EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, DC 20503

The Biden-Harris Administration's Statement of Drug Policy Priorities for Year One

The overdose and addiction crisis has taken a heartbreaking toll on far too many Americans and their families. Since 2015, overdose death numbers have risen 35 percent, reaching a historic high of 70,630 deaths in 2019.[1] This is a greater rate of increase than for any other type of injury death in the United States.[2] Though illicitly manufactured fentanyl and synthetic opioids other than methadone (SOOTM) have been the primary driver behind the increase, overdose deaths involving cocaine and other psychostimulants, like methamphetamine,[3] have also risen in recent years, particularly in combination with SOOTM. New data suggest that COVID-19 has exacerbated the epidemic,[4, 5] and increases in overdose mortality[6] have underscored systemic inequities in our nation's approach to criminal justice and prevention, treatment, and recovery.

President Biden has made clear that addressing the overdose and addiction epidemic is an urgent priority for his administration. In March, the President signed into law the American Rescue Plan, which appropriated nearly $4 billion to enable the Substance Abuse and Mental Health Services Administration and the Health Resources and Services Administration to expand access to vital behavioral health services. President Biden has also said that people should not be incarcerated for drug use but should be offered treatment instead. The President has also emphasized the need to eradicate racial, gender, and economic inequities that currently exist in the criminal justice system.

These drug policy priorities—statutorily due to Congress by April 1st of an inaugural year—take a bold approach to reducing overdoses and saving lives.[7] The priorities provide guideposts to ensure that the federal government promotes evidence-based public health and public safety interventions. The priorities also emphasize several cross-cutting facets of the epidemic, namely by focusing on ensuring racial equity in drug policy and promoting harm-reduction efforts. The priorities are:

- Expanding access to evidence-based treatment;
- Advancing racial equity issues in our approach to drug policy;
- Enhancing evidence-based harm reduction efforts;
- Supporting evidence-based prevention efforts to reduce youth substance use;
- Reducing the supply of illicit substances;
- Advancing recovery-ready workplaces and expanding the addiction workforce; and
- Expanding access to recovery support services.

ONDCP will work closely with other White House components, agencies and Congress to meet these priorities.[8] ONDCP will also work closely with State, local, and Tribal governments,

especially around efforts to ensure that opioid lawsuit settlement funds are used on programs that strengthen the nation's approach to addiction.

Priority 1: Expanding access to evidence-based treatment

President Biden is committed to achieving universal coverage which will help provide more people with substance use disorders with the care they need. For far too long, people with substance use disorders have faced stigma and other barriers inside and outside of health care and addiction services.[9] Additionally, addiction treatment and mainstream health care have existed in two separate systems. As President Biden has emphasized, ensuring Americans have access to affordable, high-quality health care and achieving universal health care are the most crucial steps toward addressing substance use disorders. Continued enforcement of the Mental Health Parity and Addiction Equity Act (MHPAEA)[10] is essential to integrating treatment for substance use disorder into mainstream health care and improving the quality of care. Provider shortages,[11,12] the cost of health care services,[13] reimbursement,[14,15] and other barriers to treatment[16] combine to make access to quality treatment out of reach for too many.[17]

American researchers, health care systems, and payers need to develop, scale up, and support a broader array of evidence-based treatment and recovery supports, including services such as housing. A lack of adequate support from leadership and for reimbursement can dissuade providers from entering an area of practice.[18,19] Moreover, experts believe that even with greater support, regulatory oversight of providers and prescribers of medications for opioid use disorder (MOUD)[20,21,22] and attitudes toward individuals with substance use disorders[23] may cause health care providers to be reluctant to provide services to those in need.[24,25] The Biden-Harris Administration will carefully examine this complex legal and regulatory web, decide which changes are critical, and put in place or recommend the needed regulatory or legislative changes.

In the first year, the Biden-Harris Administration will work through ONDCP to coordinate with other White House components and the interagency to:

- ***Evaluate progress*** made since the 2016 Mental Health and Substance Use Parity Task Force issued its recommendations[26] and identify additional steps that need to be taken to complete these recommendations;
- ***Review policies*** relating to methadone treatment and develop recommendations to modernize them;
- ***Remove unnecessary barriers*** to prescribing buprenorphine and identify opportunities to expand low-barrier treatment services;
- ***Develop and establish a working group*** with health care insurers and employers to promote full implementation of the MHPAEA[27] to eliminate discriminatory barriers to mental health and substance use disorder services;
- ***Urge extension of the Opioid Public Health Emergency*** declaration and identify actions that can be taken under public health authorities to expand access to care;
- ***Evaluate and explore making permanent the emergency provisions*** implemented during the COVID-19 pandemic concerning MOUD authorizations, including allowing providers to begin treating patients with MOUD by telehealth without first requiring an

in-person evaluation, as well as evaluating and ensuring the continuation of Medicaid and Medicare reimbursements for these telehealth services;
- ***Identify and address policy barriers*** related to contingency management interventions (motivational incentives) for stimulant use disorder;
- ***Explore reimbursement*** for motivational incentives and digital treatment for addiction, especially stimulant use disorder;
- ***Expand access to evidence-based treatment*** for incarcerated individuals by working with Congress and appropriate Departments and agencies;
- ***Publish final rules this year*** regarding telemedicine special registration and methadone treatment vans; and
- ***Explore, identify barriers, and establish policy*** to help pregnant women with substance use disorder obtain prenatal care and addiction treatment without fear of child removal.

Priority 2: Advancing racial equity in our approach to drug policy

There is a clear and discernable need to take steps to advance racial equity issues[28] resulting from current drug policy. President Biden has emphasized the need to eradicate racial inequities in the criminal justice system and has stated that people should not be incarcerated for drug use but should be offered treatment instead. Executive Order 13985, *Advancing Racial Equity and Support for Underserved Communities Through the Federal Government*, directs agencies to pursue a comprehensive approach to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality.[29] Such inequalities manifest in disparate access to care, differential treatment, and poorer health outcomes. For many people with substance use disorders, access to care in the United States is inadequate, but for Black, Indigenous, and People of Color (BIPOC), the situation is worse. A recent study showed that Black individuals generally entered addiction treatment 4-5 years later than White individuals and this effect remained when controlling for socio-economic status.[30] In Latino communities, those who need treatment for substance use disorder were less likely to access care than non-Latino individuals.[31] This discrepancy in treatment access is important to address at a time when rates of overdoses are increasing for some communities of color.[32]

In the first year, the Biden-Harris Administration will work through ONDCP to coordinate with other White House components and the interagency to:

- ***Identify data gaps*** related to drug policy to target unmet needs in diverse communities, in collaboration with the Equitable Data Working Group established by Executive Order 13985;
- ***Establish a research agenda*** to meet the needs of historically underserved communities;
- ***Establish an interagency working group*** to agree on specific policy priorities for criminal justice reform;
- ***Develop a drug budget*** that includes an accounting and analysis of how federal dollars meet the needs of diverse populations and shape drug budget recommendations to target resources to address equity issues;

- ***Direct agencies to begin collecting budget data*** that is thoroughly disaggregated by demographic category where this information is not available;
- ***Identify culturally competent and evidence-based practices*** for BIPOC across the continuum of care that includes prevention, harm reduction, treatment, and recovery services; and
- ***Promote integration of the National Standards for Culturally and Linguistically Appropriate Services*** (CLAS) in Health and Health Care for providers of SUD prevention, treatment, and recovery support services**,** starting with a review of CLAS standards by executive departments and agencies with health care roles.[33]

Priority 3: Enhancing evidence-based harm reduction efforts

Access to quality health care, treatment, and recovery support services is essential for people with substance use disorders. However, for some people with chronic conditions, formal systems of care are often inaccessible. Their first point of contact may be through organizations that offer low-barrier services, including harm reduction. Such services meet people where they are. These services include life-saving and evidence-based interventions such as providing the overdose antidote naloxone, sterile syringes, fentanyl test strips (FTS), and testing for the human immunodeficiency virus (HIV) and Hepatitis C virus. Research has shown that syringe services programs (SSPs) reduce HIV prevalence.[34,35,36] They also have the potential to connect at-risk populations to needed care.[37]

Harm-reduction organizations provide a key engagement opportunity between people who use drugs (PWUD) and health care systems, often employing peer support workers. Regular engagement between harm reduction staff and PWUD builds trust,[38] allowing for an ongoing exchange of information, resources, and contact. This relationship can encourage individuals to further pursue a range of treatment options including MOUD induction, psychosocial treatment, and long-term recovery. Harm reduction staff can build trust over time with patients and are in a unique position to encourage PWUD to request treatment, recovery services, and health care.

In the first year, the Biden-Harris Administration will work through ONDCP to coordinate with other White House components and the interagency to:

- ***Integrate and build linkages*** between funding streams to support SSPs;
- ***Explore opportunities to lift barriers*** to federal funding for SSPs;
- ***Identify state laws that limit access*** to SSPs, naloxone, and other services;
- ***Develop and evaluate the impact*** of educational materials featuring evidence-based harm reduction approaches that link PWUD with harm reduction, treatment, recovery support, health and social services through a diverse range of community members, including first responders, and train law enforcement officials in evidence-based approaches that address overdose and provide police-assisted recovery;
- ***Examine naloxone availability*** in counties with high rates of overdose and identify opportunities to expand access in targeted areas among pharmacies, clinicians, peer support workers, family and community members, and PWUD;
- ***Amplify best practices for FTS services,*** standards for FTS kits, and use of FTS as a means of engagement in health care systems; and

- ***Support research*** on the clinical effectiveness of emerging harm reduction practices in real world settings and test strategies to best implement these evidence-based practices.

Priority 4. Supporting evidence-based prevention efforts to reduce youth substance use

Preventing youth substance use, including the use of alcohol, tobacco and illicit drugs, is essential to young people's healthy growth and development. Delaying use until after adolescence also decreases the likelihood of developing a substance use disorder.[39] Illicit drug use rises during adolescence and young adulthood (16.1 percent of those ages 16-17 years and 26.4 percent of young adults ages 21-25 years reported past month use); rates generally decline incrementally thereafter, indicating teens and young adults are key populations for prevention efforts.[40] Interventions can be conducted with youth at higher risk as well as those who have already initiated substance use. Research has shown that youth prescription opioid misuse is also associated with other risky behaviors.[41] It is also important that we consider social determinants of health such as poverty, homelessness, and other conditions as we build effective prevention strategies.

Scaling up science-based, community-level interventions to prevent and reduce youth and young adult use as is evidenced by the Drug-Free Communities Support Program can be an essential element of a comprehensive prevention policy approach.

In the first year, the Biden-Harris Administration will work through ONDCP to coordinate with other White House components and the interagency to:

- ***Use its budget authorities*** to ensure that prevention programs that receive federal support are using evidence-based approaches to deliver services and monitor the fidelity and outcomes of those approaches through continuous quality improvement;
- ***Conduct an inventory of prevention programs*** developed with federal government funding and identify evaluations and assessments of their outcomes and effectiveness;
- ***Identify opportunities*** for ONDCP's Drug-Free Communities (DFC) Support Program and CDC to enhance culturally competent prevention programming;
- ***Work to identify opportunities*** for prevention programming in communities with high rates of adverse childhood experiences;
- ***Update evidence-based prevention curricula*** for families of school-aged children, including options that can be administered at home;
- ***Identify grants or other opportunities*** to increase substance use disorder/mental health screenings through school nurses, school-based health centers, and back-to-school physicals; brief interventions and referral to care and treatment, as clinically appropriate; and
- ***Promote service delivery models for care*** with strong evidence of effectiveness to address the needs of adolescents in juvenile justice programs.

Priority 5. Reducing the supply of illicit substances

The Biden-Harris Administration will take steps to reduce the supply of illicit substances in the United States. As part of a comprehensive agenda that prioritizes prevention, treatment,

recovery, and harm reduction, the Biden-Harris Administration believes that part of the solution to the opioid overdose epidemic involves preventing illicit drug trafficking into the United States. While synthetic opioids such as illicitly manufactured fentanyl, its analogues, and non-fentanyl synthetic opioids have been the driver of overdose deaths since 2015,[42,43,44] the United States is also seeing increased availability and use of methamphetamine and other synthetic drugs. Moreover, the United States continues to face the challenges posed by the availability and use of cultivated drugs such as heroin and cocaine, which are often adulterated by synthetic opioids.[45]

In addition, the misuse of licit pharmaceutical drugs, such as prescription opioids for pain, stimulants, and sedatives contribute to the nation's overdose and addiction epidemic.[46]

Many of the illicit substances harming Americans are produced outside the United States and brought through the nation's ports of entry. These substances can be marketed and sold on the dark web using cryptocurrency, and they are delivered to the purchaser through the mail and commercial carriers or brought across the nation's geographic borders by multiple conveyances.[47] The availability of drugs with historically high purity and low price, along with the increased lethality of synthetic opioids, helps drive the overdose and addiction epidemic.

In the first year, the Biden-Harris Administration will work through ONDCP to coordinate with other White House components and the interagency to:

- ***Work with key partners in the Western Hemisphere***, like Mexico and Colombia, to shape a collective and comprehensive response to illicit drug production and use by deepening bilateral collaboration on public health approaches, expanding effective state presence, and developing infrastructure. This ensures that activities to curb the production and trafficking of illicit drugs adhere to the rule of law and respect human rights;
- ***Exercise leadership*** in regional and multilateral forums, such as the North American Drug Dialogue, to advance evidence-based public health responses to substance use and prevent the proliferation of falsified medicines and the diversion of illicitly produced substances;
- ***Use established multilateral and bilateral forums*** to engage with China, India, and other source countries to disrupt the global flow of synthetic drugs and their precursor chemicals;
- ***Strengthen the U.S. government's capacity*** to disrupt the manufacture, marketing, sale, and shipment of synthetic drugs by addressing illicit Internet drug sales and the continually evolving techniques in illicit financial transactions. This includes engaging commercial carriers to disrupt the movement of synthetic drugs through postal and parcel systems;
- ***Support law enforcement efforts*** through the High Intensity Drug Trafficking Areas (HIDTA) program to disrupt and dismantle domestic drug trafficking networks and support initiatives to advance coordinated responses; and
- ***Support multi-jurisdictional task forces*** and other law enforcement efforts to disrupt and dismantle transnational drug trafficking and money laundering organizations that provide

the funding for the drug trafficking organizations through the use of the U.S. financial system.

Priority 6: Advancing recovery-ready workplaces and expanding the addiction workforce

Although the Americans with Disabilities Act of 1990 provides some protections for people with substance use disorders, employers are often reluctant to hire a person with a history of substance use disorder.[48] This reluctance is often based on misconceptions and fears, negative attitudes, and even beliefs that discrimination against people with substance use disorder is acceptable.[49] The current economic crisis, coupled with the overdose epidemic, requires the public and private sectors to work together to develop a workforce prepared to meet today's challenges.

Separately, the nation's addiction workforce is experiencing staffing shortages,[50] and we need to address future needs for various behavioral health occupations.[51] Hiring diverse practitioners who reflect the people and cultures they serve is also an important workforce issue.[52] The United States needs skilled behavioral health providers to provide the array of services necessary to meet the needs of those with behavioral health conditions.

In the first year, the Biden-Harris Administration will work through ONDCP to coordinate with other White House components and the interagency to:

- ***Identify ways*** in which the federal government can remove barriers to employment and create employment programs for people in recovery from addiction;
- ***Conduct a landscape review*** of existing programs, and subsequently conduct outreach to State and local governments, employers, and members of the workforce. This outreach could include offering grant opportunities that support recovery in the workplace and remove hiring and employment barriers, and providing recommendations to ensure all communities (including rural and underserved areas) have access to the programs;
- ***Identify a research agenda*** to examine existing recovery-ready workplaces;
- ***Request agencies to support*** training for clinicians in addiction with special emphasis on: community-based services in underserved areas, such as federally qualified health centers (FQHCs); the Veterans Health Administration; and the Indian Health Service;
    - Identify authorized, evidence-based vocational programs that can expand the addiction workforce but that have not yet secured appropriations; and
    - Explore opportunities for training bilingual immigrants who were addiction professionals in their home countries to become case managers;
- ***Produce guidelines*** for federal managers on hiring and working with people in recovery from a substance use disorder;
- ***Seek opportunities*** to expand the workforce of bilingual prevention professionals and peer specialists by offering incentives to train in the SUD field; and
- ***Identify barriers*** to treatment and prevention for populations with limited English proficiency.

Priority 7: Expand Access to Recovery Support Services

As we expand the continuum of care to address the chronic nature of substance use disorders, recovery support services help people build recovery capital to manage and sustain long-term recovery. Offered in a variety of institutional- and community-based settings, recovery support services include peer support services and engagement, recovery housing, recovery community centers, and recovery programs in high schools and colleges. Scaling up the capacity and infrastructure of these programs will create strong resource networks to equip communities to support recovery for everyone.

In the first year, the Biden-Harris Administration will work through ONDCP to coordinate with other White House components and the interagency to:

- ***Work with federal partners, State and local governments, and recovery housing stakeholders*** to begin developing sustainability protocols for recovery housing, including certification, payment models, evidence-based practices, and technical assistance;
- ***Develop interagency support*** for Recovery Month activities in September; and
- ***Engage persons with "lived experience"*** in the development of drug policy.

CONCLUSION

Addressing the overdose and addiction epidemic is an urgent issue facing the nation. The Biden-Harris Administration's multi-faceted and evidence-based approach will meet this challenge by expanding access to prevention, harm reduction, treatment, and recovery services, and reducing the supply of illicit substances. This work will also include long-overdue efforts to address racial equity issues in drug policy and health care. Working with the interagency and Congress, ONDCP will coordinate drug policy by using its authority to convene federal agencies, as well as set drug control budget and policy priorities for the government.

---

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

[2] From 2015 to 2019, numbers of U.S. injury deaths by firearms increased by ten percent, those by suicide increased by eight percent, homicide by eight percent, and those by motor vehicle crash increased by four percent. Injury death categories are not mutually exclusive. For example, 4,777 suicides in 2019 were by drug overdose. [Source: Centers for Disease Control and Prevention, National Center for Health Statistics, Multiple Cause of Death, 1999-2019 on CDC WONDER Online Database, released December 2020. Extracted by ONDCP on December 22, 2020.]

[3] The ICD-10 medical coding category T43.6 Psychostimulants with Abuse Potential (PWAP) is comprised of multiple psychostimulants. Based on results from the most recent literal text analysis conducted by CDC on 2016 data, 6,762 drug overdose death certificates made specific mention of methamphetamine within the free text field [Source: Hedegaard, H., Bastian, B.A., Trinidad, J.P., Spencer, M., Warner, M. (2018) Drugs most frequently involved in drug overdose deaths: United States, 2011–2016. *National Vital Statistics Reports;* vol 67 no 9. Hyattsville, MD: National Center for Health Statistics. https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_09-508.pdf]. Thus, methamphetamine is involved in 90 percent of the 7,542 PWAP-involved deaths in 2016.

[4] U.S. Centers for Disease Control and Prevention. "Overdose Deaths Accelerating During COVID-19." December 17, 2020. Available at https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html .

[5] Ahmad FB, Rossen LM, Sutton P. (2021) *Provisional drug overdose death counts*. U.S. Centers for Disease Control and Prevention, National Center for Health Statistics. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm
[6] U.S. Centers for Disease Control and Prevention, National Center for Health Statistics. (2020). *Underlying Cause of Death 1999-2019* on CDC WONDER Online Database, released 2020. Extracted by ONDCP from http://wonder.cdc.gov/mcd-icd10.html on January 22, 2021.
[7] Section 706(a)(1) of the Office of National Drug Control Policy Authorization Act of 1998, as amended (21 U.S.C. § 1705(a)(1))
[8] U.S. Government Accountability Office (March 2020). *Drug Misuse: Sustained National Efforts Are Necessary for Prevention, Response, and Recovery*. GAO-20-474. Washington D.C. https://www.gao.gov/assets/gao-20-474.pdf
[9] van Boekel, L. C., Brouwers, E. P., van Weeghel, J., & Garretsen, H. F. (2013). Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: systematic review. *Drug and Alcohol Dependence*, 131(1-2), 23–35. https://doi.org/10.1016/j.drugalcdep.2013.02.018
[10] The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, Name of Act, Public Law 110-343.
[11] Tong, S. T., Hochheimer, C. J., Peterson, L. E., & Krist, A. H. (2018). Buprenorphine Provision by Early Career Family Physicians. *Annals of family medicine*, *16*(5), 443–446. https://doi.org/10.1370/afm.2261
[12] Rosenblatt, R. A., Andrilla, C. H., Catlin, M., & Larson, E. H. (2015). Geographic and specialty distribution of US physicians trained to treat opioid use disorder. *Annals of family medicine*, *13*(1), 23–26. https://doi.org/10.1370/afm.1735
[13] Lagisetty, P. A., Ross, R., Bohnert, A., Clay, M., & Maust, D. T. (2019). Buprenorphine Treatment Divide by Race/Ethnicity and Payment. *JAMA psychiatry*, 76(9), 979–981. https://doi.org/10.1001/jamapsychiatry.2019.0876
[14] Molfenter, T., McCarty, D., Jacobson, N., Kim, J. S., Starr, S., & Zehner, M. (2019). The payer's role in addressing the opioid epidemic: It's more than money. *Journal of substance abuse treatment*, *101*, 72–78. https://doi.org/10.1016/j.jsat.2019.04.001
[15] U.S. Government Accountability Office (2020). *MEDICAID: States' Changes to Payment Rates for Substance Use Disorder Services.* January 2020. Washington D.C. Available at https://www.gao.gov/assets/gao-20-260.pdf.
[16] Molfenter, T., Fitzgerald, M., Jacobson, N., McCarty, D., Quanbeck, A., & Zehner, M. (2019). Barriers to Buprenorphine Expansion in Ohio: A Time-Elapsed Qualitative Study. *Journal of psychoactive drugs*, *51*(3), 272–279. https://doi.org/10.1080/02791072.2019.1566583
[17] Andrilla, C., Moore, T. E., Patterson, D. G., & Larson, E. H. (2019). Geographic Distribution of Providers With a DEA Waiver to Prescribe Buprenorphine for the Treatment of Opioid Use Disorder: A 5-Year Update. *The Journal of rural health: official journal of the American Rural Health Association and the National Rural Health Care Association,* 35(1), 108–112. https://doi.org/10.1111/jrh.12307
[18] Hawk, K. F., D'Onofrio, G., Chawarski, M. C., O'Connor, P. G., Cowan, E., Lyons, M. S., Richardson, L., Rothman, R. E., Whiteside, L. K., Owens, P. H., Martel, S. H., Coupet, E., Jr, Pantalon, M., Curry, L., Fiellin, D. A., & Edelman, E. J. (2020). Barriers and Facilitators to Clinician Readiness to Provide Emergency Department-Initiated Buprenorphine. *JAMA network open*, 3(5), e204561. https://doi.org/10.1001/jamanetworkopen.2020.4561
[19] Goodson, J. D., Shahbazi, S., & Song, Z. (2019). Physician Payment Disparities and Access to Services-a Look Across Specialties. *Journal of general internal medicine*, *34*(11), 2649–2651. https://doi.org/10.1007/s11606-019-05133-0
[20] Ostrach, B., Carpenter, D., & Cote, L. P. (2020). DEA Disconnect Leads to Buprenorphine Bottlenecks. *Journal of addiction medicine*, 10.1097/ADM.0000000000000762. Advance online publication. https://doi.org/10.1097/ADM.0000000000000762
[21] Samet, J. H., Botticelli, M., & Bharel, M. (2018). Methadone in Primary Care - One Small Step for Congress, One Giant Leap for Addiction Treatment. *The New England journal of medicine*, *379*(1), 7–8. https://doi.org/10.1056/NEJMp1803982
[22] Fiscella, K., Wakeman, S. E., & Beletsky, L. (2019). Buprenorphine Deregulation and Mainstreaming Treatment for Opioid Use Disorder: X the X Waiver. *JAMA psychiatry,* 76(3), 229–230. https://doi.org/10.1001/jamapsychiatry.2018.3685
[23] Molfenter, T., Fitzgerald, M., Jacobson, N., McCarty, D., Quanbeck, A., & Zehner, M. (2019). Barriers to Buprenorphine Expansion in Ohio: A Time-Elapsed Qualitative Study. *Journal of psychoactive drugs*, *51*(3), 272–279. https://doi.org/10.1080/02791072.2019.1566583

[24] McNeely, J., Kumar, P. C., Rieckmann, T., Sedlander, E., Farkas, S., Chollak, C., Kannry, J. L., Vega, A., Waite, E. A., Peccoralo, L. A., Rosenthal, R. N., McCarty, D., & Rotrosen, J. (2018). Barriers and facilitators affecting the implementation of substance use screening in primary care clinics: a qualitative study of patients, providers, and staff. *Addiction science & clinical practice*, *13*(1), 8. https://doi.org/10.1186/s13722-018-0110-8
[25] Haffajee, R. L., Andraka-Christou, B., Attermann, J., Cupito, A., Buche, J., & Beck, A. J. (2020). A mixed-method comparison of physician-reported beliefs about and barriers to treatment with medications for opioid use disorder. *Substance abuse treatment, prevention, and policy*, *15*(1), 69. https://doi.org/10.1186/s13011-020-00312-3
[26] Executive Office of the President of the United States (2016). The Mental Health and Substance Use Disorder Parity Task Force Final Report. Washington, D.C. (author). Available at https://www.hhs.gov/sites/default/files/mental-health-substance-use-disorder-parity-task-force-final-report.PDF
[27] The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, Public Law 110-343.
[28] Mendoza, S., Rivera-Cabrero, A. S., & Hansen, H. (2016). Shifting blame: Buprenorphine prescribers, addiction treatment, and prescription monitoring in middle-class America. *Transcultural psychiatry*, *53*(4), 465–487. https://doi.org/10.1177/1363461516660884
[29] Exec. Order No. 13985, 3 C.F.R. 7009-7013 (2021). https://www.federalregister.gov/documents/2021/01/25/2021-01753/advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government
[30] Lewis, B., Hoffman, L., Garcia, C., & Nixon, S. (2018). Race and socioeconomic status in substance use progression and treatment entry. *Journal of Ethnicity in Substance Abuse*, *17*(2), 150–166. https://doi.org/10.1080/15332640.2017.1336959
[31]Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (October 25, 2012). *The NSDUH Report: Need for and Receipt of Substance Use Treatment among Hispanics.* Rockville, MD (Author). https://www.samhsa.gov/data/sites/default/files/NSDUH117/NSDUH117/NSDUHSR117HispanicTreatmentNeeds2012.pdf
[32] Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2019 on CDC WONDER Online Database, released December, 2020. Data are from the Multiple Cause of Death Files, 1999-2019, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10.html on Dec 22, 2020 9:33:50 AM.
[33] United States. Office of Minority Health. (2013). *National standards for culturally and linguistically appropriate services in health and health care: A blueprint for advancing and sustaining CLAS policy and practice.* [Washington, D.C.]: Office of Minority Health, U.S. Department of Health and Human Services. https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf
[34] Hurley, S., Jolley, D., & Kaldor, J. (1997). Effectiveness of needle-exchange programmes for prevention of HIV infection. *The Lancet (British Edition)*, *349*(9068), 1797–1800. https://doi.org/10.1016/S0140-6736(96)11380-5
[35] World Health Organization. (2004) *Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injection drug users.* Geneva, Switzerland. (Author). http://www.who.int/hiv/pub/idu/e4a-needle/en/
[36] National Institutes of Health. (1997). *Consensus Development Statement: Interventions to prevent HIV risk behaviors, February 11-13, 1997*:7-8 Rockville, MD. https://consensus.nih.gov/1997/1997PreventHIVRisk104html.htm
[37] Amundsen EJ. Measuring effectiveness of needle and syringe exchange programmes for prevention of HIV among injecting drug users. *Addiction.* 2006;101:911–2. https://doi.org/10.1111/j.1360-0443.2006.01519.x
[38] Bartlett, R., Brown, L., Shattell, M., Wright, T., & Lewallen, L. (2013). Harm reduction: compassionate care of persons with addictions. *Medsurg nursing : official journal of the Academy of Medical-Surgical Nurses*, *22*(6), 349–358. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4070513/
[39] Rioux, C., Castellanos-Ryan, N., Parent, S., Vitaro, F., Tremblay, R. E., & Séguin, J. R. (2018). Age of Cannabis Use Onset and Adult Drug Abuse Symptoms: A Prospective Study of Common Risk Factors and Indirect Effects. *Canadian journal of psychiatry. Revue canadienne de psychiatrie*, *63*(7), 457–464. https://doi.org/10.1177/0706743718760289
[40] Substance Abuse and Mental Health Services Administration Center for Behavioral Health Statistics and Quality. (2020). *Results from the 2019 National Survey on Drug Use and Health: Detailed tables.* Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/ Table 1.6B Illicit

Drug Use in Lifetime, Past Year, and Past Month among Persons Aged 12 or Older, by Detailed Age Category: Percentages, 2018 and 2019. https://www.samhsa.gov/data/report/2018-nsduh-detailed-tables

[41] Bhatia, D., Mikulich-Gilbertson, S. K., & Sakai, J. T. (2020). Prescription Opioid Misuse and Risky Adolescent Behavior. *Pediatrics*, *145*(2), e20192470. https://doi.org/10.1542/peds .2019-2470

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

[43] Peterson, A. B., Gladden, R. M., Delcher, C., Spies, E., Garcia-Williams, A., Wang, Y., Halpin, J., Zibbell, J., McCarty, C. L., DeFiore-Hyrmer, J., DiOrio, M., & Goldberger, B. A. (2016). Increases in Fentanyl-Related Overdose Deaths - Florida and Ohio, 2013-2015. *MMWR. Morbidity and mortality weekly report*, *65*(33), 844–849. https://doi.org/10.15585/mmwr.mm6533a3

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

[45] U.S. Drug Enforcement Administration, Diversion Control Division. (2020). National Forensic Laboratory Information System: NFLIS – Drug 2019 Annual Report, Springfield, VA: U.S. Drug Enforcement Administration. https://www.nflis.deadiversion.usdoj.gov/DesktopModules/ReportDownloads/Reports/NFLIS-Drug-AR2019.pdf

[46] Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2019 on CDC WONDER Online Database, released December, 2020. Data are from the Multiple Cause of Death Files, 1999-2019, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10.html on Dec 22, 2020 9:33:50 AM.

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

[48] See 29 C.F.R. § 1630.3(a) and (b) (regulations implementing Title I of the Americans with Disabilities Act).

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

[50] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. (2018). *State-Level Projections of Supply and Demand for Behavioral Health Occupations: 2016-2030,* Rockville, Maryland. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/state-level-estimates-report-2018.pdf

[51] U.S. Department of Health and Human Services, Health Resources and Services Administration. (2020). *Behavioral health workforce projections, 2017-2030*: HRSA health workforce factsheet. Rockville, MD. Accessed at https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/bh-workforce-projections-fact-sheet.pdf

[52] Ma, A., Sanchez, A., & Ma, M. (2019). The Impact of Patient-Provider Race/Ethnicity Concordance on Provider Visits: Updated Evidence from the Medical Expenditure Panel Survey. *Journal of racial and ethnic health disparities,* 6(5), 1011–1020. https://doi.org/10.1007/s40615-019-00602-y