was discussed before, is illicit finance.

That is their operating capital and that is their profits. And another one is the precursor chemicals that are used in order to manufacture these drugs. And in many cases now, the technology is at the point where precursor chemicals are no longer regulated and some of them are so legitimate that they can't be regulated. The third one is going after the commercial shipping that moves these things around the country.

Then the fourth thing is the pill presses and the dye molds that are used to make them. And so what we are doing at the Office of National Drug Control Policy is not only working across the Federal Government, but working bilaterally with key countries like China, like Mexico, and like India in order to be able to disrupt the production of these drugs at their source and to prevent them from getting to our borders and into our communities in the first place.

That is truly an interagency effort, and it is where the bulk of our efforts lie right now.

The CHAIR. Okay. Thank you. Thank you very much. Let me turn to Dr. Delphin-Rittmon. For a lot of parents, it is really hard to help their kids navigate teenage years anyway, especially when it comes to drug and alcohol. And the fentanyl crisis has made keeping our kids safer a lot harder.

I am a mom. I am a grandma. I understand exactly how scary this is for parents today. Counterfeit pills with fentanyl are extremely dangerous and extremely easy for teens to find, often accidentally, on social media platforms. The stories from parents and family members and loved ones are heartbreaking.

Kids buy what they think are prescription opioids online, only to get lethal fentanyl laced pills instead. And in fact, the problem is so widespread that the Drug Enforcement Administration issued its first public safety alert in 6 years, warning about the dangers of those pills.

We have got to protect our communities, especially our kids, from fentanyl. It is vital that we invest in substance use disorder prevention, treatment, and recovery for youth. Talk to us about how this Committee can support the efforts, especially in our upcoming reauthorization package.

Ms. DELPHIN-RITTMON. Yes. So, thank you, Chair Murray, for that question. And you are right. I mean, this is such a challenging area. And I also want to thank you for your bipartisan work to reauthorize our programs.

We do have a specific program, the Strategic Prevention Framework for Prescription Drugs, that is geared toward helping to increase awareness of the dangers of sharing substances or substance use. It is geared toward raising awareness among youth and families and communities.

This program also does include information and training in technical assistance related to the dangers of buying substances, period, but also through the web, and particularly focuses on youth. So some of the goal is to raise awareness and to change youth behaviors through that awareness raising.

The CHAIR. Well, thank you. I am out of time. Dr. Jones, I wanted to ask you, your—what efforts CDC is doing and how we can support that. If you can give that to me in writing or if I can get a back around for a second round of questions, I will ask you that question.

Senator Cassidy.

Senator CASSIDY. Thank you, Madam Chair. Mr. Chester, you.

[Technical problems]—thank you. I am still getting feedback. Still getting feedback. Oh, well. It is irritating me, so it is probably—let's try that.

Mr. Chester, I am struck that I can speak about chemical providers in Wuhan sending chemicals here that are precursors for fentanyl that are used by Mexican cartels that are all shipped directly—you can acknowledge it in your testimony.

Now, we think of China as an area where they have surveillance cameras on every corner in which at any point someone may be arbitrarily imprisoned. I could go on, but we know what the go on would be.

How much collaboration are we getting from the Chinese in terms of this? Because some have suggested this is a form of bioterrorism.

Mr. CHESTER. Yes, Senator. No, thank you very much for the question. I can tell you that we engage regularly with the People's Republic of China on this specific issue.

Although, as you know, we have a very complicated relationship with China, this is an area where U.S. and PRC interests align, and we have made progress in the past. The most notable was our work up until May 2009——

Senator CASSIDY. Let me stop you though. I am sorry.

Mr. CHESTER. Yes, sir.

Senator CASSIDY. But if we know who those chemical manufacturers are, the Chinese know who they are. So, yes, there may be collaboration——

Mr. CHESTER. Right.

Senator CASSIDY [continuing]. But there is a fundamental breakdown there, right?

Mr. CHESTER. Yes, sir. And the first thing is ensuring we have open lines of communication so the information that we have, that we understand about seizures in the Western Hemisphere can be sent to the Chinese so that they can take action on it.

The second part of that is, and something that we have clearly communicated to the Chinese—and you mentioned it in your opening statement. I think you brought up a very good point when you talk about the mislabeling. We have asked the Chinese Government to do three very simple things.

The first one is agree with us on the list of unregulated chemicals that are used to create precursor chemicals that bear increased scrutiny. That is the first thing. The second thing is to properly label their chemical and equipment shipments in accordance with the World Trade Organization. And the third one is that they know their customer and put—know your customer procedures into place.

Those are the things we should expect of any responsible country. We have asked other countries to do this as well, and we look forward to working with the Chinese for them to implement these procedures to reduce the flow of these precursor chemicals into the Western Hemisphere.

Senator CASSIDY. Now, we have been raising this issue of the Chinese for several years now. So I guess what I am after, which I am not sure I am getting, is a level of collaboration and true collaboration as opposed to, hey, we are with you, as opposed to no, we are knocking on doors, and we are shutting down people and we are throwing them in jail.

Mr. CHESTER. Right. I would tell you that in—the relationship that we have with Chinese, with the PRC, has given us uneven progress. I wouldn't disagree with you on that. I think that there

are areas where the Chinese Government has taken quick and decisive action at a request of the United States and has had good results.

I think there are other times that we have differences with the Government of China procedurally on certain things that we ask them to do, and we have to ensure that we continue to communicate with them and impress to them how incredibly important this is, not just to the United States, but to the rest of the world.

Other countries, and Secretary Blinken brought this up in his speech about China, other countries should expect two great countries like the United States in the PRC to work together on this global issue and they understand that.

Senator CASSIDY. Now, looking at Mexico, I know you have a sense that Mexico is always teetering on whether or not it is in control or not, and several states apparently are not in control of the central Government.

But to what degree has the Mexican Government collaborated with us if these cartels are bringing these drugs from China to then bring across our border? To what degree are we getting collaboration there?

Mr. CHESTER. We have a good and long standing relationship with the Government of Mexico, which was solidified in the bicentennial framework for security that was signed just a few months ago that replaces the previous Merida Initiative that is a little bit more holistic and takes in more of the contributing factors within Mexico, not just the security side of the house.

We have, on the ground, we have a large embassy down there. We have deep law enforcement relationships with the Government of Mexico. And we have had cooperation in the past. And most recently, obviously, the apprehension of Rafael Caro Quintero is a good example of cooperation with the Government of Mexico that actually bears—that bears fruit.

Senator CASSIDY. Now, but I had a sense that recently there were some—a back, like increased liability for some of our agents who might be down there if something goes wrong. And also had a sense that President, or I will just call him AMLO, the President of Mexico, has less affection for the U.S. than perhaps some of his predecessors. Any comment on that?

Mr. CHESTER. What you are referring to is the national security law that was put in place in January of last year, that created a bunch of increased procedures for collaboration between Mexican and U.S. law enforcement agencies.

I think on the ground, that has been worked out in practical terms, that it has not had a devastating effect on law enforcement cooperation in Mexico. That is not uniform across all agencies, but I think in general terms, the national security law isn't a barrier from us working with Mexico, but I think it is clear that President Lopez Obrador sees really two things.

The first one is he wants to go after the root causes of criminality. And the second thing is he continually looks at the U.S., Mexico relationship in terms of Mexico's interests as much as United States' interests.

This has caused a recasting of our relationship with Mexico. But we have made some progress on this particular problem when working with the Government of Mexico.

Senator CASSIDY. I yield.

The CHAIR. Thank you.

Senator Murphy.

Senator MURPHY. Thank you very much, Madam Chair. Thanks for this hearing. You are all doing super important work. We appreciate the testimony. Dr. Delphin-Rittmon, I wanted to talk to you about the genesis of the opioid crisis, which, of course, at first is rooted in America's penchant to prescribe opioids and addictive pain medication at a rate that is unparalleled in the rest of the world.

We have made a lot of progress when it comes to the overall number of opioids that are prescribed in this country. And there is a direct line between individuals who become addicted to these pain medications and then those that end up seeking illicit drugs in black markets that often end up having fentanyl attached to them.

We have seen this drop in the number of opioids that have been prescribed, and we have sort of pat ourselves on the back. And yet when you look at our numbers, even with this drop compared to the rest of the world, we are still a crazy outlier, right.

We are still 5 percent of the world's population and somewhere between 70 and 80 percent of the world is opioid prescriptions, even with a 40 percent drop in the overall number of prescriptions that are being made.

Just talk for a second about, as we are as we are talking about the fentanyl crisis here, the work that we still have to do to alter prescribing patterns as a means to stop people from getting on this pathway to fentanyl.

Ms. DELPHIN-RITTMON. Yes. Thank you for that question, Senator. And, the prescribing patterns and, ultimately ensuring that people have access to evidence based services and supports is so critical.

We have seen that over time, and we know that the evidence based practices and treatment such as medication assisted treatment, whether it be buprenorphine or methadone, can help people who are struggling with opioid related substance challenges.

In terms of prescribing patterns, I mean, one thing that we are working on is to increase that access for individuals that may be struggling, is to allow individual prescribers that is, prescribers to treat up to 30 individuals with buprenorphine.

We have revised the buprenorphine practice guidelines such that those individuals can control individuals struggling with opioid addiction with buprenorphine.

Senator MURPHY. But I guess what I am talking about, right, pain management. I am talking about the fact that we still are prescribing far more pain medication, addictive pain medication than the rest of the world.

That we have got to—from your perspective, right, you have got to focus on trying to find alternative ways to manage pain so that people never get in the position of being addicted to pain medication that then becomes an addiction to heroin, fentanyl, etcetera.

Ms. DELPHIN-RITTMON. Yes. And we do have grants actually that do that type of training. So for example, our state opioid response grant does train providers on alternatives to pain management such that prescription medications aren't the first course. And so other strategies to manage pain and that can help to alter and change some of the prescribing practices that we are seeing.

Senator MURPHY. Mr. Chester, I want to talk to you a little bit about how fentanyl and other illicit substances come into the United States through the Southern border. It is still true, correct, that the lions share, the vast majority, not all, but almost all of the products coming into the United States comes through our ports of entry.

We have made through the Appropriations Committee, I chair the subcommittee that writes the budget for DHS, some significant investments in technology at those ports of entry. But there is sometimes there is an impression here that a lot of this product is being, moved across in the dead of the night through the desert.

But the reality is we still don't catch as much as we should that is walking straight through public ports of entry. And there is additional investments that we can make to try to catch more of it and ultimately deter more of that activity.

Mr. CHESTER. Yes, Senator. No, you are correct. So the preponderance of the drugs do come through the existing ports of entry. The technology that they have available is very impressive. And the men and women of Customs and Border Protection, those are our most experienced folks on the ground.

It is the most efficient way to be able to move them across and then have access on the other side to an available network to get them quickly across the country. So they do come through most of the ports of entry, but there is obviously more that we can do.

The President has asked for $300 million in enhancements for Customs and Border Protection for that very reason that this is an evolving threat. But there are other places, obviously, through the mail system, through maritime conveyances, that these drugs get into the country as well.

Senator MURPHY. I just make that point, Madam Chair, because a lot of our colleagues think that by putting up this wall on the border you are going to stop fentanyl from coming into the country.

The reality is that fentanyl is coming in through the ports. And so we can make investments, but the idea that it is the one wall portions of the border where the fentanyl is pouring in is just not what the facts bear out. Thank you, Madam Chair.

The CHAIR. Thank you.

Senator Marshall.

Senator MARSHALL. Thank you, Madam Chair. Dr. Jones, do you consider the fentanyl crisis to be a public health emergency?

Dr. JONES. Yes. And there is currently a public health emergency declared for the opioid crisis.

Senator MARSHALL. Okay. Thank you. Like every state, my home State of Kansas is now a border state. That is right, as you can see from this map behind me, Kansas is literally at the crossroads of fentanyl trafficking.

With three major arteries coming out of Mexico piercing the heart of our great state, and all three bisecting the Nation is busiest East-West byway, we are now at ground zero. In fact, just recently, officers in Kansas City, Kansas, seized nearly 15,000, 15,000 fake pills laced with fentanyl during a 2-day bust. Fentanyl is now killing a Kansan and almost every day is killing over 250 Americans every day.

Sadly, fentanyl is now the No. 1 killer of young adults, poisoning deaths. And I mention and I stress these are poisoning deaths from synthetic opioids, particularly fentanyl, have increased by more than 600 percent. So where does it come from and why is it so cheap? As we all know, the fentanyl precursors are made in China.

You could call this China's revenge on the West for the opium war. In Mexico, Chinese chemists and their cartels convert these precursors into fentanyl, and they lace fake pills like Adderall or Xanax or Percocet, they mix them with illicit drugs like meth and cocaine, or simply they sell it in various pure forms.

Unfortunately, this is one supply chain from China that is not broken. It goes without saying, with an open, porous Southern border, the supply is abundant, driving the street price down. For where oxycodone tablets maybe cost $60, you can pay $2 to $6 for a fentanyl tablet.

One final point I want to go back to, returning to this fake pills concept. Dying from fentanyl is poisoning. It is not an overdose. That is poisoning. If a non-suspecting student takes a fake Adderall pill they purchased online or wherever they purchased and dies, that is poisoning, and the criminals should be tried for murder.

At least that is how I see it. Mr. Chester, would securing borders and decreasing smuggling impact the fentanyl crisis?

Mr. CHESTER. Yes, Senator. I mean, as I said in response to Senator Murphy as well, the men and women that we have at our Southern border are the finest we have.

Senator MARSHALL. We understand, but you agree it would have a significant impact. Dr. Jones, same question. Would securing our borders and decreasing the smuggling and the easy access to fentanyl impact the crisis?

Dr. JONES. I would reiterate Mr. Chester's points about the efforts in the National Drug Control Strategy to address——

Senator MARSHALL. But they are not working. You can rewrite the points, but obviously with a 600 percent increase in deaths, whatever we are trying to do, reiterating the points, forming committees, talking to people, something is not working. Dr. Jones, do you believe we should apply Title 42 to drug smuggling across the Southern border?

Dr. JONES. Well, Title 42 is rooted in protecting public health from communicable diseases. So while there is a declared 319 public health emergency for the opioid crisis, it falls outside of the scope of Title 42.

Senator MARSHALL. Okay. Mr. Chester, you stated that first, the most important action we can do right now is to get more naloxone out. As a physician, that is like telling me to give people with brain tumors, Tylenol, to say that is the most important thing. Do you really feel that giving out naloxone would have a bigger impact than securing our borders?

Mr. CHESTER. Senator, by most important thing, what I meant was most important thing in saving lives now because it can reduce an opioid overdose. But that is not exclusive of all the work that is being done at the Southern border and with other countries and with the Postal Inspection Service and all of the other means that we do to keep the drugs out of our communities. The Naloxone is designed to reduce an overdose death and save a life immediately.

Senator MARSHALL. What we are doing now is we are putting a finger in the dike and the entire dike is giving away. If we don't secure our borders, this epidemic is only going to get worse. Mr. Chester, you also stated that the U.S. routinely engages with the People's Republic of China to address shipments.

You go on to say the PRC actions in that regard have a direct and positive impact. How can you objectively, quantitatively substantiate your statement when we are seeing a 600 percent increase in deaths?

I know you are talking to them. I know there is collaboration. But what is your objective evidence that says that China is doing anything to slow this machine down?

Mr. CHESTER. The best example I can give you is the work that we did with China prior to May 2019, when China class scheduled all fentanyl related substances, and as a result, the direct shipment of fentanyl and fentanyl related substances from China to the United States went down to almost zero. Now——

Senator MARSHALL. That was in 2019?

Mr. CHESTER. That was in 2019. Yes, sir. And now, the traffickers moved from producing finished fentanyl into precursor chemicals, which they supplied to Mexican suppliers and that went up, but that speaks to the dynamic and interactive nature of a very determined, profit driven——

Senator MARSHALL. But quantitatively, what have you done that can show me that we have impacted that? What—is there any objective evidence that we have impacted China's supply? I mean, they are sending it to us like we send wheat to them.

Mr. CHESTER. The number of seizures of precursor chemicals and pre-precursor chemicals in the Western Hemisphere has been consistently high. And in many of those cases, that was due to cooperation with Chinese officials, or subsequent to the seizure, the information was sent to the Chinese officials so that they could take action and hold the individuals responsible.

Senator MARSHALL. Thank you, Madam Chair. I yield back. But the point is, the seizures are going up because objectively, China

is not doing—is not stopping the supply of these precursors. Thank you. I yield back.

The CHAIR. Senator Hassan.

Senator HASSAN. Thank you, Madam Chair. And thank you to all of our witnesses for being here today. I want to start with a question to you, Mr. Chester. Deaths from fentanyl among teenagers more than tripled between 2019 and 2021.

As Chair Murray mentioned, many of these teens were not seeking fentanyl. They purchased what they thought was Percocet, Oxycodone or Adderall, only to take a fatal dose of fentanyl. And the stories are truly heartbreaking. How are young people getting exposed to these fentanyl laced drugs?

Mr. CHESTER. Thank you for the question, Senator. And I think the distinction was made between poisonings and overdose deaths. And I think it is an important one because you bring it up in your question. Unfortunately, they are being exposed to these drugs in a greater variety of means than they ever were before.

In many cases, and Dr. Gupta has said this several times, getting access to these drugs is as simple as in the palm of your hand, through a social media app. And so when you are dealing with global drug traffickers who want to reduce their risk and reduce their overhead and increase their customer base and increase their profits, it is in their interest to make it available through a variety of means.

The first thing is to have access to them through social media apps, through the dark web, sometimes through the clear web, sometimes through their own personal interactions. The second thing is how those drugs move across our borders and into the United States. And in some cases it is the Southwest border, but in some cases it is through our mail and express consignment.

The work we have done with the Postal Inspection Service, where the number of seizures in the mail has increased, I think has been admirable in being able to disrupt that vector coming into the country.

Senator HASSAN. Thank you. Another question for you. Last year's National Defense Authorization Act included a bipartisan bill that Senator Toomey and I authored, the Blocking Deadly Fentanyl Imports Act.

This law requires the Government to publicly identify countries that are major producers or traffickers of illicit fentanyl and cutoff foreign aid to those countries if they fail to increase efforts to fight drug trafficking.

Mr. Chester, what steps has the Administration taken to evaluate whether we should cutoff foreign aid to countries due to the production or trafficking of fentanyl and fentanyl analogs within their borders?

Mr. CHESTER. Thank you for the question. I am sure you understand, I can't take a position on pending legislation. What I can tell you is that the current process that we have, that we apply under the majors list process for plant based drug producing countries, has been effective over the years. And we welcome any tool that gives us the ability—[technical problems]——

Senator HASSAN. Thank you. I appreciate that. How is our audio here? Is there—Okay. We are good.

The CHAIR. I can hear you. I am not sure we can hear the witness. Is it off?

Senator HASSAN. I think we are all right now. I want to turn to Ms. Johnson with another question, and I appreciate Mr. Chester's response to the last one.

Ms. Johnson, according to the Department of Health and Human Services, the country must add more than 100,000 general psychiatrists and 43,000 addiction psychiatrists to meet the current need. This shortage impacts States like New Hampshire, where patients may have to drive hours to find treatment for a substance use disorder.

As part of funding I helped advocate for, the Department of Health and Human Services awarded a $1.4 million grant to Dartmouth-Hitchcock in January to train behavioral health clinicians, paraprofessionals, and other residents of rural New Hampshire communities to address the substance use disorder needs of residents.

Ms. Johnson, how will these grant programs help build the behavioral health workforce over the long term? How will they help rural areas in particular?

Ms. JOHNSON. Thank you, Senator. And thank you for your leadership in supporting and developing these critical programs that are really part of what it is going to take for us to confront this crisis, for us to be able to build critical programs that my colleagues across the table have identified.

We need a workforce to be able to deliver on that. And it is the types of programs that you have helped create that give us the tools to be able to recruit people into the field, to get them the training that they need, and then to deploy them into the communities where they are needed most.

We are looking forward to the work that will happen at Dartmouth under the grant program.

Senator HASSAN. Well, thank you for that. Quickly, I have a question for Dr. Delphin-Rittmon. While we know that medication assisted treatment, like buprenorphine, is the gold standard for opioid use disorders, access to treatment is limited by the requirement that providers obtain a special DEA waiver known as the X-waiver in order to prescribe buprenorphine.

About 40 percent of counties across the United States in 2018 lacked even a single waiver practitioner who was able to provide this treatment. Dr. Delphin-Rittmon, if the X-waiver continues, how will the lack of treatment providers offering medication assisted treatment impact fentanyl overdose rates?

Ms. DELPHIN-RITTMON. Yes. Thank you for that question, Senator, and for all of your work in this critical area. We know that it is just vital that people have access to medication assisted treatment when they are struggling with opioid use disorder.

Data shows that. It can help people move into long term recovery along with other services and supports. In terms of increasing the number of providers, we have removed some of the barriers and we

are in full support of removing barriers to such that additional providers can be—can prescribe buprenorphine.

That is why we changed some of the training requirements along with the buprenorphine guidelines. And so that did bring an additional 17,000 prescribers into the field since we put that in place.

Senator HASSAN. Well, that is important, but I think we have more to do. So I have introduced the Bipartisan Mainstreaming Addiction Treatment Act, which would eliminate the X-waiver and expand access to treatments that we know will save lives. Thank you so much, Madam Chair.

The CHAIR. Thank you. Senators know that a vote has been called. I am going to call on Senator Moran and Senator Lujan. I will go vote and come back. Senator Casey will hold the gavel while I am gone.

Senator MORAN. Chair, thank you. Thank you very much for your presence today. Let me start with Administrator Johnson. In your testimony, you mentioned that HRSA is working on better connecting substance abuse disorder treatment with access to mental health care.

I come from a state, but I also come from a nation in which access to mental health care is limited in—for a number of reasons, but particularly the rural parts of our state, the inability to attract and retain health care professionals is a huge issue. I see this in my Veterans Affairs Committee where we are trying to take steps necessary to prevent veteran suicide.

The services, if they exist, are a distance away. Senator Smith and I recently introduced a bill authorizing a grant program under HRSA to help primary care practices integrate behavioral health care services into their offices. Designed to take those circumstances in which you do have a hometown physician, a family practice doctor, and bring mental health care services to that practice.

Do you think better integrating behavioral health services into primary care settings for adults and children makes sense? And would that help address the substance abuse crisis that our Country is facing?

Ms. JOHNSON. Thank you, Senator. I thank you so much for your leadership on this issue. I think integrating behavioral health, mental health and substance use disorder services in primary care is essential for us to confront this crisis.

We are not going to be able to solve this problem unless people can get the care and services they need, and that means we have to deploy all available assets to the problem. And that means there needs to be no wrong door for getting in to get mental health and substance use disorder services.

That is why we are really focused on trying to leverage the programs that HRSA and are grateful for the support of this Committee to identify ways that we can continue to help the primary care workforce understand and treat and identify mental health and substance use disorders.

Senator MORAN. Thank you. I intend to use your endorsement in our efforts to get the legislation passed. Dr. Delfin-Rittmon, in ad-

dition to serving on this Committee, I am also the lead Republican on the Appropriations subcommittee that funds the Department of Justice.

What—in your testimony you touched on the First Responders Comprehensive Addiction and Recovery Act grant program, which helps to train and equip first responders to respond to overdose related incidents. This grant program, as you note—noted, includes a rural set aside.

For many rural departments, the loss of man or woman power while an officer or deputy is off training is almost as prohibitive as the lack of funding. What is your department doing to make training and other resources more accessible, such as through online training courses to small and understaffed departments?

Ms. DELPHIN-RITTMON. Thank you for that question, Senator. You are right. I mean, it is so important to be able to have multiple modalities, to be able to offer training. And so we do have a number of training and technical assistance centers.

We have addiction training and technical assistance center, as well as the provider clinical support system that provides a range of technical assistance, training, and education for prescribers as well as other behavioral health providers in the field.

Those include both in-person as well as remotely through webinars and online strategies and means as well.

Senator MORAN. I might suggest to you that, at least in our state, we have a number of law enforcement training centers across the state geographically. You may want to integrate your program or share the opportunity for training in those settings and utilize the services that generally the law enforcement community has already created for ongoing training for members of law enforcement.

I also appreciate your attention to ensuring that rural communities have the resources needed to fight fentanyl and substance abuse. There are two issues—these two issues are often associated with urban areas. I can assure you, it is not a urban, suburban issue. It is, it is not solely that.

Rural America is battling the epidemic, and we do—are doing so with, as I indicated earlier, a more strained health care delivery system and limited workforce. One particular program, you talk about in your testimony, that Kansas is utilizing well is a certified community behavioral health clinic programs.

In 2021, Kansas became the first state to establish the model at the state level, and by 2024, we have 26 state certified CCBHCs. Would you speak further to the role of localized care like these community mental health centers have in fighting substance abuse that we are talking about today?

Ms. DELPHIN-RITTMON. Yes, absolutely. And I want to commend Kansas for having that number of CCBHCs. It is a wonderful model. It provides both mental health, substance use services, as well as coordination and connection and linkage to primary care services as well. It is a model that also provides wraparound prevention treatment and recovery services and supports.

It is critical in terms of being able to connect people that are struggling with opioid use disorders, as well as other substance use

disorders to services and supports, to include recovery services and supports as well.

Senator MORAN. Thank you both for responding to my questions.

Senator CASEY. Senator Lujan.

Senator LUJAN. There we go. Thank you very much, Madam Chair, for this important hearing. I do want to start by echoing something from my colleague from Connecticut and bringing attention to our ports of entry. Somehow this keeps getting politicized.

If, in fact, the United States wants to be serious about stopping the flow of illicit substances into the United States, we must remember there is a Southern border and a Northern border, and there is two water borders, and then you go down and you remember the Gulf of Mexico with our water ports.

Don't forget about our airports. The screening or lack thereof that is done at our ports should alarm all of us. 5 or 6 percent just improve to 10 percent with passenger screening into the Southern border is embarrassing.

The United States must adopt 100 percent screening into the United States with commercial goods and with passenger traffic at all of our ports of entry. Only then will we start to understand how these cartels and other entities are throwing product at the problem.

I hope that we can at least come together there and work together to get something done. By the way, one of the last pieces of legislation that was signed by President Trump was a bipartisan initiative challenging the Department of Homeland Security to tell Congress how to get to 100 percent screening of our ports.

Let's find a way to work together. Second, Mr. Chester, I appreciate the attention to the illicit financial markets. The United States should be embarrassed by the lack there of process that we have with prosecuting against illicit financial markets. And it is not just Democrat or Republican Administrations. It is both.

When major financial institutions in the United States are found to be laundering money for cartels, and the outcome is no one goes to jail, someone gets a fine, well that is just a new cost of doing business. If someone can make that much money and only get fined, it is going to continue.

If there is one thing that all these bad people have in common in what is happening here is that they are making money. And until you stop the flow of that money, you are not going to stop any of this.

I am hopeful that these are some areas, I know we are not in the committee of jurisdiction, but some areas that we can find some common ground to go after these entities that are not politicized.

Now, the questions that I have, I want to echo a statement made earlier, pushing on buprenorphine or improving screening at ports of entry in America. Dr. Delphin-Rittmon, does the United States need to adopt both, access to treatments as well as trying to stop these movements of these illicit substances from around the world in the United States?

Ms. DELPHIN-RITTMON. Thank you for that question, Senator. I can certainly speak to the work of SAMHSA. I know Mr. Chester has comments in terms of the movement. It does seem that we are taking a multi-level approach, and so certainly there are is quite a bit of work underway to increase access to medication assisted treatment, as well as other vital prevention and recovery services and supports as well.

It does sound like there is quite a bit of work in terms of border—work at the border as well. But in terms of SAMHSA's, the programs and initiatives that we have in place, both through the source of state opioid response grant, as well as the substance abuse treatment block grant, there are a range of services and supports available across the country to help individuals that are struggling with opioids, to include the dissemination of fentanyl test strips, which allow for the testing of substances and allow for the testing of the presence of fentanyl.

Senator LUJAN. Dr. Delphin-Rittmon, would access to fentanyl testing strips save more lives?

Ms. DELPHIN-RITTMON. What we are seeing is that fentanyl test strips do allow for the identification of fentanyl and substances. That is helpful for individuals that are not interested—that don't want to take fentanyl. Often what we find is that harm reduction programs also disseminate information about how to access services.

Often people are connected with a recovery coach or recovery programing. So the harm reduction offers an opportunity to sort of disseminate the fentanyl test strips, but also to disseminate information about how to navigate and access services and supports as well.

Senator LUJAN. I believe access to those strips will save lives. It alarms me that in some states those strips are treated as illegal use or treated in a way where people can't use them. I hope that one thing we can do is come together to ensure that access to meds, to strips, things of that nature is something that can be accessible across the United States.

I do have other questions for the record that I will submit. The one point that I wanted to raise, though, is, according to the CDC, only about one in every ten American Indian, Alaska Native, and Hispanic people with substance use disorder reported receiving treatment.

The numbers are about 70 percent of the 2 million folks across the country that are not getting any treatment, predominantly in rural and Native American communities, and in Hispanic communities, Black communities, other communities of color as well.

I appreciate that there is more attention being brought to these, but again, what has been happening? The data shows where this is occurring and there is still no response. Madam Chair, I am certainly hopeful that as we have this conversation and we are moving to move legislation to encourage more and demand more access to meds, but that we understand where the data is based on the number of folks that we are losing, while we also stop these illicit financial markets, and we improve dramatically and require present

screening at our borders to begin to make the drastic steps necessary to be able to get our hands around this. Thank you. I yield back.

Senator CASEY. Senator Collins.

Senator COLLINS. Thank you, Chair, Members of the panel, I say this with grave respect for each of you. I know that you care deeply and that the policy and programs that you are implementing are well-intentioned, but I think we have to face the very unpleasant truth that what we are doing is not working.

The data overwhelmingly demonstrate that, whether you look at national data or data from the State of Maine. Maine's leading drug overdose, drug death researcher, Dr. Marci Sorg from the University of Maine recently called Maine's overdose epidemic, "the worst it has ever been."

Tragically, we lost a record high 627 Mainers in 2021. And the data from the first part of this year shows a 9 percent increase over a comparable period of last year. The number of total overdoses in Maine exceeded 9,500 last year.

Fentanyl was involved in 77 percent of deadly overdoses in Maine. That is a dramatic increase. So I want to talk to you about two issues. One is enforcement and interdiction, and the second is prevention and education.

In 2021, the Maine Drug Enforcement Agency seized more than 10,000 grams of fentanyl. That is a 67 percent increase. But they tell me they cannot possibly keep up. They are overwhelmed. And that Maine's overdose crisis is primarily driven by the increased supply of illicit fentanyl originating in China and smuggled through Mexico into our Country.

I have been to the border with Mexico. I have seen the cartels who are smuggling people across the border. I talked with the Border Patrol officers out on their midnight shift, and they have expressed such frustration that they have had to divert their resources to handling the tremendous influx of people crossing the border, rather than focusing on illicit drug interdiction.

Like my colleagues, I cannot help but conclude that our inability to secure the Southern border has an adverse impact and contributes directly to our inability to stop the flow of drugs into this country. I have also talked to the Coast Guard and their efforts and how frustrated they feel.

My first question, Mr. Chester, is, do you agree that the unprecedented surge of people illegally entering the United States has diverted limited Government resources away from drug interdiction?

Mr. CHESTER. Thank you for your question, Senator. And I know Marcy Sorg and I have worked with her for the past several years, and she is an incredible professional.

Senator COLLINS. She is.

Mr. CHESTER. She understands this issue better than just about anybody, so I appreciate that. There is no doubt that there are a number of challenges at the Southwest border of the United States. But what I would ask that we all bear in mind is a couple of things.

The first one is, these are very determined drug traffickers who are going to find any means to get these drugs into our Country, whether it is the Southwest border, whether it is the mail, express consignment, maritime, or air conveyances. I think that is the first thing.

I think the second thing is our focus that we have not only in commercial disruption, but going after the illicit finance, not only the profits that are the motivation for doing this, but the operating capital that allows it to happen, is an overarching way to be able to deal with this very frustrating problem.

The last thing I would tell you, ma'am, is this is a very dynamic problem in a very dynamic situation. And when you say that what we are doing is not working, it would be easy to say, well, what we have done is not working.

What we have to do is very quickly identify when we have new vulnerabilities, when the traffickers have changed the ways that they do business and close those gaps and vulnerabilities as quickly as we possibly can. And that is what we are in the process of doing right now.

Senator COLLINS. Thank you. I am going to submit my next question for the record, because my time has expired. But Dr. Delphin-Rittmon, it is for you. I just want to tell you about Hannah Flaherty, a 14 year old girl from Portland.

A straight-A student with no history of drug abuse who died from a suspected fentanyl poisoning last month. And my question for you is going to be, for the record, given the time, what more can we do to reach young people?

I am not talking just about high school. I am talking about middle school students, to educate them about the dangers of drug abuse so that they don't think a pill is harmless, it is injecting yourself which is dangerous, which I think is common—a common misperception.

I would like to follow-up and talk with you about that, because I remember very well when I was growing up in Caribou in Northern Maine, that we had a recovered heroin addict come in and talk to us and it was so powerful.

It was incredibly powerful. So I am wondering what more we can do to educate students at a young age about the dangers. And I know I am out of time but thank you.

The CHAIR. Thank you, Senator Collins. Critical question, and I think we all would look forward to your answering that in the response.

Senator Baldwin.

Senator BALDWIN. Thank you, Madam Chair. I am listening to my colleagues as well as the responses and there is sort of a pattern that I have observed over time.

When we were talking in this Committee about the opioid epidemic just several years ago, it was much more, the conversation was much more focused on prescribers and overprescribing and, 30 day supply after dental surgery rather than something that would be much more appropriate to avoid substance abuse.

Now we are talking a lot about accidental overdose and getting—folks who have gotten fentanyl laced pills, etcetera. Like my colleagues, I want to share the stories of several Wisconsin families that I have gotten to know this year because they have gone through this crisis themselves.

Cade Reddington was a graduate of Waunakee Community High School, a student at UW Milwaukee, and a kid who was full of life and energy and excitement. On November 4th of last year, Cade died in his dorm room after taking what he thought was a Percocet pill. That pill contained fentanyl.

Combating fentanyl is a critical task for this Committee and this entire Administration, but I am concerned we are not doing enough to warn our Nation's young people about the dangers of counterfeit pills.

But Dr. Jones, I wanted to just draw your attention to the work that, and I am sure you know about it, the work that the DEA has been doing to spread the word that, "one pill can kill." This message, in my mind, has not yet been shared widely enough. And so I wonder how the CDC is working with the DEA to elevate this particular message and make sure that this information is being shared with young people.

Dr. JONES. Great. Thanks so much for the question. And we worked closely with DEA before that campaign was launched because we have experience over the last several years multiple campaigns that we have done at CDC around prescription opioids, transitioning to recovery, and now the illicit fentanyl market.

We have learned lessons along the way about how to communicate and wanted to make sure that we could assist DEA in their messages. So we worked with them prior to the launch, and we certainly worked across agencies here with DEA to help disseminate those messages.

I think that campaign is an important one because it is very catchy. One pill can kill. That makes sense. And that is something that is not lost on people. And it does reflect the toxicity of the illicit drug market, as many Senators here have mentioned today, the issue of poisoning versus overdose.

I recently participated in a DEA event that brought families together who have lost individuals through those exact scenarios, taking counterfeit pills that they thought was Xanax or Percocet and was actually pressed fentanyl. But I think I will highlight two things at CDC that I think complement the work of DEA and how we can continue to spread these messages.

The first is our Stop Overdose campaign, which I mentioned in my opening statement, which focuses specifically on fentanyl and the toxicity of the illicit drug market, the availability of naloxone, possibly substance use, which is also contributing to overdose, as well as unintentional exposure, people thinking they are using something else and they are actually getting fentanyl, and then decreasing stigma, which we know is a barrier for people to seek help.

That campaign was formally tested among young adults, 18 to 34 year olds. And so that is something that is freely available. People

can take what we have done and use it and apply it in their communities. So that is, I think, a new asset that is available to help spread the message about the toxicity of the drug market.

The last thing I will say is that there is a real opportunity to focus on upstream primary prevention. We need to get messages out about the toxicity of the drug market. But fundamentally, as a long run strategy to addressing this issue, we need to help instill resilience, life skills, problem solving, conflict resolution, focus on root causes like adverse childhood experiences that really set the trajectory for someone to have risk for substance use.

We know that people with ACEs initiate substance use earlier, which increases your risk of having a substance use disorder. So there are really powerful opportunities for public health prevention in that space.

Senator BALDWIN. Thank you, Dr. Jones. And I didn't want to cut you off because this is very responsive to my question. I did—I will do as Senator Collins did and submit some questions for the record.

But I did want to indicate that both Cade, who I just told you about, and Nickolas Barrett Graves of Beloit, were—have passed away of fentanyl poisoning. Nicholas of Beloit, Wisconsin could have been saved by naloxone, as could have Cade.

That is why I have been pressing manufacturers to make their products available over the counter and working on legislation to reauthorize the opioid overdose reversal medication access and education grant programs.

For Dr. Delphin-Rittmon, again, for the record, I will be inquiring what SAMHSA needs to make sure that naloxone is more readily available to first responders and in key locations such as school dormitories and community centers. And that will be submitted for the record.

The CHAIR. Thank you.

Senator Braun.

Senator BRAUN. Thank you, Madam Chair. My question is going to be for Mr. Chester. Want to cite a few things that I think most Americans would be appalled at what is happening. Since 2021, January, 3.2 million migrants have crossed the border illegally. We have intercepted 1.2 million pounds of illegal drugs, over 16,000 pounds of fentanyl.

That is approximately 3.7 billion lethal doses coming into the country to kill the population ten times over. Also, we have got 100,000 per year overdose deaths nationally and 2,000 opioid overdose deaths every year in my State of Indiana.

I don't know that we need to dispute the facts. I think mostly what I am interested—and look at your background. It is impressive in that it has kind of been your job to figure out how to disrupt the supply chain. Of course, now the main manufacturer is China. The main distributor is Mexico.

When I was down there in March, I think of 2021, illegal crossings were 40,000, 50,000 going up to 60,000 or 70,000. Now they exceed 200,000. We all remember the vivid interception recently of I don't know how many pounds of fentanyl.

Are you confident that what we are doing is aggravating the problem, just encouraging more proportionately from what it was pre-Biden administration? And are we making any headway?

Dr. JONES. Thank you very much. It is a very comprehensive question and I want to hit all of it. The first thing is, I would ask that we all bear in mind that there has absolutely been an increase in the number of drugs seized at our Southwest border.

Those are drugs that are not in our communities, and that is money that will not go to drug traffickers for their benefits. And I think that is the first thing. I think the second thing is, and I think I have mentioned this before, what you described very accurately is the results of a global business enterprise that is driven by profits and is focused on finding vulnerabilities in order to expand their customer base and make as much money as they can with the decreased amount of risk.

Synthetic drugs like fentanyl and synthetic opioids can be produced at much lower overhead and sold for much more money. And so that is the second thing. And then the third thing is that this is not confined, the problem doesn't begin or end at the Southwest border, but rather it is deep in a country where those drugs are produced.

It is the conveyances that move them and their raw materials around the world, and they are shipped through multiple means into the United States and into our communities. And so what we cannot do is take individual pieces of that complex and focus our efforts on it and ignore the others.

We have to look at it in its totality. We have to determine when there are changes in that environment and focus our efforts against those changes for the ultimate goal, and you use the exact right word, I think, in disrupting over time their ability to be able to move these drugs into our Country.

Snapshots in time, I absolutely understand that they give certain numbers in certain indicators, but I can tell you is we are approaching this in a holistic fashion, which is what it deserves, because that is the complex of issues that we are dealing with under this particular drug trafficking——

Senator BRAUN. Let me follow-up with this, because that sounds like a good approach in terms of how you are analyzing it. But we had 40,000 to 60,000 illegal crossings about a year and a quarter ago. Now it is up to over 200,000.

Can—and what they told us then was that the wall, which I don't think ever was talked about being from sea to shining sea, where it was, it was our most important tool along was the stay in Mexico policy.

How do you explain why it is gone from 40,000 to 60,000 illegal crossings to what could be approaching 300,000 and how we could be doing a better job at intercepting all the illicit material that comes along with the illegal crossings?

Dr. JONES. Yes, Senator, thank you. And please understand, I am going to limit my comments and my answers to the issue of illicit drug trafficking.

But what I can tell you is, that is precisely why in the Presidents Fiscal Year 2023 budget, we have asked for $300 million to enhance the capability of CBP to be able to deal with illicit drug trafficking across our borders, and another $300 million for the Drug Enforcement Administration to be able to do its work within the United States at being able to seize drugs as well.

As I mentioned before, these are very determined drug traffickers that are going to find a way to get the drugs into the country. We have the greatest professionals on the face of the earth, but we can always do more in order to give them the tools that they need in order to be most effective against this problem——

Senator BRAUN. I think I am out of time, and I won't go for another round of questions. But I think carefully about that relationship between how many people are coming across and what is underlying the fact that you are going to be intercepting a lot more illicit materials as well. Thank you.

The CHAIR. Thank you.

Senator Hickenlooper.

Senator HICKENLOOPER. Thank you, Madam Chair. Mr. Chester, I wanted to ask a question about pyral, because even as fentanyl devastates our communities, more is coming and in Colorado we are just starting to see pyral, a drug that appears to be ten times stronger than fentanyl.

I know, Mr. Chester, you have made disrupting the supply of illicit drugs a major focus of your career. And how do illicit drugs like pyral, where do they come from? How does it end up in Colorado, and what is the Administration going to try to intercept supply routes?

Mr. CHESTER. Yes, thank you for the question, Senator.

I know in particular, I–75 is a major corridor for you and the amount of concerns that are involved with the physical movement of drugs throughout your state and really throughout the region on that corridor. That particular drug and others like it—and I want to be clear kind of in our characterization here.

You have fentanyl itself and then you have fentanyl analogs, which are alterations, additions, or substitutions to the base fentanyl molecule, an entire class of substances. And then you have other non-fentanyl synthetic opioids. And that is the nitazenes family and those are others that come up.

The reason we see them is for two reasons. No. 1, one of the best accelerants for the production of a new drug is action taken against an existing one. These are profit seeking enterprises that have very smart chemists who want to market new substances, post them on the internet or on social media for availability, and get people to be early adopters to them.

That is the first time that is the first way that you see them. And then the second way that you see them is, it is generally product placement. They have the available precursor chemicals, they have a chemical formulation they can get on, and they advertise it is having a certain qualitative effect on the body.

All of them are illicit. All of them are dangerous. And all of them are available on the internet and on the dark web, and to be

shipped in either physically into the United States or across our borders through mail and express consignment. The last thing I will tell you is, and I know the Rocky Mountain HIDTA did very well.

We are very proud of the High Intensity Drug Trafficking Areas Program that we administer and manage here in ONDCP. It is organized—and we have extended the overdose response strategy for the HIDTA program to all 50 states, the Virgin Islands, Puerto Rico, and DC.

That brings together drug intelligence officers and public health individuals in order to be able to better understand the environment, identify those new and emerging threats like the one that you just mentioned, to be able to take action on them, and they do very good work.

Senator HICKENLOOPER. All right. And thank you for this, for the HIDTA. It has been very effective and remarkably effective. Dr. Delphin-Rittmon, fentanyl has killed 1,600 Coloradans in the last almost 3 years.

Just a few months ago, we had a high school sophomore from Durango, Colorado, who died from an accidental fentanyl overdose. We received $23 million, maybe a little more than point $23 million for the substance abuse prevention treatment block grants as part of the Rescue Plan, the American Rescue Plan.

As this help goes out across Colorado, do you see, or let me be—what specifically do you see as the most effective utilizations of that funding? What are the best investments we can use to try and go after the fentanyl overdose rates, and how is SAMHSA working with states to provide that real time information and data and technical assistance to get there.

Ms. DELPHIN-RITTMON. Yes. So often what we find is states will use the strategic prevention framework approach to be able to identify approaches and strategies that will work most effectively within their context.

Many of the community coalitions will do focus groups, meet with schools, meet with students to be able to develop messaging that is going to resonate with students and resonate with schools.

In some instances, the coalitions will work with schools and students to develop some of that messaging so that it is really coming from students. So I think that is one thing that is helpful, developing messaging that students can take in and that raises awareness about the dangers of fentanyl, to include social media access of fentanyl, as well as just the dangers of fentanyl use.

I think another strategy that can help is working with schools to raise awareness about and being able to identify students that may be struggling with substances or that may be having trouble. And ultimately being able to connect those students to services and supports.

Senator HICKENLOOPER. All right. Thank you. And I think that—I think we are making progress in actually identifying the types of kids that might, would be likely to experiment.

Often with fentanyl, it seems like so often that it is somebody who has almost no experience in drug use. Not always, obviously,

but too often. Anyway, I am out of time. I have got a couple other questions, but I will file them in written form. Thank you.

The CHAIR. Thank you.

Senator Casey.

Senator CASEY. Thank you, Chair Murray. And I want to thank you for calling this hearing, and I want to thank our witnesses for their testimony and for the expertise they bring to bear on this awful, awful fentanyl crisis that has consumed the country.

Pennsylvania is third in a category we don't want to be third in, third in overdose deaths. Pennsylvania had 5,438 deaths in 2021 alone. That is around one death every 2 hours. And of course, just like in so many other places, fentanyl is the dominant, the dominant opioid. So it has consumed so many families, so many communities.

Like Chair Murray, I am very concerned about the rise in fentanyl related overdose deaths in adolescents who, because of their stage of development, are more vulnerable to opioid use disorder.

This is particularly the case when a young person has a mental health condition like ADHD, depression, or anxiety, which too often goes undiagnosed and untreated. So I will start with Dr. Delphin-Rittmon. Can you speak to two things, No. 1, the relationship between opioid use disorder and other mental health conditions?

No. 2, how timely mental health care for young people can help prevent opioid misuse.

Ms. DELPHIN-RITTMON. Yes. Thank you for that question, Senator, and for all your work and advocacy in this area. We know that for some youth as well as adults, use of opioids or other substances is connected to, for some individuals, mental health challenges.

To the extent that services and supports are, and we talk a lot about this, that we are able to take a co-occurring approach, that services and supports are able to address both mental health and substance use challenges. But that is important also in terms of identification.

We do have a program called, for short it is, the youth family tree. And what that program is about is early identification of youth that may be struggling, youth, as well as transition age individuals, and other members of families.

It is a grant that takes a community based approach, a family based approach, and really uses multi-system approach to be able to identify, do early identification, but also early connection to services and supports such that the addiction doesn't progress.

I think that is one area that is an important area of work. In fact, that grant is up for authorization so certainly appreciate this Committee's commitment to that area of work. There is also work in terms of being able to ensure access.

You mentioned the piece around ensuring that there is timely access to services and supports. And so I think that is an important part of the system of care work as well, ensuring that whether it is a school system or whether family members, that there is aware-

ness around how to access and connect students or families to services and supports.

Senator CASEY. Thank you very much, doctor. And I wanted to turn to Carole Johnson, with whom I worked on the Aging Committee.

It is great to see you again, I guess twice in a week. But Carole, wanted to make a reference to both the screening and access to medications for opioid use disorder, which, of course, are not yet meeting demand.

We know there are wide gaps in the workforce that are caring for adolescents. I have a bill with Senator Cassidy to support cross training of the pediatric health care workforce to address mental health and substance use disorders.

Given the serious threat of fentanyl to young people, we can't afford to miss any opportunity to screen adolescents for these disorders. How do we increase opioid use disorder competency in the pediatric health care workforce?

Ms. JOHNSON. Thank you so much, Senator Casey, and thank you for your leadership on this issue. We think this is critically important, making sure that we create sort of norms and standards in the health care workforce.

That primary care sites, pediatrics offices, primary care physicians, our community health centers are places where our clinical workforce is trained to identify mental health and substance use disorders and, where appropriate, be able to help begin treatment. And so that is why we are committed to this work.

We appreciate the progress that we have made with the Pediatric Mental Health Access Program, which has helped us be able to bring mental health expertise directly into pediatricians' offices. But we want to continue to look for ways to grow the capacity of the primary care workforce and pediatricians to address substance use disorder directly.

Senator CASEY. Thanks very much. Thanks, Chair Murray.

The CHAIR. Senator Rosen.

Senator ROSEN. Thank you, Chair Murray. I really appreciate holding this very important hearing today, and of course, the witnesses for all of your work in this area. And so, like so many of us, we are just so worried about our communities and the overdose disparities, especially in Nevada in our Latino communities.

The synthetic fentanyl crisis has gotten worse in recent years in Nevada. It has unfortunately disproportionately impacted our growing latino population. In fact, between 2019 and 2020, drug overdose deaths among Latinos in Nevada increased 120 percent, and the proportion of those involving fentanyl increased 135 percent, the highest among any demographic group.

Compounding this problem is a lack of awareness in our Latino community about resources, including harm reduction strategies, as well as a shortage of substance abuse disorder providers, particularly culturally competent Spanish speaking providers.

Dr. Delphin-Rittmon, what kind of targeted community outreach is SAMHSA doing to ensure Latino communities not just in Nevada

but across the country, have access to evidence based substance use disorder resources to help curb addiction, including those harm reduction strategies?

Ms. DELPHIN-RITTMON. Yes, thank you for that question, Senator Rosen. And so this is an area that is a priority for SAMHSA. It is certainly a priority as well within the Secretary's overdose prevention strategy, or it is one of the cross-cutting areas that is equity.

One of the things that we do is we fund the Hispanic and Latino Addiction Technology Transfer Center. What that center does is it provides a broad range of training and technical assistance to providers across the Country.

That helps to ensure that those providers are able to implement culturally responsive services, services that meet the needs of Latino individuals and diverse groups. And so that training is available across the Country.

Another area of work we have through our Office of Behavioral Health Equity for our new grantees and actually previous grantees as well that we have strengthened this program. We now do disparity impact statements. And so grantees have to identify disparity populations that may be serving within their region or area, and then identify how that grant will be used to address disparities among those individuals or groups that—where disparities exist.

Then what we have increased, we have now increased, or will be increasing, the technical assistance to grantees to ensure that they have the resources and support that they need in terms of addressing the needs of diverse groups.

We are excited about that program. We think that will make a real difference in terms of working across our grant programs to help them to be able to identify disparity populations, but also address those disparities as well to include among Latino individuals.

Senator ROSEN. Well, that is great that you are doing that, but we know that you need the resources and that means the workforce.

While SAMHSA's minority fellowship program, you have made strides in increasing provider diversity and boosting cultural competency and behavioral health, data suggests that people of color still only constitute a significant minority of the substance abuse disorder workforce.

Again, Dr. Delphin-Rittmon, as the Committee seeks to reauthorize and enhance SAMHSA programs this year, I really want to see how we can expand and improve on these minority fellowship programs to bring people into the workforce to ensure we are attracting and retaining these providers, mentoring the next gen of them, and they can better serve the trust of Latinos, of course, all of our minority populations, underserved populations across the Nation.

Ms. DELPHIN-RITTMON. Yes. Thank you for that. And that is a program, well, for one I can say it is near and dear to my heart. I went through the fellowship program 1992 to 1993.

One thing we are doing to expand that program is to increase the number of individuals that can go through at the master's level. Either they are doctoral level fellowships that are provided.

I went through the doctoral program, but now we are increasing that to the master's level. That will help to increase the numbers of individuals that are able to begin practicing and begin working in the field sooner.

We are real excited about that. And we know the programs coming up for authorization. That is some of what we will use those resources for. Other programs we have are around working with HBCUs and Hispanic serving institutions as well around attracting individuals to the behavioral health professions who may be considering behavioral health or may be interested in behavioral health.

That is an additional program that works to increase the numbers of individuals from diverse populations that are entering the behavioral health fields or individuals interested in working with diverse populations as well.

Senator ROSEN. Thank you. I think my time has expired. Thank you, Madam Chair.

The CHAIR. Thank you.

Senator Kaine.

Senator KAINE. Thank you, Chair Murray. And thank you to our witnesses for being here today and for your important testimony. So my state is like others, I have heard each Senator talk about the tragedy of this in their states.

There were 2,656 overdose deaths in Virginia in 2021. It was a 15 percent increase from 2020, and fentanyl was responsible for 77 percent of those fatal overdoses. So we are all grappling with this, and I appreciate the testimony, and colleagues of mine have asked many questions that I was going to.

I wanted to ask you a question about a strategy to deal with this issue, Dr. Delphin-Rittmon, that we have talked about before. The last time you were here, I asked a question about connecting incarcerated individuals to treatment services and in particular about drug courts.

You shared information from SAMHSA's drug court program, and those are programs most of us have in our states. Work to divert individuals from further involvement with the justice system into behavioral health treatment that is more likely to lead to a successful outcome.

When I meet with sheriffs in Virginia, I always ask them this as the opening question, what percentage of people in your jail shouldn't be there? I don't have to describe my terms. I don't have to define what I mean. They know what I mean.

They know that I am asking what percentage of people in jail aren't really bad people, are not really crooks, they are not criminals, but they are people with substance use issues that have either been diagnosed and not treated or not effectively treated, or in some instances never diagnosed.

I have never had a sheriff give me a number less than 40 percent. And often sheriffs give me numbers 50, 60, 65 percent. Since 2017, Virginia has received four SAMHSA supported grants for drug courts, one in Lynchburg, Harrisonburg, Richmond, and Abingdon in far Southwest Virginia.

I have been to some of the drug courts to talk to them about what they do. I have been to some graduations. In fact, I have been to two graduations in the last couple of years. In one, the drug court program was started by a local circuit court judge whose child had died of a drug overdose and that led her to spur the effort to start it.

Then the other one that I went to, one of the probation officers who works with the drug court program came up to me and said, and this is my second graduation this week, and I said, I thought this county only had one program going on at any one time. He said, we do, but my first graduation was my son graduated from a drug court program in another county and here is the one that where I am the probation officer and I am here for—because I am proud of my graduates.

Talk a little bit about the effectiveness of the drug court programs in SAMHSA. There is funding issues. Do we have enough funding to operate them? I happen to believe the moneys we invest in these are some of the best investments we make. But if you, Dr. Delphin-Rittmon, talk about drug court programs.

Ms. DELPHIN-RITTMON. Yes. Thank you for that question, and just for all your work in this area. I mean, what we find and what we know is that drug court programs, they make a difference. They make a meaningful impact in people is lives.

That it is an opportunity to reduce further penetration into the justice system for individuals that are struggling with substance use challenges. It is an opportunity to connect people to evidence based services and supports, to include medication assisted treatment, and to really change the trajectory of an individual's life because they are able to get that treatment that is critical.

As you know, we also do enriched programing. And so the enriched programing is for individuals that are connected, are further along, and maybe before release, whether it is from jail or prison, we work to connect them to services and supports to include buprenorphine if necessary.

In fact, right after this hearing I will be flying to the national annual meeting of drug court professionals and will be doing a series of meetings with different court groups related to their work. This is vital lifesaving work, and this program is coming up for reauthorization as well. So, I certainly appreciate the Committee's commitment and interest in this area.

Senator KAINE. Please pass on, as you go out and talk to drug court professionals, the respect that we have for the work that they do. Here is a question dealing with fentanyl coming into the United States from abroad.

What can you tell us, particularly those with the National Drug Control Office, what can you tell us if there is a pie chart, some come by mail, some people smuggle over the border, some maybe come around the borders, but I understand that huge percentages of the fentanyl that come in the United States come in across our ports of entry in vehicles.

Because we only inspect one out of every however many vehicles, cartels figure they can play the odds and they can actually just

smuggle it right across the border through ports of entry. Can you share what the data is about that?

Mr. CHESTER. Yes, Senator. And it is an understandable question, but I am afraid it is an unknowable question, because the only thing that we can calculate is what we see and what we find, right. But your characterization of vehicles is correct, but I think for a different reason. Our Customs and Border Protection do have the ability to be able to do non-intrusive detection that is very impressive.

I was down last fall in El Paso, and the non-intrusive detection capability that they have is very good. But more importantly are those ports are manned with incredibly experienced agents who can pull a vehicle into secondary just based upon, I have seen this before, just based upon intuition.

They also have heuristic models and algorithms that can determine the right time to pull folks into secondary. So there are a lot of reasons why someone get pulled in the secondary.

But your characterization of drug traffickers is absolutely correct, because a drug trafficker can send ten vehicles across knowing that two may get pulled aside, but that is just built into the business model and the amount of profit and knowing that the remainder are going to be able to get through.

That is the challenge that we have. And even if we were able to reduce that number to C7 and only three get through, drug traffickers in pursuit of profits are going to find other ways in order to be able to circumvent that and get the drugs into the Country.

What we do by looking at it really in a more holistic fashion is to determine when we see changes in the environment and how quickly we can surge in order to address that change as well. And that is why we would describe it as a dynamic environment. That is what we mean by that.

Senator KAINE. Well, I am over time. But Madam Chair, to me, what that suggests is if any of our efforts on the enforcement side just lead creative people who want to make profits to figure out another way to do it, then ultimately you have got to tackle this on the demand side. And so that is prevention, and that is the kind of things you have been testifying to. And if we don't talk about—[technical problems]——

The CHAIR. Thank you. That will conclude our hearing today. And I want to thank all of my colleagues, and especially I want to thank our witnesses today, Mr. Kemp, Dr. Delphin-Rittmon, Ms. Johnson, and Dr. Jones.

Thank you for a very thoughtful conversation on such an urgent crisis for all of our communities. If there is one thing we take away from today's conversation, I hope it is that our communities can't wait.

They need urgent action from the Administration and from us in Congress to disrupt the supply of dangerous illicit fentanyl, to support those on the front lines of this crisis in our communities, and especially to connect people with the prevention, the treatment, and recovery support services that we know saves lives.

That is why it is really important to me, as—more important to me as ever that we can advance a bipartisan package that makes meaningful progress on these issues.

I hope that all of my Republican colleagues agree and that we can continue our process negotiating a very robust mental health and substance use disorder bill that will support the programs we have seen make such a difference and provide additional tools and resources to tackle the new threats and emerging challenges in this space.

For any Senators who wish to ask additional questions, questions for the record will be due in ten business days, August 9th at 5.00 p.m. And the Committee stands adjourned.

ADDITIONAL MATERIAL

PREPARED STATEMENT OF RANKING MEMBER RICHARD BURR

The rise in overdose deaths is being driven by illicit fentanyl and has affected every corner of our communities. My home State of North Carolina has not been spared, and too many individuals and families in my state have dealt with tragedy as a result of fentanyl. In order to address the fentanyl problem in the United States, we need strong leadership and an effective, multi-sectoral strategy that addresses both the source of the drugs and also the substance use disorder prevention and treatment needs of the response.

I had hoped to have Customs and Border Protection here to discuss with the Committee what they are seeing, particularly at the border, with respect to drug trafficking. Just last week, two men in Washington State were charged with smuggling 91,000 fentanyl pills inside potato chip containers in connection with a transnational criminal organization. Or the Drug Enforcement Administration, which just earlier this month, announced the seizure of 100,000 fake oxycodone pills containing fentanyl and could provide us with a clear picture of the criminal networks that are mass-producing illicit fentanyl and fake pills in clandestine laboratories. But Chair Murray did not want to invite those agencies to this hearing, despite requests, so that we might gain a better understanding of the complexity behind the illicit fentanyl and fentanyl analogues problem in the United States and their sources.

Every day, illicit drugs are entering the country from China, Mexico, and India. The recent news from Washington State is just one example of this problem. And it's driving overdose deaths. According to DEA, the agency's lab testing demonstrated that 4 out of every 10 pills with fentanyl contain a potentially lethal dose. Permanently scheduling fentanyl analogues, which drug traffickers use to skirt trafficking laws, as Schedule I under the Controlled Substances Act would play a significant role in reducing the supply of illicit fentanyl smuggled into the United States. I urge my colleagues to consider the *HALT Fentanyl Act*, a bill that Senator Cassidy and I worked on together that would permanently schedule fentanyl analogues as Schedule I under the Controlled Substances Act.

We also need to continue to support and improve public health programs charged with responding to the substance use disorder prevention, treatment and recovery needs of communities that were hit hard by the opioid crisis and now are grappling with high overdose rates driven by illicit fentanyl. With the passage of the Comprehensive Addiction and Recovery Act of 2016, the 21st Century Cures Act, and the SUPPORT for Patients and Communities Act, Congress has demonstrated its commitment to supporting substance use disorder needs. We need to make sure our programs are effectively utilizing data, leveraging innovative medical products for treatment and overdose reversal, and partnering with different sectors to promote effective solutions on the ground. I am thankful for Senator Bill Cassidy's expertise and willingness to serve as Ranking Member for the Senate HELP Committee hearing today, and look forward to continuing to work on this issue.

QUESTIONS AND ANSWERS

RESPONSE BY KEMP CHESTER TO QUESTIONS OF SENATOR BALDWIN, SENATOR ROSEN, SENATOR BURR, SENATOR COLLINS, SENATOR MURKOWSKI, AND SENATOR SCOTT

SENATOR BALDWIN

Question 1. Steven Welnetz's mother recently shared his story with me. She described him as a person with a heart of gold. On November 6, 2021, he took what he thought was a Xanax. It had been pressed with fentanyl, and he died shortly thereafter.

Fentanyl is being brought in to the United States in large quantities, including through International Mail Facilities.

How is ONDCP working with other agencies to combat the importation of fentanyl, including fentanyl that is entering the country through the mail?

Answer 1. Illegal substances enter the United States through a variety of means. They can be marketed and sold on the dark web using cryptocurrency and delivered to the purchaser through the mail and commercial carriers, or can be brought across the Nation's geographic borders by multiple conveyances; from body carries, to containers on cargo ships, through commercial and private vehicles, or purpose-built watercraft. The Biden-Harris administration is committed to exploring and using every means available to reduce the supply of illicit substances in America's communities. This includes ensuring our law enforcement agencies have the resources they need to disrupt the sale of these drugs on the internet and the flow of drugs across our borders and working with our international partners to halt drug production outside the United States. Those international efforts include controlling the chemicals used to produce both plant-based and synthetic drugs, and ensuring those involved in any aspect of the global drug trade, including their illicit proceeds, are held accountable.

There are a number of robust and ongoing interagency efforts investigating drug sales on the internet and shipped through the mail system. As you can imagine, we do not make a lot of that information public so that drug traffickers cannot adapt their tactics based upon knowledge the extent of our activities. Discussing law enforcement activities in detail could compromise ongoing investigations, but successful initiatives are underway, such as the FBI Joint Criminal Opioid and Darknet Enforcement (JCODE) program which pursues traffickers who exploit the dark web to market and sell opioids, as well as other drugs.

We also know that transnational criminal organizations (TCOs) are poly-crime, and that their illicit revenues come from a variety of criminal activities in addition to illicit drugs. Organizations like Homeland Security Investigations' (HSI) Cyber Crimes Center (C3) is dedicated to the criminal investigation of transborder internet-related crimes, including the sale and distribution of illicit drugs, as well as other criminal activities such as money laundering, illegal arms trafficking, child exploitation, and human trafficking.

The United States Postal Inspection Service is at the forefront of both domestic and international efforts to stem the flow of illicit drugs through the mail. For example, The United States and Canada agreed to a bilateral Joint Action Plan on Opioids to strengthen cross-border cooperation and develop effective approaches to addressing the opioid crisis. Within this bilateral agreement, The U.S.-Canada Postal Security Action Plan was created, which directly supports the bilateral priorities between the two Governments to address the ongoing opioid crisis and the emergence of dangerous synthetic drugs in the supply chain within the mail system.

Over the last 3 years, the Postal Inspection Service has witnessed a dramatic decrease in international seizures of opioids, especially from China, while domestic seizures are increasing. Since 2019, the Inspection Service has not had a direct seizure of fentanyl from China. Ninety-nine percent of Postal Inspection Service seizures in fiscal year 2021 and fiscal year 2022 were from domestic mail, most originated from southwest border states. Overall, the Postal Inspection Service has greatly increased seizures of illicit synthetic opioids from the mailstream in terms of both the number of seizures and weight. In the past few years, the Postal Inspection Service has seen an increase in the weight of synthetic opioids per seizure. Nonetheless, China remains one of the top global suppliers of precursor chemicals for fentanyl production and continues to supply Mexico with these essential ingredients to the drug trade.

The United States will pursue TCOs through all appropriate means, whether those are investigations into illicit drug trafficking, or any of their numerous other criminal activities.

If you would like a more in-depth discussion on engagements by individual departments and agencies, I refer you to my colleagues in the Departments of Justice and Homeland Security, and the U.S. Postal Inspection Service.

SENATOR ROSEN

Question 1. SUPPORTING LAW ENFORCEMENT EFFORTS TO COMBAT FENTANYL IN NORTHERN NEVADA: While synthetic fentanyl took hold quickly in other parts of the country, it had been slower to reach Northern Nevada, which includes many rural communities. However, according to the Washoe County Sheriff's Office, as the amount of fentanyl in Northern Nevada has spiked in the last year and a half, fentanyl is now the second-deadliest drug in Washoe County, behind only methamphetamine. Synthetic fentanyl is increasingly being pressed into pills to look like prescription drugs. As so many of my colleagues have pointed out, this is a public health crisis, and we must do more do support both law enforcement and the public alike to combat it.

Mr. Chester, is ONDCP witnessing similar trends among other smaller, rural counties across the country, and what more can Congress and the Administration do to help support our local law enforcement agencies like the Washoe County Sheriff's Office in further disrupting fentanyl trafficking and production?

Answer 1. ONDCP works to coordinate the efforts of Federal, state, Tribal, and local law enforcement to reduce the supply of fentanyl and other dangerous drugs through multijurisdictional task forces, such as those funded through ONDCP's High Intensity Drug Trafficking Areas (HIDTA) Program. HIDTA currently augments efforts in Washoe County through the Nevada HIDTA. In addition, Congress should pass the Biden-Harris administration's approach to reduce the supply and availability of illicitly manufactured fentanyl-related substances (FRS) by permanently scheduling FRS, while safeguarding against racial disparities in prosecution and sentencing and reducing barriers to scientific research for all Schedule I substances.

SENATOR BURR

Question 1. In years' past, and as recently as 2020, the National Drug Control Strategy (NDCS) has highlighted the beneficial role that Prescription Drug Monitoring Programs (PDMPs) play in combating prescription drug abuse and saving lives, going as far as to call for an increase in the utilization of PDMPs and their integration into Electronic Health Records (EHRs) to increase utilization. However, in the recently released 2022 NDCS, there is no mention of PDMPs the role they can play in helping to prevent the use and abuse of medications and the fact that 47 PDMPs have successfully integrated their PDMP into EHRs and Pharmacy Dispensation Systems. Why did the ONDCP decide to no longer highlight the positive role that PDMPs are playing in reducing access to, and abuse of, controlled prescription medications?

Answer 1. ONDCP's response to overprescribing and the diversion of prescription opioids through prescribing guidelines, PDMPs, and provider training has been successful but more can be done to save lives. Overprescribing and "pill mills" still cause harm but the nature of the overdose crisis shifted from prescription opioid overprescribing to illicitly manufactured fentanyl, and our strategies for responding have shifted to address this new reality. The *National Drug Control Strategy* is a forward-looking document that identifies key drug policy priorities for the Federal Government and lays out a plan for addressing the most urgent work ahead. It is imperative that we focus our supply and demand reduction efforts on the key driver of overdose deaths today: illicitly manufactured fentanyl.

Question 2. As the ONDCP has stated in previous years' National Drug Control Strategy that a barrier to the increased utilization of Prescription Drug Monitoring Programs (PDMPs) is due to a lack of integration into providers' Electronic Health Records (EHRs) and a lack of interstate data sharing capabilities. Technology underlying the PDMPs has made great strides in recent years to alleviate these issues, improving integration into EHRs, providing prescribers with complete and interstate data and improving the usability and ease to increase uptake and utilization of the PDMP services in all geographies. However, there are still impediments to fully realizing the PDMPs capabilities due to certain Federal entities discouraging states from using their preferred vendor and significantly obstructing progress in the market. Will you commit to ensuring that the ONDCP works with PDMP service providers and other Federal agencies to ensure that the PDMP market is fair and capable of offering the best services available for both patients and providers? Will you commit to ONDCP ensuring that Federal agencies do not impose any unnecessary

conditions that could jeopardize the success of these programs by adversely impacting patients, providers, states, and/or the public health?

Answer 2. ONDCP recognizes that PDMPs are a helpful tool for monitoring care. ONDCP is supportive of Centers for Disease Control's and Prevention and the Bureau of Justice Assistance's work related to developing PDMP infrastructure within States and fostering bidirectional capacity for data-sharing within and across States that enhances and maximizes bidirectional connectivity. ONDCP is embracing a combined public health and public safety approach to reduce demand and supply which will complement provider use of the PDMPs.

SENATOR COLLINS

Question 1. Actionable Overdose Data (Mr. Chester and Dr. Jones). Mr. Chester, I appreciate that the National Drug Control Strategy prioritizes the need for more actionable data to track nonfatal overdoses, which you recognize in your testimony as "one of the most accurate predictors of whether someone will experience a fatal overdose in the future." I was also encouraged to hear Director Gupta recently met with officials in Maine to see firsthand how Maine collects detailed overdose data. This data is critical for law enforcement and health care providers to appropriately gauge the scope of the crisis in their local communities and target resources where they are needed. I understand the Administration has recently created a Drug Data Interagency Working Group that will assist with the development of a new national plan for obtaining data in near real-time. However, this is expected to take 1 year to develop fully.

Mr. Chester, can you provide an update on the status of this overdue data effort, including how the 1-year timeline was determined?

Answer 1. The SUPPORT Act of 2018 mandated that ONDCP develop a "systematic plan for increasing data collection to enable real time surveillance of drug control threats, developing analysis and monitoring capabilities, and identifying and addressing policy questions related to the National Drug Control Strategy and Program." In order to develop a comprehensive Data Plan that meets these statutory requirements, it was critical for ONDCP to obtain and incorporate input from Federal agencies engaged in drug-related activities, since much of the data collection and analytical activities occur within these entities. In order to facilitate discussion and obtain feedback from each of the National Drug Control Program Agencies, ONDCP reconstituted the Drug Data Interagency Working Group in December 2021. The working group has convened four times in total with approximately 60 participants from 25 different Federal agencies. Through these communications, the working group identified data needs, discussed methods, analytical approaches, and challenges to developing evidence to support policymaking, and identified steps to be taken to implement the plan.

The 2022 National Drug Control Strategy (pages 123–125) summarized the background and process for developing the Data Plan, and proposed an approximately 1-year timeline to develop a more comprehensive plan.

Question 2. Mr. Chester and Dr. Jones, how is ONDCP utilizing partners like the CDC who have expertise in data collection and partnerships across state and local public health agencies?

Answer 2. ONDCP routinely meets and collaborates with organizations who have expertise in data collection and analysis. We have convened the Drug Data Interagency Working Group four times since December 2021 to discuss data-related topics with the National Drug Control Program Agencies. We also meet periodically with CDC and other agencies on a regular basis to coordinate and discuss when new data has become available (such as the CDC's monthly releases of provisional estimates on drug overdose deaths), and to review and provide feedback on new data products and deliverables (such as the CDC's State Unintentional Drug Overdose Reporting System (SUDORS) and Drug Overdose Surveillance and Epidemiology (DOSE) Dashboards). ONDCP also hosts a monthly webinar which allows state and local governments to showcase their opioid and synthetic drug data. We also engage in stakeholder meetings with non-profit organizations, private sector companies, and academic institutions to learn about innovative data sources and analytic approaches (such as wastewater-based epidemiology).

SENATOR MURKOWSKI

Question 1. I am concerned about the transportation of illicit fentanyl and other substances through the southern border and ports of entry. Throughout the U.S., many of the hardest-hit and most at-risk communities of the fentanyl and opioid crisis are often remote and rural areas. In Alaska, for example, many towns and vil-

lages are unconnected to major roadways and have limited access to land, air, and sea travel, and yet, continue to suffer from the inflow of fentanyl and fentanyl analogs into their communities.

How is illicit fentanyl making inroads into the U.S. and Alaska's most rural communities, and what measures are being taken to address the trafficking that occurs within our own borders?

Answer 1. The Biden-Harris administration is exploring and using every means available to reduce the supply of illicit substances in America's communities. This includes working with our international partners to halt drug production outside the United States, which includes monitoring and controlling the chemicals used to produce both plant-based and synthetic drugs; facilitating international law enforcement cooperation, ensuring our law enforcement agencies have the resources they need to disrupt the sale of these drugs on the internet and the flow of drugs across our borders; and ensuring those involved in any aspect of the global drug trade, including those that benefit from their illicit proceeds, are held accountable.

The National Drug Control Strategy addresses both domestic and international priorities to reduce the supply of illicit substances coming into the United States. Domestically, we prioritize improving information sharing and cooperation; disrupting domestic production, trafficking, and distribution; improving efficiency and effectiveness of resource allocation, and protecting individuals and the environment from criminal exploitation.

A key domestic partnership between Federal, state, local and Tribal law enforcement which is key to our supply reduction efforts in communities across the United States is the High Intensity Drug Trafficking Area (HIDTA) Program. HIDTA task forces work to disrupt and dismantle drug trafficking organization (DTO) networks that traffic Mexican sourced fentanyl into and throughout the United States. The HIDTA Program's continued efforts to address fentanyl trafficking played a significant role in the response to this threat. In 2021, in Alaska, in particular, the Alaska HIDTA has disrupted drug trafficking organizations operating in the region, and seized thousands of dosage units of fentanyl throughout the state.

Question 2. According to preliminary data from the CDC, the U.S. experienced a 15 percent increase in overdose deaths from 2020 to 2021. Meanwhile, in Alaska, that increase was a staggering 75 percent, roughly five times the national average. Due to historical trauma other inequities, our Alaska Native population have experience high rates of substance use and alcoholism. I am concerned about the impact of the fentanyl epidemic on our rural Alaska Native communities, who are already experiencing significant increases in overdose deaths. How will you ensure the Federal efforts to address the rise of fentanyl overdose deaths will address the needs of those in rural areas, specifically American Indians and Alaska Natives?

Answer 2. ONDCP continues to work closely with the Health Resources and Services Administration to ensure the fentanyl overdose prevention and opioid use disorder treatment needs of rural areas are being met. This includes expanding access to medication for opioid use disorder, naloxone to reverse overdoses, and fentanyl test strips where applicable under the law. In addition, ONDCP supports the Alaska HIDTAs in their efforts to reduce the supply of illicit fentanyl in the state.

Question 3. In Alaska and around the country, drug addiction and substance use disorders are ending the lives of far too many youths. This past June, I, along with my colleagues Senator Feinstein, Senator Sullivan, and Senator Hassan, introduced S. 4358, Bruce's Law. This bill authorizes funding for the Department of Health and Human Services (HHS) to conduct a public awareness campaign targeted toward school-aged children and youth on the dangers of fentanyl, establish an inter-agency working group on fentanyl contamination, and authorizes an expansion of grants for community coalitions to engage school-aged children and youth in outreach and prevention efforts.

What type of outreach and prevention efforts are the CDC and SAMHSA currently supporting to educate youth and school-aged children on the dangers of counterfeit drugs laced with fentanyl? What inter-agency coordination takes place between the CDC, SAMHSA, and ONDCP on these efforts?

Answer 3. ONDCP, CDC, and SAMHSA regularly amplify prevention efforts, new resources and training opportunities among the youth substance use prevention field. The most recent example of collaboration amongst ONDCP, CDC, and SAMHSA Center for Substance Abuse Prevention is the sharing of a monthly resource document to ensure Federal staff supporting prevention efforts are aware of the resources available amongst the three agencies. The sharing of this monthly resource will ensure the Federal Government continues to be well equipped to support the evolving needs of communities.

In addition, the Drug-Free Communities (DFC) Support Program is the Nation's leading effort to mobilize communities to prevent and reduce substance use among youth. Created in 1997 by the Drug-Free Communities Act, administered by the White House Office of National Drug Control Policy (ONDCP), and managed through a partnership between ONDCP and CDC, the DFC program provides grants to community coalitions to strengthen the infrastructure among local partners to create and sustain a reduction in local youth substance use.

The Drug Enforcement Administration (DEA) also issued its first national public safety alert in 6 years and launched the "One Pill Can Kill" public awareness campaign to raise awareness of the dangers of fake prescription pills laced with fentanyl.

Question 4. How does ONDCP believe that Bruce's Law, if enacted, would enhance their prevention efforts?

Answer 4. While the Administration has not yet taken a position on the legislation, ONDCP supports evidence-based prevention and reduction of youth substance use and evidence-based overdose prevention.

SENATOR SCOTT

Question 1. The Drug Enforcement Agency has referred to Mexican drug cartels as the "greatest drug trafficking threat to the United States." According to the U.S. Customs and Border Patrol Agency, fentanyl seizures at our ports of entry increased 1,066 percent in 2021. This came at a time when the Biden administration was moving to end the previous Administration's "zero tolerance" border policy.

Mr. Chester—In your testimony, you describe routine engagements between the U.S. and China regarding shipments of precursor chemicals and illicit financing schemes with ties to Chinese criminal organizations.

How confident is the Biden administration in its Chinese Communist Party counterparts to cutoff the flow and finance of illicit Chinese fentanyl into North America, given the lack of cooperation on investigations into the origins of COVID–19 and recent provocations by the Chinese Communist Party in the Taiwanese region?

Answer 1. The Chinese government must do more to hold accountable the individuals and entities within its borders who supply synthetic opioids and drug precursors to drug trafficking organizations. Dr. Gupta made this point recently in a Wall Street Journal opinion piece urging The People's Republic of China (PRC) to join the United States' efforts to stop the flow of illicit precursor chemicals and substances. He wrote that "Unless other countries, including the PRC, join the U.S. and act, drugs such as fentanyl and methamphetamine synthesized with precursors made in the PRC will continue to flood the world."

Question 2. What specific actions has the Biden administration taken to not just address the deficit of trust but to also hold the Chinese Communist Party accountable in the international fight against illicit fentanyl flows and financing?

Answer 2. There are practical and common-sense steps nations can take to disrupt the global trafficking of synthetic opioids and their precursors. They include implementing "know your customer" standards to prevent the diversion of chemicals to illicit drug manufacturing; proper labeling of chemical shipments from host countries through enforcement of World Customs Organization standards; and monitoring for the diversion of uncontrolled chemicals and equipment in international flows.

Dr. Gupta recently expressed the need for the Chinese government to reengage in the international arena. Without the Chinese government's engagement, shipments of precursor chemicals to illicit drug producers in Mexico will continue, and traffickers will keep moving these drugs into America. The Chinese government's decision to suspend full cooperation on this issue will result in more American deaths and more deaths worldwide. The U.S. will continue to work domestically and with its partners around the world to disrupt criminal organizations, get people the care they need and save lives. The Biden administration is turning partnerships it has renewed and strengthened, such as the Bicentennial Framework with Mexico and the Opioid Action Plan with Canada, into action. The Biden administration will continue to make action against the synthetic-drug supply chain a priority in order to save lives.

Question 3. Mr. Chester—Are the relaxed border policies of the Biden administration coupled with rouge district attorneys and prosecutors who fail to prosecute criminals contributing to, in whole or part, America's opioid crisis?

Answer 3. There are record amounts of illicitly manufactured fentanyl being seized at our borders thanks to the brave men and women on the front lines. Dr. Gupta has been to the border and seen first-hand the great work being done there.

For example, in fiscal year 2022 through July, CBP seized 231,186 pounds of drugs along the southwest border, 68 percent of which were seized at southwest border Ports of Entry (POE). When you look at fentanyl and methamphetamine, the percentage of drugs seized at POEs is even higher. POE seizures account for 85 percent of the weight of fentanyl and 88 percent of the weight of methamphetamine seized along the southwest border.

The good news is that those drugs won't make their ways into our communities. But we must also ensure that the men and women on the front lines have the resources they need to ramp up their efforts to address the immense influx of supply they face at our borders. That's why the President called for more than an $18 billion investment to reduce the supply of illicit substances in the United States in his fiscal year 23 budget. This includes $747.5 million in increases for efforts to reduce the availability of drugs, including efforts to interdict illicit drugs at ports of entry and disrupt drug trafficking networks, support domestic law enforcement efforts to reduce drug-related violence and property crime, and availability of illicit substances and work with international partners to reduce drug production.

However, the challenge of drugs like illicit fentanyl making its way into our communities does not begin or end at the border, so we must also counter the criminal networks who produce and traffic them; disrupt every aspect of their commercial enterprise; target drug transportation routes and modalities; and aggressively reduce the production of illicit drugs in the countries where they are created. Effectively bolstering border security and reducing drug trafficking require effort and coordination both domestically and abroad.

Domestically, our nationwide drug interdiction efforts are focused on the most prolific drug trafficking routes and modalities, and we seek to fully leverage drug interdictions to help illuminate and dismantle the criminal organizations responsible for manufacturing and trafficking illicit drugs. Information sharing between agencies is vitally important to this end.

One of the things ONDCP does is provide funds directly to our state and local partners through the national HIDTA program to disrupt drug trafficking organizations. For fiscal year 2023, ONDCP requested $293.5 million for the national HIDTA program.

Abroad, we work with our key partners in the Western Hemisphere, like Mexico, to shape collective and comprehensive responses to illicit drug production and trafficking. We also engage with nations like the PRC and India to disrupt the global flow of synthetic drugs and the precursor chemicals used to produce them to nations, like Mexico, where illicit synthetic drugs are produced in large quantities.

RESPONSE BY DR. MIRIAM E. DELPHIN-RITTMON TO QUESTIONS OF SENATOR BALDWIN, SENATOR LUJAN, SENATOR BURR, SENATOR CASSIDY, SENATOR COLLINS, SENATOR MURKOWSKI AND SENATOR SCOTT

SENATOR BALDWIN

Question 1. Nikolas Barrett Graves of Beloit, Wisconsin had plans to go to culinary school. He was active and outgoing. On December 22, 2018, he died after trying heroin that contained fentanyl. Cade Reddington was a graduate of Waunekee Community High School, a student at UW-Milwaukee, and a kid who was full of life, energy and excitement. On November 4th, 2021, Cade died in his dorm room after taking what he thought was a Percocet pill. That pill contained fentanyl.

Nikolas and Cade could have been saved by naloxone.

What does SAMHSA need to make sure that naloxone is more readily available to first-responders and in key locations, such as schools and community centers?

Answer 1. The promotion and distribution of naloxone and fentanyl test strips represent an opportunity to not only promote life-saving interventions, but to also provide education on drug potency and mortality. However, some grantees are faced with challenges in the distribution of fentanyl test strips due to state laws that classify fentanyl test strips as illegal paraphernalia.

SAMHSA has focused on promoting education about synthetic opioids through its grantees and education networks such as the Addiction Technology Transfer Centers. We have also produced evidence-based guides on addressing polysubstance mis-

use in order to overcome the growing incidence of concurrent substance use disorders.

Through SAMHSA's State Opioid Response (SOR) program, grantees are required to implement prevention and education services including: training of peers, first responders, and other key community sectors on recognition of opioid overdose and appropriate use of the opioid overdose antidote naloxone; developing evidence-based community prevention efforts such as strategic messaging on the consequences of opioid and stimulant misuse; implementing school-based prevention programs and outreach; and distributing the opioid overdose antidote reversal naloxone. Naloxone is an important tool in preventing overdose deaths and many studies have demonstrated the value of naloxone distribution [1] and that increased saturation in communities reduces overdose deaths. [2] Therefore, SAMHSA has required that all SOR grantees submit a naloxone distribution and saturation plan particularly focused on areas with high rates of overdose mortality. With SAMHSA funds, states have the flexibility to purchase and distribute naloxone in areas they deem most appropriate based on the needs of the state. SAMHSA will continue working with states on the implementation of these plans.

The SOR grant program has supported local educational campaigns on naloxone for younger Americans. For example, through an agreement with Morgan State University (MSU), MSU created three digital ads on stigma, the dangers of fentanyl, and how to use naloxone. These ads were displayed on digital advertising boards at three local shopping malls over a 90-day period. MSU also created augmented reality spots for the social media platform, TikTok, using the Maryland Helpline: *Call 211, press one campaign*. These were all geared for the younger demographic as a way to provide lifesaving information through an interactive app on their cell phones.

SAMHSA's Substance Abuse Prevention and Treatment Block Grant (SABG) program is another resource for states to use to combat the overdose crisis. Through the SABG, states are able to promote education about naloxone through a wide variety of school, community, and faith-based organizations. States also have the option to use block grant funds for the purchase and distribution of naloxone. A particularly critical area of focus is through substance use prevention, harm reduction, and treatment programs. These actions through the SABG can assure more ready access to and rapid use of naloxone by members of the broader community, including prevention, harm reduction, and treatment professionals and affiliates, community centers, educational institutions, the medical community, clients and potential clients, family members, and persons in the larger recovery community.

SAMHSA's First Responders—Comprehensive Addition and Recovery Support Services Act (FR-CARA) grant program provides resources to first responders (such as firefighters, law enforcement officers, paramedics, emergency medical technicians, mobile crisis providers, Tribes or Tribal organizations that respond to adverse opioid related incidents) to train, carry and administer naloxone and other drugs and devices for emergency reversal of known or suspected opioid overdose. The FR-CARA grant program specifically targets populations which are especially vulnerable to overdose, including communities with an incidence of individuals with opioid use disorder that is above the national average and communities with a shortage of prevention and treatment services.

SENATOR LUJAN

Question 1. According to the CDC, only about 1 in every 10 American Indian, Alaska Native, and Hispanic people with substance use disorder reported receiving treatment. [3] In fact, more than 70 percent of the over 2 million Americans struggling with opioid addiction are not getting treatment. [4] Will improving access to medication assisted treatment for opioid use disorder save lives?

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[1] Walley AY, Xuan Z, Hackman HH, Quinn E, Doe-Simkins M, Sorensen-Alawad A, Ruiz S, Ozonoff A. Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis. BMJ. 2013 Jan 30; 346: f174.

[2] Irvine MA, Oller D, Boggis J, Bishop B, Coombs D, Wheeler E, Doe-Simkins M, Walley AY, Marshall BDL, Bratberg J, Green TC. Estimating naloxone need in the USA across fentanyl, heroin, and prescription opioid epidemics: a modelling study. Lancet Public Health. 2022 Feb 10: S2468–2667(21)00304–2. doi: 10.1016/S2468–2667(21)00304–2. Epub ahead of print. PMID: 35151372.

[3] *https://www.cdc.gov/media/releases/2022/s0719-overdose-rates-vs.html*.

[4] Center for Behavioral Health Statistics and Quality, 2017 National Survey on Drug Use And Health: Detailed Tables, Rockville, Md,: Substance Abuse and Mental Health Services Administration, 2018.

Question 2. Despite an expansion in access to medication assisted treatment for opioid use disorder in some areas, rates of overdose remain high for American Indian and Alaska Native communities.[5] How important is the availability of culturally competent treatment for historically marginalized communities?

Question 3. Does increasing access and reducing barriers to proven recovery support services reduce future overdose deaths?

Question 4. What are the primary barriers for those seeking recovery services?

*Question 5.*Harm reduction tools are critical to saving lives. New Mexico recently passed legislation to decriminalize the possession of fentanyl test strips. How have harm reduction measures, like fentanyl test strips, impacted people's behavior?

Answers 1–5. Evidence-based treatments for substance use disorder reduce substance use, related health harms, overdose deaths, and increase odds for long-term recovery. Medications for opioid use disorder (MOUD) in particular have been shown to significantly reduce the risk of opioid-related overdose.[6] However, these medications continue to be underutilized, in part due to the stigmatization associated to them compounded by other barriers to treatment access.

Addressing this stigmatization and expanding access to MOUD is a significant focus for SAMHSA. Part of this work is ensuring that MOUD and other substance use disorder services and policies are culturally responsive, evidence-based and in the best interest of those receiving services. For instance, SAMHSA's Tribal Opioid Response program is specifically focused on providing Tribal Nations resources to address opioid use disorder and stimulant use disorder in their communities. Another of SAMHSA's grant programs, the Tribal Behavioral Health grant program, also known as Native Connections, is intended to prevent suicide and substance misuse, reduce the impact of trauma, and promote mental health among American Indian/Alaska Native (AI/AN) youth. This program fosters culturally responsive models that reduce and respond to the impact of trauma and involve AI/AN community members (including youth, tribal leaders, and spiritual advisors) in all grant activities.

SAMHSA also has a long history of advancing recovery supports. SAMHSA defines recovery as a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. Recovery support services make up a crucial component of the continuum of care for people with substance use disorders given the long-term nature of these conditions. With the non-clinical nature of these services, other funding sources often do not cover them, even when they are evidence-based, validated recovery services that are integrated into treatment settings. The Administration supports the addition of a 10 percent set-aside within the Substance Abuse Prevention and Treatment Block Grant (SABG) for recovery support services. This 10 percent recovery set-aside will ensure that each state is supporting:

- the further development of local recovery community organizations and centers, recovery and resiliency focused strategies and educational campaigns, trainings, and events to combat stigma;
- addiction recovery resources and support system navigation;
- the recovery of diverse populations; and
- collaboration and coordination with local private and non-profit clinical health care providers, the faith community, city, county, and Federal public health agencies, and criminal justice response efforts.

Moreover, the increase in SABG harm reduction and treatment activities will help to fortify efforts to reduce drug overdose deaths. Additionally, the increased emphasis on the widespread implementation of MOUD treatment services can begin to help eliminate community and provider barriers to effective engagement in MOUD treatment, and encourage clinical, administrative, and fiscal policies and practices

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[5] Higher availability of treatment services does not mean improved access to care. Opioid overdose rates in 2020 were higher in areas with higher availability of opioid treatment programs compared with areas with lower treatment availability, particularly among Black (34 vs. 17) and AI/AN (33 vs. 16) people per 100,000. The known differences in access, barriers to care, and healthcare mistrust could play a role in exacerbating inequities even when treatment is available in the community.

[6] Krawczyk, N., Mojtabai, R., Stuart, E. A., Fingerhood, M., Agus, D., Lyons, B. C., Weiner, J. P., and Saloner, B. (2020) Opioid agonist treatment and fatal overdose risk in a state-wide US population receiving opioid use disorder services. *Addiction*, 115: 1683–1694. *https://doi.org/10.1111/add.14991.*

that incentivize the continued long-term involvement of clients in both MOUD treatment and recovery support services.

Evidence-based harm reduction strategies are also key to minimizing the negative consequences of drug use to both the individual and the community. That is a key reason why the Department of Health and Human Services (HHS) announced in April 2021 that grantees in certain programs, such as State Opioid Response (SOR) grants and the SABG program, may use grant funds to purchase rapid fentanyl test strips to help curb the dramatic spike in drug overdose deaths largely driven by strong synthetic opioids, including illicitly manufactured fentanyl. Reports from states such as California, Arizona, Nevada, and Alaska note that fentanyl test strips funded through SOR have become an important component of syringe service programs; education and awareness building toolkits; and innovative, low-threshold, on-demand treatment programs. From the start of the reporting period on April 1, 2022 to June 30, 2022, grantees reported distributing 259,025 fentanyl test strips.

Additionally, SAMHSA has awarded 25 grants for the first-ever SAMHSA Harm Reduction grant program. The Harm Reduction grant program supports community-based overdose prevention programs, syringe services programs, and other harm reduction services including test strips for fentanyl and other synthetic drugs. In adherence with Federal, state, and local laws, regulations, and other requirements, Harm Reduction grant recipients enhance overdose and other types of prevention activities to help control the spread of infectious diseases, support distribution of FDA-approved overdose reversal medication, build connections for individuals at risk for, or with, a SUD to overdose education, counseling, and health education, and to encourage individuals to take steps to reduce the negative personal and public health impacts of substance use or misuse.

SENATOR BURR

Question 1. In 2018, Congress passed the SUPPORT Act with broad bipartisan support, which included Section 6082 directing CMS to review its existing packaging policies for the outpatient and Ambulatory Surgical Center (ASC) settings, "with a goal of ensuring that there are not financial incentives to use opioids instead of non-opioid alternatives." Yet, even with this directive from Congress, CMS has made no changes to packaging policies in the outpatient setting, and only limited changes in the ASC setting.

For 2022, CMS adopted a policy in the ASC setting that would pay for non-opioid pain alternatives separately, but only those costing over $130/day separately. Non-opioid pain alternatives with lower prices, but still with a meaningful differential compared to less costly generic opioids, continue to be bundled in single payment. Potentially incentivizing providers to choose opioids over non-opioid options that cost under $130. Despite this potential, CMS has proposed to keep the $130/day unbundling threshold for 2023 in the Outpatient Prospective Payment System proposed rule.

Though CMS, CDC, HRSA, and SAMHSA are all under HHS, there seems to be a lack of comprehensive strategy to combat the opioid epidemic. While CDC, HRSA, and SAMHSA are working to put out the fires caused by illicit fentanyl, CMS is implementing policy through the Outpatient Prospective Payment System that may misalign incentives for the prescribing of opioids over non-opioid alternatives.

Ms. Johnson, Dr. Delphin-Rittmon, and Dr. Jones, can you please provide:

1. The number of times your agencies have reached out to CMS to share information or expertise to inform their rulemaking regarding opioids policies

2. The number of times CMS has reached out to your agencies for information or expertise to inform their rulemaking regarding opioids policies

3. The number of times your agency has met with CMS over the past year (by phone, video, or in person) to discuss opioid addiction, abuse, and deaths

4. The extent to which aggregated data and information collected by your agencies is shared with CMS to inform rulemaking

Answer 1. SAMHSA and CMS staff coordinate regularly on multiple levels. One example of that is through the Behavioral Health Coordinating Council (BHCC), a group I co-chair along with the Assistant Secretary for Health, that convenes to inform and improve the various mental health and substance use-related projects and programs that HHS Operating Divisions, like CMS and SAMHSA, are managing an d leading. In particular, the BHCC has an Overdose Prevention Subcommittee

which coordinates programs and policies across HHS in terms of implementing the HHS Overdose Prevention Strategy. The BHCC also has a Performance Measures, Data and Evaluation Subcommittee at which data collected by HHS operating divisions is shared.

Additionally, since May 2021, CMS, AHRQ, SAMSHA touch base every other month on the 1003 project concerning a demonstration grant expanding OTP treatment across 11 states. In December 2021 and January, SAMHSA engaged with Medicare and Medicaid to confirm SAMHSA's upcoming rulemaking to make telehealth flexibilities permanent would be compliant with Medicare and Medicaid regulations. Last, SAMHSA met with CMS throughout May and June to discuss evidence-based treatment models for opioid use disorder, including models for individuals who also have other complex medical conditions.

SENATOR CASSIDY

Question 1. Dr. Delphin-Rittmon, Congress provided the Administration discretionary spending of more than $6 billion per year from fiscal year 2018 through 2020 for opioid-related programs. This was further increased by $2.5 billion via COVID-relief funds. In 2019, SAMHSA received $3.7 billion for substance use-related activities. Despite these resources, overdose deaths have increased to more than 100,000 Americans in the 12-month period ending February 2022. What metrics does SAMHSA use to determine whether opioid-related funding is being used efficiently and effectively?

Answer 1. Through the Government Performance and Results Act (GPRA) of 1993 and the Modernization Act of 2010, SAMHSA's Center for Substance Abuse Treatment (CSAT) evaluates program performance and effectiveness through six National Outcome Measures, which include:

- Abstinence
- Crime and Criminal Justice
- Employment/Education
- Health/Behavioral/Social Consequences
- Social Connectedness
- Stability in Housing

In fiscal year 2021, 1,559,592 clients were served by the Substance Abuse Prevention and Treatment Block Grant (SABG), State Opioid Response (SOR), and Medication-Assisted Treatment for Prescription Drug and Opioid Addiction programs. Across the three programs, participating clients reported positive rates of change for each outcome measure. The fiscal year 2021 performance measures for CSAT's programs are available in SAMHSA's Fiscal Year 2023 Justification of Estimates for Appropriations. [7]

Question 2. Dr. Delphin-Rittmon, the Bipartisan Policy Center has estimated that in 2019, mandatory spending on Medicaid beneficiaries with opioid use disorder (OUD) exceeded $23 billion. This is a nearly 150 percent increase in Medicaid spending compared to 2013 when spending on OUD was estimated by the Kaiser Family Foundation to be about $9.4 billion. From 2013 to 2019, the number of Medicaid beneficiaries getting treatment for OUD increased by 150 percent, and from 2010 to 2019, the number of Medicaid covered OUD medication prescriptions increased by 550 percent. However, overdose deaths kept increasing during that timeframe, not decreasing or even plateauing. Which SAMHSA-developed or SAMHSA-recommended outcome measures should CMS and State Medicaid agencies use to ensure accountability in opioid-related Medicaid spending?

Answer 2. SAMHSA plans to continue collaboration with CMS and State Medicaid agencies to support outcome improvements for individuals with Substance Use Disorder (SUD including Opioid Use Disorder (OUD)). For Medicaid 1115(a) demonstrations, CMS continues to develop tools to assist states and provide them with CMS's expectations and guidance to support rigorous evaluation activities as well as to improve access to and quality of treatment to Medicaid beneficiaries as part of a Department-wide effort to combat the ongoing opioid crisis. States can utilize a flexible, streamlined approach to respond to the national opioid crisis while en-

[7] *https://www.samhsa.gov/sites/default/files/samhsa-fy-2023-cj.pdf.*

hancing states' monitoring and reporting of the impact of any changes implemented through these demonstrations. [8]

Additionally, CMS has provided tools and guidance to support state approaches to monitoring and evaluation of SUD and tools to meet the requirements in special terms and conditions for SUD section 1115 demonstrations. These tools include templates and guidance for implementation, monitoring protocol and reporting, and evaluation design. CMS also provides mid-point technical assistance to support states with planning and executing the assessment. [9]

SENATOR COLLINS

Question 1. Increase in Teen Overdoses (Dr. Delphin-Rittmon). Last month, Hannah Flaherty, a 14-year-old girl from Portland, died from a suspected fentanyl overdose 1 day after her middle school graduation. According to her friends and family, she was a straight A student with no history of drug use. Sadly, Hannah's death is not an outlier. According to a new study from UCLA researchers, after staying flat for a decade, the overdose death rate among adolescents in the United States nearly doubled from 2019 to 2020, and then increased again by 20 percent in the first 6 months of 2021. This is the first time in recorded history that the teen drug death rate has seen an exponential rise, which researchers attribute to drug use "becoming more dangerous, not more common." Dr. Delphin-Rittmon, we are not prioritizing primary prevention enough. What more can be done to educate teens and young adults about the dangers of fentanyl and counterfeit pills in particular, so we can prevent them from turning to drugs in the first place?

Answer 1. Education is the cornerstone of prevention, however, in order to ensure that education works, it must be population specific, culturally conscious and easily understood.

SAMHSA's Substance Abuse Prevention and Treatment Block Grant (SABG) program provides funds to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, 6 Pacific jurisdictions, and 1 tribal entity to prevent and treat substance abuse. SAMHSA requires that grantees spend no less than 20 percent of their SABG allotment on substance abuse primary prevention strategies. These strategies are directed at individuals not identified to be in need of treatment. SABG grantees develop a comprehensive primary prevention program that targets both the general population and sub-groups that are at high risk for substance abuse. Grantees use a variety of primary prevention strategies, including but not limited to education, healthy alternatives, and community-based process, to target the populations at greatest risk for substance use in their community. The prevention set-aside is one of SAMHSA's main vehicles aimed at preventing substance misuse and allows states to develop prevention infrastructure and capacity.

SAMHSA's Strategic Prevention Framework for Prescription Drugs (SPF-Rx) grant program provides resources to help prevent and address prescription drug misuse within a state or locality. The SPF-Rx program is designed to raise awareness about the dangers of sharing medications and to highlight the risks of fake or counterfeit pills purchased over social media or through other sources.

Finally, the SABG and State Opioid Response Grant (SOR) programs are funds that states can also use to support youth SUD prevention efforts. The SOR grant program, for example, funds state strategies that focus on the prevention of substance use for at-risk youth. SOR grantees also use funds to support interventions through Teen Courts, Recovery High Schools, and Peer Mentor Programs.

SENATOR MURKOWSKI

Question 1. According to preliminary data from the CDC, the U.S. experienced a 15 percent increase in overdose deaths from 2020 to 2021. Meanwhile, in Alaska, that increase was a staggering 75 percent, roughly five times the national average. Due to historical trauma other inequities, our Alaska Native population have experience high rates of substance use and alcoholism. I am concerned about the impact of the fentanyl epidemic on our rural Alaska Native communities, who are already experiencing significant increases in overdose deaths. How will you ensure the Federal efforts to address the rise of fentanyl overdose deaths will address the needs of those in rural areas, specifically American Indians and Alaska Natives?

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[8] *https://www.Medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd17003.pdf.*

[9] *https://www.Medicaid.gov/Medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html.*

In Alaska and around the country, drug addiction and substance use disorders are ending the lives of far too many youth. This past June, I, along with my colleagues Senator Feinstein, Senator Sullivan, and Senator Hassan, introduced S. 4358, Bruce's Law. This bill authorizes funding for the Department of Health and Human Services (HHS) to conduct a public awareness campaign targeted toward school-aged children and youth on the dangers of fentanyl, establish an interagency working group on fentanyl contamination, and authorizes an expansion of grants for community coalitions to engage school-aged children and youth in outreach and prevention efforts.

Question 2. What type of outreach and prevention efforts are the CDC and SAMHSA currently supporting to educate youth and school-aged children on the dangers of counterfeit drugs laced with fentanyl? What inter-agency coordination takes place between the CDC, SAMHSA, and ONDCP on these efforts?

Question 3. How does ONDCP believe that Bruce's Law, if enacted, would enhance their prevention efforts?

Answer 1-3. One of the key cross-collaboration principles that drives SAMHSA's work is promoting greater equity within the behavioral health system. This includes addressing the longstanding inequities faced by Tribal citizens.

The Tribal Opioid Response grant (TOR) program assists in addressing the public health crisis caused by escalating opioid and stimulant misuse and use disorders across tribal communities. The purpose of the program is to prevent overdoses in Tribal communities by increasing access to FDA approved medications for the treatment of opioid use disorder and to support culturally appropriate prevention, harm reduction, treatment, and recovery support services.

SAMHSA's Tribal Behavioral Health grant program, also known as Native Connections, is intended to prevent suicide and substance misuse, reduce the impact of trauma, and promote mental health among American Indian/Alaska Native (AI/AN) youth. This program fosters culturally responsive models that reduce and respond to the impact of trauma and involve AI/AN community members (including youth, tribal leaders, and spiritual advisors) in all grant activities.

The SAMHSA Tribal Training and Technical Assistance Center and the National American Indian and Alaska Native Technology Transfer Centers for addiction, prevention and mental health provide training and technical assistance specific to working with tribes and tribal citizens in the behavioral health arena. 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 to develop and strengthen the specialized behavioral healthcare workforce and the primary healthcare workforce that provide these services.

Furthermore, SAMHSA works closely with the State Opioid Treatment Authorities (SOTA) assigned in each state to support MOUD by overseeing Opioid Treatment Programs, providing guidance regarding MOUD, and facilitating MOUD services within the state. Specific to Alaska, SAMHSA has been working with the SOTA to identify ways in which state funds and the current Opioid Treatment Programs (OTP) can utilize medication unit guidance, issued in November 2021, to establish additional sites in Alaska, expanding the reach of current OTPs. Three new OTPs have opened in the last year and at least one mobile medication unit is planned. In addition, as of July 31, 2022, 792 practitioners in Alaska had received a waiver to prescribe buprenorphine.

The drastic increase in overdoses contributed to fentanyl is of pressing concern to Substance Abuse Prevention and Treatment Block Grant (SABG) Program and Strategic Prevention Framework—Partnership for Success (SPF-PFS) grant recipients. Grant recipients utilize a range of evidence-based and culturally informed strategies to educate youth and school-aged children on the dangers of counterfeit drugs laced with fentanyl. By conducting a local needs assessment, grantees are able to target the populations and communities that are most at risk for substance use. SAMHSA's Strategic Prevention Framework for Prevention Drugs (SPF Rx) grant program provides resources to help prevent and address prescription drug misuse within a State or locality. The program was established in 2016 to raise awareness about the dangers of sharing medications as well as the risks of fake or counterfeit pills purchased over social media or other unknown sources, and work with pharmaceutical and medical communities on the risks of overprescribing. Grant recipients are required to track reductions in opioid related overdoses and incorporate relevant prescription and overdose data into strategic planning and future programming. Recipients are expected to leverage knowledge gained through participation in the SPF process to more effectively address targeted community needs.

The HHS Behavioral Health Coordinating Council (BHCC) is tasked with coordinating all Federal Government resources to address inequities and gaps within the mental health and substance use disorder system. The BHCC's chief goals are to share information about the various mental health and substance use projects and programs that HHS Operating Divisions and Staff Divisions are managing and leading, as well as ensure that all behavioral health issues are being handled collaboratively and without duplication of effort across the department. HHS's BHCC has five areas of focus: Children and Youth Behavioral Health, Performance Measures, Data and Evaluation, Behavioral and Physical Health Integration, Suicide Prevention and Crisis Care, and Overdose Prevention.

SENATOR SCOTT

Question 1. Dr. Delphin-Rittmon—Faith-based organizations provide vital community supports and can play a critical role in addressing this crisis. Can you discuss how your Agency is currently working with faith-based organizations to address this public health emergency and your vison for partnership growth?

Answer 1. SAMHSA engages with faith-based organizations in several ways. Through the STOP Act Program and Partnership for Success program, we have maintained strong faith-based sector support in the development of anti-drug strategies impacting youth. The faith-based community has integrated numerous youth programs as a strong addition to community coalition efforts in several funded communities over the years. Faith-based leaders have provided important perspectives which contribute to the collaborative sprit of successful anti-drug community level campaigns.

In addition, SAMHSA's Substance Abuse Prevention and Treatment Block Grant (SABG) grantees effectively engage with faith-based organizations using SABG funds to address the fentanyl overdose crisis. These efforts include the active involvement of faith-based communities in statewide needs assessments of recovery support services that are aimed at addressing specific issues related to the staggering increases in fentanyl overdoses. Grantees are expanding recovery support services and developing targeted initiatives with faith-based groups, recovery community organizations, recovery community centers, and peer advocates to support individuals in long-term recovery. Grantees are also engaging substance use disorder treatment providers in developing culturally appropriate faith-based models to focus on the disproportionate overdose rates among African Americans.

Moreover, through the Medication Assisted Treatment-Prescription Drug Opioid and Opioid Addiction (MAT-PDOA) program, some grantees provide outreach to faith-based communities through radio programming. Utilizing community outreach teams, these grantees connect with faith-based leaders to ensure that they are supported and that information regarding treatment and recovery services are appropriately communicated to congregations. They also provide recommendations to pastors on effective methods of conveying information to congregants on the array of services that are available for persons with an opioid use disorder either virtually (during COVID) or through the distribution of flyers and pamphlets (provided by the grantee) to their parishioners and members of their local communities.

In addition, SAMHSA's discretionary grants work in collaboration with the Health and Human Services (HHS) Partnership Center for Faith-based and Neighborhood Partnerships to extend the reach and impact all of HHS related programs into communities. This includes those related to mental well-being and recovery from substance use disorders and encourages and supports faith-based community organizations in their work to the individuals they serve.

RESPONSE BY CAROLE JOHNSON TO QUESTIONS OF SENATOR ROSEN, SENATOR LUJAN, AND SENATOR BURR

SENATOR ROSEN

INCREASING ACCESS TO FENTANYL TEST STRIPS: We know that fentanyl test strips are relatively easy to use, accurate, and can help prevent overdoses. That's why I'm glad the Nevada state legislature recently voted—nearly unanimously—to legalize fentanyl test strips in our state. I'm also proud of the work that community partners like Northern Nevada Hopes—a federally Qualified Health Center (FQHC) in Reno—and the Southern Nevada Health District in Las Vegas are doing to distribute them to some of our most vulnerable patients.

Question 1. Ms. Johnson, how is HRSA partnering with federally Qualified Health Centers across Nevada and the country to increase awareness of and access to

fentanyl test strips for those who may need them, and how can Congress help you improve this outreach?

Answer 1. Health Centers that are funded and designated by HRSA under section 330 of the Public Health Service Act (which are among the types of federally Qualified Health Centers as defined under the Social Security Act for purposes of Medicare and Medicaid reimbursement) play a key role in providing substance use disorder and mental health services. Aligned with the Biden-Harris administration's 2022 National Drug Control Strategy, which identified expanding substance use disorder services in federally qualified health centers as a strategy to increase access to treatment services, HRSA's Health Center Program funding supports health centers in implementing and advancing evidence-based strategies to expand access to quality integrated substance use disorder prevention and treatment services, including those addressing opioid use disorder and other emerging substance use disorder issues.

In addition to this health center work, HRSA supports a range of prevention, treatment and recovery services and supports through other programs, such as the Rural Communities Opioid Response Program (RCORP). Between September 1, 2021, and February 28, 2022, approximately 40 percent of HRSA's RCORP awardees reported actively distributing fentanyl test strips in their rural service area.

HRSA looks forward to working with you to ensure these important programs continue to be successful and reach the populations in need of substance use disorder and mental health services.

SENATOR LUJAN

Question 1. Would incorporating MAT training in primary care and emergency department residency programs increase access to this lifesaving treatment? What would this additional expertise mean for those in rural areas?

Answer 1. One of HRSA's top priorities is integrating behavioral health into primary care, including medications for opioid use disorder training, to increase access to evidence-based treatment for opioid use disorder. The integration will help to ensure that opioid use disorder can be addressed and treated by more providers along the continuum of care, including those practicing in rural areas.

For example, to support these goals, HRSA's Rural Communities Opioid Response Program is funding a $10 million in grant awards to expand access to MAT in rural communities in fiscal year 2022.

Additionally, HRSA's Teaching Health Center Graduate Medical Education Program also helps support opioid use disorder training in primary care settings, many of which are in rural areas. HRSA will continue to support strategies to expand access to MAT by training additional providers.

Question 2. How does targeted training for health care providers alleviate the stigma associated with treating individuals for opioid use disorder?

Answer 2. HRSA programs aim to increase access to treatment for substance use disorder, including opioid use disorder, and educate health care providers and the communities they serve on the need for providing treatment across patient populations. HRSA's training highlights the various touch points at which health care providers may encounter individuals with opioid use disorder or substance use disorder and provide potentially lifesaving treatments and interventions. HRSA programs train health care professionals to provide mental health and substance use disorder services, as well as focus on training to integrate behavioral health care into primary care. Furthermore, these programs focus on training and maintaining workforce in rural and underserved communities.

Question 3. COVID has caused rapid burnout across all health care providers. Behavioral health workers face the same challenges. How would sustained and coordinated retention efforts help sustain a robust behavioral health care workforce?

Answeer 3. To improve the retention of health care workers, reduce burnout and promote mental health and wellness among the health care workforce, the American Rescue Plan Act authorized new HRSA grant programs to support evidence-informed training on burnout reduction and promotion of resilience for providers and help health care organizations establish, improve, or expand evidence-informed programs and practices to promote mental health and well-being within the health care workforce.

In Fiscal Year 2023, the President's Budget proposes $50 million for the Promoting Resilience and Mental Health Among Health Professional Workforce program. These funds would support strategies to help the health care workforce better prepare for and respond to workplace stressors, while fostering healthy workplace

environments that promote mental health and resilience by improving the quality of training and increasing access to care through partnerships and linkages. The program is authorized by the Dr. Lorna Breen Health Care Provider Protection Act (P.L. 117–105). HRSA looks forward to continuing to work with Congress on this important issue.

SENATOR BURR

In 2018, Congress passed the SUPPORT Act with broad bipartisan support, which included Section 6082 directing CMS to review its existing packaging policies for the outpatient and Ambulatory Surgical Center (ASC) settings, "with a goal of ensuring that there are not financial incentives to use opioids instead of non-opioid alternatives." Yet, even with this directive from Congress, CMS has made no changes to packaging policies in the outpatient setting, and only limited changes in the ASC setting.

For 2022, CMS adopted a policy in the ASC setting that would pay for non-opioid pain alternatives separately, but only those costing over $130/day separately. Non-opioid pain alternatives with lower prices, but still with a meaningful differential compared to less costly generic opioids, continue to be bundled in single payment. Potentially incentivizing providers to choose opioids over non-opioid options that cost under $130. Despite this potential, CMS has proposed to keep the $130/day unbundling threshold for 2023 in the Outpatient Prospective Payment System proposed rule.

Though CMS, CDC, HRSA, and SAMHSA are all under HHS, there seems to be a lack of comprehensive strategy to combat the opioid epidemic. While CDC, HRSA, and SAMHSA are working to put out the fires caused by illicit fentanyl, CMS is implementing policy through the Outpatient Prospective Payment System that may misalign incentives for the prescribing of opioids over non-opioid alternatives.

Ms. Johnson, Dr. Delphin-Rittmon, and Dr. Jones, can you please provide:

Question 1. The number of times your agencies have reached out to CMS to share information or expertise to inform their rulemaking regarding opioids policies

Question 2. The number of times CMS has reached out to your agencies for information or expertise to inform their rulemaking regarding opioids policies

Question 3. The number of times your agency has met with CMS over the past year (by phone, video, or in person) to discuss opioid addiction, abuse, and deaths

Question 4. The extent to which aggregated data and information collected by your agencies is shared with CMS to inform rulemaking

Answer 1–4. As a part of interagency clearance on the OPPS/ASC rule, HRSA reviews and provides input, as appropriate, on Section 6082 policies, HRSA works in close collaboration with CMS and other HHS operating divisions to combat the opioid epidemic, including through Secretary Becerra's *Behavioral Health Coordinating Council* (BHCC). The BHCC is a significant mechanism for HRSA to coordinate existing efforts and future initiatives with other HHS operating divisions, including CMS, CDC, and SAMHSA. For example, HRSA collaborated with other HHS agencies through the BHCC to implement the HHS *Overdose Prevention Strategy*. We will continue to collaborate with our colleagues across HHS to combat the opioid epidemic.

RESPONSE BY CHRISTOPHER JONES TO QUESTIONS OF SENATOR CASEY, SENATOR COLLINS, AND SENATOR MURKOWSKI

SENATOR CASEY

I hear from Pennsylvanians who have suffered tragic losses from the scourge of fentanyl and opioid overdose gripping our Nation. I also hear from Pennsylvanians who suffer from debilitating chronic pain and depend on medically appropriate use of opioids to lead meaningful lives. As our country has taken steps to address the opioid epidemic, some of these patients have faced barriers to the care they need.

In 2016, CDC published its Guideline for Prescribing Opioids for Chronic Pain, and subsequently issued a statement in 2019 advising against misapplication of the Guideline. In that statement, CDC acknowledged that "some policies and practices that cite the Guideline are inconsistent with, and go beyond, its recommendations," and noted that these issues "could put patients at risk." CDC is now working on its successor, the 2022 CDC Clinical Practice Guideline for Prescribing Opioids.

Question 1. As CDC revises the 2022 draft based on feedback and prepares to release the updated Guideline, how will CDC work with Federal, state, and local agen-

cies, as well as clinicians, to clarify acceptable and unacceptable practices for prescribing physicians?

Question 2. How will CDC ensure that the latest guidelines are not misapplied, restricting access for patients with a legitimate medical need for opioids, and encourage application consistent with CDC's position that "patients with pain deserve safe and effective pain management"?

Answer 1–2 CDC is working to ensure effective communication about the 2022 Clinical Practice Guideline for Prescribing Opioids for Pain. CDC is carefully reviewing how recommendations are written to ensure they are properly applied and not misinterpreted.

The 2022 Clinical Practice Guideline addresses these critical issues by emphasizing that the 2022 Guideline is a *clinical tool* to improve communication between clinicians and patients and empower them to make informed, person-centered decisions related to pain care together. The 2022 Clinical Practice Guideline includes call out boxes and language throughout the document that clearly states the purpose of the Guideline, what it is intended for, and what it is NOT intended for. For example:

- The Clinical Practice Guideline **IS** a clinical tool to improve communication between clinicians and patients and empower them to make informed, person-centered decisions related to pain care together.
- The Clinical Practice Guideline **IS NOT** intended to be applied as inflexible standards of care across patients, and/or patient populations by healthcare professionals, health systems, pharmacies, third-party payers, or governmental jurisdictions or to lead to the rapid tapering or abrupt discontinuation of opioids for patients.

CDC will also release a suite of translation and communication materials with the 2022 Guideline that will emphasize these critical messages and provide resources to clinicians providing pain care to patients. These materials will help achieve the goal of providing flexible, patient-centered care that is tailored to the needs and circumstances of the patient.

CDC also will work with public and private payers as well as other decision-makers and share evidence that can be used to inform decisions regarding coverage for a broader range of pain therapies. To assist in uptake and understanding of the 2022 Guideline, CDC will update and develop tools and resources for clinicians, health systems, and patients. In September 2019, CDC launched the multiyear Overdose Data to Action (OD2A) cooperative agreement with 66 recipients (referred to as jurisdictions) comprised of state, territorial, county, and city health departments in which dissemination and TA on the Guideline will also go out through these funded partners. CDC is also working with ASTHO to develop tools and resources for state agencies and policymakers to support implementation of the Guideline.

Question 2. In your testimony, you discuss CDC's efforts to use data for overdose prevention and the essential role of data in informing a public health response to the overdose crisis. I appreciate that "CDC is committed to using data . . . as part of a whole-of-government approach to save lives and bring an end to our Nation's overdose crisis," and encouraged by your collection of data which you report "improves coordination and strategic planning for intervention and response efforts among health departments, community members, healthcare providers, public health, law enforcement, and government agencies."

In what ways are the CDC data being used to "improve coordination and strategic planning"?

Question 3. What barriers exist to CDC collaborating and sharing data with other government agencies to help ensure the government's approach to combatting the crisis is informed by the best available clinical evidence and health statistics?

Answer 2–3. CDC partners across Federal Government agencies to leverage data sources to inform prevention, treatment, and harm reduction efforts. For example, CDC participates in a number of Federal interagency workgroups focused on the improvement of data systems and data sharing, including the White House ONDCP Drug Data Interagency Workgroup, the HHS Behavioral Health Coordinating Council subcommittee on data and metrics, and the Federal Interagency Medicolegal Death Investigation Working Group. In addition, CDC regularly partners with other HHS agencies, such as SAMHSA, CMS, NIDA, and FDA to collaborate and leverage data sources focused on substance use, overdose, and prescribing and patient behav-

iors to help inform translation and dissemination of data to the public. Two recent examples of data sharing and collaboration from these interagency efforts include research papers in JAMA Psychiatry examining COVID–19 related emergency policy changes for methadone take-home doses from opioid treatment programs opioid treatment programs [1] and use of telehealth in the treatment of opioid use disorder among Medicare beneficiaries. [2] Findings from these papers are informing ongoing discussions related to potential permanent adoption of these COVID-19 flexibilities.

CDC also partners with Federal agencies, such as the Department of Justice and High Intensity Drug Trafficking Programs, to leverage drug supply data that can help inform prevention efforts. For example, the Overdose Response Strategy is funded by the Centers for Disease Control and Prevention (CDC) and the White House Office of National Drug Control and Policy (ONDCP). The CDC Foundation and 33 High Intensity Drug Trafficking Areas (HIDTAs) are working together to support this unique and unprecedented collaboration between public health and public safety, which allows agencies to share timely data, pertinent intelligence and innovative strategies to address overdoses. Through the project, ORS teams made up of drug intelligence officers (DIO) and public health analysts (PHA) work together on drug overdose issues within and across sectors. In addition to these efforts, CDC's Overdose Data to Action (OD2A) program is designed to facilitate data sharing and use data to inform prevention efforts at the state and local levels, and CDC works closely with funded jurisdictions to optimize their data to action strategic frameworks.

Question 3. What more can be done to encourage proactive use of CDC-provided resources to develop data-driven approaches to combating fentanyl and reducing overdose deaths across public health, law enforcement, and other elements of the Federal response?

Answer 3. CDC's funding to state, local, and territorial entities has evolved and expanded with the overdose crisis. CDC data have been integral to informing this evolution and the response across jurisdictions. CDC's Overdose Data to Action program is forecasted to expand support for local communities through a new 5-year funding opportunity, Overdose Data to Action: Limiting Overdose through Collaborative Actions in Localities (OD2A: LOCAL). Additionally, CDC's new forecasted 5-year funding opportunity for states, Overdose Data to Action in States (OD2A-S), will build off the work and gains made through previous overdose surveillance and prevention investments supporting state health departments through the promotion of overdose surveillance strategies and evidence-based and promising interventions that have an immediate impact on reducing morbidity and mortality associated with overdoses, with a primary focus on opioids, stimulants, and polysubstance use. OD2A-S will emphasize health equity, and strategies will be underpinned by a data-to-action framework that aims to expand and strengthen fatal and non-fatal overdose surveillance efforts of State Health Departments and their use of these and other data to drive prevention strategies and policies. Data-driven strategies within each of these funding opportunities aim to enhance partnerships and collaborations across public health, public safety, law enforcement, and the medical community, among others, and to promote evidence-based prevention strategies, interventions, and care.

CDC also provides extensive technical assistance (TA) to OD2A funded recipients. The OD2A TA Hub centralizes and standardizes TA provides to recipients across 13 domains using a tech-based portal and 5 step prioritization process. This portal facilitates access to a coordinated network of TA and training services in surveillance and prevention activities. It also focuses on:

- systematic amplification and dissemination of CDC scientific and programmatic technical assistance to OD2A funded recipients to better equip them to address the overdose epidemic
- assessment and enhancement of capacity of recipients to successfully implement and evaluate surveillance and prevention activities of OD2A in coordination and collaboration with CDC and as elaborated in the Overdose Prevention Capacity Assessment Tool (OPCAT)

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[1] Jones CM, Compton WM, Han B, Baldwin G, Volkow ND. Methadone-involved overdose deaths in the US before and after Federal policy changes expanding take-home methadone doses from opioid treatment programs. JAMA Psychiatry. 2022;79(9):932–934.

[2] Jones CM, Shoff C, Hodges K, Blanco C, Losby JL, Ling SM, Compton WM. Receipt of telehealth services, receipt and retention of medications for opioid use disorder, and medically treated overdose among Medicare beneficiaries before and during the COVID–19 pandemic. JAMA Psychiatry. 2022;Aug 31. Doi:10.1001/jamapsychiatry.2022.2284.

- translation and dissemination of data to inform action as well as best practices and resources; and
- development and maintenance of an electronic resource library.

In addition, CDC is partnering with SAMHSA to provide technical assistance on harm reduction strategies. The Harm Reduction Technical Assistance Center is designed to strengthen the capacity and improve the performance of Syringe Services Programs (SSPs) throughout the United States by supporting enhanced technical assistance (TA) to ensure the provision of high-quality, comprehensive harm reduction services.

SENATOR COLLINS

Question 1. Actionable Overdose Data (Mr. Chester and Dr. Jones). Mr. Chester, I appreciate that the National Drug Control Strategy prioritizes the need for more actionable data to track nonfatal overdoses, which you recognize in your testimony as "one of the most accurate predictors of whether someone will experience a fatal overdose in the future." I was also encouraged to hear Director Gupta recently met with officials in Maine to see firsthand how Maine collects detailed overdose data. This data is critical for law enforcement and health care providers to appropriately gauge the scope of the crisis in their local communities and target resources where they are needed. I understand the Administration has recently created a Drug Data Interagency Working Group that will assist with the development of a new national plan for obtaining data in near real-time. However, this is expected to take 1 year to develop fully. Mr. Chester and Dr. Jones, how is ONDCP utilizing partners like the CDC who have expertise in data collection and partnerships across state and local public health agencies?

Answer 1. CDC actively participates in the ONDCP Drug Data Interagency Working Group, sharing lessons learned from implementing our nonfatal and fatal overdose surveillance efforts in funded jurisdictions. CDC contributes to the overall development of working group outputs related to drug overdose mortality and morbidity efforts, focused on improving the timeliness and comprehensiveness of data related to drug overdose and related harms, including ongoing discussions on how to continue to leverage CDC data systems like the Drug Overdose Surveillance and Epidemiology (DOSE) syndromic surveillance system to improve awareness about overdoses seen in Emergency Departments across the U.S.

With support from the *Office of National Drug Control Policy (ONDCP)* the *Overdose Response Strategy (ORS)* is a unique collaboration between CDC and the *High Intensity Drug Trafficking Areas (HIDTA)* program designed to enhance public health and public safety partnerships. The mission of the ORS is to help communities reduce fatal and non-fatal drug overdoses by connecting public health and public safety agencies, sharing information, and supporting evidence-based interventions. This program offers evidence-based intervention strategies that can be implemented at the local, regional, and state level. CDC has expanded its investment in this partnership to support the public health component in all 50 states, Puerto Rico and the U.S. Virgin Islands. Drug intelligence officers and public health analysts collaborate and leverage supply and overdose data to problem-solve and address local and regional issues, including spikes in overdoses related to illicit fentanyl.

SENATOR MURKOWSKI

In Alaska and around the country, drug addiction and substance use disorders are ending the lives of far too many youth. This past June, I, along with my colleagues Senator Feinstein, Senator Sullivan, and Senator Hassan, introduced S. 4358, Bruce's Law. This bill authorizes funding for the Department of Health and Human Services (HHS) to conduct a public awareness campaign targeted toward school-aged children and youth on the dangers of fentanyl, establish an interagency working group on fentanyl contamination, and authorizes an expansion of grants for community coalitions to engage school-aged children and youth in outreach and prevention efforts.

Question 1. What type of outreach and prevention efforts are the CDC and SAMHSA currently supporting to educate youth and school-aged children on the dangers of counterfeit drugs laced with fentanyl? What inter-agency coordination takes place between the CDC, SAMHSA, and ONDCP on these efforts?

Answer 1. The Drug Free Communities (DFC) Support Program is the Nation's leading effort to mobilize communities to prevent and reduce substance use among youth. Administered by ONDCP and managed by CDC, the DFC Program funds community-based coalitions to identify and respond to the drug problems unique to

their community and change local community environmental conditions tied to substance use. The DFC coalitions focus efforts on youth and in many instances, promote health equity and aim to reduce disparities that impact youth substance use, and address the risk and protective factors that negatively impact health outcomes in communities. As the overdose crisis has evolved to a crisis driven by illicit fentanyl and fentanyl analogs, DFC coalitions have responded by increasing their focus on this threat to youth. Examples of their work include collaboration with CDC's Overdose Response Strategy include:

- DFC coalitions in the state of CT collaborate on a fentanyl awareness campaign targeting teens, young adults, and caregivers on the dangers of counterfeit pills. The campaign, which is available through social media, billboards, TV coverage, newspaper ads, banners, and postcards, aims to educate not only how young people are accessing counterfeit medications, but also why they are using them and to provide families with tools and resources that they can use to offer support.
- Westbrook Partners for Prevention (ME): Updated Westbrook School District medication dispensing policy to include naloxone administration. Training will be provided to interested staff, coaches, and others in overdose recognition and response protocols in the 2022/2023 school year. Coalition staff worked to update the Westbrook School District medication dispensing policy to allow for school staff to dispense naloxone if necessary. Staff provided education to school nurses about the policy and new protocols. A plan was made to provide training to teachers, staff, and coaches in the upcoming school year as well.
- Griswold PRIDE (CT): In January, CT had the first youth overdose on fentanyl while at school . . . a middle school. This prompted many discussions, education opportunities, and policy changes among school districts. In April, all 500 high school students watched Natural High's Dead on Arrival documentary, which was followed up with lessons and discussion using their Fentanyl Toolkit. Parents were also provided information on the lessons and a link to the documentary to follow-up at home. Also stemming from that overdose student death, came Narcan/naloxone training for support staff from each of the schools, Griswold Elementary, Middle, High, and Alternative. Before this, only the high school was trained and carried naloxone onsite. Now after a district policy, all of their schools have staff trained, and have naloxone on site.

CDC recognizes the historical increases in drug overdose deaths associated with illicit fentanyl and the risks posed by an increasingly changing illicit drug supply. In addition to leveraging data and working with public safety to address emerging drug threats and co-involvement of fentanyl in the illicit drug supply, CDC is also raising awareness of the risks of fentanyl and polysubstance use. Our *Stop Overdose* campaign focuses on the risks associated with illicit fentanyl and polysubstance use as well as the importance of naloxone as a life-saving antidote for overdose. The intended audience for these campaigns is people who use drugs between the ages of 18–34 and there has been widespread pick-up of this campaign, which has received over 2 billion impressions over the past year.

Question 2. How does ONDCP believe that Bruce's Law, if enacted, would enhance their prevention efforts?

Question 3. According to preliminary data from the CDC, the U.S. experienced a 15 percent increase in overdose deaths from 2020 to 2021. Meanwhile, in Alaska, that increase was a staggering 75 percent, roughly five times the national average. Due to historical trauma other inequities, our Alaska Native population have experience high rates of substance use and alcoholism. I am concerned about the impact of the fentanyl epidemic on our rural Alaska Native communities, who are already experiencing significant increases in overdose deaths.

How will you ensure the Federal efforts to address the rise of fentanyl overdose deaths will address the needs of those in rural areas, specifically American Indians and Alaska Natives?

Answers 1–3. The increases in overdose deaths among American Indian and Alaska Native persons is very concerning, and CDC recently called attention to this issue in our July Vital Signs on drug overdose. Efforts specific to the needs of the AI/AN population are underway across the Federal Government to address this crisis. CDC is working to ensure that multiple programmatic efforts are reaching tribal populations.

Targeted AI/AN Funding

CDC ensures that American Indian and Alaska Native communities are reached through many of our national and local programs that are represented below, but also provides targeted, tailored funding and support that goes directly to tribal and Alaska Native communities and tribal serving organizations. AI/AN specific funding includes:

- Capacity building funding to tribal epidemiological centers to provide actionable data on opioid use disorder (OUD), stimulant use disorders (StUD), and polysubstance use.
- Funding to address strategic plan priority areas such as epidemiologic surveillance and public health data infrastructure; implementation of evidence-based health systems interventions; or innovative community-based strategies.
- Funding the National Indian Health Board (NIHB) to produce an opioid conference track at a national conference annually.
- Funding tribal serving organizations to provide training and technical assistance to tribes related to opioid overdose prevention and to develop resources such as a toolkit that translates Indigenous evaluation approaches into actionable guidance for tribal public health & opioid overdose prevention programs.

Drug Free Communities (DFC)

During the application process of the DFC program, CDC and ONDCP encourage coalitions to pay particular attention to communities or populations disproportionately affected by substance use including but not limited to those with reduced economic stability; limited educational attainment, access or quality, limited healthcare access or quality, people from non-English populations, tribal populations, rural communities and other geographically underserved areas, racial/ethnic minority groups, and sexual and gender minority groups. Currently, the DFC program funds the Healing Our People and Environment (HOPE) Coalition and the Ketchikan Wellness Coalition in Alaska.

Partnership with BJA

CDC partners with the *Bureau of Justice Assistance's Comprehensive Opioid, Stimulant, and Substance Abuse Program* on multiple projects to support effective state, local, and tribal responses to illicit substance use. These projects promote public safety, and support access to treatment and recovery services in the criminal justice system in order to reduce overdose deaths. This partnership has focused on rural responses, expanding use of the *Overdose Detection Mapping Application Program (ODMAP)* in states and tribes, harm reduction education and training for law enforcement, building bridges between jail and community-based treatment, and *overdose fatality review (OFR)* implementation. The ODMAP Initiative, co-funded by the Bureau of Justice Assistance and the Centers for Disease Control and Prevention, supports the implementation of the ODMAP in four tribal communities. The project strengthens the ability of the selected tribes to assess information gathered from public safety, public health, and behavioral health responses. This initiative also strives to enhance the ability of the selected tribes to implement tailored prevention and intervention activities to reduce overdose deaths and facilitate access to treatment and recovery services to survivors of nonfatal overdoses. Sites include:

- *Eastern Band of Cherokee Indians*
- *Oneida Nation Behavioral Health*
- *Tulalip Tribes of Washington*
- *White Earth Band of Chippewa Indians through its Behavioral Health Division*

Health IT

In January 2020, CDC and ONC successfully completed an integration of the Utah Navajo Health System Electronic Health Records (EHRs) through RxCheck, a system that allows healthcare providers within clinical settings to access patient prescription history within their EHR workflow. CDC and ONC successfully launched a PDMP-EHR pilot with the Ponca Health Services in Nebraska and with Blue Mountain Health in Utah, which serves both the Ute and Navajo tribes. NCIPC and the Office of the National Coordinator for Health Information Technology (ONC) have collaborated on this CDC-ONC project to advance and scale sustainable pathways to PDMP integration within health IT systems (e.g., EHR). CDC and ONC are piloting this work in at least six health systems across multiple states.

This project also included two additional systems that will pilot CDC Guideline-concordant electronic clinical decision support.

CDC also provided funds to the National Indian Health Board to support the implementation of evidence-based health interventions to prevent substance use disorder and drug overdose in American Indian and Alaska Native populations. These interventions include addressing challenges in accessing state PDMPs and increasing their use, linking people to opioid use disorder treatment services, creating translation materials, evaluating the effectiveness of implemented interventions, and adapting current CDC factsheets or other materials for clinics that serve American Indian and Alaska Native populations.

[Whereupon, at 12 p.m., the hearing was adjourned.]

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