NATIONAL DRUG CONTROL STRATEGY

THE WHITE HOUSE
EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY

MAY 2024

Table of Contents

★ ★ ★ ★ ★ ★

Preface from Dr. Gupta, Director

I recently called a mother to express my condolences. She had just lost her daughter, Michelle, to drug overdose. Three years prior, her other daughter, Maya, had passed away after developing substance use disorder (SUD) related to prescribed pain medications, and the mother had been the one to find Maya unresponsive at home – every parent's worst nightmare. In the last few years, I've met too many Americans like Michelle, Maya, and their mother who have been impacted by this Nation's overdose crisis. Addressing this crisis is a top priority across the Nation. The experiences of all those impacted by this crisis—parents, grandparents, children, siblings, friends, neighbors, community members, caregivers, siblings, teachers, police officers, correctional officers, doctors, nurses, peers, harm reductionists, and people in recovery—are the building blocks behind the 2024 *National Drug Control Strategy (Strategy)*.

This *Strategy* doubles down on the ongoing efforts to address two key drivers of the overdose crisis: untreated addiction and the manufacturers and drug trafficking networks that profit from its distribution and sale. Here's the bottom line: SUD is a disease that must be treated, and the supply chain for illicit drugs must be disrupted. It is now critical to accelerate our endeavors to prevent young people from initiating drug use; expanding access to life-saving interventions like naloxone; acting on emerging drug threats like xylazine; removing barriers to, and stigma of, treatment; and supporting people in recovery and welcoming others to pursue it. We also need to tackle the supply of these deadly drugs using every tool in our toolbox to go after the producers, distributors and sellers or these drugs, as well as the illicit financial networks that support this deadly activity.

We have taken important steps, including by increasing global counternarcotics cooperation, increasing prosecutions of drug traffickers, strengthening drug detection technologies on the border, stepping up sanctions on drug trafficking organizations (DTOs) and individuals who threaten and harm Americans, and making life-saving treatments more readily available. Because of this work, El Chapo's son is behind bars; naloxone is available over the counter; and the X-waiver, which was a barrier to both prescribing and accessing buprenorphine for treating opioid use disorder, is no more. And every day, there are more people in recovery because of our work[1]—people like Freddie.

I first met Freddie at a jail in New Jersey where he shared his long history of struggling with opioid use disorder, and how that led to his involvement with the criminal justice system. While in jail, he received the treatment he needed, and now he talks of hope, family, and a future. Because evidence-based public health and public safety measures were implemented with fidelity, Freddie received the support and resources he needed to support his recovery journey.

But we still have work to do. All too many Americans like Michelle and Maya are still dying every year of an overdose,[2] and many people are using more than one substance.[3] This is a crisis, and we will not stop until we have squeezed every choke point in the global supply chain of illicit drugs, fully denied producers and traffickers operating capital and profits by disrupting the commerce of illicit drugs, and advanced technology to detect and stop the import of all deadly drugs. Let's give every impacted person and family a reason to hope by tackling this crisis together.

Rahul Gupta, MD, MPH, MBA
Director of National Drug Control Policy

★ ★ ★ ★ ★ ★

Introduction and Executive Summary

America is facing the deadliest drug threat in our history. Over the last 25 years, drug overdose deaths in the United States from synthetic opioids, including fentanyl, have risen to more than 100 times their 1999 levels. The rate of fatal overdoses from other drugs, including cocaine and methamphetamine, has also surged.[4] The overdose crisis calls for bold action.

The Office of National Drug Control Policy (ONDCP) has outlined vital steps for attacking two drivers of this crisis. First, we need to protect against overdoses and reduce demand for drugs, including by preventing drug use before it starts, saving lives, and supporting people in recovery. Second, we need to dismantle the supply chains of illicit drugs, including cracking down on the global criminal networks fueling American deaths. These lines of effort are two sides of the same coin. Both must be pursued aggressively for meaningful and lasting change.

We have made progress. State Opioid Response (SOR) grant programs have prevented over 600,000 overdose deaths.[5] Historic federal investments have scaled up treatment efforts, with SOR programs delivering nearly 10 million naloxone kits since 2020[6]. Pharmacy prescriptions for life-saving naloxone, an opioid overdose reversal medication (OORM), have surged 37 percent in the last two years,[7] while naloxone has started being sold over-the-counter for the first time ever, thanks to actions by the Food and Drug Administration (FDA). The share of eligible veterans in the Department of Veterans Affairs (VA) system receiving medication for opioid use disorder (MOUD) has climbed steadily since 2020,[8] as has the percentage of people involved in the criminal justice system with opioid use disorder (OUD) receiving treatment in federal prisons, from 3 percent in 2020 to 60 percent today.[9] Meanwhile, our workforce of addiction professionals continues to grow and the FDA's approval last year of two naloxone products for over-the-counter sales has expanded accessibility further. A bipartisan law, the Mainstreaming Addiction Treatment (MAT) Act, increased the number of providers who may initiate buprenorphine treatment from 129,000 to more than 2 million, bringing the medication to many rural and underserved communities for the first time.[10] The Department of Health and Human Services (HHS) has also expanded flexibility to prescribe MOUD in telehealth appointments, facilitated the operation of mobile vans providing MOUD services, and increased opportunities for states to apply for Medicaid funding to treat OUD in prisons and jails.

The American Rescue Plan (ARP) of 2021, which delivered direct relief to Americans in response the COVID-19 pandemic, sharply scaled up efforts, including through expending more than a billion dollars boosting mobile crisis intervention units, and another billion to expand the community health workforce, including mental health care workers. Finally, the ARP ushered in unprecedented measures to prevent homelessness, both a symptom of overdose crisis and a major barrier to recovery. Most significantly, it ushered in a national eviction ban that helped bring down eviction filings to 20 percent below their pre-2021 average.[11]

Other efforts are helping prevent drug use before it begins and support people in recovery, saving lives, all while improving equity. Partnering with the Ad Council, ONDCP launched the Real Deal on Fentanyl campaign. Through the campaign, targeted messages on social media and digital billboards have reached millions of young people nationwide, educating them on the dangers of fentanyl and how to save lives by administering naloxone. Additionally, historic

★ ★ ★ ★ ★ ★

numbers of people with federal criminal offenses for simple possession and use of marijuana have received federal pardons. Bipartisan legislation that invests in creating jobs has also contributed to efforts against the overdose crisis. For example, the Bipartisan Infrastructure Law is investing $546 billion to create good-paying jobs,[12] which have downstream effects that help stop drug use and support people seeking recovery.

On the supply side, officials stopped more fentanyl at ports of entry (POE) over the last two years than in the previous five years combined,[13] helping keep tens of millions of fentanyl-laced pills and thousands of pounds of fentanyl powder away from our communities. New drug detection machines and enforcement surges at the border have interdicted historic amounts of illicit drugs, and the number of drug traffickers and their affiliates facing sanctions has more than doubled since 2020.[14] The United States has criminally charged leaders of the world's largest and most powerful drug cartel – including Ovidio Guzman Lopez, the son of "El Chapo" – and thousands of drug traffickers distributing fentanyl on our streets and on social media. The Department of the Treasury has leveraged new authorities to sanction more than 290 people and organizations involved in the global illicit drug trade. The United States has also built a global coalition to accelerate the fight against illicit drugs, engaged key partners, such as Mexico, Canada, and others to work collaboratively to detect emerging drug threats and disrupt trafficking. After a period of suspended cooperation, the People's Republic of China (PRC) agreed to resume bilateral cooperation on counternarcotics, and we launched the United States-PRC Counternarcotics Working Group (CNWG) in January 2023, with the goal of reducing the flow of precursor chemicals and deadly drugs into the United States and around the world.

Yet, there is much more work to do be done. With fatal overdoses and poisonings still claiming the lives of many tens of thousands of Americans every year, ONDCP and its federal partners will continue to do all it can to meet the crisis.

ONDCP's 2024 *Strategy* looks to the future this Nation needs. That future is one with greater access to prevention, treatment, harm reduction and recovery support services; with a focus on equity and equal justice; with support for incarcerated individuals, as well as post-incarceration reentry assistance; with a SUD and health care workforce that meets our Nation's needs; with a payment system that sufficiently funds care; and with a concerted transnational effort to hold drug traffickers, their enablers, and facilitators accountable.

The 2024 *National Drug Control Strategy*

The 2024 *Strategy* is aimed at addressing the overdose crisis from multiple angles. This includes preventing youth substance use, expanding access to life-saving medications like naloxone, expanding access to evidence-based treatment, building a recovery-ready Nation, and ramping up efforts to disrupt and dismantle drug trafficking.

Chapter 1: Strengthening Prevention and Early Intervention

National survey data highlight the progress made in decreasing substance use from 2020 to 2021 among 8th, 10th, and 12th graders across many substances, including alcohol, marijuana, and vaped nicotine.[15] Other data demonstrates that current use of alcohol, marijuana, and binge drinking among high school students decreased from 2019 to 2021.[16] Agencies such as HHS

have supported school-based programs that have referred over 200,000 students for behavioral health or related services in recent years. But despite this progress, important challenges remain. For example, almost one-third of high school students report substance use, and among those, more than one-third report they are using more than one substance.[17]

Achieving further success in preventing substance use before it begins will require focusing on root causes, as well as key risk and protective factors at the individual, family, and community levels, and promoting mental health and wellness, particularly among youth and adolescents. With continued challenges with suicidal behaviors and deaths by suicide among adolescents,[18] some of which involve opioids or other substances,[19] attention and investment towards prevention and early intervention among youth populations are necessary.

This chapter of the *Strategy* outlines areas where further prevention efforts can make a measurable difference, including by raising awareness of substance use harms in the collegiate community and the workplace, establishing a community of practice for evidence-based prevention of youth substance use and adverse childhood experiences (ACEs), expanding screening for substance use for school-aged children in health care settings, translating research findings into clinically and culturally appropriate tools, and more. It also includes continued support for community institutions, like Drug-Free Communities (DFC) coalitions, with a documented track record of reducing youth substance use.

Chapter 2: Expanding Access to Evidence-Based Harm Reduction Strategies

Prior Administrations have not incorporated harm reduction into its activities as an evidence-based strategy for reducing adverse outcomes resulting from substance use, especially in the cases of people who do not receive services through traditional health care systems. These programs involve an array of essential health and social services, including OORM (such as naloxone), sterile supplies like syringes, access to MOUD, and test strips for drug checking, among other services. In many cases, the strong relationships that develop between harm reduction program clients and staff lead to clients expressing interest in entering formal SUD treatment on their own terms, with the confidence of choice and control.

Access to harm reduction services remains vital, particularly as illicitly manufactured fentanyl continues to be increasingly present in the drug supply. Illicit fentanyl, a highly potent synthetic opioid, is involved in the vast majority of drug overdose deaths in the United States.[20] Bringing awareness to and widely distributing OORM is an important step toward slowing the rise in overdose deaths. Recent efforts with naloxone present one example. Historic federal investments in the SOR grant program, which helps deliver life-saving naloxone to people who need it, have prevented over 600,000 overdose deaths in the last three years.[21]

Since the publication of the 2022 *Strategy*, progress has been made to broaden access to harm reduction services in jurisdictions that permit these activities, and advocate for change in jurisdictions that do not yet allow them. This chapter of the *Strategy* focuses on ways to do this, including through model state laws, training and education for the treatment workforce, engaging states to ensure the experiences and perspectives of people actually performing lifesaving harm reduction work are considered in decisions around funding, and more.

★ ★ ★ ★ ★ ★

Chapter 3: Expanding Access to Evidence-Based Treatment

In order to save as many lives as possible and bring down the rate of overdose fatalities, it is imperative that people living with SUD have access to health care that identifies and treats their condition while supporting them with needed additional services to ensure they can enter recovery and thrive during and after the recovery process.

Since the publication of the 2022 *Strategy*, progress has been made in expanding access to substance use treatment. This includes taking the step to expand access to treatment for OUD for millions of Americans. Under the Consolidated Appropriations Act of 2023, prescribers of controlled substances no longer must secure a waiver from the federal government to register as an opioid treatment program (OTP) to initiate buprenorphine treatment for OUD, meaning people can access treatment from their primary care provider.[22] This policy change significantly increased the number of providers who can offer this treatment. Other progress includes certification of many new mobile units that provide MOUD, as well as federal investments that have steadily expanded the number of eligible veterans receiving MOUD within the VA system. Landmark legislation like the ARP, in particular, has dramatically scaled up health workforce training and mobile unit deployment in recent years, with the ARP investing billions of federal dollars in these areas.

This chapter examines ways to further expand access to treatment for SUD so every American who needs it can access it by 2025. Additionally, the ONDCP Treatment Plan (Appendix A), required by the 2018 Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act), elaborates further on screening, connections to care, workforce, and other elements necessary to continue reducing overdose and fatalities.

Chapter 4: Building a Recovery-Ready Nation

In 2022, an estimated 48.7 million Americans aged 12 or older had SUD. [23] Notably, among people aged 18 and older with SUD, more than 60 percent, or nearly 27 million Americans, were employed, and more than 3 out of 4 worked full-time.[24] SUD is widespread, including in the workplace[25,26,27] and in secondary and higher education settings.[28,29,30,31] Fortunately, recovery is prevalent as well. That same year, among the estimated 30 million Americans aged 18 or older who recognized that they experienced a lifetime alcohol or other drug issue, 21.3 million (71 percent) identified as "in recovery" or "recovered" from a substance use issue.[32] Stigma, discrimination, and misunderstanding are among the most pervasive barriers to treatment and a life in recovery.[33]

Since the publication of the 2022 *Strategy*, progress has been made in advancing efforts to build a recovery-ready Nation. For instance, the federal government has worked to promote the adoption of recovery-ready workplace (RRW) policies across the public and private sectors, including within the federal government. More states today operate RRW initiatives than ever before, and since 2020, peer-led recovery community organizations nationwide have surged by nearly 50 percent.[34]

★ ★ ★ ★ ★ ★

This chapter focuses on continuing to build a recovery-ready Nation, one community at a time. Federal agencies will continue to partner with states, local governments, employers in the for-profit and not-for-profit sectors, and communities to address the social determinants of health and the laws, regulations, and practices that can serve as barriers to treatment and recovery support. Concurrently, work must be done to build recovery capital at the individual, family, caregiver, community, and societal levels.

Chapter 5: Reducing the Supply of Illicit Substances in the Homeland

Since the publication of the 2022 *Strategy*, the federal government has made progress on taking important steps to tackle the supply of deadly drugs, in accordance with the *Strategy* objectives. This includes collaboration across state, local, Tribal, territorial, and federal law enforcement agencies to keep drugs off our streets.

In Fiscal Year (FY) 2023, for example, the federal High Intensity Drug Trafficking Areas (HIDTA) program, which funds grants across all 50 states to improve law enforcement intelligence sharing and operational coordination among federal, state, Tribal, territorial, and local law enforcement agencies, supported the seizure of more than 29,000 pounds of illicit fentanyl, more than 248,000 pounds of methamphetamine, nearly 365,000 pounds of cocaine, over 4,300 pounds of heroin, and denied DTOs $20 billion in illicit profits.[35] U.S. Customs and Border Protection (CBP) seized almost 240,000 pounds of illicit drugs, primarily at southwest border POE, which includes nearly 27,000 pounds of fentanyl.[36] And the United States Postal Inspection Service (USPIS) seized over 4,200 pounds of fentanyl from the domestic mail system.[37] In the last two years, officials have halted more fentanyl at POEs than over the previous five years combined.[38] These actions took deadly drugs off the streets and prevented overdose deaths.

This chapter focuses on the ongoing efforts to identify and seize deadly drugs before they hit our streets, and otherwise disrupt the supply chain for illicit drugs.

Chapter 6: Cracking Down on the Global Suppliers of Illicit Drugs and Related Criminal Networks

Though the impact of the overdose epidemic is felt acutely in local community emergency rooms, the problem is global, and the solution is global as a result. For this reason, the United States' collaboration with partner countries to reduce the supply and flow of fentanyl and precursor chemicals into the United States is a key component of reducing the number of fentanyl-related deaths in the country.

In the past few years, the United States has prioritized disrupting the global supply chain and global networks that manufacture and ultimately distribute deadly drugs into the United States. The United States has stepped up counternarcotics cooperation with key governments – including Mexico, Canada, India, and the PRC– and launched the Global Coalition to Address Synthetic Drug Threats, which unites more than 150 countries in the fight against drug trafficking cartels and illicit finance. The Trilateral Working Group with Mexico and Canada has worked collectively to identify key enforcement gaps, collaborate on particular enforcement efforts, and address related concerns associated resulting from arms trafficking. After years of

★ ★ ★ ★ ★ ★

suspended cooperation, the United States and the PRC launched a CNWG in January 2024, aimed at increasing joint enforcement efforts, a direct outcome of President Biden's and President Xi Jinping's Leaders' Summit in Woodside, California, in November 2023.

The United States also has taken law enforcement action against drug traffickers and their key enablers that operate around the globe. The Department of Justice (DOJ) has prosecuted leaders of some the world's largest and most powerful drug cartels. And since 2021, the Department of the Treasury also has sanctioned more than 290 people and organizations involved in the global illicit drug trade.

Chapter 7: Improving the Criminal Justice System's Response to Substance Use Disorder

People with SUD who have contact with the criminal justice system should have access to quality, evidence-based treatment to support sustained recovery and reduce the risk of recidivism. Throughout the last two years, strides have been made to make this goal a reality. These steps include investments in evidence-based diversion and deflection programs led by prosecutors, courts, and law enforcement officers, which safely reduce unnecessary criminal justice system involvement as appropriate and consistent with public safety. They also include expanding access to FDA-approved MOUD to people in jails and prisons, to facilitating successful reentry outcomes, investing in evidence-based approaches improve individual and collective public health and public safety outcomes. Today, a majority of people who need MOUD in federal prisons now receive it, and 43 percent of state and local jails are providing MOUD in correctional settings, up from barely any just a few years ago.[39]

These evidence-based approaches, based upon successful and proven federal, state, and local strategies, improve individual and collective public health and public safety outcomes and also advance equal justice under the law. As an illustrative example, while white, Black, and Brown people use marijuana at similar rates, Black and Brown people have been arrested, prosecuted, and convicted at disproportionate rates. Addressing disparities in arrest, prosecutions, convictions, and sentences is essential. Equally important is taking action to relieve the collateral consequences of convictions, which needlessly raise barriers to successful reentry and in fact undermine public safety. Recent years have brough progress on these issues, including with the full, unconditional pardon of many Americans with prior federal or District of Columbia convictions for use or simple possession of marijuana. These pardons have lifted barriers to employment, housing, education, and other opportunities. ONDCP is committed to working to end the sentencing disparity between crack and powder cocaine, which has led to disproportionate sentences for Black and Brown Americans.

This chapter includes a discussion of the progress that has been made, areas for additional focus, and a story that brings this work to life.

Chapter 8: Building Better Data Systems and Research

Effective drug prevention and treatment policies will improve the health and safety of our communities, increase life expectancy, reduce the economic burden associated with drug use, and most importantly, prevent overdose and overdose deaths. Development of such policies

requires timely, comprehensive, and geographically precise data to inform local communities about the dangers of the illicit drug supply and to provide data-driven insights that inform the distribution of lifesaving overdose reversal drugs, harm reduction programs, and treatment services and supports.

Since the publication of the 2022 *Strategy*, progress has been made in advancing data systems and research. One example is the development of the nonfatal opioid overdose tracker, led by ONDCP and the Department of Transportation's (DOT) National Highway Traffic Safety Administration (NHTSA), which uses national Emergency Medical Services (EMS) data to determine where nonfatal overdoses are occurring so jurisdictions can direct resources to these areas. This dashboard is updated regularly and has only a two-week lag, which is a significant improvement over past efforts to track overdoses, and provides key information for local and national policymakers.

This chapter looks at some of the remaining shortcomings in existing data systems, how to develop methods for identifying emerging drug use trends in real-time or near real-time, how to prioritize data and analytical efforts to support advancing equity for underserved populations, and more. Additionally, the ONDCP Drug Data Plan (Appendix B), required by the 2018 SUPPORT Act, presents a plan to collect, analyze, and use data to inform implementation and assessment of the *Strategy*.

Specific Goals and Measuring Federal Performance

The 2022 *Strategy* established goals and objectives with measures and targets that were detailed in the 2022 *Performance Review System* report (PRS), and are incorporated herein by reference. In the midst of a dynamic illicit drug environment where progress has been made but additional work is needed to strengthen public health and public safety outcomes, the 2024 *PRS* details a discussion of evolving goals, objectives, and targets.

Consultation for the 2024 National Drug Control Strategy

ONDCP is statutorily required to consult with and solicit input for the *Strategy* from a variety of parties affected by federal drug policy, including federal agencies and departments charged with carrying out these policies; members of Congress and congressional committees; states, local, Tribal, and territorial governments; nongovernmental organizations and community activists; and foreign governments, among others.

The consultation process for the 2024 *Strategy* began in February 2023, and ONDCP received significant input from a wide range of interested parties. ONDCP convened the National Drug Control Program Agencies (NDCPA) for in-person consultation, and received written input from these agencies as well, and held virtual meetings and received written input from dozens of leaders while developing this *Strategy*. Input was received from drug policy experts, advocates, and stakeholders from across the Nation, including federal, state, Tribal, territorial, and local leaders; law enforcement; public health; academia; and more. Following publication, ONDCP will coordinate with the interagency to implement this *Strategy*. ONDCP thanks all partners who

provided input for the 2024 *Strategy*, and for their commitment to addressing the overdose crisis and saving lives.

Conclusion

The overdose crisis is not a red state or blue state issue. It is not limited to any race or gender, to urban or rural, or to rich or poor; it's an American issue. Democrats and Republicans have a long history of coming together to address substance use because it affects us all. Today, ONDCP calls on all Americans to come together to solve one of our greatest challenges.

★ ★ ★ ★ ★ ★

Chapter 1: Strengthening Prevention and Early Intervention

In recent years, our Nation has seen progress scaling up prevention efforts and bringing down youth substance use, with, for example, key measures of alcohol use and e-cigarette use by young people declining. That said, more work remains to prevent initiation of substance use (referred to as primary prevention) and, for people who have already initiated use, prevent individuals from continuing to use (referred to as secondary prevention).[40] The data makes clear that initiating substance use can increase the likelihood of engaging in high-risk behaviors, progression to SUD, or even death. Between 2019 and 2021, fatal drug overdoses and poisonings among adolescents increased by 133 percent (from 492 to 1,146). The increase in adolescent fatal overdose outpaced national overdose trends as a whole, which increased by 51 percent (from 70,630 to 106,699) during this time period.[41]

To be effective, substance use prevention efforts must be multi-faceted and include prevention strategies that reduce risk factors and increase protective factors within the individual, peer, family, school, and community domains of influence.[42] The focus will continue on preventing initial substance use, promoting good mental health, and ensuring youth and adolescents are surrounded by well-informed adults who can help them enjoy healthy lifestyles. Nearly half of young adults aged 18 to 25 had experienced either any mental illness (AMI) or SUD in the past year (45.8 percent or 15.3 million people), and 13.5 percent (or 4.5 million) had both AMI and SUD.[43] All this suggests that continued progress in combatting our Nation's mental health crisis can aid prevention and save more lives. Meanwhile, continued attention to, and investment in, prevention and early intervention efforts will be necessary to address suicidal behaviors[44] and intentional overdose deaths among adolescents.[45]

In addition to supporting primary prevention, federal agencies are supporting and ramping up support for youth through early intervention efforts to halt the progression to SUD. Multiple partners have made investments to provide education, tools, and resources to parents, health care providers, schools, and other social service providers to address risk factors that increase vulnerability to initiating substance use and to support early intervention to prevent escalation to more frequent and poly-substance use. HHS-funded mental health programs in schools, for example, have engaged over 800,000 health care and other professionals, while referring over 200,000 students for behavioral health and other services since 2018.

Progress

Since the publication of the 2022 *Strategy*, progress has been made in advancing primary prevention. Key actions are listed by action items.

Helping K-12 schools expand access to substance use prevention efforts.

(Agencies Involved: DOJ/OJP; ED; HHS/CDC, HRSA, NIH, SAMHSA)

In 2022, ONDCP and the Department of Education (ED), through its technical assistance (TA) center, the National Center for Safe Supportive Learning Environments (NCSSLE), hosted a

series of *Lessons from the Field* webinars connecting school personnel around the country to share information, strategies, and resources on a range of substance use related issues that affect learning. The webinars featured presentations, roundtables, and resources to help schools adopt policies and practices to address youth substance use trends. They reached more than 13,000 educators, counselors, school administrators, state and local school district leaders, parents, and education associations from more than 48 states and territories.

These efforts to proliferate resources related to substance use can make a big difference for students. For example, one promoted resource was the Centers for Disease Control and Prevention's (CDC) *What Works in Schools Program*, which supports capacity-building in local education agencies to help improve student health and well-being. CDC's program provides funding to support implementation of quality health education, increased accessibility of health services, and safer, supportive school environments. When fully implemented in schools, these resources have been shown to decrease substance use, violence, and suicide, while improving mental health.[46]

CDC reports that roughly two million middle and high school students now have access to the *What Works in Schools Program*. While this represents important progress, the program has yet to touch millions of other students. As part of the FY 2025 budget, CDC will continue to build upon the progress by scaling up the program to schools in 75 of the largest districts, touching all 50 states and 7 territories with new investments that amount to approximately $10 per student. To assist more schools to adopt the program, CDC has also created materials to help school administrators and staff plan, develop, and implement effective programmatic strategies, and activities.

The Substance Abuse and Mental Health Services Administration (SAMHSA) supports the Prevention Technology Transfer Center National Coordinating Office and ten regional centers (PTTCs) to provide TA and support to the prevention field, including school administrators and the school-based prevention workforce. PTTCs provide training and resources to improve substance use prevention interventions. These resources cover topics such as selecting evidence-based programming for school settings; addressing substance use related issues such as vaping and marijuana; and understanding the cultural intersections of lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI+) youth and SUD.

ONDCP will continue collaboration with federal partners to advocate for increased, coordinated funding for evidence-based primary prevention that can reduce substance use among youth and adolescents, and to ensure programs and services are available for every school aged youth in the Nation. Culturally and linguistically appropriate standards should undergird the development and implementation of curricula appropriate to each developmental age group of students. Such curricula should educate youth about the dangers of alcohol, tobacco, and other drugs, and promote skills that increase wellness. In partnership with ED, CDC, SAMHSA, National Institute on Alcohol Abuse and Alcoholism, and National Institute on Drug Abuse (NIDA), examples of effective practices will be disseminated to State Educational Agencies (SEAs) and Local Educational Agencies (LEAs) for academic and extra-curricular activities in schools. Additionally, this collaboration will identify and address gaps in existing research, program development, service delivery, and outcome evaluation of resources to improve the reach and impact of effective substance use prevention.

★ ★ ★ ★ ★ ★

Supporting organizations seeking to establish or expand Student Assistance Programs with evidence-based practices and federal funding.

(Agencies Involved: ED; HHS/SAMHSA)

In FY 2022 and 2023, ED funded $255 million across 264 grantees for two programs – the School-Based Mental Health Services (SBMH) Grant and the Mental Health Service Professional (MHSP) Demonstration Grant – to help meet the goal of doubling the number of school counselors, social workers, and other mental health professionals supporting youth. The Bipartisan Safer Communities Act is a step forward in keeping the Nation's school children safe and providing them the care they need. The SBMH program and MHSP Demonstration Grant program will enable communities to hire approximately 5,400 school-based mental health professionals and train an estimated 5,500 more to build a pipeline of mental health providers in schools, especially those with the greatest needs.

Additionally, ED and HHS have partnered to provide TA resources to help state and local officials to ensure children have physical and behavioral health services and supports needed to build resilience and thrive. Through the National Technical Assistance Center for Children's Mental Health, the National Center for School Mental Health, and other offices, ED and HHS provide guidance on federal funding available for school-based health services, including on how Medicaid can support mental health and other services. ED and HHS also provide support that helps reduce federal administrative burden on states and localities, including LEAs, and reduce barriers to adopting school-based health services.[47,48] Additionally, HHS has published a comprehensive list of school-based health services for education administrators, community leaders, and parents to support youth.[49]

SAMHSA's Advancing Wellness and Resiliency in Education (AWARE) program further develops sustainable infrastructure for school-based mental health programs and services. Project AWARE lets SAMHSA partner with SEAs, LEAs, Tribal Educational Agencies (TEAs), State Mental Health Agencies (SMHAs), and community-based organizations providing behavioral health care services. Partnerships help these organizations implement mental health-related promotion, awareness, prevention, intervention, and resilience activities, including by providing training for school personnel and other adults to identify students experiencing trauma, support them, and connect them to services. As a result of Project AWARE funds, grantees from 2018-2022 have:

- Facilitated formal written agreements engaging 1,816 organizations to improve practices, coordinate services, and strengthen partnerships to provide additional support for school-aged youth;
- Adopted, in coordination with SEAs and LEAs, 796 policy changes to improve behavioral health programs and services;
- Engaged 834,481 mental health professionals, first responders, teachers, school staff, administrators, families, community members and others in trainings; and,
- Referred 205,874 students for behavioral health or related services.

SAMHSA has developed a suite of resources to assist schools in implementing Student Assistance Programs. The "Talk. They Hear You." Student Assistance Resource Guide and Guide for School Administrators provide school leaders and administrators with key information

★ ★ ★ ★ ★ ★

regarding student assistance services, including key components of effective programming, considerations for implementation, and planning for success. Promotional materials are also available free of charge for a variety of school audiences.

Continued efforts will ensure the growth of a diverse workforce equipped with cultural and linguistic competency, allowing more students access to trained professionals that they can trust without bias, shame, or stigma. Grants, professional development, and TA resources to education agencies will encourage partnerships with Historically Black Colleges and Universities, Tribal Colleges and Universities, and other Minority Serving Institutions to support students in diverse communities.

Expanding research on screening for school age children in health care settings and translate research into clinically and culturally appropriate tools.

(Agencies Involved: DOJ/OJP; ED; HHS/CDC, CMS, HRSA, NIH, SAMHSA)

Federal programs currently support, and have been increasing support for, screening programs for school-age children in myriad ways. For one, Medicaid covers the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit for beneficiaries under age 21. The EPSDT benefit includes mental health screening and necessary health care services that must be made available for treatment of all mental illnesses or conditions discovered by any screening and diagnostic procedure.[50] States are required to provide access to any Medicaid-coverable service for youth in any amount that is medically necessary, regardless of whether the service is covered in the state's Medicaid plan.

As for other recent funding, in 2021, ARP provided additional funding of $80 million, supporting 29 Pediatric Mental Health Care Access (PMHCA) awards through 2025. Through this investment, PMHCA programs expanded to 43 states, the District of Columbia, Tribal organizations and territories.[51] The Bipartisan Safer Communities Act (BSCA), enacted in FY 2022, provided an additional $80 million in BSCA funds over four years to further support the program, including expansion into hospital emergency departments and schools. The American Academy of Pediatrics, the Emergency Medical Services for Children Innovation and Improvement Center, and the School-Based Health Alliance received one-year expansion awards to provide training and technical assistance (T/TA) to PMHCA programs. In September 2023, the Health Resources and Services Administration (HRSA) announced awards to support existing and new PMHCA programs awarding $19 million to 25 states and territories.

To build upon its progress, HRSA awarded 77 awards to health centers totaling $25 million in 2023 to expand access to primary health care services, including mental health and SUD services, at service delivery sites in schools. This funding requires school-based health center grantees to add or expand behavioral health services as a requirement of the funding award.

Beyond funding efforts, in January 2023, NIDA launched two brief online screening tools to assess for SUD risk among adolescents 12-17 years old. The Brief Screener for Tobacco, Alcohol, and other Drugs, (BSTAD) and the Screening to Brief Intervention (S2BI) equips clinicians with validated tools to triage patients into one of three levels of SUD risk: no reported use, lower risk, and higher risk. These tools make it easier for healthcare providers to integrate

★ ★ ★ ★ ★ ★

prevention and early intervention services into their practice supporting the American Academy of Pediatrics recommendation for universal SUD screening in pediatric primary care.

Under its Bright Futures Pediatric Implementation Program, HRSA has also updated its Guidelines for pediatric providers to encourage increased screening opportunities to recognize and address substance use among youth. At least 37 states have used Bright Futures as their EPSDT pediatric preventative care screening recommendations. Guidelines include recommendations for services that pediatric providers should offer at every well-child visit from before birth to age 21, including screening for behavioral, social, and emotional concerns; adolescent depression and suicide risk; and substance use. The Guidelines also recommend the frequency and timeline of when such services should be offered. Additionally, the guidelines recommend clinicians utilize validated tools such as the widely used BSTAD, S2BI, or CRAFFT screening tests to screen for the use of alcohol, tobacco, nicotine, marijuana, and other drugs, as well as vaping.

SAMHSA has developed a mobile app, Screen4Success, that provides parents and other concerned adults with resources to better understand the health, wellness, and wellbeing of their children. Screen4Success houses a 10-minute screener that adults can use to look for signs of elevated risk for substance use and mental health issues in youth, and connects them with information on recommended support services that are available in the user's area and at the national level.

These efforts align with ongoing efforts to address inequity in policies and disparities in health outcomes. ONDCP is partnered with the National Institute on Minority Health and Health Disparities, SAMHSA-funded Centers of Excellence, and other relevant stakeholders to promote adoption of culturally and linguistically appropriate services and models for screening, prevention, and intervention services for youth populations. Such partnerships are vital in analyzing and addressing disparities in Black, Latino, LGBTQI+, rural, and Tribal communities.

Empowering community coalitions to implement evidence-based prevention.

(Agencies Involved: DOJ/OJP; HHS/CDC, SAMHSA)

The 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 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. Coalitions bring together schools, parent and youth groups, law enforcement, civic and fraternal organizations, businesses, and health organizations to collectively educate youth about the risk and harms of substance use, equip them to make healthy choices, and address community risk factors that can make youth vulnerable to substance use. In FY 2023, 751 coalitions across the United States received DFC funding. In 2022, one in five Americans lived in a community with a DFC-funded coalition.[52] A 2021 cross-site evaluation of the DFC program reported several key positive outcomes from the prevalence and sustainability of coalitions:[53]

- DFC coalitions successfully mobilized nearly 35,000 community members to engage in evidence-based youth substance use prevention/reduction efforts.

★ ★ ★ ★ ★ ★

- Among high school and middle school youth in each of the samples, there were significant decreases in past 30-day use across all core measure substances (alcohol, marijuana, tobacco, prescription drug misuse).
- Past 30-day use of alcohol and marijuana among high school students in DFC communities were significantly lower than rates in the national Youth Risk Behavior Survey.

Building on strategic plans developed under DFC awards, SAMHSA's Center for Substance Abuse Prevention provides funding to current and former DFC coalitions to support efforts in preventing and reducing underage drinking through the Sober Truth on Preventing (STOP) Underage Drinking program. This program prevents and reduces alcohol use among youth and young adults ages 12-20 in communities throughout the United States. The program aims to address norms regarding alcohol use by youth, reduce opportunities for underage drinking, create changes in underage drinking enforcement efforts, address penalties for underage use, and reduce negative consequences associated with underage drinking (e.g., motor vehicle crashes, sexual assaults). In FY 2022 alone, STOP Act grantees directly served nearly 500,000 individuals through evidence-based programs such as Life Skills Training and Communities that Care, and saw reductions in past 30-day alcohol use and increases in perceptions of the harms of drinking, including binge drinking. They also indirectly reached over 11.5 million through universal prevention strategies such as media campaigns and information dissemination.

The SAMHSA Center for Substance Abuse Prevention's Voices of Youth Initiative partners with youth organizations to generate youth perspectives on substance use prevention topics to inform work being done at the federal level. This partnership utilizes a human-centered design approach to empower youth to be engaged in the development of substance use prevention messages and activities in their own communities. In addition to providing education about healthy decision-making and the risks of substance use, the Voices of Youth initiative generates "youth-to-youth" messages designed to resonate with young people.

Areas for Additional Focus

While progress to date has advanced the prevention priorities established in the 2022 *Strategy*, work remains to be initiated or completed.

Establish a community of practice for evidence-based youth substance use prevention and adverse childhood experiences.

(Agencies Involved: HHS/CDC, SAMHSA)

Eliminating exposure to ACEs is critical for addressing the overdose crisis. ACEs are potentially traumatic events that occur before the age of 18, and they have been shown to increase risks for substance use, as well as for future legal system involvement.[54] They include witnessing or experiencing abuse or neglect, household or community violence, or having an incarcerated family member. Importantly, other forms adversity or trauma in childhood and adolescence can also raise risks for SUD.

★ ★ ★ ★ ★ ★

NDCPAs have invested significant resources and coordinated prevention efforts across a number of agencies and programs demonstrating the inter-connectedness of poor mental health, substance use, infectious disease, and suicide. Research has shown that these public health issues share similar risk and protective factors, enabling multi-faceted programs to have positive outcomes on a number of indicators.[55,56,57] Creating and sustaining safe, stable, nurturing relationships and environments for all children and families can prevent ACEs and help all children reach their full potential.

To advance this work, ONDCP will partner with the CDC to ensure implementation of strategies outlined in *Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence*. This TA guide provides actionable strategies to help states and communities use the best available evidence to prevent ACEs.

ONDCP will maximize collaboration with DOJ's Office of Justice Programs (OJP) and other juvenile justice partners to identify and highlight evidence-based prevention practices for supporting youth with significant ACEs including children of incarcerated parents; and youth who are participating in judicial accountability programs, including juvenile drug treatment courts, and mentoring programs for youth impacted by opioids and other substance use. Substance use prevention initiatives must continue to address risk and protective factors further upstream to truly reduce the number of youth at risk for engaging in substance use and other unhealthy behaviors. ONDCP will partner with SAMHSA and the Administration for Children Youth and Families to encourage communities to leverage CDC programs and resources, such as the *Essentials for Childhood: Preventing ACEs through Data to Action (PACE:D2A*) program. This program combines two existing prevention programs focused on preventing ACEs, such as child abuse and neglect, while promoting positive childhood experiences through surveillance and data collection to inform and drive proven primary prevention activities.

ONDCP will partner with HRSA to leverage the Comprehensive Systems Integration for Adolescent and Young Adult Health program to substantially increase the capacity of states, territories, and Tribal organizations to establish and strengthen cross-sector alliances to integrate behavioral health services into primary care, schools, and community systems. Finally, ONDCP will continue to work with CDC to ensure delivery of the Guide to Community Preventive Services (*The Community Guide*) Office on four systematic reviews of youth substance intervention frameworks to develop a technical package for state, local, and Tribal partners on the effectiveness of particular interventions. This will be a youth-focused communications campaign to be used as a resource for action in substance misuse and drug overdose and poisoning prevention efforts.

Spotlight substance use harms in the collegiate community.

(Agencies Involved: ED; HHS/NIH, SAMHSA)

The National Survey on Drug Use and Health (NSDUH) data consistently shows higher prevalence of substance use and SUD in the 18–25-year-old population.[58] These findings show the need for innovative and effective methods of providing information, resources, and support to young adults. In partnership with the Ad Council, ONDCP launched a campaign in 2023 to educate young people (ages 13-24) on the dangers of fentanyl, the cause of 77 percent of adolescent overdose deaths in the first half of 2021.[59] The campaign also stressed the life-saving

★ ★ ★ ★ ★ ★

effects of naloxone, an OORM.[60] Social media influencers such as college athletes and lifestyle content creators reach millions of youth and young adults. In addition to social media platforms, information is disseminated through digital billboards in places that young people frequent, including college campuses, gas stations, public spaces, and restaurants.

Since the campaign launch, $11.3 million of media has been donated to increase fentanyl awareness among youth and has yielded 826.2 million impressions by youth across several media. An additional $1.5 million of media has been donated to raise awareness among parents about the dangers of fentanyl, signs and symptoms to look for, and how to talk to their children about fentanyl; more than 384 million impressions have been logged by parents across multiple platforms. One website linked to the campaign, DropTheFBomb.com, has logged 177,200 users with 34.2 percent (60,500) of those sessions showing user engagement and 67,900 user conversions. A second website, RealDealOnFentanyl.com, has logged 3.3 million users with 14.6 percent (586,600) of those sessions showing user engagement and 619,400 user conversions. Further opportunities exist to engage key stakeholders to develop guidelines, tools, peer-led awareness campaigns, and other resources to encourage screening for mental health and substance use in multiple settings. Bolstering the efforts of ED's student support programs for institutions of higher education, such as the Postsecondary Student Success and TRIO programs will provide opportunities to leverage partnerships to raise awareness of risk and harms of substance use and provide services to intervene in risky use and related health consequences.

Encourage evidence-based employer-based wellness programs.

(Agencies Involved: HHS/ACF, CDC, SAMHSA; Labor; Treasury/IRS)

Employers provide an underutilized platform to reach adolescent and young adult employees and their families with vital information and resources to address substance use. The Workplace Supported Recovery Program of CDC's National Institute for Occupational Safety and Health details important steps employers can take to prevent work-related injuries and illnesses that could lead to substance use or misuse. This information promotes policies and practices that reduce difficult working conditions or work demands that might lead to daily or frequent pain. Opportunities exist to inform employers and youth employees about the dangers of substance use, harm reduction actions such as securing and safely disposing of unused medications, and responding to overdoses using naloxone. Employers can also promote and sustain workplace culture and environments that build awareness, reduce stigma, and promote wellness and health-focused activities. Workplaces have an important role to play in community-based prevention efforts. Workplaces contribute to the economic security of a community, create opportunities for advancement and leadership, and contribute to social norms in the community. Workplaces can partner with community coalitions and other sectors of the community to implement workplace-based substance use prevention programs, expose youth to positive adult role models and youth leadership development programs and engage in substance use awareness activities in the community.

Success Story

Effective substance use prevention extends beyond information about the harms and risks of alcohol, tobacco, and other drugs. Substance use is often initiated during childhood or early adolescence.

★ ★ ★ ★ ★ ★

Studies have shown that interventions promoting positive parenting practices, ensuring mental safety, and meeting basic human needs of children support prevention of substance use and mental health conditions.[61,62,63,64] SAMHSA initiated Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) to promote the wellness of young children, from birth to eight years of age, by addressing the social, emotional, cognitive, physical, and behavioral aspects of their development. Family and community experiences in early childhood greatly influence the vulnerability to behavioral health challenges, including substance use and mental health conditions, for youth and young adults. Through consultations, mentoring and training, the Project ensures regular mental health and substance use screening for youth and their caregivers, and access to a range of other services and supports to promote family wellness. Local Project LAUNCH Advisory Councils comprised of family representatives and community partners develop culturally appropriate, community-based strategies to integrate behavioral health into primary care, childcare and education settings. Together, these activities aim to prepare young children to thrive in school and beyond. From its inception in 2009, Project LAUNCH has accomplished significant milestones including:

- Trained 26,530 members of the behavioral health workforce;
- Screened 62,076 young children and caregivers for behavioral health or related interventions;
- Referred 22,041 young children and caregivers for behavioral health and related services;
- Provided evidence-based behavioral health and related services to 38,335 young children and caregivers; and
- Established 1,160 new partnerships with other child-serving and related agencies and organizations to serve children and families.

Through SAMHSA Strategic Prevention Framework – Partnerships for Success funding, Social Advocates for Youth (SAY) San Diego has had phenomenal success with implementing the Project Safeguard Project, which includes several innovative strategies to reduce substance use among youth aged 9-20. The goals of Project Safeguard are to (1) reduce youth access to alcohol and marijuana by using evidence-based approaches to increase local business compliance with state and local laws; (2) decrease the prevalence of alcohol and marijuana use by minors by engaging parents, youth, and community members in evidence-based outreach and education initiatives; and (3) increase youth referrals to SUD treatment and early intervention by engaging the community, local law enforcement, and school district in implementing the evidence-based programs that address and reduce early initiation of use. Project Safeguard targets youth located in Southeast San Diego where over 51 percent youth live in poverty. SAY San Diego's youth coalition "Youth Unite" partnered with the Playwrights Project and Elevate Youth to support a play, "Pros and Cons of Feeding Stray Cats," which focuses on substance use, alternative support juvenile justice programs, and empathy. The play follows two youth who meet at a weekend program for teens who have been arrested for drug-related offenses. After the play, there was a panel of experts including SAY San Diego to provide substance use prevention resources. The feedback received from youth was very positive, including feeling more comfortable about having a conversation with friends who may be struggling with substance use.

★ ★ ★ ★ ★ ★

Chapter 2: Expanding Access to Evidence-Based Harm Reduction Strategies

Multiple studies confirm that the vast majority of people in the United States who need substance use treatment do not receive it.[65,66] Among those who do feel they need treatment but do not receive it, survey data indicates that the most common reason is not being ready to stop using, along with not knowing where to go or not finding a program offering the services they want or need.[67] This gap in care can, and should, be filled by increasing access to services and programs that keep people alive and providing low-barrier treatment or referrals to more formal treatment services when people indicate their interest in that. That is why significant work is underway to encourage expanded access in states and localities that permit these services and to advocate for evidence-based rule changes to improve access in areas where harm reduction services are not currently authorized and/or accessible. Harm reduction is an evidence-based approach that emphasizes working directly with people who use drugs (PWUD) to help prevent overdose and infectious disease transmission; improve the physical, mental, and social well-being of the people served; and offer low-threshold options for accessing SUD treatment and other health care services.[68,69,70]

Specifically, ONDCP and its federal partners are focused on increasing access to OORM, fentanyl and other drug test strips, and syringe services programs (SSPs) in states where they are authorized by law. Access to overdose reversal medications, such as naloxone, and fentanyl test strips remains critical, particularly as illicitly manufactured fentanyl continues to be increasingly present in the drug supply. Naloxone has helped SOR programs prevent over 600,000 overdose deaths in the last three years,[71] while newly approved over-the-counter sales of naloxone are expanding access to this life-saving drug all across the country.

Similarly, SSPs are critical access points for distributing overdose prevention tools, in addition to sterile equipment like syringes that prevent infectious disease transmission; yet, these programs are not legal in every jurisdiction. The benefit of harm reduction programs, including SSPs, is that they are often better able to reach PWUD because they provide nonjudgmental care and allow people to develop self-directed goals to improve their quality of life, even if they are not currently receiving formal treatment. However, harm reduction programs still face legal barriers in some states and localities, and are often underfunded even when legally permitted to operate. It is critical to encourage authorization of, and/or expand implementation of, existing legal programs and to sustain funding for those currently in use to improve access to overdose prevention, infectious disease prevention, and other health care services for PWUD and people with SUD. Furthermore, with the designation of fentanyl adulterated or associated with xylazine as an emerging threat,[72] harm reduction programs play a vital role in helping people who are exposed to xylazine. That includes addressing the added complications of overdose involving xylazine, due to its long-acting sedative properties and the necrotic wounds people experience that require specialized care to prevent infection and limb loss. By encouraging recurring interactions with harm reduction services, program staff build trusting relationships with clients over time and can engage people in other health care and social services that they might not otherwise receive. In fact, studies show that people who regularly utilize harm reduction

services are five times more likely to engage with formal SUD treatment compared to people who do not attend a harm reduction program.[73,74]

Without harm reduction interventions, the risk of morbidity and mortality among PWUD will rise. Increasing direct funding for these services in the states and localities where they are permitted and integrating harm reduction into SUD care delivery models will save lives and ensure access to comprehensive care that holistically addresses drug-related health harms in addition to providing treatment.

Progress

Since the publication of the 2022 *Strategy*, progress has been made in advancing harm reduction. Key developments are listed by action item below.

Boosting access to life-saving naloxone.

(Agencies Involved: HHS/CDC, CMS, FDA, HRSA, IHS, SAMHSA; ONDCP; VA/VHA)

Increasing distribution of OORM like naloxone is indispensable for the overdose crisis response. Recent years have brought rapid progress in this area. The actions detailed below contributed to this progress, including 600,000 overdose deaths prevented by medication delivered through SOR programs, a 37 percent increase in naloxone prescriptions filled in pharmacies from October 2021 to August 2022, and a 12 percent decrease in the price of naloxone products purchased in pharmacies.[75]

First, in 2023, the FDA authorized over-the-counter sales of two naloxone products at grocery stores and pharmacies, bringing naloxone to people who have long struggled to access it. Specifically, FDA approved the 4-milligram naloxone nasal spray product for nonprescription status, which became available in retail stores in the summer of 2023. A second 3-milligram naloxone nasal spray product was also approved and became available several months later. Additionally, FDA issued guidance to help facilitate the availability of naloxone to harm reduction organizations by clarifying the scope of the Opioid Public Health Emergency exclusion and exemption under the Drug Supply Chain Security Act as they apply to the distribution of FDA-approved naloxone products by harm reduction programs. And FDA issued a preliminary assessment that certain types of naloxone drug products, including the widely distributed 4-milligram nasal spray product, had the potential to be safe and effective for use as directed in nonprescription drug labeling without the supervision of a healthcare practitioner. ONDCP has also worked with HHS to help improve naloxone access for harm reduction programs, health care partners, and other organizations well positioned to distribute naloxone to people who need it.

For grants at the community and program level, many federal have agencies added purchasing and distributing naloxone as an allowable expense where possible. For example, CDC allowed Overdose Data to Action (OD2A) grantees to use funding, approximately $2 million per state, to purchasing naloxone in year four of the program, and HRSA's Rural Communities Opioid Response Program (RCORP) grantees are permitted to support naloxone training, distribution, and administration. HRSA also released guidance making it easier for community health centers to broadly distribute naloxone in their communities through community events and other off-site

★ ★ ★ ★ ★ ★

settings. SAMHSA awarded $93.5 million in discretionary grant funding at the community and program level to support purchasing and distribution of naloxone and for training in naloxone administration.

Finally, to improve access and distribution at the state level, ONDCP also published, through a partnership with the Legislative Analysis and Public Policy Association (LAPPA), a model state law that incorporates a variety of best practices to increase access to emergency opioid antagonists for people most at risk for overdose.[76] The model law includes statewide standing orders, co-prescribing an OORM with prescription opioids, legal immunity for people who administer one of these medications, insurance coverage, models for reaching people most at risk for overdose, and education initiatives. Since its release on November 16, 2021, seven states have introduced bills influenced by this model act and over 125 bills introduced on naloxone access advanced one or more goals outlined in the model act. And importantly, SAMHSA is requiring all applications for the SOR grant to include a plan for saturating areas of highest need with naloxone and is providing TA to states on implementation of these naloxone saturation plans, including an all-state virtual Learning Community in January 2023 and a Policy Academy for ten states in July 2023.

Funding vital harm reduction work by state and local partners.

(Agencies Involved: AmeriCorps; DOD; DOJ/OJP; HHS/CDC, HRSA, SAMHSA; USDA; VA/VHA)

Harm reduction stakeholders consistently identify a lack of funding as the greatest barrier to meeting the needs of people they serve. The FY 2025 funding request of $459 million for harm reduction activities would improve federal efforts for states and localities to support organizations providing legally authorized harm reduction services.[77] To that end, ONDCP coordinated an interagency effort to identify federal grant funding that can be utilized on harm reduction services (e.g., naloxone, drug checking), low-threshold buprenorphine initiation, and other systems that affect PWUD (e.g., housing, criminal justice system). This information will be published as a reference for state and local governments, as well as other harm reduction providers, to determine the eligibility of different programs for funding.

The 25 grants that SAMHSA awarded in FY 2022 to harm reduction organizations to support community-based overdose prevention programs, SSPs, and other harm reduction services that are legally authorized in their respective jurisdictions are already having an impact on the ground. Within the first 18 months of the project (September 2023), grant recipients conducted over 17,000 naloxone trainings for 40,780 individuals. They purchased nearly 3 million syringes and 86,420 fentanyl test strips to distribute. They provided 135,253 service encounters both at their facilities and in the field, including 11,309 linkages to services, 17,378 health education sessions, and 25,896 overdose education/prevention sessions. Grant funds also support capacity development to strengthen harm reduction programs as part of the continuum of care.

SAMHSA and CDC have also enhanced their efforts to provide TA to grantees on using federal funding for harm reduction. In 2022, the National Harm Reduction Technical Assistance Center expanded from three TA providers to eight, enabling the program to more directly support integration of harm reduction in prevention, treatment, and recovery spaces. TA may be requested by the general public (e.g., harm reduction organizations; state, local, or national

entities), and specialized and targeted technical assistance is provided to the 25 SAMHSA Harm Reduction grant program recipients.

Addressing social determinants of health for those receiving harm reduction services.

(Agencies Involved: AmeriCorps; DOD; HHS/CDC, HRSA, SAMHSA; HUD; USDA; VA/VHA)

PWUD and who have SUD are disproportionately more likely to be unhoused or unstably housed and face barriers to obtaining permanent, safe, and affordable housing.[78,79] Accordingly, the United States Interagency Council on Homelessness (USICH) and the Department of Housing and Urban Development (HUD) have begun promoting the inclusion of harm reduction strategies and interventions in their work. USICH's Federal Strategic Plan to Prevent and End Homelessness reinforces the importance of a Housing First approach, which does not place preconditions on engagement in treatment or abstinence in order to obtain housing.[80] The plan also promotes the inclusion of harm reduction services authorized under state or local law for people in homeless shelters and encampments, such as overdose prevention education and naloxone distribution.

In alignment with this vision, HUD awarded $486 million to 62 communities across 30 states, in combination with approximately 3,300 Stability Vouchers for 139 Public Housing Agencies that partnered with grantee communities, to address unsheltered and rural homelessness by grounding projects in a Housing First approach that removes barriers to entry commonly faced by PWUD by making service participation voluntary rather than required.[81] Grantees can use the grant money to partner with harm reduction organizations to meet housing-related needs.

USICH's Federal Strategic Plan will continue to be the framework for housing initiatives throughout the Administration.

Enabling appropriate diversion and deflection to harm reduction programs.

(Agencies Involved: DOJ/COPS, OJP; HHS/ASPE, CDC, HRSA, SAMHSA; ONDCP)

The general public often views law enforcement as the only available public entity for responding to situations in which someone is experiencing an overdose or a mental health crisis. While law enforcement may sometimes be a critical partner in responding to these crises, often these situations require public health responses that may be beyond the scope of what law enforcement authorities should be reasonably expected to address. Too often, people experiencing a mental health or substance use crisis end up interacting with the criminal justice system when they need mental health and SUD services.

Today, significant work is underway to shift this paradigm. Law enforcement and other government offices are broadening crisis intervention and related models, while taking additional steps to enhance the crisis services infrastructure. For instance, ONDCP published in March 2022, through partnership with LAPPA, a model state law for developing and implementing law enforcement and other first responder deflection programs. Deflection programs aim to create non-arrest pathways to treatment and services for people with SUD, mental health conditions, or co-occurring disorders in non-violent, low-level cases, consistent with public safety. Importantly, these are voluntary services that offer a variety of deflection pathways. Pathways

include interventions to help people under arrest as well as preventive options and outreach post-overdose.

These programs not only ease the burden on law enforcement in appropriate cases, consistent with public safety; they also enhance the ability of public health and other government officials to support people in crisis. All of this helps ensure that people receive the help they need to break the cycle of substance use and criminal justice system involvement.

Marshaling expertise to advance harm reduction.

(Agencies Involved: DOD; DOJ/OJP; HHS/CDC, HRSA, SAMHSA; USDA/ORD; VA/VHA)

In December 2021, SAMHSA, CDC, and ONDCP held a two-day Harm Reduction Summit that convened experts from federal, state, local, and Tribal governments and harm reduction leaders to develop a definition of harm reduction for SAMHSA that includes harm reduction principles and pillars.[82] From this summit, SAMHSA formed a Harm Reduction Steering Committee that developed a framework to operationalize the definition of harm reduction into specific strategies for this work at SAMHSA and for the activities of a harm reduction interagency working group (IWG) convened by ONDCP.[83]

In early 2023, the Interdepartmental Substance Use Disorder Coordination Committee (ISUDCC) formed three subcommittees to develop recommendations for how to best integrate harm reduction principles, approaches, and practices into the continuum of prevention, treatment, and recovery at a systems level. ISUDCC includes people with lived experience, researchers, providers, and state and judicial leaders, along with representatives from ONDCP, HHS, ED, VA, and other federal agencies. Focusing on the intersectionality of harm reduction, prevention, treatment, and recovery with expert voices has allowed the Committee to identify best practices and gaps that still need to be addressed.

On a quarterly basis, the ONDCP Director holds meetings with harm reduction stakeholders to discuss updates on the Administration's work in this area, as well as to hear from the field about additional needs. These meetings help identify barriers and inform the Administration's priorities for improving access to harm reduction services moving forward.

These accomplishments are necessary and important improvements on a federal vision for harm reduction that provides opportunities for policy and practice changes at the state, local, and program level that enhance public health and public safety. The next step is to assist with implementation on the ground to ensure that, where allowed by federal and state policy, harm reduction approaches and services are increasing and leading to meaningful changes in the lives of PWUD.

★ ★ ★ ★ ★ ★

Areas for Additional Focus

While progress has been made to advance evidence-based harm reduction priorities established in the 2022 *Strategy*, work remains to be initiated or completed.

Redouble our focus on naloxone access, while expanding access to drug checking, syringe services programs, and buprenorphine at harm reduction programs.

(Agencies Involved: DOJ; HHS, CMS; ONDCP)

Increasing access to OORM remains a core pillar of the response to the overdose crisis. The progress to date on naloxone has not just increased the available supply; it has created an entirely new system for accessing naloxone, particularly via retail stores. This ongoing work, however, will require continued implementation efforts to ensure that life-saving medication reaches as many Americans as possible who need it.

Additional efforts include continued assistance to states through SAMHSA's naloxone saturation initiative to ensure no-cost distribution of naloxone through states, local health agencies, and community-based organizations, and addressing issues that may arise in this new overdose reversal medication landscape, such as insurance coverage for over-the-counter products. Federal partners have met with manufacturers of overdose reversal products to reiterate the importance of these medications being available, affordable, and distributed to the areas that need them most.[84] Agencies will continue to work with manufacturers, states, and community organizations to monitor progress.

In addition to expanding naloxone access, ONDCP and federal partners are working hard to increase uptake to other vital services across the country, including SSPs, drug checking services, buprenorphine induction, and other core harm reduction services. For example, ONDCP is continuing to work with LAPPA to promote the adoption of state model laws related to harm reduction: SSP authorization access to OORM and deflection in appropriate non-violent, low-level cases, consistent with public safety.

Decades of research show that SSPs are critical, lifesaving tools that significantly reduce rates of HIV and hepatitis C in the communities they serve, engage people who may otherwise not receive health services, and do not negatively impact public safety.[85,86] Yet, there are still states that have not authorized these programs or have restricted their implementation in ways that inhibit their effectiveness, such as restricting the number of syringes that can be provided to participants. To provide states with an example of how to best authorize SSPs, ONDCP published in December 2021, through partnership with LAPPA, a state model law on implementation and operational best practices that maximize the benefits of these programs.[87] This model law outlines best practices for a needs-based distribution model for syringe services. It also generally addresses the services that these programs should provide, discusses data collection, provides legal immunity for participants and administrators of SSPs, and encourages state funding for SSPs. In 2023, over 20 bills proposed in states to expand access to SSPs coincided with one or more aims of this model law.

★ ★ ★ ★ ★ ★

In addition, LAPPA released another model law for states that outlines how to authorize the use of fentanyl test strips and other drug checking equipment, since these tools may be considered drug paraphernalia under some state laws.[88] Considering the risk of overdose and other harms that come from unknowingly using fentanyl and/or xylazine, it is imperative to make sure people can identify if these contaminants are in their drugs prior to use. Individuals can use the results of drug checking to adjust their behavior, such as using less or not using at all, to reduce overdose risk. Over 70 bills introduced in states in 2023 incorporated elements of this model law that aims to increase access to at least one type of drug checking equipment. Along these lines, HHS released guidance for SAMHSA and CDC grantees permitting the use of federal award funds in specific awards to purchase fentanyl test strips in states and localities that permit them.[89]

Furthermore, ONDCP has learned from meetings with harm reduction stakeholders that they are often not included in decision-making around how a state spends federal grant funds. ONDCP, in partnership with grant-making agencies like SAMHSA, CDC, and HRSA, will continue working with state and local officials to convey the importance of collaboration with harm reduction stakeholders to better allocate federal dollars to the allowable harm reduction activities that the Administration has highlighted throughout notices of funding opportunities.

ONDCP will also engage with states through organizational stakeholder meetings and site visits to support and encourage them to develop the infrastructure and funding needed in their harm reduction programs for Medicaid reimbursement of eligible services. This process includes collaborating with harm reduction and public health providers and individuals with lived experience, addressing barriers to Medicaid provider enrollment, adding covered services or provider types, and building capacity for billing with harm reduction program staff. States can utilize a variety of Medicaid coverage options to provide certain services offered by these organizations through a State Plan Amendment, waivers, or demonstration projects, and through different delivery system options, such as fee-for-service or managed care. Establishing Medicaid reimbursement as a funding source for harm reduction programs could help support their sustainability and expand the range of services offered to an underserved population of PWUD to improve individual health and public health by saving lives and reducing overdoses.

Identify opportunities to expand Medicaid coverage for harm reduction.

(Agencies Involved: DOD; HHS/CDC, CMS, HRSA, IHS, SAMHSA; ONDCP; VA/VHA)

In addition to syringe services, many PWUD do, or would prefer to, receive additional health care services through harm reduction programs due to established rapport with program staff.[90,91] These trusted providers offer non-judgmental services in contrast to stigma encounters that PWUD still unfortunately commonly experience in the traditional health care system. SUD is often associated with other health issues like viral hepatitis and HIV. Providing integrated care in a single location for these conditions can overcome some of the barriers PWUD face in trying to access health care.

Harm reduction programs can fill the gaps in a disjointed healthcare system. Studies show that integrating services is acceptable to clients and can lead to cost-savings compared to traditional care models.[92,93,94,95] Yet, harm reduction programs are often unable to provide this comprehensive set of services due to lack of funding or unsustainable models of funding through time-limited grants. Though many of these pertinent health services and supports commonly

offered by harm reduction programs are reimbursable under state Medicaid programs, only one state, New York, has included harm reduction programs as Medicaid qualified providers. Medicaid reimbursement for legally authorized harm reduction programs can introduce an important source of sustainable funding to complement grant dollars and ensure continuity of care for PWUD.

Through interagency collaboration with the HHS, ONDCP developed examples of services (see below) that can be provided by harm reduction programs through a Medicaid State Plan Amendment or other statutory authorities. State Medicaid Agencies can use this information to update their covered services, and the provider types qualified to furnish those services, to create a sustainable funding source for harm reduction programs. States with legally authorized SSPs can help them build capacity to provide and bill for these services using funds from eligible federal grants and opioid settlement funds, and by incorporating harm reduction capacity building into their state budgets.

Activities commonly offered by legally authorized harm reduction programs that could be authorized under Medicaid include:

- Community-based prevention and individual health education to prevent overdose and infectious disease transmission and encourage safer practices, including
  - Overdose prevention education: information on how to recognize an overdose and how OORM, such as naloxone can help prevent a fatal opioid overdose;
  - Prevention of HIV, viral hepatitis, and other bloodborne infectious disease transmission: information on safer drug use practices, including safer injection practices, and materials regarding post-exposure prophylaxis (PEP) and pre-exposure prophylaxis (PrEP);
  - Reproductive health education: information on safer sex practices, distribution of safer sex materials; and
  - Education on SUD treatment: information on treatment modalities, including the efficacy of MOUD.
- Testing/screening for HIV, viral hepatitis, other bloodborne infectious diseases transmitted through injection drug use and sexually transmitted infections (e.g., syphilis).
- Vaccinations for hepatitis A, hepatitis B, human papillomavirus (HPV), influenza, pneumococcal, Tdap (tetanus, diphtheria, pertussis), MPOX, and COVID-19.
- Wound care to treat the symptoms of skin and soft tissue infections that may result from drug use, particularly injection drug use.
- Service plan development to assess current condition, needs, and self-directed goals, and the services and activities necessary to meet them.
- Individual counseling provided by a trained mental health provider, ideally with lived or living experience, and including post-overdose supportive counseling.
- Group therapy provided by a licensed mental health professional, ideally with lived or living experience.
- Peer support services to provide non-clinical, strengths-based support and to leverage their lived experience and expertise.
- Care navigation to provide guidance on moving through the health care system, including financial/insurance and clinical referral/appointment navigation.

★ ★ ★ ★ ★ ★

- Case management to assist gaining access to needed medical, social, educational, and other services (e.g., transportation, child care).
- Crisis intervention, including stabilization services.
- Medications that may be used to complement the services above, including
  - Antibiotics (e.g., for wound infections and to treat sexually transmitted infections such as syphilis);
  - Viral hepatitis medications;
  - PEP and PrEP;
  - Buprenorphine treatment for OUD; and
  - Distribution of OORM, such as naloxone.

Support harm reduction training and education for the treatment workforce.

(Agencies Involved: AmeriCorps; HHS/CDC, CMS, HRSA, SAMHSA; USDA; VA/VHA; HUD)

Building capacity to provide harm reduction and other low-threshold services requires growing the harm reduction provider workforce, as well as providing training and education on harm reduction principles and practices to other providers who serve PWUD like medical professionals, social service workers, and homeless shelter staff. ONDCP will work with interagency partners, including HHS, HUD, and VA, to develop resources based in the harm reduction framework to certify that service providers are aware of the harm reduction needs of PWUD and are delivering services through an equitable approach that respects the autonomy of individuals to determine their goals related to their drug use. Some agencies have already begun this process; for example, HRSA works with T/TA providers to share trainings with RCORP grantees on addressing health disparities in medication treatment for patients with OUD and best practices for HIV prevention for PWUD.

ONDCP will also work with interagency partners, including the Centers for Medicare & Medicaid Services (CMS), HRSA, SAMHSA, and VA to promote and increase workforce models that foster harm reduction-oriented approaches to service provision, such as incorporating peer support specialists and care navigators into care teams and implementing nurse care manager models to comprehensively address the needs of people using MOUD.

Expand state and local harm reduction funding.

(Agencies Involved: AmeriCorps; DOD; DOJ/OJP; HHS/CDC, HRSA, SAMHSA; USDA; VA/VHA)

Building on important work described above to fund harm reduction, federal agencies are awarding new money and requesting additional funding for legally authorized harm reduction programs. In September 2022, CDC awarded approximately $7.7 million through the Strengthening Syringe Services Programs cooperative agreement to (1) develop a national network of SSPs, where not prohibited by law, and oversee an annual survey to assess the Nation's SSP capacity and service delivery and (2) fund SSPs across the country, where not prohibited by law, to implement or expand their capacity to provide services.[96] In alignment with other overdose prevention guidance released by CDC, the latest OD2A program places increased emphasis on the implementation and support of evidence-based harm reduction strategies and interventions (e.g., collaborating with SSPs and harm reduction organizations, and initiating, expanding, and supporting efforts that center people with lived experience in programs

and communities they represent). In addition, the FY 2025 budget includes increased funds to continue and expand SAMHSA's Harm Reduction grant program.[97]

Efforts to fund evidence-based harm reduction in recent years mark the first time that such services have been prioritized in federal funding opportunities. While this was a major first step, there are lessons learned from early efforts that can be incorporated into this next round of work to build on the progress that has been made. ONDCP will work on an improved mechanism for budget requests for funding for community-based organizations directly providing services to PWUD and people with SUD. ONDCP will also coordinate across interagency partners to provide additional TA to align the use of multiple grant streams to provide comprehensive services.

Plan for new translational research to supplement current evidence.

(Agencies Involved: DOD, DOJ; HHS/CDC, HRSA, NIH, SAMHSA; ONDCP; USDA; VA/VHA)

This work includes and is shaped by the substantial body of research supporting the efficacy of evidence-based harm reduction interventions that prevent the negative consequences of drug use. That said, there are still opportunities for additional research to better understand the scope of drug use across the country and to help identify additional practices for implementing and engaging people in these services where not prohibited by law. In 2022, the National Institutes of Health (NIH) Helping to End Addiction Long-term (HEAL)® Initiative launched a research program that supports a national network of research projects to study and improve the effectiveness, implementation, and impact of existing and new harm reduction policies and practices.[98] ONDCP also convened interagency partners to work together to identify gaps in knowledge and contracted with the National Academies of Science, Engineering, and Medicine to inform a harm reduction research agenda for the Administration. Results from these research projects can be used to inform future funding opportunities.

Success Story

Additional dollars were appropriated to states and territories through the SOR grants, and those investments are advancing innovative initiatives to reduce opioid overdose deaths. In Washington, D.C., the Department of Behavioral Health is using SOR funding to partner with D.C. Fire and Emergency Medical Services to create Overdose Response Teams. Currently, there are two teams, each with a paramedic and community outreach specialist responding in pairs. When Fire and Emergency Medical Services revives someone in the community with naloxone who does not want to be transported to the hospital, they alert the Overdose Response Teams (through a data-sharing agreement) to follow up with the person who experienced an overdose by meeting them where they are. The Overdose Response Team then distributes naloxone to the person who experienced the overdose, as well as to bystanders, and shares referrals for treatment and recovery resources. Since the program's inception in November 2022, 1,408 naloxone kits have been distributed to overdose victims, their families and other bystanders. In addition, the Department of Behavioral Health works with community organizations, including SSPs, to do targeted outreach and naloxone distribution in the areas with the highest rates of Fire and Emergency Medical Services overdose response to ensure those at-risk communities have the resources they need to keep people alive and give them access to care.

★ ★ ★ ★ ★ ★

Chapter 3: Expanding Access to Evidence-Based Treatment

In order to save lives, it is imperative that people who have a SUD have access to health care and additional services to give them an opportunity to achieve recovery and thrive. Substantial progress has been achieved in this goal over recent years. For example, the Drug Enforcement Administration (DEA) has worked to certify new mobile units that provide MOUD, increasing the number of such units by over 60 percent since mid-2021,[99] and federal investments have steadily expanded the number of eligible veterans receiving MOUD within the VA system. Continued work to improve the availability and accessibility of treatment for SUD is a critical priority. Additionally, landmark legislation such as the ARP has dramatically scaled up health workforce training and mobile unit deployment in recent years. The ARP invested over one billion dollars in each of these areas, while ushering in the rapid deployment of over 14,000 community outreach workers.

Expanding access to care for SUD requires building capacity and addressing barriers that prevent treatment providers from delivering that care. Unfortunately, many evidence-based approaches for treating SUD are not available in all programs or across all health care settings. For example, too many people in jails and prisons often are not provided with needed MOUD,[100] even though the share of people in need of MOUD who receive it in federal prison has surged from zero several years ago to over 60 percent today. Similarly, people with methamphetamine and cocaine use disorder who would benefit from treatment with contingency management (CM) interventions are still too often unable to access those services.

Untreated SUD can have rippling impacts, including for the infants and children of people who had substance use during pregnancy. In 2022, ONDCP worked closely with a neonatologist and a committee of child and maternal health experts across the federal government to create a report on improving care for pregnant and post-partum women with SUD and their children.[101] Because regulations for treatment in this population are largely controlled at the state level, ONDCP works closely with external experts and state and local stakeholders to help address treatment-related policy that falls under their authority, for example, by releasing a model state law on pregnancy, the Model Substance Use During Pregnancy and Family Care Plans Act.[102] To ensure all those struggling with addiction can receive the care they deserve, health practitioners must also be willing to serve people with SUD.

Progress

Since the publication of 2022 *Strategy*, progress has been made in improving the accessibility and quality of substance use treatment. See Appendix A for the National Treatment Plan. Key developments are listed by action item below.

★ ★ ★ ★ ★ ★

Working with Congress and private sector partners to remove outdated requirements that limit access to medications for opioid use disorder.

(Agencies Involved: HHS/FDA, SAMHSA; DOJ/DEA; ONDCP)

Because expanding access to MOUD treatment is critical to ending the overdose epidemic, it is essential to eliminate barriers to access. Such barriers included the outdated requirement for practitioners to obtain a DEA waiver in order to prescribe buprenorphine. The 2023 Consolidated Appropriations Act removed administrative burdens that limited access to buprenorphine by permitting all DEA registrants in the practitioner category to prescribe buprenorphine to treat OUD where it is legally permissible in their states.[103] ONDCP and other federal partners collaborated with Congress in advancing this work, and ONDCP will continue to work closely with practitioners in ensuring all eligible health practitioners prescribe buprenorphine. Finally, ONDCP will continue identifying barriers and increasing access to other MOUD, such as methadone.

Developing guidance on the DEA prescriber requirement.

(Agencies Involved: DOJ/DEA; HHS/FDA, SAMHSA; ONDCP)

All practitioners wishing to prescribe controlled medication need to register with the DEA. The Consolidated Appropriations Act of 2023[104] requires all practitioners who are either newly applying for or renewing their DEA registration to attest to having eight hours of training on the identification and management of substance use. Board-certified addiction medicine practitioners/addiction psychiatrists are considered to have met this requirement, as have practitioners who took prior X-waiver training and practitioners who, within five years of graduation, successfully completed this education during medical, nurse practitioner, physician assistant, or dental training. To inform practitioners, DEA issued a "Dear Registrant" letter concerning these changes.[105] To assist practitioners and others in identifying recommended content for this SUD training, SAMHSA worked with DEA and other federal and external experts to develop guidance to providers on these new requirements.[106] Because this attestation is a non-recurring requirement for practitioners renewing their DEA registration, after three years only new DEA registrants will need this training if they have not received it during medical, nurse practitioner, physician assistant, or dental training.

Expanding mobile units for medications for opioid use disorder, including to prisons and jails.

(Agencies Involved: DOJ/BOP, DEA, OJP; HHS/SAMHSA; VA/VHA; ONDCP)

With only 2,115 OTPs that offer methadone available nationwide, and 114 medication units, accessing this form of medication treatment for people with limited transportation remains challenging. People in prison and jail have difficulty accessing these programs by virtue of their confinement, which can also be in geographically remote locations. The federal interagency is working hard to expand access to MOUD via mobile units which can travel to people, including those in jails and prisons who cannot otherwise regularly access brick-and-mortar clinics. In June 2021, a 17-year moratorium on mobile units was lifted following DEA's publication of a final rule that allows OTP registrants to add mobile units to an existing clinic registration.[107] To date, DEA has certified 29 mobile units, 64.5 percent more than were available during the

★ ★ ★ ★ ★ ★

moratorium.[108] To support states, SAMHSA has permitted the use of Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant and SOR grant funds to purchase such units via a letter to State Substance Use Directors.[109] States may enter into procurement contracts with for-profit entities using block grant funds.[110] CMS is also paying for coverable treatment provided by mobile clinics to Medicare beneficiaries.

Supporting "low-threshold" or "low barrier to entry" engagements.

(Agencies Involved: HHS/SAMHSA; DOD, VA/VHA)

Delivery of services via telehealth may lower barriers for people seeking OUD treatment by reducing the requirement for transportation to engage in initial or ongoing treatment. With the assistance of interagency partners and in concert with HHS, DEA published a notice of proposed rulemaking that, if finalized, would enable initiation of buprenorphine via telemedicine, including through audio-only options.[111] As just one example, VA has expanded access to OUD treatment in veterans' preferred settings of care, including in primary care, pain, and mental health clinical settings. The percentage of veterans with OUD who received MOUD in VA facilities in FY 2020 was 44.4 percent; by the end of FY 2023 it increased to 48.1 percent.[112]

Expanding evidence-based treatment in federal prisons.

(Agencies Involved: DOJ/BOP, DEA; ONDCP)

People reentering society from prisons and jails are at five times greater risk for overdose than the general population.[113] And until recently, few prisons and jails offer MOUD, with just 3 percent of people in federal prison diagnosed with OUD receiving MOUD in 2020.[114]

The Bureau of Prisons (BOP), however, has since expanded access to all three forms of FDA-approved MOUD, and, with the elimination of the X-waiver, has allowed all authorized health care providers to prescribe buprenorphine after training completion. Ensuring access for a wide range of MOUD is valuable because some research estimates that offering all forms of OUD treatment can save more lives than offering just one form. As of 2022, the percentage of eligible people in federal prisons receiving MOUD had surged to 60 percent. By June 2023, more than 3,100 patients were actively receiving MOUD in BOP facilities systemwide.[115] With the establishment of OTPs, BOP will be able to provide full access to MOUD without reliance on community OTPs. BOP's expedited expansion of MOUD in 2023 is reaching even more people with OUD.[116]

Funding treatment for people who are incarcerated.

(Agencies Involved: HHS/ASPE, CMS, SAMHSA; DOJ/BOP)

In 2021, an estimated 8.6 percent of the noninstitutionalized population aged 12 or older who received substance use treatment in the past year received it in a state, local, Tribal, or territorial prison or jail settings.[117] Medicaid, which provides comprehensive health care coverage to many Americans, including those with low incomes, is generally prohibited from covering the cost of treating people in prisons and jail.[118] Additionally, Medicaid and the Children's Health Insurance Program (CHIP) cover 60.4 percent of youth in jail or juvenile detention, many of whom have mental health and/or substance use conditions along with other medical conditions.[119] Among youth beneficiaries in jail or juvenile detention facilities from 2015–2019,

★ ★ ★ ★ ★ ★

16.9 percent reported receiving any substance use treatment in the past year.[120] In 2023, CMS approved a section 1115 demonstration project to enable California's Medicaid program or CHIP to provide certain care up to 90 days before a beneficiary is released from prison or jail.[121] CMS also approved an 1115 reentry demonstration project in Washington state.[122]

In 2023, CMS followed up by providing guidance to State Medicaid Directors on an opportunity to provide similar coverage in their states and territories.[123] This guidance includes coverage of many health care services, not just SUD treatment, and is a critical step in closing the gap in care and improving public health and public safety outcomes.

Additionally, DOJ's OJP, through multiple grant funding programs, including the Comprehensive Opioid, Stimulant and Substance Use Program (COSSUP), Residential Substance Abuse Treatment (RSAT) for State Prisoners Program, select Second Chance Act (SCA) Reentry programs, and Tribal Justice Systems grants, as well as SAMHSA, through their SOR and Tribal Opioid Response (TOR) grants, offer funding for projects to treat people with SUD who are in prisons and jail and who are reentering society.[124,125] These agencies also offer T/TA to state, local, and Tribal detention facilities and their community partners to support continuity of care.

Areas for Additional Focus

While progress to date has advanced SUD treatment priorities, work remains to be initiated or completed in several key areas. Additionally, the ONDCP Treatment Plan (Appendix A), required by the 2018 SUPPORT Act, elaborates further on the actions needed for screening, making connections to care, developing the workforce, and other elements necessary to continue reducing overdose-related fatalities. The target action items needing additional emphasis include:

Implement a national case-finding initiative.

(Agencies Involved: DOD; HHS/CMS, HRSA, SAMHSA; VA/VHA; ONDCP)

As with other medical conditions like diabetes and heart disease, the number of people who recover from SUD largely depends on how many people are identified through screening and assessment, and subsequently successfully treated. This progression from identification of cases through linkage and engagement in care and recovery supports is often termed "the cascade of care." ONDCP recently launched an IWG and identified "cascade of care models" for SUD. Such models were integral to addressing the HIV/AIDS crisis. Cascade of care models work by using data and metrics to monitor and address identification of a health condition and engagement in progressive levels of care. Critical to supporting a cascade is "case finding," the process of identifying individuals diagnosed or treated for a reportable condition. Screening plus an assessment (if indicated from screening) are an evidence-based way to "case find."[126] Case finding and linkage, or a "warm handoff" in which patients are delivered from one member of the care team to treatment staff in-person,[127] are critical to getting more people into and completing treatment and then sustaining recovery.

CDC is developing linkage to care indicators and an accompanying toolkit that spans the continuum of care for SUD. Screening might involve clinical examinations; clinical interviews

★ ★ ★ ★ ★ ★

by providers; administration of a standardized screening instrument like the Global Appraisal of Individual Need (GAIN-Q3), which asks individuals to self-report prior health behaviors including mental health history and SUD history; urine testing for illicit drugs and/or prescription drug monitoring program query; or annual screenings regardless of symptoms, especially in patients with high rates of substance use such as injured veterans.[128] Case finding for people who show obvious signs of problematic substance use should emphasize the importance of confidentiality and the availability of new treatments, as well as telehealth opportunities. Anyone identified through screening and assessment (case finding) should be offered access to SUD treatment, ideally with a warm handoff and immediate access to evidence-based care in the least restrictive setting available to meet their needs. The goal of this initiative is to begin screening interventions nationally by 2024 to identify as many people in need of treatment as possible and move them into care.

Case finding has no utility without successful linkage to evidence-based care. As part of this initiative, it is essential that pediatricians and providers who offer SUD treatment to adolescents 16 and older begin offering extended-release naltrexone[129] or buprenorphine. To ensure providers are equipped and supported in conducting screening and treatment, agencies will need to examine coverage and reimbursement policies. SAMHSA will work with VA, DoD, the Indian Health Service (IHS), and HRSA to support training of non-SUD specialty providers to assess SUD and/or determine if remote assessment should be used for this effort. NIH and other research agencies may consider partnering with the private sector to develop digital screening and assessments that may be administered via telemedicine or on a phone or tablet during or prior to medical visit check in.

Explore motivational incentives and digital therapeutics.

(Agencies Involved: HHS/ASPE, CMS; VA/VHA, DOD)

Currently no FDA-approved medication exists for treating cocaine or methamphetamine use disorder. CM, which involves offering motivational incentives contingently for evidence of abstinence or for completing other treatment related activities such as attendance at treatment sessions, is one of the most effective treatments for people with stimulant use disorder.[130] VA offers CM intervention services, but delivering these services remains challenging in many other treatment programs that take third-party reimbursement. CMS has approved Section 1115 Medicaid demonstration projects in states including California and Washington to provide CM with evidence-based incentive levels, with other states considering submitting similar proposals. Additionally, until additional payers like TRICARE and private insurers establish billing for CM, including digital treatments that use CM, it will be difficult for people to access this therapy.

NIH has developed digital forms of screenings and assessments for evidence-based therapies including motivational incentives. They will continue to work with interagency partners and the field to identify additional research needed to facilitate adoption and implementation. SAMHSA has published an Advisory entitled "Digital Therapeutics for Management and Treatment in Behavioral Health."[131] Along with CM therapies, digital therapeutics may include structured interventions therapists might normally deliver in research trials, such as computer-based cognitive behavioral therapy for SUD or the Therapeutic Education System.[132,133,134] Using a computerized platform for new therapies can reduce the need to re-train therapists while allowing patients access to evidence-based treatments that might not normally be available to

★ ★ ★ ★ ★ ★

them. One study has shown adding cognitive behavioral therapy to primary care has potential to compensate for low patient acceptance of SUD specialty care referrals.[135]

Review and update opioid treatment program regulations.

(Agencies Involved: HHS/ASPE, CMS; VA/VHA, DOD)

Methadone is an effective medication for treating OUD. It reduces cravings, treats withdrawal, and stabilizes individuals with an OUD, including involving illicit fentanyl. Methadone is only available for OUD treatment through federally regulated OTPs. Moreover, not all states (the exception is Wyoming) nor every community has an OTP.[136] During the COVID-19 public health emergency, strict regulations related to methadone and OTPs were relaxed to safeguard public health. Research has shown that these changes, particularly those concerning methadone take-home medication, were not associated with increased methadone-related mortality or diversion.[137]

Over the course of the past year, ONDCP has worked with the interagency to identify both regulatory and legislative options for expanding access to MOUD. Prior to this work, SAMHSA published a notice of proposed rulemaking on 42 CFR Part 8 in December 2022.[138] This notice of proposed public rulemaking sought to reduce barriers to methadone treatment, including making permanent flexibilities put forth during the COVID-19 pandemic with regard to take-home medication doses and use of telehealth for buprenorphine prescribing.[139] In 2024, SAMHSA finalized the rule; ONDCP will continue convening the interagency partners to explore options for expanding access to methadone and continue to find ways to expand access to MOUD.

Every year, CMS reviews and updates payment rates and policies for the Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center services. In the calendar year 2024 final rule, CMS established Medicare payment for intensive outpatient program services, as authorized by the Consolidated Appropriations Act of 2023, to address a gap in coverage when Medicare beneficiaries require a level of services more frequent than individual outpatient therapy visits, but less intensive than a partial hospitalization program.[140] Further, the Act established a new Medicare benefit category for Marriage and Family Therapist (MFT) and Mental Health Counselor (MHC) services furnished by and directly billed by MFTs and MHCs to expand the types of providers that can deliver behavioral health services to beneficiaries and address a shortage of Medicare-eligible mental health providers. The calendar year 2024 Physician Fee Schedule[141] implemented these provisions by, among other things, extending Medicare enrollment to MHCs and establishing Medicare payment for a new Medicare benefit category for MHC services.

Update withdrawal management programs and policies.

(Agencies Involved: DOD; DOJ/DEA; HHS/CMS, IHS, SAMHSA; VA/VHA)

The practice of withdrawing people from opioids and releasing them without ensuring access to ongoing treatment medications is outdated and dangerous. In Detoxification Programs, which DEA recognizes as a type of OTP provided that they have SAMHSA authorization to operate, people may be withdrawn from opioids with no ongoing care. Although voluntary withdrawal through medicine tapering should be permitted for people moving to drug-free facilities, such as carceral settings, it must be done safely. OJP's Bureau of Justice Assistance and National

★ ★ ★ ★ ★ ★

Institute for Corrections released *Guidelines for Managing Substance Withdrawal in Jails*[142] in June 2023 to support the development of policies and procedures to detect and properly manage acute withdrawal from substances among people in jails. Guidelines regarding withdrawal practices, such as the *Federal Guidelines for Opioid Treatment Programs,*[143] which includes policies like involuntary withdrawal for non-compliance, should be updated to incorporate harm reduction approaches and require ongoing care after discontinuation of methadone or buprenorphine for any reason. Withdrawal is even more complicated where illicitly manufactured fentanyl is adulterated with other substances such as xylazine; protocol development for this emerging threat is in its infancy. ONDCP and interagency partners will work together to review and update withdrawal management protocols so treatment programs, providers, and places that do not provide access to MOUD (such as some jails and prisons) are trained on how to manage opioid withdrawal comfortably and safely.

Build capacity in the behavioral health workforce.

(Agency Involved: HHS/CDC, HRSA, SAMHSA)

To support every individual with SUD who needs treatment, growing the workforce equipped and trained to address behavioral health issues is essential. To engage more clinicians in addiction medicine, early training experiences are critical, starting with both medical school curriculum and training opportunities. Similarly, psychologist training, including internships and externships, are needed, especially as the field of emerging therapeutics further develops to treat mental health conditions like post-traumatic stress disorder and depression, which have high rates of comorbidity with substance use. Other clinicians such as nurses, social workers, and counselors are also needed to support care. ONDCP's call to action, through its Cascade of Care launch in 2023 with federal partners and the medical field, aims to train more providers in the field on SUDs to increase existing workforce capacity. Expert groups developed a report that included SUD core curricula content for all health professions' academic programs.[144] This curricula will help all health professionals learn about SUD as a chronic disease that can be treated, as well as the set of services across the health care continuum from prevention to early intervention, harm reduction, treatment, and recovery supports.

Success Story

Specialized mobile medical clinics, much like mobile mammography and dental clinics, are evidence-based ways to bring health care services to people who may not ordinarily be able to access them because of transportation difficulties or conflicts with clinic hours from childcare, work, or other responsibilities. Unfortunately, until recently, people needing OUD treatment with methadone were unable to access mobile care due to regulatory limitations and concerns around methadone security. In 2021, DOJ, in concert with HHS, released a proposed rule enabling mobile OUD clinics that dispense methadone to operate.[145] CODAC Behavioral Healthcare, the largest not-for-profit in Rhode Island, was the first program to support mobile treatment after the new regulations went into effect. According to CODAC President and CEO Linda E. Hurley, the mobile clinic is parked near an encampment where unhoused people live, providing access to care for an underserved and marginalized population.[146] The mobile clinic also serves working professionals who receive methadone and then go to work. It offers walk-up services so treatment can start when a patient is ready, truly meeting people where they are and

providing low-barrier access. The mobile unit has a room for one-on-one exams, counseling appointments, a charting space, a bathroom, and meets all DEA requirements for security. Adding the mobile clinic means additional reach for the Cranston-based program.

★ ★ ★ ★ ★ ★

Chapter 4: Building a Recovery-Ready Nation

In 2022, an estimated 48.7 million Americans aged 12 or older (or 17.3 percent of the population) had a SUD. Notably, 65 percent of people aged 18 and older with SUD (30.3 million) were employed; of these individuals, 78.7 percent (23.8 million) worked full time.[147] SUD is common, including in the workplace[148,149,150] and in secondary and higher education settings.[151,152,153,154] Fortunately, recovery is prevalent as well. That same year, an estimated 21.3 million Americans aged 18 or older identified as "in recovery" or "recovered" from an alcohol or other drug problem.[155] The authors noted that more than one in ten adults reported a lifetime substance use problem. Nearly 75 percent of these adults (20.5 million) indicated that they were in recovery.[156] And, subsequently, work to advance recovery across the country has only scaled up. More states than ever now operate RRW initiatives, and since 2020, the number of peer-led recovery community organizations nationwide has risen by more than 25 percent.

The millions of Americans in recovery not only provide evidence that recovery is possible, they also contribute in significant ways to their communities, their states, and the Nation. Building a recovery-ready Nation requires learning from and leveraging the experiences of people in recovery, working with the organized recovery community, and communicating openly about SUD and recovery in order to reduce stigma and misunderstanding and remind the public that recovery is possible.

To keep building a recovery-ready Nation, one person and one community at a time, federal partners will continue to partner with states, local governments, employers in the for-profit and not-for-profit sectors, and communities in order to address the social determinants of health and update the laws, regulations, and practices that serve as barriers to treatment and recovery support. Concurrently, recovery capital must be built at the individual, family, community, and societal levels. This requires the development of local, state, and national partnerships among prevention, harm reduction, treatment, and recovery support services stakeholders; law enforcement and other criminal justice and public safety agencies; the health care sector; schools; employers; and a range of other parties. Such partnerships can be formalized through coalitions or commissions, or can be the fruit of ongoing, largely informal collaboration among stakeholders across these sectors. Such comprehensive collaboration is essential to building local recovery ecosystems and recovery-ready communities.

Stigma, discrimination, and misunderstanding are among the most pervasive barriers to treatment and a life in recovery. Efforts to build the Nation's peer recovery support services workforce and the organizational infrastructure, upon which it relies, will continue, along with a call for ongoing, dedicated federal funding sources for recovery support services. Finally, ONDCP will continue its efforts to advance research on the recovery process, the relative effectiveness of various recovery support services approaches and institutions, and related topics. This research is critical to developing science-based policy in relation to recovery.

Progress

Since the publication of the 2022 *Strategy*, progress has been made in advancing efforts to build a recovery-ready Nation. Key accomplishments are listed by action item below.

★ ★ ★ ★ ★ ★

Expanding peer recovery support services capacity and fostering the adoption of more consistent standards for the peer workforce, recovery community centers, recovery community organizations, and similar peer-led organizations.

(Agencies Involved: HHS/CMS, HRSA, IHS, SAMHSA; Labor/ETA, ODEP; VA/VHA)

A lack of consistent standards for peer certification, recovery community centers (RCC), and recovery community organizations (RCO) limits peer workforce mobility across state lines, impedes development of reimbursement mechanisms and rates by national and regional public and private funders, and creates challenges for the development of relevant federal policies. In recognition of this, HHS developed the National Model Standards for Peer Support Certification.[157] This reinforced a key component of the broader *Strategy* priority to foster the adoption of more consistent standards for the peer workforce, RCCs, RCOs, and similar peer-led organizations. To develop the standards, SAMHSA's Office of Recovery (OR) convened a technical expert panel that provided input as it developed draft standards, which were published for public comment in April 2023. In June 2023, SAMHSA released the National Model Standards for Peer Support Certification and, in August 2023, convened a National Peer Support Summit to expand the peer workforce. To help build the Nation's peer recovery support services (PRSS) organizational infrastructure, SAMHSA awarded over $5.5 million in funds to support the Building Communities of Recovery grant program and established the Peer Recovery Center of Excellence to build the capacity of RCCs nationally in 2023. These grants will help further strengthen the organizational infrastructure that is vital to ensuring that recovery support services are accessible nationally, including to individuals who are not receiving treatment.

Additionally, VA has made progress in developing its PRSS workforce. As part of the President's Mental Health Strategy, VA committed to hiring hundreds of veterans as peer support specialists, and is now one of the largest employers of peer specialists in the United States. Staffing models for several VA health care service programs have evolved to stipulate including peer specialists as part of the interdisciplinary teams that provide health care services to veterans with mental illness, SUD, and/or chronic health conditions, as well as veterans experiencing homelessness, unemployment, and those involved with the criminal justice system. To address the challenge posed by variability in state-issued peer specialist certifications, VA implemented time-limited, peer support apprentice positions. VA peer support apprentices complete a VA-contracted peer specialist certification course, designed to VA's specifications, and VA assists them with obtaining the necessary certification to transition to permanent peer specialist positions at the end of the apprenticeship.

To sustain and build upon this progress, SAMHSA will continue to award discretionary grants and will work with states to leverage the SUPTRS Block Grant to build the Nation's PRSS infrastructure and VA will continue to build its peer workforce. Additionally, ONDCP will work with SAMHSA, the Administration for Children and Families, and ED to identify approaches for funding recovery high schools and collegiate recovery programs, and to provide TA to school districts, institutions of higher education, and other entities seeking to implement, expand, or enhance these critical school-based recovery support initiatives.

★ ★ ★ ★ ★ ★

Expanding employment opportunities and promoting recovery-ready workplace policies.

(Agencies Involved: Commerce; DOL/ETA, ODEP; OFCCP; EEOC; HHS/ASPE, CDC, SAMHSA; OPM; VA/VHA)

Laws, rules, policies, and practices can undermine SUD recovery efforts by creating barriers to housing, employment, and education, all three of which are key forms of recovery capital and important social determinants of health. The reduction of barriers to employment for people in recovery and the promotion of RRW policies were key areas of focus in the 2022 *Strategy*.

With support from the federal agencies participating in the RRW IWG, ONDCP led the development and launch of the RRW Resource Hub through the Department of Labor's Employment and Training Administration (ETA).[158] The hub provides a wide and growing range of resources for employers in the for-profit, nonprofit, and government sectors and links to the National Institute on Occupational Health and Safety's Workplace Supported Recovery Program, which offers a range of relevant resources. New resources are added regularly and, in April 2023, a hub-specific search function and the GovDelivery subscription service were added so that individuals can limit site searches to hub materials and can subscribe and receive email notifications when new resources are added or other updates are made. In 2023, the RRW Toolkit was released through the RRW Resource Hub. The toolkit is designed to provide useful guidance for RRW implementation in diverse workplaces. It includes resources such as assessment and planning checklists, sample RRW statements or declarations, a sample fair chance employment policy, information on SUD and medications for the treatment of alcohol and opioid use disorders, sample survey and training topics, information on treatment and recovery support services, and links to informational resources and to SAMHSA's treatment and recovery support services locators. Concurrently, ONDCP released a model state law, the Model Recovery-Ready Workplaces Act, through its contractor, LAAPA[159]. Developed with input from a range of experts, the model law will help states launch or further formalize statewide RRW initiatives.

In addition to participating in interagency efforts to promote the adoption of RRW policies, ETA has advanced *Strategy* priorities through discretionary grants under which grantees have provided reemployment services for individuals with or in recovery from OUD and other SUDs, trained individuals to enter professions key to the response to opioids and other drugs, and created temporary employment opportunities for peer recovery support specialists and other individuals in other roles that have a direct impact on the opioid and other drug overdose epidemic. Rhode Island and New Hampshire used dislocated worker grants from their state Workforce Innovation and Opportunity Act funds to train American Job Center staff on how to more effectively serve people with or in recovery from OUD or other SUD, and ETA has offered training on RRW policies, including through a March 2023 WorkforceGPS webinar featuring the ONDCP lead on RRW.

ONDCP supported the Office of Federal Contract Compliance Programs in developing language to update the standard Voluntary Self-Identification of Disability (Form CC-305. OMB Control Number 1250-0005) to incorporate language clarifying that SUD is a disability, provided the individual is not currently using drugs illegally (i.e., is not using illegal drugs or unlawfully using drugs that can be legally prescribed or administered). Under Section 503 of the Rehabilitation

Act, the federal government and federal contractors and subcontractors must provide equal employment opportunity to qualified people with disabilities. Designated federal contactors must also develop an affirmative action program. The updated form will help promote employer and employee recognition that SUD is a health condition, that it is considered a disability under federal law, and that federal contractors and subcontractors have associated obligations. Additionally, DOT updated the Federal Motor Carrier Safety Administration (FMCSA) guidance in its Medical Advisory Criteria, published in Appendix A to 49 CFR part 391, to remove a reference to methadone, which effectively prohibited certification of an individual taking methadone for the treatment of OUD to operate a commercial motor vehicle. In its new Medical Examiner's Handbook, FMCSA clarifies that methadone use is to be evaluated in the same manner as use of any other Schedule II controlled substance and that FMCSA will rely on the medical examiner to determine whether an individual treated with methadone should be issued a medical examiner's certificate. This aligns the practice with that applicable to all other non-schedule I controlled substances and better aligns the guidance with statutory language.

VA has also made significant strides in reducing barriers to employment for veterans with, or in recovery from, SUD. During FY 2022, VA initiated the phased hiring of supported employment specialists dedicated to serving veterans with SUD in all of its Veterans Integrated Service Networks (and it expanded these efforts in FY 2023). These specialists utilize Individual Placement and Support (IPS), an evidence-based approach to supported employment for people with mental illness and for which there is growing evidence of effectiveness for people with SUD and other disabilities.[160] IPS specialists develop relationships with employers and help their clients secure competitive employment that is meaningful to them. This represents a significant new resource for veterans with SUD.

ONDCP has begun working with the Office of Personnel Management (OPM) and other federal agencies to develop and implement plans to pilot RRW policies in federal workplaces. ONDCP and OPM will collaborate with the Chief Human Capital Officer Council, an interagency forum that advises and coordinates human capital leadership efforts, in their RRW implementation efforts. The information gained from the initial pilots will be used to inform broader dissemination of RRW policies in federal workplaces. Additionally, ONDCP will work with DOT, SAMHSA, and other federal partners to raise awareness that taking methadone for the treatment of OUD no longer results in de facto ineligibility for a commercial driver's license, as this determination will be made by the medical examiner, as is the case when drivers take other medications. VA will also continue to expand access to IPS for veterans with SUD by continuing to expand the number of IPS specialists serving veterans in or exiting SUD treatment.

★ ★ ★ ★ ★ ★

Areas Requiring Additional Focus

While progress to date has advanced the priorities established in the 2022 *Strategy*, work remains to be initiated.

Expand peer recovery support services capacity and foster the adoption of more consistent standards for the peer workforce, recovery community centers, recovery community organizations, and similar peer-led organizations. *(Agencies Involved: HHS/CMS, HRSA, IHS, SAMHSA; Labor/ETA, ODEP; VA/VHA)*

Federal efforts to develop sustainable funding streams for recovery support services and recovery housing are in their early stages. Through SAMHSA's SUPTRS Block Grant, ONDCP will work with SAMHSA and other stakeholders to ensure that there is guidance to help states leverage the funding set aside to optimally build the peer workforce and the various organizational entities essential to it.

To support recovery in academic and after-school settings, ONDCP, SAMHSA, and ED will collaborate to develop mechanisms for funding recovery high schools, collegiate recovery programs, and alternative peer groups. Additionally, ONDCP will work with CMS, SAMHSA's OR, and HRSA around the utilization of Medicaid to cover PRSS, and the development of strategies for braiding or blending funding to ensure availability of this vital service over time and across systems.

SAMHSA released *Best Practices for Recovery Housing*[161] in September of 2023, and plans to co-convene a federal IWG with HUD to ensure coordination of efforts around recovery housing. In the recovery housing domain, efforts to promote more consistent standards will build on the Model Recovery Residence Certification Act developed under ONDCP's model state drug law program.

Expand employment opportunities and promote recovery-ready workplace policies.

(Agencies Involved: Commerce; DOL/ETA, ODEP; EEOC; HHS/ASPE, CDC, SAMHSA; OPM; VA/VHA)

While important progress has been made in promoting adoption of RRW policies, more can be done nationally, including by advancing federal agencies' efforts to become RRW. Further progress on this work will be particularly impactful given that the federal government is the Nation's largest employer. By making continued progress, agencies stand to improve outcomes for people in recovery, to garner productivity gains, and to conserve resources. ONDCP is building upon past discussions with OPM to develop and implement RRW pilots as part of a strategy for promoting the adoption of RRW policies across federal workplaces. Given the diversity of federal workplaces and the differing legal and regulatory structures under which they operate, ONDCP and OPM plan to pilot RRW policy adoption in varied types of federal workplaces. Engagement of labor unions representing federal employees will be crucial to the success of such efforts.

★ ★ ★ ★ ★ ★

Use consistent, neutral, science-based language regarding substance use across federal programs.

(Agencies Involved: DOD, DOL/ETA, ODEP; DOJ/DEA, OJP; DOS; HHS/CDC, CMS, FDA, HRSA, IHS, NIH, OASH, SAMHSA; ONDCP; VA/VHA)

The stigma of substance use leads to misperceptions, including negative stereotypes about people with, or in recovery from, SUD; discriminatory treatment; ill-informed policies and practices; social exclusion; and fear of acknowledging and seeking help for SUD. Research shows that the language adopted when discussing SUD has the ability to either increase and sustain stigma or to reduce it. Ensuring the use of consistent, neutral, science-based language across the federal government is essential to reducing barriers to recovery and resilience. In 2024, ONDCP and federal partners will launch efforts to promote the adoption of consistent, neutral, science-based, and person-first language about SUD, harm reduction, treatment, recovery, and related topics across the federal government. These efforts will build upon updated language guidance NIDA will be releasing.

Reduce legal, regulatory, policy, and practice barriers to recovery.

(Agencies Involved: DOL/ETA, ODEP; DOJ/DEA, OJP; HHS/ASPE, CMS, IHS, OASH, SAMHSA; HUD; VA/VHA)

Numerous federal, state, and local laws, rules, and policies create unnecessary and sometimes seemingly insurmountable barriers to rejoining and contributing to the community and leading a life in recovery. These include the suspension of driver's licenses for offenses not involving impaired driving and the suspension or removal of voting rights. Work to reduce barriers to recovery by building upon efforts to identify and address legal, regulatory, and practice barriers to housing, employment, and education will occur by working systematically to build recovery capital at the community level, and by taking steps to address the social determinants of health that affect SUD prevalence and outcomes. Across all of these efforts, ONDCP will also work to ensure equitable access to services and opportunity for all Americans.

Success Story

SAMHSA's OR was created within the Office of the Assistant Secretary for Mental Health and Substance Use in September of 2021. This marks the first time ever that a SAMHSA component has been created not to prevent or treat SUD, but to help more Americans achieve and sustain recovery. OR accomplishes this, in part, by better focusing and coordinating SAMHSA efforts and by giving the recovery community an advocate within SAMHSA. Charged with advancing the agency's commitment to, and support of, recovery for all Americans from substance use, mental health, and co-occurring disorders, OR has developed a national action agenda to advance the following goals:

1. Promote the inclusion of people with lived experience in behavioral health systems as well as the social inclusion of people in recovery;
2. Address the need for equity to ensure all Americans – particularly those from under-resourced and underrepresented populations – have access to the services and supports they need to achieve and sustain recovery;
3. Expand peer-provided services across the Nation;

4. Increase attention to social determinants including employment, housing, and education; and
5. Support the wellness of people with substance use and/or mental health conditions to reduce co-morbid health conditions and early mortality.

Further, OR is focused on increasing the data and evidence related to recovery supports, addressing trauma, and promoting the rights of people in recovery. Initial activities include the development of model national standards for peer specialist certification, the convening of a Tribal recovery summit, and updating guidance on recovery housing. Additionally, OR hosted a recovery research summit and is represented on the ONDCP- and NIDA-led IWG developing a federal recovery research agenda. OR also hosted a technical expert panel on digital recovery support services, as well as convened a national peer workforce summit and several regional meetings with preventionists, harm reductionists, treatment providers, and recovery service providers. Recognizing the importance of peer recovery support services, which are anchored in shared lived experience, OR leadership and a number of OR team members are in recovery from SUD and/or mental health conditions, and can therefore bring this important perspective to their work.

★ ★ ★ ★ ★ ★

Chapter 5: Reducing the Supply of Illicit Substances in the Homeland

The illicit drug supply chain is a multinational, complex network spanning public and private entities, leveraging legitimate commerce pipelines, and exploiting financial and banking systems to fund illicit activities. This chapter focuses on some of the ongoing efforts to disrupt drug production, trafficking, distribution, and the illicit finance and proceeds that finance illicit drug trafficking networks.

Progress

Since the publication of the 2022 *Strategy*, progress has been made on advancing efforts to reduce the supply of illicit substances through domestic collaboration and interagency coordination. Examples of key accomplishments are listed by action item below.

Seizing illicit drugs to keep them off our streets.

(Agencies Involved: DHS/CBP, ICE, USCG; DOJ/ATF, DEA, FBI; HHS/FDA; USPIS)

Law enforcement and other government partners across the country have been scaling up efforts to seize illicit drugs, prevent drugs from reaching our streets, and hold traffickers accountable. In Fiscal Year 2023, for example, the federal High Intensity Drug Trafficking Areas (HIDTA program, which funds grants across all 50 states to improve law enforcement intelligence sharing and operational coordination among federal, state, territorial, Tribal, and local law enforcement agencies, supported the seizure of more than 29,000 pounds of illicit fentanyl, more than 248,000 pounds of methamphetamine, nearly 365,000 pounds of cocaine, over 4,300 pounds of heroin, and denied drug trafficking organizations $20 billion in illicit profits.[162] Customs and Border Protection (CBP) seized almost 550,000 pounds of illicit drugs, primarily at southwest border POE, which includes nearly 27,000 pounds of fentanyl.[163] And the United States Postal Inspection Service (USPIS) seized over 4,200 pounds of fentanyl from the domestic mail system.[164] These actions took deadly drugs of our streets.

The President has also prioritized deploying cutting-edge drug detection technology across our southwest border, which further enhances the ability to detect and seize more drugs. In 2023, the Department of Homeland Security (DHS) launched Operation Blue Lotus to leverage newly installed non-intrusive inspection (NII) technology at southwest border POEs in surge operations. Overall, CBP's NII deployments include:

- 123 large-scale drive-through X-ray systems, as well as revising the inspection process to significantly increase vehicle and truck scanning rates across the southwest border.
- 88 low-energy portals to scan passenger occupied vehicles.
- 35 multi-energy portals to scan commercially occupied vehicles.[165]

These tools allow CBP to scan more vehicles and conveyances in a shorter amount of time, increasing the efficiency and accuracy of the agency's operations and catching more of the deadly drugs, precursors, and equipment used to make the illicit products. CBP anticipates that

★ ★ ★ ★ ★ ★

after these installations are complete, the scanning rates are estimated to increase from one to two percent of personally owned vehicles to approximately 40 percent, and from 15-17 percent for commercial vehicles to more than 70 percent. The NII, coupled with increased United States Border Patrol (USBP) presence and interagency coordination, netted over 10,000 pounds of seized fentanyl and 284 arrests.[166] To supplement the NII, CBP has deployed over 600 Chemical Identification Systems across its facilities to quickly test and detect illicit substances, enabling on-the-spot seizures and arrests, and is also using Artificial Intelligence tools to identify risky travel patterns and suspicious vehicles and refer them for additional screening.

FDA's Office of Criminal Investigations (OCI) supplements these efforts by targeting the importation and sale of counterfeit opioids, including the darknet marketplaces and vendors that manufacture and sell these counterfeit drugs. OCI's investigations in this area have resulted in 55 arrests; 24 convictions; and forfeiture, fines, and restitution of more than $8.4 million since 2021.[167] OCI has increased the number of special agents assigned to domestic ports and facilities in support of these efforts.

Strengthening the High Intensity Drug Trafficking Areas program and other multi-jurisdictional task forces to disrupt and dismantle drug trafficking organizations.

(Agencies Involved: DHS/CBP, ICE, USCG; DOJ/ATF, DEA, FBI, OCDETF; DOD; Treasury/FINCEN, IRS, OFAC, TFFC; USPIS)

The HIDTA Program oversees 33 regional HIDTAs in all 50 states, Puerto Rico, the U.S. Virgin Islands, and Washington, D.C.. With HIDTA presence in over 600 counties across the country, an estimated two-thirds of Americans live in a HIDTA-designated county.[168] The federal agencies that support the HIDTA Program include ATF, the Bureau of Indian Affairs, the Bureau of Land Management, CBP, DEA, the Federal Bureau of Investigation (FBI), the Federal Protective Service, the Financial Crimes Enforcement Network (FinCEN), FDA, the Homeland Security Investigations (HSI), the Internal Revenue Service (IRS), the National Guard Bureau, the National Parks Service, the Naval Criminal Investigative Service, the Organized Crime Drug Enforcement Task Forces (OCDETF), the United States Attorney's Office, the U.S. Army Criminal Investigative Division, United States Border Patrol (USBP), the U.S. Coast Guard, the U.S. Fish and Wildlife Service, the U.S. Forest Service (USFS), the United States Marshals Service, the United States Park Police, USPIS, and the United States Secret Service.

HIDTAs help counterdrug task forces and partner agencies improve information sharing and transparency to reduce duplication of effort. HIDTA deconfliction systems, a process of determining when law enforcement personnel are conducting activities in close proximity to one another, performed 287,097 event deconflictions in 2023 to alert agencies when their tactical operations are occurring in the same general location and timeframe as operations by other agencies, police departments, and smaller task forces. Additionally, HIDTA compared nearly 1,000,000 pieces of case information looking for connections among cases. In total, 3,529 law enforcement agencies participated in HIDTA case coordination and more than 3,520 law enforcement agencies participated in officer safety efforts.[169]

The HIDTA Program continues to strengthen investigative and information-sharing relationships through collaboration and innovative initiatives, including by expanding its partnership with the

★ ★ ★ ★ ★ ★

ATF's Crime Gun Intelligence Centers (CGICs) across the country. CGICs are interagency collaborations to collect, analyze, and distribute intelligence data about crime guns across multiple jurisdictions. Actionable intelligence developed through CGICs provide investigative leads to support crime gun intelligence initiatives and as well as the identification, disruption, and dismantling of armed DTOs and criminal organizations throughout the United States and beyond.

The HIDTA Program also continues to leverage the Automated License Plate Reader (ALPR) Program to increase the real-time sharing of information and increase officer safety. The ALPR Program allows partner agencies to rapidly identify drug and violent criminal threats through a system of cameras on roadways across the country. Use of the system enables better allocation of resources, less bias in law enforcement, and increased sharing of information.

The HIDTA Program will continue to grow and maintain relationships to reduce the availability of drugs and combat traffickers.

Focusing investigations on priority transnational criminal organizations engaged in drug trafficking.

(Agencies Involved: DOJ; DHS; USPIS)

The United States government has stepped up efforts to hold the most notorious drug trafficking networks to account. In April 2023, DEA announced indictments against the Chapitos, the leaders of the Sinaloa Cartel, and their criminal network.[170] The indictments charged 28 members of the Chapitos network, including suppliers of fentanyl precursor chemicals based in the People's Republic of China (PRC) and a broker based in Guatemala assisting with the transport of chemicals from the PRC to Mexico. Also charged were managers of clandestine fentanyl laboratories based in Mexico converting the precursor chemicals into fentanyl pills and powder; weapons traffickers and assassins perpetuating extreme violence in Mexico; smugglers transporting the fentanyl from Mexico into the United States; and illicit financiers laundering proceeds through bulk cash smuggling, trade-based money laundering, and cryptocurrency.

A month later, in May 2023, DEA announced the results of Operation Last Mile, a year-long national operation targeting operatives, associates, and distributors affiliated with the Sinaloa and Jalisco Cartels who were located in the United States and responsible for the "last mile" of fentanyl and methamphetamine distribution in United States communities.[171] And in June 2023, DEA announced Operation Killer Chemicals and the first-ever indictments of four chemical companies, as well as eight individuals, based in the PRC for knowingly providing customers in the United States and Mexico with the precursor chemicals and scientific know-how to manufacture fentanyl.[172]

In support of these efforts, DEA has developed a network-focused strategy to defeat the Sinaloa and Jalisco Cartels, the global criminal networks most responsible for the influx of fentanyl from Mexico into the United States. DEA has built a new strategic layer, DEA's Counter Threat Teams, that map each cartel, analyze their networks, and develop targeting information on the members of those networks wherever they operate around the globe. The teams are composed of special agents, intelligence analysts, targeters, program analysts, data scientists, and digital specialists. DEA has also built an Illicit Finance Counter Threat Team, comprised of intelligence

★ ★ ★ ★ ★ ★

research specialist and special agents from DEA and IRS, and is identifying and mapping the critical nodes in the cartels' global money laundering networks. DEA is using the combined information and resources of its Counter Threat Teams, its 334 offices worldwide, and its local, state, Tribal, territorial, federal, and international counterparts, to target and dismantle every part of the global illegal drug supply chain.

DOJ's OCDETF also supports the prosecution of priority targets through the collection and, when requested, dissemination of key information to federal law enforcement and prosecution partners. OCDETF-designated investigations resulted in a total of 6,963 convictions in 2023, 19 percent of which were Sinaloa and/or the CJNG members or affiliates.[173] Since 2021, OCDETF also organized two new National Strategic Initiatives to support local and regional efforts, including those focused on the targeting and disruption of the illicit finance, proceeds, and laundering operations fueling the transnational criminal organizations (TCOs) and regional DTO operations.

Cutting drug traffickers off from private shipping and the United States Postal Service.

(Agencies involved: DHS/CBP, ICE USPIS; DOJ)

Drug traffickers exploit the mail and express consignment service industry to distribute deadly drugs, precursor chemicals, and associated equipment. To combat this activity, CBP officers and HSI Special Agents assigned to Border Enforcement Security Task Forces have increased their presence, coordination, and inspection at international express consignment carrier (ECC) facilities. Domestic task forces at ECC hubs seized over 24,250 pounds of illicit drugs from small parcels in 2021 and 2022. These seizures included over 1,100 pounds of illicit fentanyl.[174]

In 2021, USPIS created a Southwest Border Initiative at major induction points along the southwest region of the country. This operation deployed "jump teams" of Postal Inspectors from across the country who conduct interdictions and investigations related to the southwest border, where illicit drugs, such as fentanyl, are crossing over the United States borders, mostly through ports of entry, and then are deposited into the domestic mail system. In 2022, phase two of this initiative resulted in the seizure of 170 pounds of methamphetamine, 136 pounds of fentanyl, 56 pounds of cocaine, and over $465,000 in illicit proceeds seized in the mail. Additionally, a significant number of investigations have been initiated. In early February 2023, USPIS started its third border initiative phase, seizing a total of 205 pounds of methamphetamine, nearly 45 pounds of fentanyl, 42 pounds of cocaine, and over $437,509 in illicit proceeds. Over 69 parcels were referred to destination divisions for enforcement action.[175]

In order to bolster interagency cooperation on illicit drug trafficking through the United States Mail and ECC services, USPIS also established an Investigative Support Section (IS2). IS2 is responsible for working closely with CBP and HIDTAs to identify and share information on drug trafficking trends. This group consists of intelligence analysts and subject matter experts who directly support contraband interdiction and investigations (CI2) inspectors and analysts in building comprehensive, high-impact, DTO dismantlement investigations to combat the distribution of illegal contraband through the United States Mail and the international postal system. Since July 2021, IS2 has supported over 93 USPIS cases, to include domestic and international investigations, in all 17 field divisions.[176]

★ ★ ★ ★ ★ ★

USPIS is also engaged with international law enforcement and Foreign Post platforms such as EUROPOL, Universal Postal Union, International Narcotics Control Board (INCB), and the North American Drug Dialogue (NADD) to better enhance other countries' abilities to detect illicit drugs in the international mail. Recent bilateral work has occurred with Canada Post, and with India through the United States-India Counternarcotics Working Group. As a result of these combined efforts, in 2023, Postal Inspectors made over 2,000 arrests involving drug trafficking, seized over 95,500 pounds of illegal narcotics, and seized over $17 million in illicit proceeds.[177]

Areas for Additional Focus

While there has been progress to date, there is a need to redouble efforts to disrupt the illicit drug supply chain.

Continue to disrupt the global illicit drug supply chain.

(Agencies Involved: DHS/CBP, ICE, USCG; DOD; DOJ/DEA, FBI, OCDETF; DOS; Treasury/FINCEN, IRS, OFAC, TFFC)

The interagency is redoubling its efforts to strategically disrupt the illicit drug supply chain, by targeting key nodes in the supply chain, using all available tools to do so, including seizures, foreign partnerships, law enforcement actions, sanctions, and disruption of illicit financing mechanisms.

Address the criminal destruction of our protected natural resources due to domestic marijuana growth on public land.

(Agencies Involved: DHS; DOD/NGB, NRO; DOI/BLM, NPS, USFWS; DOJ/DEA; EPA; USDA/USFS)

The increase in illegal marijuana grown on public land throughout the United States causes environmental damage. The Department of the Interior is now taking more aggressive action to combat this issue in concert with NDCPAs. While several states permit possession or sales of marijuana for medical or non-medical use, marijuana remains a federally controlled substance, and certain activities that may be authorized under state or local law may be prohibited under federal law. Growers are encroaching on federal land to grow marijuana for illicit trafficking and they use illicit and highly damaging pesticides, which run off into fresh water sources. The National Marijuana Initiative (NMI) and USFS completed phase one of a multi-tiered approach to assess, disrupt, and prosecute illicit grow activity on federal property in the National Forests and National Parks. ONDCP is leveraging support for this effort through the HIDTA program to continue countering the widespread efforts of illegal farming and illegal pesticides on federal land and to disrupt trafficking. NMI and USFS are entering the second phase of a national operation to study and determine outcomes to disrupt and enforce illicit marijuana farming, the use of environmentally harmful pesticides, and the subsequent effect on fresh water ecosystems and potable water.

★ ★ ★ ★ ★ ★

Success Story

The Memphis Project is a data-driven investigative program focused on transnational crime with an emphasis on international contraband smuggling. This program is designed to detect the trafficking and distribution of contraband, derived from TCOs, throughout the global chain. By combining shipping, financial, and communications data, the Memphis Project identifies principal members and various levels of co-conspirators within identified criminal organizations. The program initiates and supports investigations in conjunction with various federal, state, local, and international partners. It is an HSI-led initiative supported by personnel from Tennessee Bureau of Investigations, Memphis Police Department, USPIS, CBP, Tennessee Army National Guard, and the Immigration and Customs Enforcement and Removal Operations.

From 2021 to 2022, the Memphis Project, through a combined effort of the participating agencies, seized over 6,000 kilograms of illegal drugs globally.

- Methamphetamine 4,007 kg
- Fentanyl 233 kg
- Cocaine 840 kg
- Heroin 104 kg
- DMT (N,N-Dimethyltryptamine) 878 kg

Additionally, working with various federal, state, local, and international partners, the Memphis Project supported 250 criminal arrests, 158 firearms seized, and the seizure of over 220 illicit pill/tablet manufacturing implements.[178]

★ ★ ★ ★ ★ ★

Chapter 6: Cracking Down on the Global Suppliers of Illicit Drugs and Related Criminal Networks

The United States cannot solve the drug crisis unilaterally and, therefore, has led a coordinated effort to engage bilaterally and multilaterally to disrupt the illicit synthetic drug trade; worked successfully to schedule more than a dozen precursor chemicals with global partners through the United Nations' Commission on Narcotic Drugs (CND); and built a global coalition of over 150 countries to prevent illicit drug manufacturing, detect emerging drug threats, disrupt trafficking, address illicit finance, and respond to public safety and public health impacts.

Progress

Since the publication of the 2022 *Strategy*, progress has been made in developing relationships with international partners to reduce the supply of illicit substances. Noteworthy accomplishments are listed by action item below.

Working with Mexico on joint enforcement efforts.

(Agencies Involved: DHS/CBP, USCG, ICE; DOJ/ATF, DEA, FBI, OCDETF; State, Treasury)

The United States and Mexico work jointly to disrupt the drug trafficking networks that send drugs north. This includes trilateral work through the United States – Mexico – Canada Fentanyl Working Group and ongoing communication and cooperation at the operational level. This bilateral partnership with Mexico has yielded tangible results, including the September 2023 extradition of Ovidio Guzman Lopez (son of "El Chapo") to the United States and the November 2023 arrest of the notorious head of security for the Chapito faction of the Sinaloa Cartel, Néstor Isidro Pérez Salas ("El Nini").[179] In calendar year 2023, Mexico extradited 28 alleged drug traffickers. Among those extradited to the United States are Eleazar Medina Rojas ("Chelelo"), a high-ranking member of the Zetas Cartel, and Edgar Herrera Pardo ("Caiman"), a cartel enforcer who is an alleged leader of Los Cabos, which operates to secure control of Tijuana for the Jalisco Cartel for trafficking drugs into the United States.

The United States also provides Mexican law enforcement partners with tactical support, such as by providing Mexican law enforcement equipment needed to carry out investigative duties against traffickers. On January 19, 2024, for example, Army Joint Task Force-North and the FBI El Paso Field Office donated 15 pallets of personal protective equipment to the Chihuahua State Attorney General's Office, Chihuahua State Police, and Ciudad Juarez Municipal Police. The equipment, consisting of coveralls, heavy-duty rubber gloves, heavy-duty steel toe rubber boots, and respirator filters, provides critical protection to Mexican law enforcement officials engaged in the disruption drug laboratories manufacturing methamphetamine and fentanyl.[180] Over the past several years, the State Department also has provided 500 canines to support Mexican law enforcement partners, which have helped support more than 50 fentanyl seizures that included over 213 kilos of fentanyl powder, over 485,000 pills, and 2,700 liquid doses.

★ ★ ★ ★ ★ ★

DOJ and DHS are also working to stem the flow of illegal firearms into Mexico that arm the violent Mexican-based drug cartels. On April 4, 2024, the United States publicly announced a new Crime Gun Intelligence Unit, which will allow for ATF to conduct more joint investigations with its Mexican counterparts.[181] ATF continues working with states in Mexico to expand eTrace, an internet-based system through which participating law enforcement agencies submit firearm-related information, allowing ATF to better trace and take action against the illegal distributors of these weapons. As of April 15, 2024, 22 states in Mexico have eTrace access.

The United States is also partnering with Mexico on a comprehensive binational public health campaign to prevent and reduce the risk of consuming fentanyl and other drugs. The Real Deal on Fentanyl Ad Council website was translated into Spanish in early 2024. ONDCP continues to progress toward the roll-out of a binational public awareness campaign on drug use and SUD through coordination with HHS. This initiative will help drive cooperation between Mexico and the United States on combined efforts to disrupt illicit drug trafficking through prevention and supply reduction methods.

Leveraging the United States-Mexico-Canada Trilateral Fentanyl Committee.

Agencies Involved: DHS, DOJ, State, Treasury)

In January 2023, the United States-Mexico-Canada Trilateral Fentanyl Committee (TFC) was initiated to drive joint efforts between the three nations to reduce the supply of illicit fentanyl and other illicit drugs. Over the past year, the TFC has increased and expanded cooperation to investigate and prosecute drug traffickers, tackle the supply chain of illicit drugs, develop a common baseline of post-mortem toxicology examinations to help understand drug trends across the region, and promote public health interventions to reduce harm and demand.[182]

The fourth meeting of the TFC took place in Mexico City on February 7, 2024. At the meeting, the United States, Mexico, and Canada committed to increasing collaboration on the control of precursor chemicals and equipment related to illicit drug production, further engaging the private sector to combat the production of illicit synthetic drugs, and to work to strengthen broader multilateral efforts to tackle the global drug treat. To advance public health, they committed to developing and implementing a common drug and substances analysis protocol, which will allow toxicologists from the three countries to improve their understanding of regional drug trends. In addition, the TFC committed to convene a forum to discuss strategies, and their implementation, for assisting the long-term recovery of individuals with substance use disorders.

In support of the TFC, the North American Drug Dialogue (NADD), which also involves the United States, Mexico and Canada, continues to make progress on multilateral efforts to strengthen regional partner capacity, identify and disrupt supply routes and modalities, and share information. Within the coming years, the NADD seeks to prioritize border security to disrupt transnational criminal activity. NADD also seeks to make opioid overdose reversal medication more accessible across the continent.

★ ★ ★ ★ ★ ★

Strengthening Cooperation with the PRC, including through the United States-PRC Counternarcotics Working Group

(Agencies Involved: DHS; DOD; DOJ; DOS; HHS; NSC; Treasury)

After a period of suspended cooperation and under President Biden's leadership at the Woodside, California summit in November 2023, President Xi Jinping agreed to resume bilateral cooperation to combat global illicit drug manufacturing and trafficking, including synthetic drugs like fentanyl, and to establish a working group for ongoing communication and law enforcement coordination on counternarcotics issues. Since then, the PRC has taken concrete action to disrupt illicit synthetic drug supply chains, including issuing a law enforcement notice to industry warning PRC-based companies against illicit trade in precursor chemicals and pill press equipment; increasing law enforcement action against particular companies of concern; submitting an unprecedented number of seizure incidents to the International Narcotics Control Board's global Ion Incident Communication System database to share real-time information internationally about suspicious shipments and suspected trafficking; and launching a scientist-to-scientist consultation with the United States to share actionable information about chemical make-ups of dangerous drugs, chemicals of concern, and emerging trends. And in January 2024, the United States and the PRC launched the Counternarcotics Working Group, focused on concrete actions to disrupt the production and trafficking of illicit drugs and the illicit financing mechanisms that fuel the drug trade. In April 2024, the Department of the Treasury announced a joint Cooperation and Exchange on Anti-Money Laundering with the People's Bank of China, which provides a forum to share best practices and information to clamp down on loopholes in our respective financial systems.[183]

While there is much more work to be done, these developments mark an important shift in bilateral engagement with the PRC on counternarcotics.

Pursuing additional bilateral and multilateral initiatives.

(Agencies Involved: DHS/CBP, ICE; DOJ/ATF, DEA, FBI; DOS; Treasury; USPIS)

Launched in July 2023, the Global Coalition to Address Synthetic Drug Threats has brought together more than 150 countries and 14 international organizations committed to preventing the illicit manufacture and trafficking of synthetic drugs; detecting emerging threats and patterns of use; and advancing public health interventions and services to prevent and reduce drug use, save lives, and support recovery for people who use drugs.[184] Participants established three working groups and seven sub-working groups that meet monthly. As a result of these sessions, policy recommendations are being developed, including how to improve international systems, processes, and tools to make greater progress on counternarcotics. The sub-working groups also raise global awareness of the threat of illicit fentanyl and new trends among the more than 150 member countries, including when diverted injectable solutions of pharmaceutical fentanyl had been reported in countries, such as Nigeria, Colombia, Honduras, and El Salvador, where illicitly manufactured fentanyl was not yet a pressing threat. These engagements will help underscore the importance of a comprehensive approach to address synthetic drug challenges, with equal emphasis on healthcare and law enforcement interventions.

The United States also continues to leverage its engagement in the United Nations' Commission on Narcotic Drugs (CND). With United States leadership, the CND has led the international

★ ★ ★ ★ ★ ★

community in actions to disrupt precursor chemical trafficking and the proliferation of illicitly manufactured synthetic drugs, as well as those derived from plants such as poppy and coca. At the 66th session of the CND in 2023, the Commission placed international controls on seven substances, including four synthetic opioids, one synthetic cannabinoid, and two synthetic cathinones.[185] During the 67th session in March 2024, the CND voted to control two additional chemicals used by drug traffickers to produce fentanyl. Parties to the United Nations drug conventions must take domestic action to control these substances, which helps law enforcement investigate and prosecute cases involving illicit manufacturing and trafficking of controlled substances. The United States also actively champions public health approaches to reduce drug use and its consequences at the CND and is working with international partners such as the United Nations' Office on Drugs and Crime to increase access to evidence-based prevention programs, as well as harm reduction, treatment, and recovery support services for SUD.

The United States also continues to elevate illicit drugs as an urgent public health and security priority in multiple multilateral fora, including the G7, G20, and Organization of American States Inter-American Drug Abuse Control Commission. At their Leaders' Summit in September 2023, G20 leaders for the first time highlighted the public health and security threat of illicit drugs, including synthetic drugs and their precursors, and called for strong international cooperation.[186] In the Western Hemisphere, OAS member states are working together to address these threats, including the non-medical use of fentanyl, and committing to take action to develop innovative control approaches to improve national controls on synthetic drugs and chemical substances used to manufacture them.

The United States has also supported multiple other initiatives, including the United Nations Toolkit on Synthetic Drugs, a dedicated platform that provides resources and practical guidance for those seeking to address the synthetic drug threat. The United States additionally supports the INCB Global Rapid Interdiction of Dangerous Substances Programme, the Databank on Precursor Chemicals, and other information-sharing platforms to enhance real-time international law enforcement cooperation to prevent the diversion and illicit manufacturing of precursor chemicals and disrupt the illicit supply chain for synthetic drugs. In June 2023, the United States and India committed to work toward a broader and deeper bilateral drug policy framework for the 21st century. Under this framework, both countries aspire to expand cooperation and collaboration to disrupt the illicit production and international trafficking of illicit drugs, including synthetic drugs, such as fentanyl, amphetamine-type stimulants, and illicit use of their precursors. The nations committed to a holistic public health partnership to prevent and treat illicit drug use; address workforce shortages and skilling requirements; and showcase a secure, resilient, reliable and growing pharmaceutical supply chain as a model for the world.[187]

Combatting transnational criminal organizations' financial structures and targeting their illicit proceeds and operating capital.

(Agencies Involved: DHS/CBP, ICE; DOJ/ATF, DEA, FBI, HIDTA, OCDETF; DOS; DOD; Treasury/FINCEN, OFAC, TFFC, IRS)

Narcotics traffickers operating on a global scale require an extensive support network, including procurement, logistics, transportation, communications, security, money laundering, and other facilitation. Disguising the vast profits derived from major drug operations requires the purchase of ostensibly legitimate enterprises capable of handling business on an international scale. These

illicitly funded "corporate empires" can be extensive and complex, and can undermine the integrity of financial systems. They are also one of transnational criminal organizations' greatest vulnerabilities. As a result, disrupting the illicit financial network is a national priority to help disrupt the flow of illicit fentanyl, its precursors and related equipment, such as pill presses.

In 2021, the Department of the Treasury received new sanctions authorities for combating the illicit drug trade.[188] Specifically, it received authorization to target any foreign person engaged in drug trafficking activities, regardless of whether they are linked to a specific kingpin or cartel, and further enables Treasury to sanction foreign persons who knowingly receive property that constitutes, or is derived from, proceeds of illicit drug trafficking activities. Treasury's Office of Foreign Assets Control (OFAC) has since designated 170 individuals and 123 entities.[189] Treasury has since leveraged these authorities to sanction more than 290 people and organizations involved in the global illicit drug trade.

When OFAC designates an individual or entity, any assets within the United States or the possession or control of a United States person anywhere in the world must be frozen. Trade with or through the United States is cut off. Moreover, many businesses and banks not based in the United States voluntarily sever ties with individuals and entities that OFAC has listed. As a result, designated persons may lose access to their bank accounts outside the United States, disrupting their operations and freedom of access. In addition, in many cases, partner nation authorities have taken law enforcement actions against designated companies or properties after OFAC has listed them.

In addition to sanctions, since 2021, the Department of State has approved up to $111 million in reward offers for information leading to the arrest or conviction of 35 different individuals from both the PRC and Mexico involved in the fentanyl supply chain through the Narcotics and TOC Rewards Programs.[190]

Areas for Additional Focus

While progress to date has advanced the international supply reduction priorities established in the 2022 *Strategy*, work remains and is ongoing in all the areas highlighted above.

Working with Colombia to reduce production and trafficking of cocaine while increasing alternative economic opportunities.

(Agencies Involved: DOD; DOJ/DEA, OCDETF; DOS; IC/NSC; Treasury; USAID; DHS/USCG)

Colombia remains a major source of cocaine for global markets and bilateral cooperation with this vital international partner is imperative to disrupting cocaine production and distribution. During Colombian President Petro's visit to Washington, D.C. in April 2023, both nations reaffirmed their commitment to address cocaine production in Colombia through a holistic strategy that prioritizes bringing government presence, security, infrastructure development, and licit economic opportunity to the areas most affected by narcotrafficking and the cultivation of illicit substances. Through the United States-Colombia Counternarcotics Working Group (CNWG), the United States is working closely with the Colombian government to strengthen interdiction operations and anti-money laundering efforts to continue targeting the highest value

★ ★ ★ ★ ★ ★

portions of the supply chain. With the assistance of the United States Agency for International Development, Colombia is working to fulfill its plans to provide viable alternatives to coca cultivation with licit livelihoods, market access, and facilitating land titling, which has proven successful in dramatically reducing the likelihood of a farmer returning to coca cultivation.[191] The Department of Defense continues to work with the Colombian military, including advising and training the Colombian Navy to adapt riverine and littoral interdiction tactics and procedures to cartel operations. Additionally, the Department of State's Bureau of International Narcotics and Law Enforcement Affairs continues to build the capacity of the Colombian National Police and other Colombian criminal justice system partners to investigate and prosecute crime more effectively.

Additional initiatives being advanced through the CNWG include implementing the holistic strategy in targeted geographic areas, developing specific measures to increase Colombian state presence and rural security, strengthening United States and Colombian efforts to increase interdiction operations, expanding intelligence sharing, and agreeing to revamp and broaden the metrics agreed upon in 2021 for measuring the success of counternarcotics efforts. Colombia is a key partner, and United States-Colombian counternarcotics cooperation is critical to reducing narcotrafficking and its associated violence to save lives and shape a more stable region.

Strengthening Ecuador's drug control, law enforcement, and developmental initiatives.

(Agencies Involved: DOD; DOJ/DEA, OCDETF; DOS; Treasury; USAID; USCG; WHA)

Ecuador is a prime example of a country in which drug producers and traffickers undermine security, governance, and civil order to achieve freedom of action. In the wake of increasing gang violence in Ecuador in early 2024, the United States surged support to Ecuadorian law enforcement including facilitating the delivery of bullet proof vests and emergency response equipment; providing training to Ecuadorian migration officers and members of Presidential and Vice-Presidential protective details; and enabling Ecuadorian law enforcement investigations through reach-back support to technical experts at DOJ, FBI, and DEA. While immediately responsive to the uptick in gang violence, these investments will continue to pay dividends for Ecuador's counter-drug efforts.[192] The Ecuadorian military and police have achieved record drug seizures in recent years, and the United States has committed to providing Ecuador the support and resources it needs to address the striking levels of violence and insecurity caused by the corrosive effects of drug production and trafficking.[193]

Success Story

In early October 2023, FBI investigative information and facilitation support from FBI personnel in Mexico supported Mexican law enforcement partners to locate a drug laboratory controlled by the Sinaloa Cartel in Mexicali, Mexico. Mexican law enforcement subsequently conducted an enforcement operation at the laboratory. Mexican law enforcement arrested seven subjects and seized two vehicles, two rifles, 35 kilograms of fentanyl pills, and three kilograms of methamphetamine. Mexican law enforcement estimates the daily production output of the lab was approximately 25 kilograms of fentanyl pills per day.

★ ★ ★ ★ ★ ★

Chapter 7: Improving the Criminal Justice System's Response to Substance Use Disorder

People with SUD who have criminal justice system involvement should have access to quality, evidence-based treatment to support sustained recovery and reduce the risk of future involvement in the criminal justice system. Efforts to support these populations are an important part of addressing the overdose crisis.

To illustrate the urgency of this task, in 2021, there were 1.2 million people in state and federal prisons[194] and 636,000 people in local jails.[195] Research shows that an estimated 65 percent of people in prisons have an active SUD.[196] Another 20 percent did not meet the official criteria for SUD, but were under the influence of drugs or alcohol at the time of their offense conduct or arrest.[197] One study found that people released from prison are 129 times more likely to die of an overdose in the first two weeks after their release than the general population.[198] Black and Brown people are more likely to be incarcerated for drug-related offenses than white people.[199]

In just the last few years, significant work has taken place to address the root causes of criminal justice system involvement and to provide people in prisons and jails with the health care they need. Several years ago, very few jails and prisons were providing evidence-based treatment.[200,201] But today, those numbers are growing, with 43 percent of jails providing at least one form of MOUD, which translates to more lives saved.[202] For incarcerated people who receive MOUD, there is a 75 percent reduction in fatal overdoses in the first month after their release from prison or jail.[203] And importantly, a majority of people who need in MOUD in federal prisons now receive it, up from virtually none receiving this treatment in 2021 or prior.

Other critical progress has come from law enforcement-led diversion and deflection programs that safely reduce unnecessary criminal justice system involvement in appropriate non-violent, low-level cases, consistent with public safety; from expanding access to FDA-approved MOUD to people in jails and prisons; and from facilitating successful reentry outcomes. There has been an investment in evidence-based approaches that strengthen individual and collective public health and public safety outcomes.

These evidence-based approaches, based upon successful and proven federal, state, and local strategies, prevent or reduce crime while also easing the burden on law enforcement and prosecutors so they do not have to respond to non-violent situations that may not merit police intervention or incarceration. When a crime occurs, a sentence should both reflect the seriousness of the offense and provide a chance at meaningful rehabilitation. This will help break the cycle of recidivism and improve individual and collective outcomes. For the more than 70 million Americans who have a criminal history record and for their communities, this can and must be done better.[204] Along the way, doing so can strengthen the economy, save taxpayer dollars, and improve individual and community outcomes.

★ ★ ★ ★ ★ ★

This chapter details the progress that has been made, areas for additional focus, and a story that brings this work to life.

Progress

Since the publication of the 2022 *Strategy*, progress has been made in ensuring access to treatment and recovery services throughout the entirety of an individual's contact with the criminal justice system. Key accomplishments are listed by action item below.

Expanding access to medications for opioid use disorder in state and local correctional facilities and community corrections.

(Agencies Involved: DOJ/OJP, BOP, NIC; HHS/ASPE, NIH; SAMHSA)

Across the country, many jails and prisons do not provide access to MOUD. There is a focus on lifting regulatory barriers and increasing financial resources to expand access to all three FDA-approved MOUD— methadone, buprenorphine, and naltrexone — in state, local, Tribal, and territorial jails and prisons throughout the country. Critically, in recent years all BOP facilities have been equipped and trained to ensure access to all three FDA-approved forms of MOUD. As the largest prison system in the Nation, BOP is building capacity to ensure that every individual in its custody for whom it is clinically appropriate has access to this treatment.

Agencies such as HHS have also worked to reduce financial barriers to providing care on the state and local level. Pursuant to the SUPPORT Act, in 2023, CMS announced a new section 1115 demonstration opportunity to allow Medicaid coverage for certain health services provided to people in jails and prisons for up to 90 days before their expected release date. As part of the minimum set of pre-release services under this program, participating states must cover and ensure access to MOUD and counseling, as well as other critical health services. Such demonstration projects in states such as California[205] and Washington[206] have already been approved by CMS.

In addition, grant funding from both SAMHSA and DOJ are available to support states, localities, and Tribal jurisdictions that are looking to expand access to this care. Resources to expand access to care, as well as other related activities, can be found on SAMHSA's grant forecast webpage and on OJP's recently updated COSSUP and Drugs & Substance Use websites.[207,208]

Further efforts are underway to reduce regulatory and administrative burdens on jails and prisons wishing to expand access to MOUD in their facilities, including through TA. DEA's 2021 OTP mobile medication unit rule[209] and SAMHSA's 2022 proposed OTP rule[210] both take significant steps to lower the barriers to methadone for incarcerated individuals. Likewise, the 2022 elimination of the X-waiver eases the administrative burden on jails and prisons setting up programs that include buprenorphine.[211] NIDA's Justice Community Opioid Innovation Network (JCOIN), funded by OJP and the NIH (including funds through the HEAL Initiative), works to study approaches to increase high-quality care for people with OUD in justice settings.[212] In August 2023, SAMHSA held a Policy Academy with five states looking to integrate or expand access to MOUD in their state prison systems and compiled draft guidelines for states on integrating MOUD in their prisons. Additionally, OJP, in partnership with DEA and

★ ★ ★ ★ ★ ★

SAMHSA, will be supporting up to 15 jails through a nine-month planning initiative to implement or expand access to MOUD, including access to methadone and buprenorphine.

VA's SUD services for justice-involved veterans are being provided through two dedicated national programs, Health Care for Reentry Veterans (HCRV)[213] and Veterans Justice Outreach (VJO).[214] Known collectively as the Veterans Justice Programs, HCRV and VJO facilitate access to needed VA health care and other services for veterans at all stages of the criminal justice process, from initial contact with law enforcement through community reentry following extended incarceration. VJO specialists at each VA medical center work with veterans in the local criminal courts (including, but not limited to, the Veterans Treatment Courts), conduct outreach in local jails, and engage with local law enforcement by delivering VA-focused training sessions and other informational presentations. Each VA medical center has at least one VJO Specialist, who serves as a liaison between VA and the local criminal justice system.

In combination, this work has led to tangible, life-saving results on the ground. Just a few jails offered this treatment a few years ago, and today 43 percent of local jails are providing MOUD in their correctional settings. People in these jails can now receive the help they need – a major change from the recent past.[215]

Engaging and training prosecutors, judges, and court staff to advance equity.

(Agencies Involved: DOJ/OJP, BOP, SAMHSA)

Police officers, prosecutors, and judges in federal, state, local, Tribal, and territorial criminal justice systems have implemented evidence-based accountability approaches that divert individuals with SUD who are charged with non-violent, low-level offenses from the criminal justice system in appropriate cases, consistent with public safety. This work helps to strengthen public safety, support improved public health outcomes, and advance equal justice and equity. Through its grant-making authority, ONDCP awarded grant funding to All Rise (formerly the National Association of Drug Court Professionals) through the Treatment Court Institute to launch a new training program that provides court professionals with evidence-based practices and approaches to enhance public health and public safety outcomes. This training is aimed at reducing the role of bias in screening eligible non-violent, low-level drug court program candidates and ensuring that all eligible individuals can participate in these judicially supervised accountability programs to support their rehabilitation and break the cycle of recidivism, thereby improving public safety.

ONDCP will support All Rise in providing peer-to-peer, judge-to-judge training for state adult criminal court, family court, and juvenile court judges on the science of SUD, its implications in the criminal justice and family court systems, and how courts can adopt best practices to save lives. This work is in addition and complementary to the drug treatment court program, T/TA, and research supported by OJP, including a partnership with the Treatment Court Institute to develop and offer a research-informed training curriculum to assist treatment courts to increase retention and graduation rates for underserved populations participating in a drug court program.[216]

★ ★ ★ ★ ★ ★

Supporting appropriate pre-arrest diversion programs for non-violent individuals.

(Agencies Involved: DOJ/OJP, BOP; HHS/ASPE, SAMHSA)

LAPPA, a recipient of ONDCP's Model Laws grantmaking initiative, developed and published a model law on how jurisdictions can implement and/or expand the use of law enforcement and other first responder-led deflection programs for people with SUD who are charged with non-violent, low-level offenses in appropriate cases, consistent with public safety.[217] The Model Law Enforcement and Other First Responder Deflection Act would codify law enforcement and other first responder-led "non-arrest pathways to treatment and services" for eligible individuals with SUD in non-violent, low-level offenses in appropriate cases, consistent with public safety. These pathways would include connection to services including treatment (e.g., MOUD), recovery, housing, peer support, and case management. Additionally, LAPPA released the Model Substance Use During Pregnancy and Family Care Plans Act, with the aim to safely keep families together and to increase access to treatment, consistent with public safety, public health, and the best interest of the child.[218] This model act requires the creation of a family care plan that connects pregnant and post-partum mothers to services including SUD and mental health treatment, as well as housing, employment, and educational assistance, and ensures the safety and well-being of the child. LAPPA released a summary of state laws[219] regarding so-called "Good Samaritan" laws, which could provide civil and criminal legal protection for individuals who call for assistance in a medical emergency, such as a drug overdose, so they are not deterred from calling for help because they fear criminal prosecution.

Allowing courts to exercise sound judicial discretion and independence.

(Agency Involved: DOJ)

The criminalization of marijuana possession has upended too many lives for conduct that is now legal in many states. While White and Black people use marijuana at similar rates, Black people are disproportionately in jail for it.[220] For this reason, many Americans received pardons in December 2023 for offenses of simple possession and use of marijuana under federal and District of Columbia law. These pardons lift barriers to housing, employment, and educational opportunities for thousands of people with prior convictions under federal and District of Columbia law for simple marijuana possession. State governors have also followed suit to issue pardons under state law, with Oregon's Governor, for example, pardoning over 47,000 people and forgiving more than $14 million in related fines and fees.[221] Likewise, Minnesota's Governor signed a bill that automatically expunged misdemeanor marijuana convictions.[222] DOJ is expeditiously reviewing how marijuana is scheduled under federal law.

Looking forward, Congress must also act to end, once and for all, the racially discriminatory sentencing disparity between crack cocaine and powder cocaine offenses, including by making this change fully retroactive. This step would provide immediate sentencing relief to the 10,000 individuals, more than 90 percent of whom are Black, currently serving time in federal prison pursuant to the crack/powder disparity.[223]

★ ★ ★ ★ ★ ★

Areas for Additional Focus

While progress to date has advanced the criminal justice system's interaction with people with SUD as established in the 2022 *Strategy*, work remains to be initiated or completed.

Eliminate collateral consequences that do not protect the public. *(Agencies Involved: DOJ/BOP, OJP)*

More than 70 million Americans have a criminal record.[224] Even after release from jail or prison, individuals may still face a broad range of civil penalties, known as collateral consequences, that can last a lifetime. These collateral consequences touch on virtually every aspect of a person's life, including the ability to secure housing and employment, pursue education, participate in civic life, maintain family bonds, or even remain in the United States. Individuals with criminal records may be ineligible for certain public assistance programs, and almost one-third of those released from custody expect to live in homeless shelters.[225]

Successful reentry into society requires advance planning; continuity of support; and individualized, multi-faceted, and extensive services. Therefore, a comprehensive strategy for addressing the systemic impediments individuals face upon reentry requires a whole-of-government and a whole-of-society approach. To improve reentry, further investment is needed in holistic wrap-around services, including education, skill-building, reentry planning, skills-based job attainment, employment, housing, health care, transportation, and subsistence benefits. Doing this work requires strong relationships and coordination among correctional agencies and facilities, community-based organizations that provide reentry services and/or workforce training, intermediary organizations that manage a network of reentry organizations, and employers to support the success of returning community members, as well as coordination among the local, state, territorial, Tribal, and federal agencies that fund or oversee such efforts.

Working with its Model Laws grantee, ONDCP will release a model law that will provide guidance to jurisdictions on how to reduce or eliminate barriers to reentry that do not strengthen public safety, such as bars on occupational licenses (like serving as a barber or plumber), and how to access supportive services that are correlated with reductions in the risk of recidivism. Research suggests that access to government subsistence benefits, health care, housing,[226] education, and employment[227] reduce the risk of recidivism. An estimated 65 percent of persons incarcerated have an active alcohol or other drug use disorder.[228] Facilitating successful reentry strengthens economic opportunities, communities, public health, and public safety.

Simplify regulation to help jails and prisons offer medications for opioid use disorder.

(Agencies Involved: DOJ/DEA; HHS/ASPE, SAMHSA)

Reducing barriers to methadone and buprenorphine will help expand access to MOUD in jails and prisons and the number of people within them who can benefit, which will save lives. Additional opportunities remain, including, for example, expanding the prevalence of OTP mobile medication units. While the new mobile methadone rules have increased flexibility in providing MOUD, uptake of OTP mobile medication unit options has been slower than expected.

★ ★ ★ ★ ★ ★

Continued study on what might safely increase uptake of OTP mobile medication unit flexibilities would provide jails and prisons with another option to provide MOUD to people in their care. In the meantime, jails and prisons have been encouraged to add nonmobile medication units to these settings. Additionally, ONDCP and federal partners will redouble efforts to support and educate states about increasing flexibilities.

Use data to identify racial inequities and to assist in driving policy changes.

(Agencies Involved: DOJ/FBI, OJP)

The United States' criminal justice spending is among the least-measured systems in the country, but the consequences of the criminal justice system funding stream are far-reaching. In order to maximize the impact of taxpayer dollars to advance public safety and equal justice, the federal government must improve how it measures and analyzes the effects of policy, funding, and other decisions. The paucity of quantitative data, as well as the dearth of qualitative feedback from people who have been stopped, searched, arrested, detained, charged, convicted, sentenced, incarcerated, and/or released, has hindered the United States' ability to measure the impact of existing initiatives, pinpoint gaps in the evidence, and identify opportunities to do better. There is also a lack of disaggregated data — data that can be broken down and analyzed by race, ethnicity, gender, sexual orientation, disability, income, veteran status, age, or other key demographic variables. ONDCP will work across data systems to ensure access to thorough, representative data that supports informed decision making. But data availability is not the only problem. Because of biases in determining which data are important (and thus should be collected) and how they are collected, these implicit value judgments must be addressed and controlled for when developing policy and analyzing available data. While government has an important responsibility for data collection and evaluation, the private sector, philanthropy, faith leaders, researchers, and civil society have complementary roles to play to ensure a coordinated and comprehensive approach to data collection and that evaluations are developed and implemented to improve the criminal justice system in its entirety. ONDCP will also continue to work with partner federal agencies to ensure that these data provide an evidence base for policy consideration, development, and implementation, in order to advance evidence-based actions that strengthen public safety, public trust, and equal justice under law.

Success Story

Providing MOUD in jails and prisons not only saves lives, but also improves rehabilitation and safety within the facility and reduces the risk of recidivism after release. In February 2018, the Camden County Correctional Facility in New Jersey started a program that included provision of all three FDA-approved forms of MOUD to people who were on MOUD in the community before their incarceration. They also provided buprenorphine initiation for individuals for whom it was clinically appropriate, but who had not been on it in the community. Today, approximately 25 percent of incarcerated people inside the facility receive some form of MOUD, with over 200 people receiving their medication on a daily basis.

Incarcerated people at the Camden County Correctional Facility have seen the benefits of this program in their lives. Freddie had been in and out of jail and prison for 20 years, and but had not previously had access to MOUD. Not only does access to MOUD support Freddie's

rehabilitation during his term of incarceration by providing him with the necessary treatment he needs for his OUD, but it is also sets him up for success after release. He will be less likely to experience an overdose, more likely to stay in treatment, more likely to thrive and succeed in the community, and will be less likely to recidivate.[229, 230]

While data shows that providing MOUD to incarcerated people prevents overdose deaths, the Camden County Correctional Facility has experienced other benefits as well. Since implementing the MOUD program, suicide attempts and emergency department visits for severe withdrawal symptoms are down, as are incidents of violence among incarcerated people and between incarcerated people and staff. Security staff report fewer contraband incidents because people are receiving the treatment they need to address their underlying OUD. "We have finally come up with the missing piece that will help people reintegrate back into society to continue with their lives. As a society we have not given up on the population we serve; the MOUD program was long overdue," said Captain Tyefa Stallings, of the Camden County Correctional Facility.

★ ★ ★ ★ ★ ★

Chapter 8: Building Better Data Systems and Research

The commitment to using evidence-based approaches to address the overdose crisis continues. Effective drug prevention and treatment policies have the potential to improve the health and safety of communities, increase life expectancy, reduce economic burden associated with drug use, and most importantly, save lives. Development of such policies requires timely, accurate, comprehensive, and geographically precise data to inform local communities about the dangers of the illicit drug supply and to provide data-driven insights that inform the distribution of lifesaving OORM, harm reduction programs, and treatment services.

Addressing the overdose crisis requires a coordinated multidisciplinary approach and, therefore, improving the Nation's drug data systems must involve collaboration with diverse stakeholders across international, federal, state, local, territorial, and Tribal governments; community organizations; academia; and private entities. When data is used effectively, drug policies are implemented when and where they are needed most, including in vulnerable and underserved communities that are disproportionately affected by adverse outcomes associated with drug use.

Progress

Since the publication of the 2022 *Strategy*, progress has been made in advancing data systems and research. Key accomplishments are listed by action item below.

Improving data accessibility.

(Agencies Involved: DOJ/DEA; DOT/NHTSA; HHS/CDC, NIH, SAMHSA)

Enhancing the utility of drug data is foundational to deploying an evidence-based approach to addressing the overdose crisis. In January 2023, the White House Office of Science and Technology Policy (OSTP) launched the Year of Open Science to advance national open science policy, provide access to the results of the Nation's taxpayer-supported research, accelerate discovery and innovation, promote public trust, and drive more equitable outcomes.[231] NDCPAs have made significant progress in improving data accessibility and making research findings available in a timely and policy-relevant manner.

ONDCP has made it a priority to publicly release regular statements highlighting findings from analyses that monitor trends of provisional overdose deaths and other data collected and reported by CDC, DEA, DHS, and NHTSA. Over time, these analyses have shown a steady slowing in drug overdose deaths in the United States after a period of sharp increase from 2019 to 2021.[232] Starting in November 2022, ONDCP's monthly statements began highlighting drug seizure activities by CBP and domestic federal, state, local, and Tribal law enforcement agencies, as well as responses by EMS where naloxone was administered. Together, these data help highlight the actions taken to address the overdose crisis and demonstrate how data is used to inform subsequent policy decisions.

★ ★ ★ ★ ★ ★

NDCPAs have also made available several user-friendly data dashboards that improve data accessibility and enable the public to interact with federally funded datasets. For example, CDC published dashboards for the Drug Overdose Surveillance and Epidemiology (DOSE) System and the State Unintentional Drug Overdose Reporting System (SUDORS) in April and June 2022, respectively. DOSE captures both nonfatal suspected overdose syndromic surveillance data, which helps to rapidly identify outbreaks and provides situational awareness of changes in drug overdose-related emergency department visits at the state level.[233] Similarly, the fatal overdose surveillance system, SUDORS, helps decision-makers better understand the circumstances surrounding overdose deaths, improves the timeliness and accuracy of overdose data, and identifies specific substances causing or contributing to overdose deaths.[234] These data can be used to educate partners about location-specific circumstances and risk factors, alert drug control partners about emerging drug threats, and assist with planning and evaluation of overdose response efforts. Two additional nonfatal overdose dashboards were published in May 2023 using emergency department and inpatient hospitalization discharge data, as well as toxicology results examining fentanyl analogues among nonfatal suspected opioid-involved overdoses.[235,236]

ONDCP and NDCPAs have also funded and published several peer-reviewed publications to make research findings on key priority policy areas accessible to the American public. These papers not only highlight priorities, but also advance the science and research on important drug policy topics. Examples of policy areas highlighted in these papers include barriers that impede use of evidence-based MOUD,[237,238] the impact of expanding treatment services during the COVID-19 pandemic,[239,240,241,242] nonfatal and fatal overdose trends by select substances and sociodemographic characteristics,[243,244,245,246,247] public health and safety with respect to the illicit fentanyl trade and darknet networks,[248] methamphetamine overdoses and violent crime,[249] and fentanyl seizure field testing.[250] Work with NDCPAs to improve data accessibility and translate research into evidence-based policy will continue.

Developing methods for identifying emerging drug use trends in real-time or near real-time.

(Agencies Involved: DOJ/DEA, OJP; DOT/NHTSA; HHS/CDC, NIH, SAMHSA; OSTP)

The drug supply is continually evolving with the development of novel synthetic drugs, as well as the emergence of new adulterants, bulking agents, and contaminants being added to the existing illicit drug supply. New patterns of drug use, including the co-occurring or sequential use of more than one drug, bring additional complexities to data collection and attributing specific substances to certain outcomes or consequences of drug use. In order to keep up with this ever-changing drug landscape, it is important that NDCPAs establish new data systems and analytical methods to ensure that evidence is driving policy.

Progress in this area has been made by developing methods for identifying emerging drug threats. In January 2023, ONDCP published criteria and procedures to help identify substances that might be considered by the ONDCP Director as an emerging drug threat.[251] To inform the development of these criteria, ONDCP convened the Evolving and Emerging Drug Threats Committee to discuss data sources and analytical approaches for identifying an emerging drug threat. The published criteria indicate that ONDCP will review for designation any substance or pattern of use that increases by at least 15 percent year-over-year in at least three of the four United States Census regions. These criteria were first used in April 2023 to support the

★ ★ ★ ★ ★ ★

designation of fentanyl adulterated or associated with the veterinary tranquilizer xylazine as an emerging drug threat.[252] Data reported by DEA was used to help inform this designation based on an increasing number of xylazine-positive overdose deaths, as well as an increasing number of forensic laboratory identifications of xylazine in all four United States Census regions. ONDCP convened an IWG to inform the development of a national response plan for this threat, which includes work on xylazine testing; evidence-based prevention, harm reduction, and treatment implementation and capacity building; epidemiology and comprehensive data systems; source and supply information and intelligence (including strategies to reduce the supply of xylazine); regulatory options; and basic and applied research (such as work on the interactions between xylazine and fentanyl).[253]

DOJ's OJP also funds the Novel Psychoactive Substances Discovery program, which is a near real-time drug warning system that analyzes biological and drug samples from a variety of sources across the Nation and reports this data in forms accessible to public health, policymakers, forensic scientists, and the public. These data insights can be used to detect emerging drug trends and have been cited by DEA for emergency scheduling actions.[254] Utilizing data and the emerging drug threats criteria to review substances or patterns of use that endanger the health and safety of the American people will continue.

Working collaboratively with federal partners.

(Agencies Involved: DOJ/OJP, DEA; DOT/NHTSA; HHS/CDC, FDA, NIH, SAMHSA; OMB/OIRA)

In order to strengthen existing data systems and build evidence to inform drug policy, collaboration and coordination between federal partners is critical because much of the existing drug data collection and analytical activities occur within these entities. ONDCP reconstituted the Drug Data IWG in December 2021 to inform the Drug Data Plan.[255] The working group convenes regularly with approximately 60 participants from 25 federal agencies. Through these communications, the working group developed policy-relevant questions that can be informed by data, identified data needs, discussed methods, analytical approaches, and challenges to developing evidence to support drug control policymaking and monitoring. The working group has also identified steps to be taken to implement the Drug Data Plan. In March 2023, the Drug Data IWG formed three sub-working groups focused on nonfatal drug poisonings, equitable data, and wastewater testing.

Subject matter expertise from federal partners on a number of key working groups and committees, such as the Evolving and Emerging Drug Threats Committee and IWGs for Drug Data, the Cascade of Care, and Recovery Research, is critical. ONDCP has also presented at multiple meetings with deputies from each of NDCPAs to provide an overview of current substance use trends and routinely collaborates with CDC, NHTSA, NIDA, OSTP, and SAMHSA to conduct research and improve data collection efforts.

★ ★ ★ ★ ★ ★

Areas for Additional Focus

While progress to date has advanced the data systems and research priorities established in the 2022 *Strategy*, more work remains. See Appendix B for the Drug Data Plan.

Identify and address shortcomings in existing data systems.

(Agencies Involved: DOT/NHTSA; HHS/ASPE, SAMHSA, NIH, CDC, FDA; DOJ/DEA, OJP; OMB/OIRA; OSTP)

Over the past several decades, the federal government has made significant investments in data systems that monitor patterns and consequences of drug use, as well as changes in the drug supply. However, as drug use patterns and the composition of the drug supply evolve, it is critical that data systems continue to be strengthened and new drug data sources be identified. One gap and opportunity of existing data systems that is being addressed is the lack of reliable real-time data for nonfatal overdose. In June 2022, ONDCP published a viewpoint in the *Journal of the American Medical Association* highlighting this issue and describing the benefits and needed actions to improve data systems in this area.[256]

Nonfatal overdose is a key risk factor for a future drug overdose death; however, current state and national-level surveillance systems significantly underestimate the number of people who experience a nonfatal overdose, in part because not all those who experience an overdose interact with EMS or present to a hospital's emergency department. Strengthening nonfatal overdose surveillance systems is a priority. In a review of state government websites published in February 2023, ONDCP identified significant variation in the types of data and specific methods used by states to monitor nonfatal overdose in the pre-hospital and hospital care settings.[257] These findings highlight a need for states and the federal government to continue to work together to expand and standardize reporting of nonfatal drug overdose to produce more accurate national, state, and local estimates.

The CDC DOSE system is one such national data system that tracks monthly trends in emergency department visits for drug overdose among participating states. However, not all individuals who experience a nonfatal overdose receive care in a hospital, thus identifying a need for complementary data sources from EMS, law enforcement, and other community programs that may respond to overdoses to get a more comprehensive and accurate picture of nonfatal overdose throughout the country. In an effort to complement nonfatal emergency department data, ONDCP partnered with NHTSA to develop case definitions for identifying EMS responses to nonfatal overdoses involving opioids, stimulants, and other drugs using the National EMS Information System. This collaboration was a novel use of an existing data system to fill a critical knowledge gap on the prevalence of nonfatal overdose. In December 2022, this partnership launched a national data dashboard of nonfatal opioid overdoses across the country, which is updated in near real-time (see Success Story). CDC is also enhancing its nonfatal overdose data collection efforts with overdose-related EMS transports, urine drug tests, and comprehensive toxicology testing of leftover urine samples from individuals following an acute overdose to uncover emerging substances.

Every nonfatal overdose represents an opportunity to connect an individual with essential prevention, harm reduction, and treatment services that could save a life. ONDCP will continue

★ ★ ★ ★ ★ ★

working to improve data systems for capturing nonfatal overdose across the pre-hospital and hospital care settings throughout the Nation to ensure that essential services and resources are provided in an equitable manner and to communities most affected by the overdose crisis.

Prioritize data and analytical efforts to support advancing equity for traditionally underserved populations.

(Agencies Involved: DOT/NHTSA; HHS/CDC, HRSA, NIH, SAMHSA; DOJ/DEA, OJP)

As NDCPAs continue to strengthen their data systems to monitor trends in drug use and its related consequences, a key focus of these efforts must be to ensure that drug data systems comprehensively capture data to support historically underserved communities. This includes capturing data about individuals' age, sex, race, ethnicity, disability, income, sexual orientation, gender identity, and other key sociodemographic characteristics, as well as information to serve specific populations, such as residents of rural and Tribal communities, English language learners, people with criminal justice system involvement, those experiencing homelessness, active military and veterans (and their families), persons with co-occurring mental illness and SUD, people who inject drugs, and opioid-exposed infants and children. The first step to advancing equity in drug-related outcomes is to gather the data necessary to advance evidence-based drug policies and programs. Disaggregating data by key population characteristics helps decision-makers identify opportunities for targeted actions that seek to improve outcomes for historically underserved communities. DOJ's OJP and VA are two examples of agencies that are developing new data platforms, analytical methods, and data linkages to support at-risk veterans and people with criminal justice system involvement.[258,259,260]

In January 2023, the Office of the Chief Statistician of the United States published recommendations on best practices for the collection of sexual orientation and gender identity (SOGI) data on federal statistical surveys.[261] This document provides recommendations and considerations for planned uses of SOGI data, strategies to ensure sufficient sample size, alignment with other surveys and datasets, examples for how to ask about SOGI using tested terminology, and a discussion about the importance of safeguarding SOGI data to manage privacy risks. The White House Federal Evidence Agenda on LGBTQI+ Equity also provides additional guidance for collecting SOGI data on forms and in other administrative contexts.[262] Similarly, the Office of Management and Budget (OMB) has proposed updating race and ethnicity statistical standards to encourage federal agencies to collect more granular data that will help enable a better understanding of disparities and outcomes within specific race and ethnicity minimum reporting categories.[263] OMB also proposed adding a new minimum reporting category for individuals who identify as Middle Eastern or Northern African. SAMHSA has already initiated efforts to standardize collection of demographic information regarding race and ethnicity and SOGI information within their grant portfolio.[264]

All NDCPAs are encouraged to strengthen their data systems to comprehensively capture data to support traditionally underserved populations. Over the next year, success can be achieved by all NDCPAs beginning the process of updating their drug data collection tools in accordance with best practice recommendations for capturing race, ethnicity, SOGI, and other key sociodemographic characteristics. Significant time and resources are necessary to update data collection instruments, but these efforts to advance equity-related data will have a significant

★ ★ ★ ★ ★ ★

return on investment through targeted actions that improve health outcomes for traditionally underserved populations.

Support data collection practices that enhance standardization, accuracy, timeliness, and relevance to policy.

(Agencies Involved: DOJ/DEA, OJP; DOT/NHTSA; HHS/CDC, NIH, SAMHSA; OSTP)

Implementation of an evidence-based approach to addressing the overdose crisis requires timely data that is accurate and relevant to policy actions. The federal government and NDCPAs must continue to work together to expand and standardize reporting of drug data so that insights are comparable across populations and geographic areas. Unfortunately, there is no single data system that can comprehensively monitor the drug landscape. The federal government relies on a variety of administrative and programmatic datasets, as well as national surveys to gain insights on key policy areas, including fatal and nonfatal overdose, drug consumption, availability, delivery, and retention in substance use treatment (including MOUD), harm reduction, and recovery support services, as well as the price, purity, and lethality of the illicit drug supply.

When developing a data system, trade-offs are necessary in terms of the scope, timeliness, and accuracy of data collected. Timely data often require concessions in terms of generalizability and accuracy, whereas more comprehensive and standardized data are often burdened with larger sample sizes, reporting requirements, and more time-consuming quality assurance tasks. For example, when monitoring emergency department visits for drug overdose, syndromic surveillance utilizes preliminary diagnoses and chief complaint descriptions to rapidly assess changes in trends, but the data is not suitable for providing count estimates, nor are estimates comparable between states due to variation in the quality and consistency of data reported by hospitals. On the other hand, hospital discharge data can provide more accurate estimates using final diagnosis information in a standard format. Discharge data enables count estimates that are comparable between states, but the timeliness of this data can lag by several months. This tension between timeliness, standardization, and accuracy permeates drug data and requires a delicate balance.

In September 2022, the NIH HEAL® Initiative announced the Data2Action program, which funds research to improve the quality, timeliness, accessibility, and usefulness of existing data systems and to use data to identify and fill service delivery gaps with evidence-based strategies.[265] Similarly in March 2023, CDC announced new OD2A funding opportunities for state and local health departments to develop infrastructure and conduct overdose-related surveillance, and implement prevention activities to decrease fatal and nonfatal overdoses and related harms.[266] In recent years, CDC has made significant efforts to improve the timeliness of nonfatal and fatal overdose data through DOSE, SUDORS, and provisional data from the National Vital Statistics System. In August 2023, CDC added a new preliminary view to the SUDORS dashboard, allowing users to view data on drug overdose deaths that occurred during 2022, aggregated across 27 states and the District of Columbia. The preliminary data page will be updated every six months (compared with annually for the final data page) and allows for the release of broad-scope SUDORS data faster than has previously been possible.

★ ★ ★ ★ ★ ★

ONDCP plans to work with NDCPAs to identify which existing federal data sources are best suited for informing timely decision-making or if the development of novel data sources (such as wastewater-based epidemiology, expanded and re-testing of leftover biological samples for a wider panel of drugs, or community drug checking services) is needed to provide more real-time drug policy insights. Over the next year, success can be achieved by getting all NDCPAs to reduce the time lag of existing data collection efforts (and reporting of such data) to less than one year, to the extent practicable. Agencies should consider alternative methods of reporting data, such as publishing provisional data tables or rapid reports in advance of a more comprehensive annual report. ONDCP understands the challenges associated with increasing the timeliness of data, while balancing accuracy and integrity, under their current capacity and availability of resources. However, more real-time drug data is absolutely necessary to address the overdose crisis, which according to available data is taking approximately one American life every five minutes.

Explore the utility of wastewater testing to inform drug consumption patterns.

(Agencies Involved: DOJ/OJP; HHS/CDC, NIH, SAMHSA; OSTP)

There are currently significant gaps in timely information on the types and volume of drugs consumed by the American public. States and the federal government currently rely on national surveys to estimate the number of people who report using drugs in a given time period (past month, past year, or lifetime use). These surveys are time and resource intensive and rely on voluntary, self-reported engagement in stigma and potentially illegal behaviors and have difficulties reaching certain populations, such as people involved in the criminal justice system, those experiencing homelessness, and youth no longer enrolled in school. PWUD may also be unaware of the types and quantities of drugs they are consuming, as polydrug use and the mixing of illicit substances in the form of powders, tars, and counterfeit pills have become more common.

Wastewater testing is a novel approach that could potentially address some of these limitations by providing timely, population-level estimates, using objective measures of the volume of drugs consumed and subsequently excreted by the human body into the wastewater treatment system. This technique was widely used in the United States during the COVID-19 pandemic as an early warning system to track the presence of SARS-CoV-2 in wastewater samples. NIDA and NIJ are currently funding work to better understand the utility and limitations of this novel method as it relates to informing drug policy.[267,268] Other countries and a few United States jurisdictions have already implemented wastewater testing programs to estimate the consumption of prescription and illicit drugs, as well as novel psychoactive substances (such as xylazine).[269,270,271,272,273,274,275,276] As more is learned about wastewater testing and the insights this novel data can provide, it is important that these programs are implemented in a de-identified and non-invasive manner so that people cannot be targeted and their privacy is respected. This data may also be useful in identifying potential emerging threats. See Appendix B for additional discussion of wastewater testing in the *Drug Data Plan*.

★ ★ ★ ★ ★ ★

Success Story

In December 2022, ONDCP, in partnership with NHTSA, launched a first-of-its-kind national data dashboard of nonfatal opioid overdoses across the country.[277] This dashboard complements nonfatal overdose data from emergency departments and fills a critical data gap by tracking overdoses for individuals who did not receive care in a hospital. This data will help first responders on the front lines of the overdose epidemic target the allocation and distribution of life-saving interventions such as naloxone and other OORM. The dashboard will also help inform service providers as they connect people to harm reduction and treatment services. In March 2023, a "Disparity Explorer" was added to the dashboard to provide more detailed insights regarding nonfatal opioid overdose broken out by age, race, gender, and urbanicity. Further enhancements have been made to report estimates for any/all drugs including stimulants, and additional work is being conducted to produce estimates for more granular geographic areas.

★ ★ ★ ★ ★ ★

Appendix A: *National Treatment Plan*

21 U.S.C. § 1705(c)(1)(N)(iv) requires the *Strategy* to include a plan to expand treatment of SUD. This *National Treatment Plan* (*NTP*), building upon the work of the 2022 *Strategy*, aims to provide treatment to individuals with SUD and support their recovery by identifying unmet treatment needs and creating a plan for closing the gap between available and needed treatment.

Addressing The Treatment Gap

In 2022, the most recent year for which data are available, nearly 49 million people in the United States had a SUD. One in four people aged 12 or older (or 24 million people) classified as needing substance use treatment in the past year received it. Among people who had received any treatment services, most (9.9 million) received outpatient substance use treatment services from a medical clinic or doctor's office.[278]

The *Strategy* and the *NTP* outline the steps required for closing the treatment gap. The *National Drug Control Budget FY 2025 Funding Highlights*[279] describes the necessary federal resources to support the *Strategy* and *National Treatment Plan*. As that document details, requested FY 2025 funding for federal drug control activities aimed at closing the treatment gap is nearly $22 billion, an increase of over $300 million from the FY 2024 enacted level.

The private sector has a vital role to play in helping to shoulder the costs of closing the treatment gap, as well. For example, private-sector payers and providers can further integrate behavioral and physical health programs, particularly with significant behavioral health challenges, in light of growing evidence that timely and effective behavioral health interventions can improve overall health outcomes and cut costs. A 2020 Milliman Research report, *How do individuals with behavioral health conditions contribute to physical and total health care spending?*[280] estimates that integrating behavioral and physical health programs could save between 9 percent and 17 percent of the excess costs incurred by people with untreated behavioral health and co-morbid physical health conditions; this could amount to saving between $37.6 to $67.8 billion in health care costs.[281]

The majority of individuals today that have identifiable complex behavioral health or co-morbid conditions, including those prescribed medications to treat behavioral health conditions, are not having their behavioral health issues treated. The study suggests that managing behavioral health as early as possible is important for lowering health care costs and improving patient outcomes.

Achieving these savings could have big effects on patients' lives—particularly for patients facing the highest costs. The study examined costs and potential savings for both the total patient population (including 21 million insured individuals) and high-cost patients specifically (2.1 million individuals). The high-cost patients face an average of $41,631 in annual health care costs. By comparison, patients outside the high-cost group face an average of $1,965 health care costs annually. Moreover, medical and surgical costs for behavioral health patients were about 3 to 6 times higher than non-behavioral health patients (although the annual costs for behavioral health care, specifically, vary significantly among the former group).

★ ★ ★ ★ ★ ★

The Cascade of Care Approach

In order to continue to reduce drug use, overdoses, and death, this *NTP* includes essential efforts to increase access to SUD services. Cascade of Care models involve the use of data and metrics to monitor health conditions, identify the appropriate method of care along continuum of approaches, and prescribe tailored interventions to improve health outcomes. The "SUD Treatment Cascade" concept suggests that the more individuals are successfully diagnosed, receive harm reduction services, enter treatment, and receive tailored evidence-based treatment, the more people will enter long term recovery, and overdoses and deaths will decline. A Cascade of Care approach examines key measures in the life cycle of a chronic disease, cascading from the initial diagnosis to the final outcome, and the framework can serve as a tool to identify gaps along the continuum of care of services and tailor interventions to improve the quality of SUD care and outcomes.

This *NTP* focuses on four public health related areas: prevention, harm reduction, treatment, and recovery. The goals of this *NTP* are to decrease SUD, increase screening and assessment, increase access to harm reduction services, increase the number of people with SUD in treatment and long-term recovery, and reduce overdoses and overdose deaths.

There are significant roles in every level of engagement with individuals, systems, and communities to address SUD. Both the public and private sector can support prevention and harm reduction, SUD screenings, the training of health professionals, and treatment and recovery. They can also work to eliminate barriers including a lack of screening, insufficient linkages to treatment, lack of providers or specialty providers in a network or community, providers moving in and out of networks, cost, unlinked treatment episodes, and brief aftercare services.[282]

Implementing the National Treatment Plan

I. Increase Prevention Efforts

Prevention and screening are critical, particularly among youths and young adults, when establishing the cascade of SUD treatment services. Data from NSDUH show a rapid escalation of drug use increasing with age through young adulthood, from ages 12 to 29. Outlined below are several efforts that NDCPAs can advance to increase prevention among youths and young adults:

Implement evidence-based youth substance use prevention efforts, which can help mitigate the effects of adverse childhood experiences on the most vulnerable populations.

(DOJ/OJP; HHS/ ACF/CDC/HRSA/IHS/NIH's NIDA/SAMHSA)

Background: Evidence-based efforts to screen and provide intervention services for vulnerable youth, including foster, transition-aged, runaway and homeless youth; children of incarcerated parents; children in juvenile drug treatment court or juvenile detention programs; and children with ACEs can reduce the risk of future mental illness and/or

★ ★ ★ ★ ★ ★

SUD.[283] Schools can also play a critical role in screening those who are vulnerable and linking them to services.[284] CDC identifies several strategies that can prevent ACEs, as well as strategies to mitigate the harms of ACEs, including: strengthening economic supports for families; promoting social norms that protect against violence and adversity; ensuring a strong start for children and paving the way for them to reach their full potential; teaching skills to help parents and youth handle stress, manage emotions, and tackle everyday challenges; connecting youth to caring adults and activities; and intervening to lessen immediate and long-term harms.[285]

Action: Through collaboration with NDCPAs, bring greater visibility through messaging and other communication vehicles regarding the use of evidence-based screening and intervention services to reach and support vulnerable youth. Some examples include:

- Medicaid covers the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit for beneficiaries under age 21 and requires states to provide access to any Medicaid-coverable service in any amount that is medically necessary, regardless of whether the service is covered in the state's Medicaid plan. The EPSDT benefit includes mental health screening and necessary health care services that must be made available for treatment of all mental illnesses or conditions discovered by any screening and diagnostic procedure.[286]
- Under its Infant, Child, and Adolescent Preventive Services Program (formerly known as Bright Futures Pediatric Implementation Program), HRSA maintains the Bright Futures Periodicity Schedule for pediatric providers, which includes screenings and assessments to recognize and address behavioral health and substance use among youth.
- SAMHSA has developed a mobile app, Screen4Success, that provides parents and other concerned adults with a 10-minute screener that adults can use to look for signs of elevated risk for substance misuse and mental health issues in youth, and connects them with information on recommended support services that are available in the user's area and at the national level.
- Programs such as Life Skills® Training, the Good Behavior Game, and Promoting Alternative THinking Strategies® (PATHS) have demonstrated benefits beyond reduced aggression and violent behavior, including reductions in youth alcohol, tobacco, and drug use; depression and anxiety; suicidal thoughts and attempts; delinquency; and involvement in crime.[287]

Expand substance use screening of youth in a broader array of settings.

(HHS/SAMHSA/IHS/NIH)

Background: Screening youth for SUDs must be expanded to schools and health care settings. In 2023, NIDA launched two brief online screening tools to assess for SUD risk among adolescents 12-17 years old. Both the BSTAD and the S2BI equip clinicians with validated tools to triage patients into one of three levels of SUD risk: no reported use, lower risk, and higher risk. These tools make it easier for healthcare providers to integrate prevention and early intervention services into their practice, following the American

★ ★ ★ ★ ★ ★

Academy of Pediatrics recommendation for universal SUD screening in pediatric primary care.

Action: Review research on effective screening approaches for school-age children in health care settings, schools, libraries, community centers, and other trusted, frequented locations. Translate research findings into culturally appropriate tools for clinical and other settings. Incentivize best practices for improved adoption.

Raise awareness of substance use harms in the middle, high school, trade school and collegiate communities.

(ED; HHS/CDC/SAMHSA/NIH's NIDA; DOJ/DEA)

Background: With an unprecedented number of overdose deaths occurring among youth between the ages of 14-18[288] in 2020 and 2021, and high drug use rates among school aged youth,[289,290] prevention efforts should focus on raising awareness of the harms of substance use.

Action: Apply targeted educational outreach to encourage mental health and substance use and misuse screening for youth and young adults in health care[291] and other settings. Partner with the ED, HHS, and DEA via Campusdrugprevention.gov, the Higher Education Center for Alcohol and Other Drugs, and provider organizations to bolster screening, interventions, referrals, and recovery support through student health services, college health centers, on-campus response teams, and student life programs. With NIDA, evaluate a defined aspect of one of these approaches.

Train personnel to address the gap of treatment providers, including pediatricians and other providers of youth and adolescent health services.

(HHS/FDA/HRSA/IHS/NIH's NIDA/SAMHSA)

Background: In the midst of the workforce shortages across the health care system, including among behavioral health providers trained in the treatment of SUD, there is a shortage of providers of SUDs treatment[292] for adolescents and youth.[293]

Action: Grow a workforce of SUD providers through SAMHSA, HRSA, IHS, FDA, NIDA, and other relevant federal partners, including pediatricians and other providers of adolescent health services, including mental health service providers such as school psychologists, social workers, and counselors.

II. Expand Harm Reduction Services

Harm reduction efforts help connect PWUD to information, tools, services, and treatment.

★ ★ ★ ★ ★ ★

Increase access to sites through community outreach, for medical and substance use disorder treatment and low-threshold programs, to bring more services to people who need them and to reduce stigma.

(SAMSHA/CDC)

Background: Community outreach and service aims to reduce stigma and negative treatment. Meeting PWUD where they are in the community, including with harm reduction (e.g. naloxone) and low-threshold services (e.g. assisting with virtual buprenorphine initiation appointments), can reduce access barriers and improve services for PWUD.

Action: Expand and promote community outreach to medical services that include harm reduction, where not prohibited by law, to increase access to health services, overdose support, and treatment for PWUD.

Bring visibility to low-barrier care models and emergency department behavioral health bridge clinics

(SAMHSA/CMS)

Background: Emergency departments are not universally designed or equipped to manage people with mental illness and SUD. Most emergency department providers do not have expertise in behavioral health and SUD and/or may engage in stigmatizing behaviors.[294,295] The complexity of patients with significant medical and psychiatric comorbid conditions reveals gaps in care and the need for a multidisciplinary team approach to improve outcomes.[296]

Low-barrier models seek to minimize the demands placed on clients and make services readily available and easily accessible. These models facilitate engagement in treatment; promote non-judgmental, welcoming, and accepting environments; and demonstrate how low-barrier models of care meet people where they are. These models also provide culturally responsive and trauma-informed care, tailored to the unique circumstances and challenges that each person faces. A recent study of a low-barrier bridge clinics serving individuals with opioid, alcohol, stimulant, sedative/hypnotic, and cannabis use disorders found that 70 percent of clients were engaged in treatment, which is higher than national averages.[297]

Action: Communicate best practice models of low-barrier programs and emergency departments and SUD bridge clinics, in order to increase access to services and reduce morbidity and mortality.

III. Improving Treatment Screening and Access

More people need to be screened, assessed, and treated. Many require assistance navigating health systems and finding in-network providers. Barriers still exist in provider networks, medications are not stocked in pharmacies, more of the workforce must be developed and trained, and advances in technology and health information technology must be adopted.

★ ★ ★ ★ ★ ★

Provide treatment navigation and entry assistance.

(HHS/CMS/CDC/NIH/SAMHSA; ONDCP)

Background: Parents, caregivers, and family members may not understand how to navigate treatment options for SUD and access care for their loved ones. Providers assist in making referrals to appropriate services, but too often reimbursement of services is denied. Health plans often have inadequate SUD provider networks, forcing individuals to go out-of-network and pay increased costs. To ensure equitable coverage for mental health and SUD treatment, Labor, HHS, and Treasury recently proposed rules[298] to update regulations implementing the Mental Health Parity and Addiction Equity Act.[299] Treatment navigators are more likely to succeed in connecting patients to care, providing valuable assistance in this complex process. For these reasons, insurance plans should include treatment navigation services and share lists of active in-network [300] providers in their plans that can help integrate SUD treatment services into mainstream health settings and other trusted establishments near where patients live.

Action: Research reimbursement for patient navigation services from primary care to improve access to needed SUD services. Encourage insurers to incentivize providers to join their networks.

Reduce remaining medications for opioid use disorder and overdose reversal medication barriers.

(ONDCP; HHS/CMS/FDA/SAMHSA/CDC/HRSA/IHS/NIDA; DOJ/DEA; VA; DOD)

Background: Elimination of the X-waiver[301] should increase prescribing of buprenorphine, but barriers to access still exist. Some insurers still require prior authorization for this life-saving drug,[302] but many states have introduced legislation to right-size or eliminate prior authorization.[303] In addition, some pharmacies may not stock, or under-stock, buprenorphine and extended-release naltrexone, creating a barrier to treatment for people prescribed this MOUD. Naloxone, the life-saving OORM, is not stocked by many pharmacies, even in states with standing orders.[304] This practice of under-stocking at the pharmacy-level may impede the ability of people who use opioids to start or maintain pharmacotherapy.[305]

Action: Encourage health plans to no longer require prior authorization for life-saving medications, like buprenorphine (as many states have done[306]) and extended-release naltrexone. Explore pharmacy stocking challenges to better understand the disparate availability of buprenorphine, extended-release naltrexone, and naloxone. Collaborate on strategies to increase availability, including looking at thresholds established by distributors. Increase provider efforts, including pharmacists, to support people who need treatment services and help them access and remain engaged in care with needed medications.

Expand access to mobile treatment vehicles.

(DEA; SAMHSA/HRSA/IHS/NIDA)

Background: Mobile units are a service delivery model that can help reach people who are less likely to be engaged with the health care system or may not have access to treatment for a SUD, such as in rural communities and, at homeless shelters, encampments, and

★ ★ ★ ★ ★ ★

correctional facilities.[307] Mobile units are a practical way to engage people in these settings with treatment and crisis psychotherapy services. Federal agencies have made funding available for mobile treatment, yet nationally there has been little uptake.[308]

Action: Assess the implementation of mobile units to understand and reduce barriers to utilizing this proven method of service delivery.

Integrate medications for opioid use disorder and substance use disorder training into core substance use disorder academic curriculum.

(ONDCP; SAMHSA)

Background: Many health professionals see patients with SUDs, but they may not be trained to appropriately assess or provide treatment. More health professionals should receive training on SUD,[309] treatment strategies, and overdose prevention and reversal early in their academic careers and throughout their training programs.

Action: In collaboration with federal partners, relevant stakeholder groups and external experts, integrate MOUD training into SUD core curriculum development within training programs at health professions schools.

Improve payment for integrated care.

(HHS/CMS/SAMHSA)

Background: Improved reimbursement rates that support services for office-based SUD treatment help patients confronting complex health challenges to more easily access and participate in care. This can also help address deficits in SUD care caused by social determinants of health, which is important to achieving sustained positive outcomes. CMS enhanced reimbursement for extended 45-minute sessions for psychotherapy with patients, which is critical for treating older adults and people with disabilities who have SUD.[310] CMS also recently finalized policies in the calendar year 2024 Physician Fee Schedule rule to pay for Community Health Integration services provided by certified or trained auxiliary personnel, including community health workers, when working under the supervision of a physician or other qualified health professionals to address these issues.[311] SAMHSA's final 42 CFR Part 8 rule also provides new and strengthened opportunities for broader integrated physical and behavioral health services to be offered through OTPs.

Action: CMS should bring visibility to these new reimbursement opportunities with a letter to State Medicaid Directors and State Opioid Authorities.

Explore utility of admission, discharge, transfer electronic patient event notifications.

(HHS/ASPE/CMS/ONC/SAMHSA)

Background: Automated, electronic notifications of patient discharge, sent simultaneously to both the receiving practitioner and patient to alert them of the setting and services received by the patient, can facilitate care coordination and appropriate follow-up. CMS regulations require that certain health care providers send admission, discharge, and transfer

notifications. These notifications could align with emergency department overdose follow-up reporting, and improve data reporting of SUD services by federal partners. Evidence in the literature supports these notifications as a way to improve care coordination.[312]

Action: Explore the use of automated, electronic notifications from a discharging provider that alert other providers that a patient with SUD has received care at a different setting. Learn more how the current admission, discharge, and transfer requirements apply to, and can be improved for, behavioral health.

Integrate standardized screening and assessment tools into electronic health records.

(HHS/CMS/ONC/SAMHSA; VA)

Background: Some electronic health record (EHR) developers have standardized screening and assessment tools integrated into their systems. NIDA has published technical specifications for EHRs for the Tobacco, Alcohol, Prescription medication and other Substance use (TAPS) Tool[313] and the Drug Abuse Screen Test (DAST-10).[314] The inclusion of screening and assessment tools in EHRs in mainstream healthcare, such as NIDA screening tools for adult and adolescent substance use,[315] would standardize screening measures for SUD. Making these measures widely available within EHRs might support clinical efforts to increase the identification of people with SUDs and increase the likelihood of referring to needed treatment services and medications.

Action: Explore the extent to which EHR developers have integrated standardized screening and assessment tools for SUD into their EHR systems. Explore the inclusion of a voluntary certification criterion to which all certified EHR technology developers could certify in order to adopt this functionality and thereby increase the identification of people with SUD.

Add more behavioral health and substance use data elements to the United States Core Data for Interoperability as a component of the case finding initiative.

(HHS/ONC/SAMHSA; ONDCP)

Background: The United States Core Data for Interoperability is a standardized set of health data classes and constituent data elements for nationwide, interoperable health information exchange. Ensuring that EHRs include data fields that are capable of collecting specific information relating to behavioral health, including substance use, is critical to improving access to care and informing the Cascade of Care. The Office of the National Coordinator for Health Information Technology (ONC) recently added data elements for Alcohol Use and Substance Use to the Health Status Assessments data class in the United States Core Data for Interoperability Version 4.[316] SAMHSA and ONC's recent collaboration on identifying and integrating more standard behavioral health measures into the United States Core Data for Interoperability Plus data set provides an opportunity for further advancing EHR inclusion of key SUD elements.

★ ★ ★ ★ ★ ★

Action: Explore whether EHRs and United States Core Data for Interoperability could include data fields that are capable of collecting specific information relating to behavioral health, including substance use, to improve access to SUD services in mainstream healthcare.

Integrate patient self-administered substance use screening tools into electronic health records.

(HHS/ONC/CMS/NIH's NIDA/SAMHSA)

Background: Federal agencies have previously invested in technologies that enable patients to conduct self-administered substance use screenings using tablet computers or other media devices and portals. Patient portals also have the capability to enable patients to complete medical history and other medical forms prior to a doctor's appointment. Further work remains to identify whether these tools can integrate information into a patient's EHR, while ensuring privacy protections.

Action: Research integration of screening tools into EHRs. Examine patient preferences for conducting self-administered screening questionnaires, with a view to equity and privacy, as well as the validity of these responses.

Train more providers to deliver treatment.

(HHS/CDC/CMS/SAMHSA/HRSA/NIDA/IHS; VA; DOL)

Background: Expanded training on SUD for health care providers is needed to ensure a well-trained workforce, increase access to SUD services, and alleviate provider shortages. The requirement for providers to register with the DEA to prescribe MOUD was eliminated, removing a barrier to expand providers prescribing buprenorphine and saving lives. Providers are required to receive training for renewal of a DEA license to prescribe controlled medications.

Action: Promote the expansion of SUD training to an array of healthcare providers, while continuing support for Addiction Medicine Fellowships,[317] such as social workers, physician assistants, nurses, licensed counselors, and other medical specialists, including in primary care, family medicine, obstetrics and gynecology, and correctional care settings. Promote Registered Apprenticeships for Peer Recovery Support Specialists to increase the SUD workforce. Review payment rates for SUD providers across healthcare, including peer specialists in a move towards equity and to keep providers practicing in the SUD field. Promote health workforce and health careers pipeline programs to focus on the recruitment, retention, and support of trainees from disadvantaged and/or underrepresented backgrounds, to improve the distribution of health professionals in high need areas. Identify optimal training approaches through implementation science.

IV. Recovery

Successful recovery requires employment, supportive employment environments, peer recovery support to help people transition to the community, and peer recovery support specialists to help people transition to community treatment and other support services.

★ ★ ★ ★ ★ ★

Use Individual Placement and Support models of employment for people in treatment.

(HHS/DOL/VA)

Background: Employment is a critical form of recovery capital associated with improved long-term outcomes. People in treatment benefit from IPS, an evidence-based employment model under which an employment specialist supports both the person who is placed in a workplace and the employer.[318] ONDCP led an interagency effort to develop the *Recovery Ready Workplace Resource Hub,* hosted by the ETA at the Department of Labor. The hub is regularly updated with new resources.

Action: Identify and implement strategies to facilitate successful transitions from treatment to employment in the community by promoting IPS through employment specialists.

Embrace peer recovery support linkages to care to help people transition to sustained recovery in the community.

(SAMHSA)

Background: While peer support services may be provided by peer workers employed by a treatment provider, they can have maximal impact when provided through a RCO or similar independent, community-based non-profit entity.[319] This permits the services to include engagement and linkage with treatment, support during and after treatment, and a potential pathway to recovery when treatment is unavailable or is declined. Co-location agreements between treatment providers and RCOs provides a mechanism for integrating these critical non-clinical services with treatment.

Action: Expand the Nation's peer recovery support services workforce (peer navigators, certified peer recovery specialists, peer support specialists) and the organizational infrastructure critical to it, including healthcare and treatment providers, RCOs, recovery residences, recovery high schools[320] (secondary schools designed specifically for students in recovery from SUD or co-occurring disorders), and collegiate recovery programs.

Engage overdose survivors as peer workers in the emergency department, healthcare settings and in the community.

(SAMHSA/NIH's NIDA/VA)

Background: Peer workers are increasingly playing a critical role by engaging with overdose survivors in emergency departments[321,322,323] and in the community.[324, 325] Peers with similar lived experience to those they serve have unique authenticity as messengers and helpers, especially among people with a long history of marginalization and poor treatment in mainstream healthcare settings. They can link overdose survivors to treatment, harm reduction, and recovery support services, and can provide a constant point of contact to patients contemplating or embarking on the pathway to recovery.

Action: Develop and promulgate best practices that promote the use of peer workers to engage with overdose survivors and others with SUD through emergency departments, other hospital settings, healthcare settings, and in the community.

★ ★ ★ ★ ★ ★

Use peer support to assist patients receiving treatment through primary care settings.

(SAMHSA/CMS/HRSA/IHS/VA)

Background: Peers have been found to be successful in helping support people in accessing treatment, linking individuals in treatment to other community resources, and connecting them with the community of recovering peers.[326]

Action: Integrate peer support specialists into primary care settings to assist in transitioning patients to treatment leveraging peers employed by RCOs and other peer-led organizations whenever possible.

★ ★ ★ ★ ★ ★

Appendix B: *Drug Data Plan*

Evidence-based approaches are essential to all aspects of the federal government's efforts to address the overdose crisis. Developing effective policies, which can improve community health and safety, reduce economic burdens associated with drug use, and, above all, save lives, requires timely, accurate, comprehensive, and geographically precise data. Community-level actors, as well, need data-driven insights to understand the harms from illicit drug activities and to facilitate treatment, harm reduction, and recovery services.

The SUPPORT Act requires ONDCP to develop "a systematic plan for increasing data collection" to advance a range of goals related to addressing the overdose crisis. This appendix lays out this plan, hereafter referred to as the 2024 *Drug Data Plan* (*Plan*). The 2024 *Plan* builds on the prior 2023 *Plan*, which outlines a range of planned and ongoing data collection efforts that remain relevant for these goals. These elements of the 2023 *Plan* are incorporated by reference herein, thereby serving to fulfill the requirements set forth in statute.

Building on the analysis and actions set forth in the 2023 *Plan*, the rest of the 2024 *Plan* first describes recent progress improving data collection and analysis before discussing additional priority data collection activities. These additional areas of focus are (1) collection of equity-related data, (2) data regarding nonfatal drug poisonings, and (3) use of wastewater data as an indicator of drug consumption patterns. The Drug Data IWG, which ONDCP convened in March 2023, identified each of these areas as a priority.

Developing Policy-Relevant Data and Evidence

The 2023 *Plan* included a list of policy-relevant questions for which data is needed on a wide variety of topics. These topics included drug overdose treatment and recovery; drug supply and emerging threats; the epidemiology of substance use and SUD, including primary prevention; poly-substance use and comorbidity; harm reduction; the overall response to the overdose crisis; and correlates of drug policy. Federal agencies have made significant progress developing data, metrics, and other evidence to address these questions, including evidence such as the following:

- Barriers that impede the use of MOUD;[327,328]
- The impact of expanding treatment services during the COVID-19 pandemic;[329,330]
- Receipt of OUD and behavioral health-related telehealth services among Medicare beneficiaries;[331,332]
- Assessments of states' completeness of documenting external cause of injury for emergency department visits and hospitalizations;[333,334]
- Incidence of unintentional drug overdose, suicide, and other mortality among emergency department patients presenting with a nonfatal overdose;[335,336]
- Trends in nonfatal overdose encounters with EMS at the county-level;[337]
- Risk factors, morbidity, mortality, and potential interventions to improve health and recovery among specific occupations;[338,339,340,341]
- Trends in fatal overdoses by select substances, such as antihistamines[342] and para-fluorofentanyl;[343] and

★ ★ ★ ★ ★ ★

- Trends in fatal overdoses by age;[344] race/ethnicity; specific circumstances surrounding overdoses; and county-level data on social, environmental, and economic factors that influence health (including income inequality and treatment provider availability).[345]

Key Questions Requiring Further Evidence

As discussed above, federal agencies have made significant progress developing data, metrics, and other evidence to address policy-relevant questions identified in the 2023 *Plan*. Although the topics and questions identified in that plan remain relevant for the overdose crisis, the rest of the 2024 *Plan*, therefore, addresses questions related to the priority areas identified by the IWG: (1) equity-related data, (2) nonfatal overdoses, and (3) wastewater testing as an indicator of drug consumption.

Advancing Equity for Historically Underserved Communities

Federal agencies are working to ensure that drug data systems accurately capture data to support historically underserved populations. These efforts include capturing data about people's age, race/ethnicity, disability, income, SOGI, and other key sociodemographic characteristics. It also includes collecting information required to serve specific populations, such as residents of rural and Tribal communities; English language learners; people involved in the criminal justice system; those experiencing homelessness; active military, veterans, and military spouses; people with co-occurring mental illness and SUDs; people who inject drugs; and substance-exposed infants and children. These data-gathering steps are essential for advancing equity. Disaggregating relevant data by key population characteristics, while respecting Tribal sovereignty and Tribal data ownership, and consistent with ethical and privacy-respecting data practices, facilitates targeted actions that improve outcomes for underserved communities.

Below are policy questions that could be answered by improved equity-related data collection:

- Do disparities exist by age, race/ethnicity, SOGI, or other key sociodemographic characteristics in terms of use of specific substances and their related consequences? If so, what factors may contribute to these disparities (e.g., ACEs, occupation, socioeconomic conditions, housing stability)?
- What factors are contributing to increases in overdose mortality among certain populations (e.g., adolescents and youth, African Americans, and American Indian and Alaska Native populations)? Factors that could be explored include, but are not limited to, access to treatment, harm reduction, and prevention services; drug use behaviors; and other socioeconomic conditions.
- What is the prevalence of SUD among historically underserved populations, including, but not limited to, people involved in the criminal justice system, those experiencing homelessness, and people with co-occurring mental illness?
- Do inequities exist by age, race/ethnicity, SOGI, or other key sociodemographic characteristics in terms of access to prevention, treatment, and harm reduction services? If so, what factors may contribute to these inequities and what interventions are most effective among these populations?

★ ★ ★ ★ ★ ★

- Did flexibilities during the COVID-19 pandemic improve access to SUD treatment services for underserved communities and how did these changes impact inequities in access between different populations?
- What underlying individual factors or life experiences are associated with prior or future drug use and its related consequences, including, but not limited to, disability, military service, housing instability, trauma, and ACEs?

Nonfatal Overdose

Nonfatal overdose is a key risk factor for a future drug overdose death. Timely, comprehensive, and geographically precise nonfatal overdose data can inform local communities about the dangers of the illicit drug supply and inform resource distribution (e.g., of OORM). Each nonfatal overdose also represents an opportunity to connect people with essential treatment and harm reduction services, which can save lives and facilitate recovery. However, as the IWG observed, current systems that track nonfatal overdose only cover people interacting with first responders or with the healthcare system, creating a significant blind spot in this important data.

Below are policy questions that could be answered by improving nonfatal overdose data:

- How are overdose trends similar or different across nonfatal overdose data sources (such as emergency department visits and EMS encounters)?
- What is the geographic and sociodemographic distribution of nonfatal overdoses and which drugs are involved?
- How many opioid overdoses are reversed by non-medical personnel in the community (e.g., by friends or family members, school administrators, or harm reduction organizations, or on college campuses)?
- How many opioid overdoses are observed by bystanders who do not have naloxone or another OORM?
- What is the impact of medically underserved areas (e.g., geographic areas with shortages in emergency departments, EMS providers, pharmacies, SUD treatment providers, and harm reduction organizations) on fatal and nonfatal overdose outcomes?
- What proportion of people who experience a nonfatal overdose receive medical or behavioral health follow-up care (e.g., from a treatment provider or harm reduction organization)?
- Is the data quality for fatal and nonfatal overdoses across the country sufficient to calculate the ratio of nonfatal to fatal overdoses? If so, to what extent does this ratio vary by substance, geographic location, and sociodemographic characteristics?
- What is the relative effectiveness of different methods (and the combination of multiple methods) for responding to overdoses for different types of drugs (e.g., administration of OORM, rescue breathing, or supplemental oxygen)?
- How do law enforcement and public health agencies identify and respond to overdose hotspots?
- How many unique overdose events are treated in multiple care settings (e.g., by EMS and emergency departments)?

★ ★ ★ ★ ★ ★

- Do state and local communities have sufficient naloxone or other OORM to respond to the number of nonfatal and fatal opioid overdoses that occurred in the past year?
- What proportion of first responders are trained to respond to opioid overdoses?

Wastewater Testing

Wastewater testing, as a potential proxy for drug consumption, can provide valuable insights into the supply and demand of both licit and illicit drugs. Although it cannot differentiate between licit and illicit drug use, this testing can assist with formulating strategies, programs, and policies; resource allocation; and assessing policies' effectiveness. To collect wastewater samples in an ethical and privacy-preserving manner, wastewater testing should be conducted on a population-level scale and in a de-identified, non-invasive manner, which would prevent the targeting of individuals.

The discontinued *What America's Users Spend on Illegal Drugs* series,[346] which used consumption estimates from the formerly operational Arrestee Drug Abuse Monitoring (ADAM and ADAM II) programs, also demonstrated that consumption data can help estimate drug use's economic impacts.[347,348] This data helped uncover that a small number of people using drugs heavily were responsible for the majority of drugs consumed — an important finding for contextualizing drug prevalence information. While programs exist for identifying emerging and evolving illicit drugs in the market (e.g., testing of seized drugs, used syringe testing, and toxicological testing), gaps exist with data collection efforts that allow for estimating total drug consumption. Wastewater testing can help fill this gap.

Below are policy questions that could be answered by robust wastewater testing data:

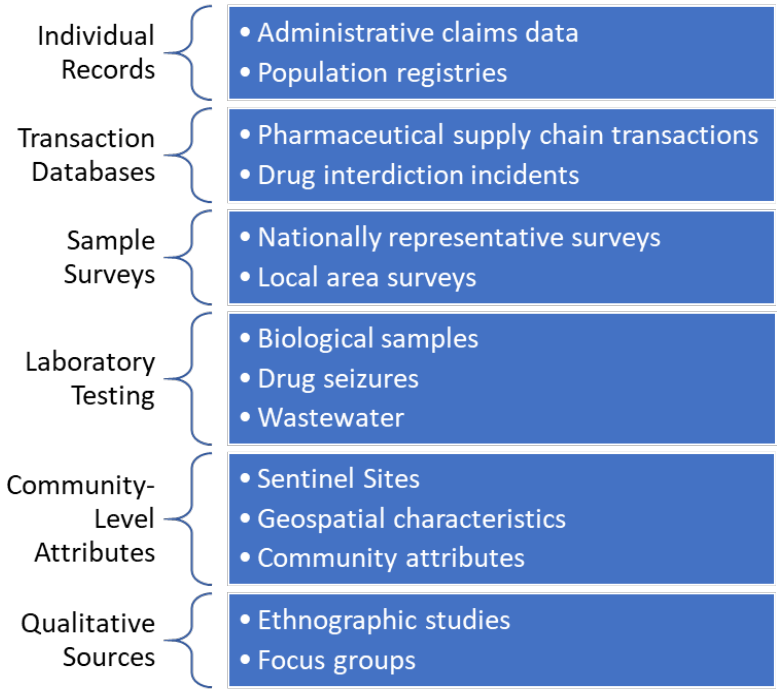
- What is the amount (and amount per capita) of drugs consumed at the local, state, and national levels?
- Which specific substances are being consumed by PWUD (this could include licit and illicit drugs, novel psychoactive substances, as well as potential adulterants, bulking agents, or contaminants)?
- Can wastewater data combined with drug seizure data be used to estimate the total amount of drugs being supplied to United States markets?
- What is the effectiveness of drug interdiction operations on the availability of drugs in specific geographic areas? Does effectiveness of these interventions vary by drug type?
- What is the relationship between the amount of drugs consumed and subsequent health outcomes within specific geographic areas?
- Which specific geographic locations have the highest drug consumption per capita and which specific interventions may be most effective in these locations?
- Can wastewater data help identify specific geographic locations with more lethal drug supplies?

★ ★ ★ ★ ★ ★

List of Data Needed to be Collected or Acquired and Used to Facilitate the Use of Evidence in Drug Control Policymaking and Monitoring

Federal agencies formulating and implementing drug policy rely on a number of federally funded data sources, as well as data collected by state, local, and commercial entities. Data may originate from a range of sources, including from individual records, databases of transaction events, nationally representative surveys, laboratory testing of biological specimens or drug seizure samples, community-level attributes, qualitative measurements, and other potential sources. Figure 1 provides illustrative examples of potential data sources.

Figure 1: Types of Data Sources for Informing Drug Policy



The 2023 *Plan* described numerous existing federal data sources, each with their own strengths and limitations. These data sources are each still relevant to build evidence to support the *Strategy*. The 2024 *Plan* therefore focuses on providing existing data sources with potential to capture data related to the three IWG focus areas discussed above.

Timely and Equity-Related Data

Obtaining timely and equity-related data may require modifying existing data sources. Table 1 provides a list of existing data sources that could, if updated, report timelier drug data, building on ongoing collection efforts. These data sources primarily consist of programmatic or administrative datasets, which tend to involver faster data processing than nationally representative surveys (which require large sample sizes and rely on voluntary participation from

respondents). Key topics covered by these data sources include drug seizures, fatal and nonfatal overdoses, and treatment.

Table 1: List of Data Sources with Potential to More Frequently Report Timely Drug Data

Abbreviation	*Data Source*	*Agency*
ARCOS	Automated Reports and Consolidated Ordering System	DEA
CCDB	Consolidated Counterdrug Database	DIA
CCW	Chronic Conditions Data Warehouse	CMS
DOSE	Drug Overdose Surveillance and Epidemiology	CDC
HCUP	Healthcare Cost and Utilization Project	AHRQ
NEMSIS	National Emergency Medical Services Information System	NHTSA
NFLIS	National Forensic Laboratory Information System	DEA
NSS	National Seizure System	DEA
NVSS-Mortality	National Vital Statistics System Provisional Mortality Data	CDC
ODMAP	Overdose Detection Mapping Application Program	ONDCP
TEDS	Treatment Episode Data Set	SAMHSA
T-MSIS	Transformed Medicaid Statistical Information System	CMS

Table 2 provides a list of existing data sources that could, if updated, collect new equity-related data concepts. The list includes programmatic and administrative datasets, as well as national surveys. Many of these data sources already collect information on people's age, race/ethnicity, SOGI, as well as other key sociodemographic characteristics, but require updating to conform with best practices.

★ ★ ★ ★ ★ ★

Table 2: List of Data Sources with Potential to Capture Equity-Related Drug Data

Abbreviation	*Data Source*	*Agency*
CMS	Centers for Medicare and Medicaid Services Claims Data	CMS
DAWN	Drug Abuse Warning System	SAMHSA
DOSE	Drug Overdose Surveillance and Epidemiology	CDC
HCUP	Healthcare Cost and Utilization Project	AHRQ
COJ	Census of Local Jails	OJP
MTF	Monitoring the Future	NIDA
NEMSIS	National Emergency Medical Services Information System	NHTSA
NSDUH	National Survey on Drug Use and Health	SAMHSA
N-SUMHSS	National Substance Use and Mental Health Services Survey	SAMHSA
NVSS-Mortality	National Vital Statistics System Mortality data, Final or Provisional	CDC
NYTS	National Youth Tobacco Survey	CDC
ODMAP	Overdose Detection Mapping Application Program	ONDCP
SUDORS	State Unintentional Drug Overdose Reporting System	CDC
TEDS	Treatment Episode Data Set	SAMHSA
YRBSS	Youth Risk Behavior Surveillance System	CDC

Some agencies, such as the Veterans Health Administration (VHA), Defense Health Agency, BOP, and IHS provide medical care to historically underserved populations and likely document SUD treatment and diagnosis information through the course of providing care to these populations. These data sources are excluded from Tables 1 and 2 given that they involve protected health information. They would therefore likely need to be aggregated and de-identified in accordance with applicable privacy laws and regulations if used to inform policy and programmatic decision-making.

Nonfatal Drug Overdose Data Sources

State- and national-level data collection systems mainly rely on emergency department visits to estimate a community's number of nonfatal overdoses. However, not all people who experience nonfatal overdoses receive care in a hospital. Obtaining a more accurate picture of nonfatal overdose trends thus requires complementary data sources from EMS, law enforcement, and other community programs, which might respond to nonfatal overdoses. Table 3 provides a list of existing data sources that capture nonfatal drug overdose data.

★ ★ ★ ★ ★ ★

Table 3: List of Data Sources That Capture Nonfatal Drug Overdose Data

Abbreviation	*Data Source*	*Agency*
DAWN	Drug Abuse Warning System	SAMHSA
DOSE	Drug Overdose Surveillance and Epidemiology	CDC
HCUP	Healthcare Cost and Utilization Project	AHRQ
NHBS	National HIV Behavioral Surveillance	CDC
NEISS-CADES	National Electronic Injury Surveillance System — Cooperative Adverse Drug Event Surveillance	CDC, CPSC, and FDA
NEMSIS	National Emergency Medical Services Information System	NHTSA
NSSSP	National Survey of Syringe Service Programs	CDC
ODMAP	Overdose Detection Mapping Application Program	ONDCP

Each source provides unique insights about the number of nonfatal overdoses that are treated in the pre-hospital and hospital care settings. However, these systems likely respond to many of the same overdose events (e.g., if a person is treated by EMS and then transported to an emergency department). These data sources, if combined, could therefore count nonfatal overdoses multiple times, producing substantial overestimates of the country's number of nonfatal overdoses. Methods of combining or deduplicating these sources are needed to produce more accurate estimates, in addition to tracking nonfatal overdoses reversed by non-medical personnel (not captured in these sources). Additional sources of data (e.g., poison control centers and electronic health records) could also be leveraged to gain further insights on nonfatal overdose.

Wastewater Testing and Other Novel Data Sources to Assess Drug Consumption

The United States currently has significant gaps in information on drug consumption. NDCPA currently rely on national surveys (such as NSDUH and MTF) to estimate the number of people who report using licit and illicit drugs in a given time period (past month, past year, or lifetime use). These surveys rely on voluntary, self-reported engagement in stigma and potentially illegal behaviors and do not cover high-risk populations (such as people involved in the criminal justice system, those experiencing homelessness, and youth no longer enrolled in school). Complicating matters, mixtures of illicit substances, in the form of powders, tars, pills, and counterfeit prescription drugs are becoming more common and PWUD may be unaware and therefore unable to accurately report the types and quantities of drugs they are consuming. These national surveys provide valuable information but are unable to quantify the total amount of drugs consumed or identify emerging substances added to the drug supply. Similarly, drug seizure data provide estimates on the types and volume of drugs seized by law enforcement (using the national seizure system [NSS] and NFLIS), but these data cannot be used to accurately extrapolate the volume of drugs consumed by PWUD.

Several data sources could be modified, acquired, or expanded to improve our understanding of drug consumption patterns. For example, a number of state and local jurisdictions currently

★ ★ ★ ★ ★ ★

conduct wastewater testing to better understand drug consumption within their communities. These could serve as examples for wastewater testing programs in other states. Jurisdictions are currently testing wastewater for opioids (including oxycodone, codeine, heroin, and fentanyl), cocaine, methamphetamine, and xylazine.[349,350,351,352,353,354] Other novel data systems that could be acquired include Millennium Health Urine Drug Testing[355] and the National Emergency Department Drug Surveillance System,[356] both of which retest urine samples for a wider panel of drugs, and which can be used to analyze trends among patients interacting with the healthcare system.

List of Methods and Analytical Approaches that May Be Used to Develop Evidence

Addressing the overdose epidemic in a comprehensive, timely, and equitable manner requires the utilization of multiple methods for collecting and analyzing drug data. The previous *Plan* provided a list of methods and analytical approaches that are used to develop evidence to support the *Strategy*. These included research and development; utilizing novel research tools; the use of sentinel sites, record linkage, geospatial analysis, qualitative and other exploratory methods; modeling and synthesis; and translational research. These methods are still appropriate for developing evidence to support drug policy. This section describes additional methods and approaches identified by Drug Data IWG participants.

Wastewater Testing Methods

Wastewater testing is a timely approach for analyzing the presence and amount of substances excreted by the human body into the wastewater treatment system. This technique was widely used in the United States during the COVID-19 pandemic as an early warning system to track the presence of SARS-CoV-2 in wastewater samples. Wastewater testing has the potential to complement traditional, yet important, self-reporting methods and testing of biospecimens to measure drug use by informing an estimate of the total amount of drugs consumed within a given population.

Further work remains to better understand the sensitivity and specificity of wastewater testing and the impact of potential confounding variables on drug consumption estimates and trends over time. NIDA and NIJ are currently funding work to better understand the utility and limitations of this novel method.[357,358] This technique has been successfully applied internationally and in a few United States jurisdictions to estimate the consumption of prescription and illicit drugs, as well as novel psychoactive substances.[359,360]

Wastewater testing follows the basic principle that any given compound that is consumed will subsequently be excreted either in its original chemical form or as a metabolite that was modified during the body's clearance process. Once these compounds are excreted into the sewer system, water samples can be collected at wastewater treatment plants and subsequently tested to measure the concentration of the excreted compound of interest. This compound concentration estimate can be used to calculate the total mass of metabolite excreted, as well as the total mass and number of doses of drug consumed. Sampling should be conducted on a population-scale and in a de-identified and non-invasive manner so that people cannot be targeted and their

privacy is respected (see more in Ethical and Privacy Concerns). This approach provides wider coverage of populations, uses objective measures of analytes found in wastewater, and provides results within a week of sampling yielding comprehensive, accurate, and timely data for practitioners and policymakers.

Re-Testing Urine and Other Biological Samples

Urine drug testing is the most common toxicological test of body fluid samples in medical settings. Positive urine tests can confirm the use of one or multiple drugs; however, the window of detection can vary depending on the substance or frequency of use.[361] Currently, toxicology screens in hospitals tend to be limited to the use of common substances (such as cannabinoids, cocaine, amphetamines, opiates, and phencyclidine), but may not include fentanyl.[362] To address this limitation, centralized surveillance systems could collect and re-test urine samples for a wider panel of drugs among populations at higher risk of fatal overdose (e.g., people who visit the emergency department for a nonfatal overdose). This could provide useful insights on local drug use patterns, including polydrug use, and identify the presence of novel psychoactive substances (such as xylazine) in the drug supply. As described in the Data Sources section, Millennium Health's Urine Drug Testing and the University of Maryland's National Emergency Department Drug Surveillance System are both examples of data systems which are re-testing urine samples for a wider panel of drugs to identify emerging drugs and analyze trends in drugs consumed among patients interacting with the healthcare system. CDC and NIDA are also collaborating to conduct a Fentalog Study which re-tests leftover blood samples on a panel of over 900 substances.[363]

Community Vulnerability Indices

Community vulnerability indices combine health, social, economic, and environmental conditions within specific geographic areas to better understand where and how communities are impacted by certain issues. Vulnerability indices could be developed and applied in the context of drug overdose to inform where prevention, treatment, and harm reduction programs should be located and how to better reach vulnerable and underserved communities. In 2018, CDC provided funding to develop and disseminate jurisdictional-level vulnerability assessments to identify sub-regional areas at higher risk for opioid overdoses and/or bloodborne infections associated with non-sterile injection drug use.[364,365] The White House Council on Environmental Quality,[366] CDC,[367] and Census Bureau[368] have all developed similar approaches to developing community vulnerability indices for non-drug use cases.

★ ★ ★ ★ ★ ★

List of Challenges to Developing Evidence to Support Policymaking, including Barriers to Accessing, Collecting, or Using Relevant Data

Federal agencies face myriad challenges associated with collecting, reporting, and using timely and equity-related drug data. The 2023 *Plan* provided a list of challenges to developing evidence to support the *Strategy*. These include timeliness and accuracy, national data versus smaller geographic areas, demographic specificity of sub-populations of interest, logistics and ethics of record linkage, resources and staffing, and making drug data and research results accessible to policymakers. Each of these challenges is still relevant for developing evidence to support drug policy. This section emphasizes additional challenges specific to data concepts prioritized by the IWG.

Balancing Data Timeliness and Quality

When developing any data system, timeliness can trade off with comprehensiveness, accuracy, and standardization. Aggregate data, moreover, can be only as timely as the slowest reporter. This concept permeates all types of drug data and requires a delicate balance. For example, at the state level, states (and their associated contractors) rely on reporting from hospitals, treatment providers, law enforcement agencies, and other drug control entities. As states collect this data, they must make decisions based on their need for timely decision-making and the level of comprehensiveness and accuracy of data reported. Additionally, at the national level, the federal government relies on reporting from each state and must determine at what point reliable national estimates can be produced to inform policy.

Standardization, similarly, ensures that data is reported in a consistent manner that allows decision-makers to make meaningful comparisons between populations. The importance of standardization is illustrated by monitoring emergency department visits for nonfatal drug overdose. For example, syndromic surveillance uses preliminary diagnoses and chief complaint descriptions to assess changing trends rapidly within a state. However, this approach is not suitable for providing overall counts, nor are its estimates comparable between states due to variation in the quality and consistency of data reported by hospitals.[369] On the other hand, hospital discharge data, which is reported using standardized billing codes, can provide more accurate count estimates that enable comparisons between states. Timeliness of this data, meanwhile, can lag by several months due to quality assurance tasks associated with finalizing diagnosis information for billing purposes.

Drug data practitioners should be transparent regarding their methods of balancing timeliness of data with comprehensiveness, accuracy, and standardization. CDC is a data steward that manages these challenges well through their reporting of provisional and final drug overdose death estimates.

Sample Size Limitations

Data practitioners must be mindful of risks involving small samples sizes and use strategies, when necessary, to ensure a sufficient sample size for producing reliable estimates. Certain

illicit drug use behaviors (e.g., past month heroin use) and their related consequences can describe relatively rare events (further exacerbated by underreporting) even when occurring within the general population. When disaggregated by specific racial, ethnic, or SOGI subpopulations, the sample sizes will be even smaller.

Sample sizes have significant implications for re-identification, concerns related to privacy and security, as well as the statistical interpretation of data findings. Drug data contains sensitive information about law enforcement operations, as well as people's medical conditions or behaviors that could carry social stigma or legal consequences if disclosed. Moreover, sample size affects the ability to detect statistical differences between groups. If an analysis is underpowered, or the sample size is too small, the analysis might reveal no statistically significant differences between groups even when differences do, in fact, exist.[370] These issues hinder policies targeted to help historically underserved communities.

During the planning stages of developing a drug data system or conducting a research study, data practitioners may find it helpful to conduct a power analysis for key drug outcomes. This analysis will help determine whether a sample is sufficiently large to detect policy-relevant differences between populations. If a sample size is too small, drug data practitioners should deploy strategies to increase sample size, such as by combining data across multiple time points (such as combining the years 2022 and 2023, instead of using only one year), broadening the sample to a larger geographic area (such as by going from city to state), or collapsing sociodemographic categories to a larger group. Data practitioners should be mindful of these strategies and consider how the resulting data will be used to inform decision-making prior to initiating a data collection.

Ethical and Privacy Considerations

Data practitioners must collect and use data in an ethical manner that ensures privacy for all people, especially for vulnerable populations and American Indian and Alaska Natives residing on Tribal lands. Given the stigma that affects PWUD, and the possible legal consequences for drug use, drug data collection must always balance data specificity with the need for confidentiality. Additionally, data collection must comply with applicable privacy rules (e.g., the Health Insurance Portability and Accountability Act Privacy Rule and 42 CFR Part 2, which governs the confidentiality of SUD patient information). If sensitive drug data is revealed in an unauthorized manner, it could be used to target people, deny them access to programs or services, or cause other harms. If an agency reports small numbers in tables or other reports, it must do so in a way to protect the identities of people and Tribal Nations.

Equity-related data should be collected with consideration for how resulting data will be used when adding data elements about people's age, sex, race, ethnicity, disability, income, SOGI, and other key sociodemographic characteristics. Data practitioners must implement appropriate safeguards to prevent and minimize risk of re-identification, breaches, and mishandling of sensitive data. Agencies should engage with relevant experts on data governance to ensure data is being collected, stored, and used in accordance with all applicable laws, regulations, policies, and wastewater treatment system customer agreements.

★ ★ ★ ★ ★ ★

Similarly, to protect the integrity of wastewater testing programs, sampling should be conducted on a population-level scale. The exact sampling locations must also be de-identified so that people cannot be targeted and their privacy is respected. Rural communities and areas that rely on septic systems to collect wastewater may not be suitable for wastewater testing as there may be a higher probability of disclosing individual households. Therefore, further data collection approaches should be considered for these areas to inform drug programs and policies.

Implementation of wastewater testing programs should always be conducted in collaboration with the local community. Such collaboration includes transparent communication and educating residents about the public health benefits of conducting drug surveillance. Implementing parties should describe how the system will be implemented, how privacy concerns will be addressed, and how the results will be used to inform decision-making. Public health agencies should also publish the results of such testing once data has been collected, analyzed, and verified to have been appropriately de-identified. Local wastewater treatment operators should also be consulted to answer questions about the implementation process and to address operators' potential concerns about the testing or the presence of illicit drugs in the wastewater supply.

Identifying Emerging Drug Threats

The SUPPORT Act requires the federal government to closely monitor evolving and emerging drug threats and to act early in the development of national trends. In January 2023, ONDCP advanced significant work in this regard by publishing criteria and procedures to help identify substances that the ONDCP Director might deem an emerging drug threat.[371] Despite this progress, establishing reliable and accurate systems to monitor emerging drug threats can particularly challenging, however, for novel psychoactive substances.

As new testing strategies are implemented, medical examiners and coroners must include the presence of the substance in their reporting. This data must be reported in a standard format so that it can be analyzed and used to inform decision-making. Best practice recommendations for reporting diagnostic codes (such as ICD-10) are needed to ensure that medical examiners and coroners are reporting substances in a consistent manner.

Description of the Steps to Implement the Drug Data Plan

The previous *Plan* described steps needed for implementation. These included conducting an inventory of existing resources and identifying data gaps, establishing data sharing arrangements, continually reviewing and improving existing drug data systems, locating an agency to manage new data collection efforts, and maintaining coordination among agencies involved in collection and use of drug data. These implementation steps are still relevant for developing evidence to support drug policy. This section emphasizes additional steps associated with improving timely and equity-related drug data.

ONDCP emphasizes the importance of continued engagement and coordination among NDCPAs during the implementation process, given that much of the existing drug data collection and analytical activities occur within these entities. In addition, agencies should explore pilots of

new kinds of data collection, including wastewater testing and partnering with local or private-sector partners to help advance these tools.

Identify Existing Data Sources that are Best Suited for Informing Timely Decision-Making

NDCPAs must work together to identify which existing federal data sources are best suited for informing timely decision-making or if development of novel data sources (such as wastewater-based epidemiology or re-testing urine or other biologic samples for surveillance purposes) is needed to provide additional more timely drug policy insights. ONDCP acknowledges that it is not practical for some data sources to provide more timely data; however, NDCPAs should take the necessary steps to reduce the time lag of existing data collection efforts (and reporting of such data) to less than one year to the extent practicable. Agencies should consider alternative methods of reporting data, such as by publishing provisional data tables or rapid reports in advance of a more comprehensive annual report.

The Administration appreciates all the efforts of NDCPAs to collect and report drug data and understands the challenges associated with increasing the timeliness of data, while balancing its accuracy and integrity, under their current capacity and availability of resources. However, more real-time drug data is critical to address the overdose crisis, which is taking approximately one American life every five minutes.

Review and Update Existing Drug Data Systems in Accordance with Best Practice Recommendations for Equity-Related Data

ONDCP encourages all NDCPAs to begin the process of updating their drug data collection tools in accordance with best practice recommendations for capturing race/ethnicity, SOGI, and other key sociodemographic characteristics. These efforts to advance equity-related data will have significant return on investment through targeted actions that improve health outcomes for historically underserved populations.

★ ★ ★ ★ ★ ★

Appendix C: *Northern, Southwest, and Caribbean Border Counternarcotics Strategies* [372]

Officials have stopped more fentanyl at land POEs over the last two years than in the previous five years combined.[373] In Fiscal Year (FY) 2023, the Department of Homeland Security's (DHS) Customs and Border Protection (CBP) seized nearly 27,000 pounds of fentanyl, almost double the amount seized the prior year, and 7,500 pounds of precursor chemicals. DHS's Homeland Security Investigations (HSI) seized over 41,000 pounds of fentanyl, almost double the amount seized the prior year, and 130,000 pounds of precursor chemicals. The Department of Justice's Drug Enforcement Administration seized more than 29,000 pounds of fentanyl, and the Federal Bureau of Investigation seized 4,493 pounds of fentanyl. In addition to fentanyl and precursor seizures, United States law enforcement agencies seized thousands of pounds of other illicit narcotics.

The Biden-Harris Administration is also working to deploy state-of-the-art detection technology at United States POEs, including by adding 31 non-intrusive inspection systems across points of entry this year and constructing 26 additional systems. These systems will augment the more than 350 non-intrusive inspection legacy systems currently deployed. Once complete, the record amounts of investment in the construction and deployment of drug-detection scanners over the past two years will result in a scanning rate increase to 40 percent for personal vehicles and 70 percent for commercial vehicles.[374]

To supplement scanners, CBP has deployed over 600 Chemical Identification Systems across its facilities to quickly test and detect illicit substances, enabling on-the-spot seizures and arrests. CBP is also using Artificial Intelligence and Machine Learning to identify risky travel patterns and suspicious vehicles to refer them for additional screening. One such system in San Diego identified a vehicle with a suspicious travel history during a split-second initial assessment and flagged it for further review. Upon inspection, over 75 kilograms of narcotics were discovered in the vehicle, leading to multiple arrests and preventing these dangerous substances from entering the country.

In addition, CBP officers and HSI Special Agents assigned to Border Enforcement Security Task Forces have increased their presence, coordination, and inspection at international express consignment carrier facilities—which are often a node for the distribution of deadly drugs, precursor chemicals, and associated equipment. At express consignment carrier hubs, law enforcement seized over 24,250 pounds of illicit drugs from small parcels in 2021 and 2022, including over 1,100 pounds of illicit fentanyl. In 2023, the United States Postal Inspection Service seized over 4,215 pounds of fentanyl.

The United States has also executed a network-focused strategy to disrupt every aspect of the global illicit fentanyl supply chain and dismantle the criminal organizations that bring drugs to our borders. In just the last year, the United States government brought 32 criminal indictments against Chinese chemical companies and Chinese nationals for supplying precursor chemicals to be made into fentanyl; criminal charges against the leaders, enforcers, and associates of the largest and most powerful drug cartel in the world, and the one responsible for the vast majority

of fentanyl entering the United States; and criminal arrests of thousands of associates of the drug cartels responsible for the last mile of distribution of fentanyl on our streets and through social media. In FY 2023, U.S. Postal Inspectors also made 2,001 arrests involving drug trafficking using the United States Mail, and seized 95,537 pounds of illegal narcotics and over $17 million in illicit proceeds.

Leveraging the expanded authorities from President Biden's *Executive Order on Imposing Sanctions on Foreign Persons Involved in the Global Illicit Drug Trade*, the United States also targeted the enablers of the global illicit synthetic drug supply chain, including key financiers. As a result, the Administration has sanctioned 123 entities and 170 individuals involved in the global drug trade since December 2021. Of the 293 total designations pursuant to this Executive Order, 192 of these designations occurred in 2023, a four-fold increase from 46 designations in 2022.

The United States continues to work through the United States-Mexico-Canada Trilateral Fentanyl Committee, established by President Biden, to drive joint efforts to combat fentanyl and other illicit drugs. Under this Working Group, the three nations have intensified and expanded cooperation to investigate and prosecute drug traffickers, tackle the supply chain of illicit drugs and weapons, and promote public health interventions to reduce harm and demand.

Despite these significant efforts, there is still more to be done to stop bad actors from smuggling illegal drugs across our borders. As a result, the *Northern, Southwest, and Caribbean Border Counternarcotics Strategies*[375] continue to focus on achieving one overarching strategic objective of reducing the supply of illicit drugs, precursor chemicals, and associated equipment smuggled across our borders.[376]

In furtherance of this objective, the federal government will continue to target the networks that produce and distribute drugs, precursor chemicals, and associated equipment across our borders, as well as the illicit financing networks that support these activities; increase our bilateral and multilateral enforcement cooperation; and expand our bilateral and multilateral diplomatic efforts designed to reduce the quantity of illicit drugs being produced and distributed across our borders.

★ ★ ★ ★ ★ ★

Glossary

ACEs:	Adverse Childhood Experiences
ACF/FYSB:	Administration for Children and Families' Family and Youth Services Bureau
ADAM:	Arrestee Drug Abuse Monitoring Program
AHRQ:	Agency for Healthcare Research and Quality
ALPR:	Automated License Plate Reader Program
AMI:	Any Mental Illness
ARCOS:	Automation of Reports and Consolidated Orders System
ASPE:	Assistant Secretary for Planning and Evaluation
ATF:	Bureau of Alcohol, Tobacco, Firearms and Explosives
AWARE:	Advancing Wellness and Resiliency in Education Program
BOP:	Federal Bureau of Prisons
BSCA	Bipartisan Safer Communities Act
CBP:	Customs and Border Protection
CCDB:	Consolidated Counterdrug Database
CcIU:	Cybercrime Investigations Unit
CCW:	Chronic Conditions Data Warehouse
CDC:	Centers for Disease Control and Prevention
CGIC:	Crime Gun Intelligence Centers
CI2:	Contraband Interdiction and Investigations Program
CJNG:	Jalisco New Generation Cartel
CM:	Contingency Management
CMS:	Centers for Medicare & Medicaid Services
CND:	United Nations' Commission on Narcotic Drugs
CNWG:	Counternarcotics Working Group
COJ:	Census of Jails
COPS:	Office of Community Oriented Policing Services
COSSUP:	Comprehensive Opioid, Stimulant and Substance Use Program
CPOT:	Consolidated Priority Organizational Targets
CPSC:	Consumer Product Safety Commission
DAWN:	Drug Abuse Warning Network
DEA:	Drug Enforcement Administration
DFC:	Drug-Free Communities
DHS:	Department of Homeland Security
DIA:	Defense Intelligence Agency
DOD:	Department of Defense
DOJ:	Department of Justice
DOL	Department of Labor
DOS	Department of State
DOSE:	Drug Overdose Surveillance and Epidemiology
DOT:	Department of Transportation
DTOs:	Drug Trafficking Organizations
ECC:	Express Consignment Carrier
ED:	Department of Education
EMS:	Emergency Medical Services

EO:	Executive Order
ETA:	Employment and Training Administration
FBI:	Federal Bureau of Investigations
FDA:	Food and Drug Administration
FINCEN:	Financial Crimes Enforcement Network
FIUs:	Financial Intelligence Units
FMCSA:	Federal Motor Carrier Safety Administration
GAIN-Q3:	Global Appraisal of Individual Need
HCRV:	Health Care for Reentry Veterans
HCUP:	Healthcare Utilization Project
HEAL:	Helping to End Addiction Long-term
HHS:	Department of Health and Human Services
HIDTA:	High Intensity Drug Trafficking Areas
HPV:	Human Papillomavirus
HRSA:	Health Resources and Services Administration
HSI:	Homeland Security Investigations
HUD:	Department of Housing and Urban Development
ICE-ERO:	Immigration and Customs Enforcement, Enforcement and Removal Operations
IHS:	Indian Health Service
INCB:	International Narcotics Control Board
IPS:	Individual Placement and Support
IS2:	Investigative Support Section
IRS:	Internal Revenue Service
IWG:	Interagency Working Group
JCOIN:	Justice Community Opioid Innovation Network
LAPPA:	Legislative Analysis and Public Policy Association
LAUNCH:	Linking Actions for Unmet Needs in Children's Health
LEAs:	Local Educational Agencies
LGBTQI+:	Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex
MHSP:	Mental Health Service Professional
MOUD:	Medications for Opioid Use Disorder
MTF:	Monitoring the Future
NADD:	North American Drug Dialogue
NCSSLE:	National Center for Safe and Supportive Learning Environments
NDCPA:	National Drug Control Program Agency
NEISS-CADES:	National Electronic Injury Surveillance System - Cooperative Adverse Drug Event Surveillance Project
NEMSIS:	National Emergency Medical Services Information System
NHTSA:	National Highway Traffic Safety Administration
NFLIS:	National Forensic Laboratory Information System
NIC:	National Institute of Corrections
NIDA:	National Institute on Drug Abuse
NIH:	National Institutes of Health
NII:	Non-Intrusive Inspection
NSC:	National Security Council

NSDUH:	National Survey on Drug Use and Health
NSS:	National Seizure System
NSSSP:	National Survey of Syringe Service Programs
N-SUMHSS:	National Substance Use and Mental Health Services Survey
NVSS:	National Vital Statistics System
NYTS:	National Youth Tobacco Survey
OAS:	Organization of American States
OASH:	Office of the Assistant Secretary for Health
OCDETF:	Organized Crime Drug Enforcement Task Forces
OCI:	Office of Criminal Investigations
OD2A:	Overdose Data to Action
ODMAP:	Overdose Detection Mapping Application Program
OFAC:	Office of Foreign Assets Control
OFCCP:	Office of Federal Contract Compliance Programs
OIRA:	Office of Information and Regulatory Affairs
OJP:	Office of Justice Programs
OMB:	Office of Management and Budget
ONC:	Office of the National Coordinator for Health Information Technology
ONDCP:	Office of National Drug Control Policy
OORM	Opioid overdose reversal medication(s)
OPM:	Office of Personnel Management
ORD:	Office of Rural Development
ORS:	Overdose Response Strategy
ORT:	Overdose Response Teams
OSTP:	Office of Science and Technology Policy
OTP:	Opioid Treatment Program
OUD:	Opioid Use Disorder
PACE:D2A:	Preventing Adverse Childhood Experiences through Data to Action
ODEP:	Office of Disability Employment Policy
PEP:	Post-Exposure Prophylaxis
PMHCA:	Pediatric Mental Health Care Access
POE:	Port(s) of Entry
PRC:	People's Republic of China
PrEP:	Pre-Exposure Prophylaxis
PRSS:	Peer Recovery Support Services
PWUD:	People who use drugs
RCCs:	Recovery Community Centers
RCORP:	Rural Communities Opioid Response Program
RCOs:	Recovery Community Organizations
RPOTs:	Regional Priority Organizational Targets
RRW:	Recovery-Ready Workplace
SAMHSA:	Substance Abuse and Mental Health Services Administration
SBMH:	School-Based Mental Health Services
SEA:	State Educational Agencies
SMHAs:	State Mental Health Agencies
SOD:	Special Operations Division

★ ★ ★ ★ ★ ★

SOGI:	Sexual Orientation and Gender Identity
SOR:	State Opioid Response
SSP:	Syringe Services Programs
SUD:	Substance Use Disorder
SUDORS:	State Unintentional Drug Overdose Reporting System
SUPTRS:	Substance Use Prevention, Treatment, and Recovery Services Block Grant
T/TA:	Training and Technical Assistance
TA:	Technical Assistance
TCO:	Transnational Criminal Organization
Tdap:	Tetanus, Diphtheria, Pertussis
TEA:	Tribal Education Agency
TEDS:	Treatment Episode Data Set
TFFC:	Office of Terrorist Financing and Financial Crimes
T-MSIS:	Transformed Medicaid Statistical Information System
USAID:	United States Agency for International Development
USDA:	Department of Agriculture
USCG:	United States Coast Guard
USICH:	United States Interagency Council on Homelessness
USFS	United States Forest Service
USPIS:	United States Postal Inspection Service
VA:	Department of Veterans Affairs
VHA:	Veterans Health Administration
VJO:	Veterans Justice Outreach
VTCs:	Veterans Treatment Courts
WONDER	Wide-ranging ONline Data for Epidemiologic Research

★ ★ ★ ★ ★ ★

References/Notes

[1] Substance Abuse and Mental Health Services Administration. (2023, November 13). 2022 NSDUH Detailed Tables. 2022 NSDUH Detailed Tables | CBHSQ Data (samhsa.gov)

[2] Ahmad, F. B., Cisewski, J. A., Rossen, L. M., & Sutton, P. (2023). *Provisional Drug Overdose Death Counts*. National Center for Health Statistics. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

[3] Crummy, E. A., O'Neal, T. J., Baskin, B. M., & Ferguson, S. M. (2020). One is Not Enough: Understanding and Modeling Polysubstance Use. *Frontiers in Neuroscience, 14,* 569. https://doi.org/10.3389/fnins.2020.00569

[4] Centers for Medicare & Medicaid Services, National Center for Health Statistics. Wide-ranging online data for epidemiologic research (WONDER). 2022. http://wonder.cdc.gov

[5] Department of Health and Human Services. *Biden-Harris Administration Announces Critical More Than $1.5 Billion State and Tribal Opioid Response Funding Opportunities* https://www.hhs.gov/about/news/2024/05/02/biden-harris-administration-announces-critical-more-than-1.5-billion-state-tribal-opioid-response-funding-opportunities.html

[6] Department of Health and Human Services. https://www.hhs.gov/about/news/2024/05/02/biden-harris-administration-announces-critical-more-than-1.5-billion-state-tribal-opioid-response-funding-opportunities.html

[7] Department of Health and Human Services. (2022, December 2). *One Year After Releasing its Groundbreaking Overdose Prevention Strategy, HHS Announces New Data Showing Nation Has Expanded its Ability to Treat Addiction and Save Lives*. https://www.samhsa.gov/newsroom/press-announcements/20221202/hhs-announces-new-data-nation-expanded-ability-treat-addiction-save-lives.

[8] Internal Veterans Administration data reported to ONDCP on 09-0212023.

[9] Bureau of Prisons Health Services Database, June 2023, Shared directly with ONDCP Staff.

[10] Drug Enforcement Administration. Registrant Population – Summary. Cycle: 011-2023. DEA Diversion Control Division, Drug Enforcement Administration. https://apps.deadiversion.usdoj.gov/RAPR/raprRegistrantPopulationSummary.xhtml?jfwid=zJofGIfMwzSeVdcrgORySHorytn8uy-2sSxstU0x:0#no-back-button

[11] Peters, G., Woolley, J.T. (March 11, 2024). FACT SHEET: The American Rescue Plan (ARP): Top Highlights from 3 Years of Recovery. The American Presidency Project. https://www.presidency.ucsb.edu/node/370740

[12] The White House. *A Guidebook to the Bipartisan Infrastructure Law.* https://www.whitehouse.gov/build/guidebook/

[13] Department of Homeland Security. *Fact Sheet: President's State of the Union Highlights DHS Efforts on the Front Lines Combating Illicit Opioids, Including Fentanyl.* https://www.dhs.gov/news/2024/03/08/fact-sheet-presidents-state-union-highlights-dhs-efforts-front-lines-combating

[14] Department of the Treasury. *Deputy Secretary Adeyemo Announces New Treasury Sanctions Against Sinaloa Cartel Fentanyl Network*. https://home.treasury.gov/news/press-releases/jy2201

[15] National Institute on Drug Abuse. (2021, December 15). *Percentage of adolescents reporting drug use decreased significantly in 2021 as the COVID-19 pandemic endured*. https://nida.nih.gov/news-events/news-releases/2021/12/percentage-of-adolescents-reporting-drug-use-decreased-significantly-in-2021-as-the-covid-19-pandemic-endured

[16] Hoots, B. E., Li, J., Hertz, M. F., Esser, M. B., Rico, A., Zavala, E. Y., & Jones, C. M. (2023). Alcohol and Other Substance Use Before and During the COVID-19 Pandemic Among High School Students — Youth Risk Behavior Survey, United States, 2021. *MMWR Suppl, 72*(Suppl-1), 84–92. https://doi.org/10.15585/mmwr.su7201a10

[17] Hoots, B. E., Li, J., Hertz, M. F., Esser, M. B., Rico, A., Zavala, E. Y., & Jones, C. M. (2023). Alcohol and Other Substance Use Before and During the COVID-19 Pandemic Among High School Students — Youth Risk Behavior Survey, United States, 2021. *MMWR Suppl, 72*(Suppl-1), 84–92. https://doi.org/10.15585/mmwr.su7201a10

[18] Gaylor, E. M., Krause, K. H., Welder, L. E., Adina, A. C., Ashley, C., Mack, K. A., Crosby, A. E., Trinh, E., Ivey-Stephenson, A. Z., & Whittle, L. (2023). Suicidal Thoughts and Behaviors Among High School Students — Youth Risk Behavior Survey, United States, 2021. *MMWR Suppl, 72*(Suppl-1), 45–54. https://doi.org/10.15585/mmwr.su7201a6

★ ★ ★ ★ ★ ★

[19] Han, B., Compton, W. M., Einstein, E. B., Cotto, J., Hobin, J. A., Stein, J. B., & Volkow, N. D. (2022). Intentional drug overdose deaths in the United States. *The American Journal of Psychiatry, 179*(2), 163-165. https://doi.org/10.1176/appi.ajp.2021.21060604

[20] Ahmad, F. B., Cisewski, J. A., Rossen, L. M., & Sutton, P. (2023). *Provisional Drug Overdose Death Counts.* National Center for Health Statistics. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

[21] Department of Health and Human Services. *Biden-Harris Administration Announces Critical More Than $1.5 Billion State and Tribal Opioid Response Funding Opportunities.* https://www.hhs.gov/about/news/2024/05/02/biden-harris-administration-announces-critical-more-than-1.5-billion-state-tribal-opioid-response-funding-opportunities.html

[22] The White House. (2023, December 23). *Dr. Gupta Applauds Omnibus Appropriations Bill That Will Expand Access to Treatment for Substance Use Disorder*. https://www.whitehouse.gov/ondcp/briefing-room/2022/12/23/dr-gupta-applauds-omnibus-appropriations-bill-that-will-expand-access-to-treatment-for-substance-use-disorder/

[23] Substance Abuse and Mental Health Services Administration. "2022 National Survey on Drug Use and Health." 2023. Detailed Tables - Table 5.1A: Substance Use Disorder for Specific Substances in Past Year: Among People Aged 12 or Older; by Age Group.

[24] Substance Abuse and Mental Health Services Administration. "2021 National Survey on Drug Use and Health." 2022. Detailed Tables - Table 5.7A Substance Use Disorder in Past Year: Among People Aged 12 or Older https://www.samhsa.gov/data/sites/default/files/reports/rpt39441/NSDUHDetailedTabs2021/NSDUHDetailedTabs2021/NSDUHDetTabsSect5pe2021.htm .

[25] Parsley, I. C., Dale, A. M., Fisher, S. L., Mintz, C. M., Hartz, S. M., Evanoff, B. A., & Bierut, L. J. (2022). Association Between Workplace Absenteeism and Alcohol Use Disorder From the National Survey on Drug Use and Health, 2015-2019. *JAMA network open*, *5*(3), e222954. https://doi.org/10.1001/jamanetworkopen.2022.2954

[26] Substance Abuse and Mental Health Services Administration. "2021 National Survey on Drug Use and Health." 2022. Detailed Tables - Tables 2.28B, 2.29B, 5.6B, 1.24B, 1.25B, 5.5B. https://www.samhsa.gov/data/report/2021-nsduh-detailed-tables

[27] Bush, D. M., & Lipari, R. N. (2015). *Substance Use and Substance Use Disorder by Industry*. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/sites/default/files/report_1959/ShortReport-1959.pdf

[28] Substance Abuse and Mental Health Services Administration. "2021 National Survey on Drug Use and Health." 2022. Detailed tables.

[29] Miech, R. A., Johnston, L. D., Patrick, M. E., O'Malley, P. M., Bachman, J. G., & Schulenberg, J. E. (2023). *Monitoring the Future national survey results on drug use, 1975–2022: Secondary school students.* Monitoring the Future Monograph Series. University of Michigan Institute for Social Research: Ann Arbor, MI. https://monitoringthefuture.org/wp-content/uploads/2022/12/mtf2022.pdf

[30] Welsh, J. W., Shentu, Y., & Sarvey, D. B. (2019). Substance Use Among College Students. *Focus (Am Psychiatr Publ)*, *17*(2), 117-127. https://doi.org/10.1176/appi.focus.20180037

[31] Patrick, M. E., Schulenberg, J. E., Miech, R. A., Johnston, L. D., O'Malley, P. M., & Bachman, J. G. (2022). *Monitoring the Future Panel Study annual report: National data on substance use among adults ages 19 to 60, 1976-2021.* Monitoring the Future Monograph Series. University of Michigan Institute for Social Research: Ann Arbor, MI. https://files.eric.ed.gov/fulltext/ED623992.pdf

[32] Substance Abuse and Mental Health Services Administration. (2022). Key substance use and mental health indicators in the United States: Results from the 2021 National Survey on Drug Use and Health. (HHS Publication No. PEP22-07-01-005, NSDUH Series H-57). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.

[33] Federal Recovery-Ready Workplace Interagency Workgroup. (2023). *Recovery-Ready Workplace Toolkit: Guidance and Resources for Private and Public Sector Employers.* https://www.dol.gov/sites/dolgov/files/ETA/RRW-hub/pdfs/RRW_Toolkit_508_FINAL_v5%2011.8.23.pdf

[34] Database from the Alliance for Recovery Centered Organizations (ARCO) that includes the membership list published by Faces and Voices of Recovery and non-ARCO member organizations that are accredited by the Council on the Accreditation of Peer Recovery Support Services (CAPRSS).

[35] The White House. (2023, July 6). *The White House Announces Nine Newly Designated Counties Across America Are Joining the High Intensity Drug Trafficking Areas Program*. https://www.whitehouse.gov/ondcp/briefing-

room/2023/07/06/the-white-house-announces-nine-newly-designated-counties-across-america-are-joining-the-high-intensity-drug-trafficking-areas-program/

[36] Department of Homeland Security. (2023). U.S. Customs and Border Protection Drug Seizure Statistics. https://www.cbp.gov/newsroom/stats/drug-seizure-statistics

[37] United States Postal Inspection Service. (2023). The Opioid Epidemic. https://www.uspis.gov/the-opioid-epidemic

[38] Department of Homeland Security. *Fact Sheet: President's State of the Union Highlights DHS Efforts on the Front Lines Combating Illicit Opioids, Including Fentanyl.* https://www.dhs.gov/news/2024/03/08/fact-sheet-presidents-state-union-highlights-dhs-efforts-front-lines-combating

[39] NORC at the University of Chicago. (2023). JCOIN's National Survey of Substance Use Services in Jails: Describing U.S. Jails and Their Screening, Treatment, Recovery, and Re-entry Practices. https://jcoinctc.org/MAT-results-from-JCOIN-national-jail-survey/

[40] National Research Council (US) and Institute of Medicine (US) Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions; O'Connell ME, Boat T, Warner KE, editors. Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. Washington (DC): National Academies Press (US); 2009. 3, Defining the Scope of Prevention. https://www.ncbi.nlm.nih.gov/books/NBK32789/

[41] Friedman, J., Godvin, M., Shover, C. L., Gone, J. P., Hansen, H., & Schriger, D. L. (2022). Trends in Drug Overdose Deaths Among US Adolescents, January 2010 to June 2021. *JAMA, 327*(14), 1398-1400. https://doi.org/10.1001/jama.2022.2847

[42] Racz, S. J., McMahon, R. J., & Luthar, S. S. (2011). Risky Behavior in Affluent Youth: Examining the Co-occurrence and Consequences of Multiple Problem Behaviors. *Journal of Child and Family Studies, 20*(1), 120-128. https://doi.org/10.1007/s10826-010-9385-4

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

[44] Gaylor, E. M., Krause, K. H., Welder, L. E., Adina, A. C., Ashley, C., Mack, K. A., Crosby, A. E., Trinh, E., Ivey-Stephenson, A. Z., & Whittle, L. (2023). Suicidal Thoughts and Behaviors Among High School Students — Youth Risk Behavior Survey, United States, 2021. *MMWR Suppl, 72*(Suppl-1), 45–54. https://doi.org/10.15585/mmwr.su7201a6

[45] Han, B., Compton, W. B., Einstein, E. B., Cotto, J., Hobin, J. A., Stein, J. B., & Volkow, N. D. (2022). Intentional drug overdose deaths in the United States. *The American Journal of Psychiatry, 179*(2), 163-165. https://doi.org/10.1176/appi.ajp.2021.21060604

[46] Li, J., Timpe, Z., Suarez, N.A., Phillips, E., Kaczkowski, W., Cooper, A. C., Dittus, P., Robin, L., Barrios, L. C., & Ethier, K. A. (2022). Dosage in Implementation of an Effective School-Based Health Program Impacts Youth Health Risk Behaviors and Experiences. *Journal of Adolescent Health*, *71*(3), 334-343. https://doi.org/10.1016/j.jadohealth.2022.04.009

[47] Cardona, M. A., & Becerra, X. (2022, March 24). [Policy Letter from Secretary of Education on TA Centers]. https://www2.ed.gov/policy/gen/guid/secletter/220324.html

[48] Centers for Medicare & Medicaid Services. (2023, May 18). *Delivering Service in School-based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming*. https://www.cms.gov/newsroom/fact-sheets/delivering-service-school-based-settings-comprehensive-guide-medicaid-services-and-administrative

[49] Department of Health and Human Services. (March 2022). School-based Health Services – HHS Resources. https://www.hhs.gov/sites/default/files/school-based-health-services-resources.pdf

[50] Periodicity Schedule, 42 CFR 441.56(b)(1) and 441.58. https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html

[51] Health Resources and Services Administration. (n.d.). *Fiscal Year 2023 Justification of Estimates for Appropriations Committees*. https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2023.pdf

[52] ICF. (2022). *Drug-Free Communities (DFC) Support Program National Cross-Site Evaluation: End-of Year 2021 Report*. Washington, DC: Office of National Drug Control Policy. https://www.whitehouse.gov/wp-

content/uploads/2022/08/DCOS-EDITS-FINAL-FY-2021-DFC-National-Cross-Site-Evaluation-EOY-Report-Published-July-2022_dfc_template_2022_JUL13_Clean-DCOS.pdf

[53] ICF. (2023). *Drug-Free Communities (DFC) Support Program National Cross-Site Evaluation: End-of Year 2022 Report*. Washington, DC: Office of National Drug Control Policy. https://www.whitehouse.gov/wp-content/uploads/2023/09/DFC-NATIONAL-EVALUATION-EOY-REPORT_2022_Report_2023_AUG_28_FINAL_ONDCP-APPROVED.pdf

[54] Hughes, K., Bellis, M. A., Hardcastle, K. A., Sethi, D., Butchart, A., Mikton, C., Jones, L., & Dunne, M. P. (2017). The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. *The Lancet Public Health, 2*(8), e356-e366. https://doi.org/10.1016/S2468-2667(17)30118-4

[55] Resnick, M. D., Bearman, P. S., Blum, R. W., Bauman, K. E., Harris, K. M., Jones, J., Tabor, J., Beuhring, T., Sieving, R. E., Shew, M., Ireland, M., Bearinger, L. H., & Udry, J. R. (1997). Protecting adolescents from harm: findings from the National Longitudinal Study on Adolescent Health. *Jama*, *278*(10), 823-832. doi:10.1001/jama.278.10.823

[56] Akseer, N., Mehta, S., Wigle, J., Chera, R., Brickman, Z. J., Al-Gashm, S., Sorichetti, B., Vandermorris, A., Hipgrave, D. B., Schwalbe, N., & Bhutta, Z. A. (2020). Non-communicable diseases among adolescents: current status, determinants, interventions and policies. *BMC public health*, *20*(1), 1908. https://doi.org/10.1186/s12889-020-09988-5

[57] Mościcki, E. K. (1997). Identification of suicide risk factors using epidemiologic studies. *Psychiatric Clinics of North America*, *20*(3), 499-517.

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

[59] Friedman, J., Godvin, M., Shover, C. L., Gone, J. P., Hansen, H., & Schriger, D. L. (2022). Trends in overdose drug deaths among US adolescents, January 2010 to June 2021. *JAMA, 327*(14), 1398. https://doi.org/10.1001/jama.2022.2847

[60] ONDCP/Ad Council Fentanyl Campaign. https://realdealonfentanyl.com/.

[61] Sanders, M. R. (2000). Community-based parenting and family support interventions and the prevention of drug abuse. *Addictive behaviors*, *25*(6), 929-942.

[62] Crano, W. D., & Donaldson, C. D. (2018). Positive parenting, adolescent substance use prevention, and the good life. *The social psychology of living well*, 277-297.

[63] Beardslee, W. R., Chien, P. L., & Bell, C. C. (2011). Prevention of mental disorders, substance abuse, and problem behaviors: a developmental perspective. *Psychiatric Services, 62*(3), 247-54. https://doi.org/10.1176/ps.62.3.pss6203_0247

[64] Belcher, H. M., & Shinitzky, H. E. (1998). Substance abuse in children: prediction, protection, and prevention. *Archives of Pediatrics & Adolescent Medicine, 152*(10), 952-60. https://doi.org/10.1001/archpedi.152.10.952

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

[66] Jones, C. M., Han, B., Baldwin, G. T., Einstein. E. B., & Compton, W. M. (2023). Use of Medication for Opioid Use Disorder Among Adults With Past-Year Opioid Use Disorder in the US, 2021. *JAMA Network Open, 6*(8), e2327488. https://doi.org/10.1001/jamanetworkopen.2023.27488

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

[68] Chan, C. A., Canver, B., McNeil, R., & Sue, K. L. (2022). Harm reduction in health care settings. *Medical Clinics*, *106*(1), 201-17. https://doi.org/10.1016/j.mcna.2021.09.002

★ ★ ★ ★ ★ ★

[69] Ritter, A., & Cameron, J. (2006). A review of the efficacy and effectiveness of harm reduction strategies for alcohol, tobacco and illicit drugs. *Drug and alcohol review, 25*(6), 611-24. https://doi.org/10.1080/09595230600944529

[70] Vearrier, L. (2019). The value of harm reduction for injection drug use: A clinical and public health ethics analysis. *Disease-a-Month*, *65*(5), 119-41. https://doi.org/10.1016/j.disamonth.2018.12.002

[71] Department of Health and Human Services. *Biden-Harris Administration Announces Critical More Than $1.5 Billion State and Tribal Opioid Response Funding Opportunities.* https://www.hhs.gov/about/news/2024/05/02/biden-harris-administration-announces-critical-more-than-1.5-billion-state-tribal-opioid-response-funding-opportunities.html

[72] The White House. (2023, April 12). *Biden-Harris Administration Designates Fentanyl Combined with Xylazine as an Emerging Threat to the United States*. https://www.whitehouse.gov/ondcp/briefing-room/2023/04/12/biden-harris-administration-designates-fentanyl-combined-with-xylazine-as-an-emerging-threat-to-the-united-states/.

[73] Hagan, H., McGough, J. P., Thiede, H., Hopkins, S., Duchin, J., & Alexander, E. R. (2000). Reduced injection frequency and increased entry and retention in drug treatment associated with needle-exchange participation in Seattle drug injectors. *Journal of Substance Abuse Treatment*, *19*(3), 247-52. https://doi.org/10.1016/s0740-5472(00)00104-5

[74] Kidorf, M., King, V. L., Neufeld, K., Peirce, J., Kolodner, K., & Brooner, R. K. (2009). Improving substance abuse treatment enrollment in community syringe exchangers. *Addiction*, *104*(5), 786-95. https://doi.org/10.1111/j.1360-0443.2009.02560.x

[75] Department of Health and Human Services. (2022, December 2). *One Year After Releasing its Groundbreaking Overdose Prevention Strategy, HHS Announces New Data Showing Nation Has Expanded its Ability to Treat Addiction and Save Lives*. https://www.samhsa.gov/newsroom/press-announcements/20221202/hhs-announces-new-data-nation-expanded-ability-treat-addiction-save-lives.

[76] Legislative Analysis and Public Policy Association. (2021). *Model Expanded Access to Emergency Opioid Antagonists Act*. https://legislativeanalysis.org/model-expanded-access-to-emergency-opioid-antagonists-act/

[77] Office of National Drug Control Policy. (2023). *National Drug Control Budget, FY 2024 Funding Highlights.* https://www.whitehouse.gov/wp-content/uploads/2023/03/FY-2024-Budget-Highlights.pdf

[78] Doran, K. M., Rahai, N., McCormack, R. P., Milian, J., Shelley, D., Rotrosen, J., & Gelberg, L. (2018). Substance use and homelessness among emergency department patients. *Drug and alcohol dependence*, *188*, 328-333. https://doi.org/10.2105/AJPH.2005.076190 https://doi.org/10.1016/j.drugalcdep.2018.04.021

[79] Schanzer B, Dominguez B, Shrout PE, Caton CL. Homelessness, health status, and health care use. *American Journal of Public Health*. 2007. 97(3):464-9.

[80] United States Interagency Council on Homelessness. (2022). *ALL IN: The Federal Strategic Plan to Prevent and End Homelessness*. https://www.usich.gov/sites/default/files/document/All_In.pdf

[81] Department of Housing and Urban Development. (2023, April 17). *HUD Announces $486 Million In Grants And $43 Million For Stability Vouchers To Address Unsheltered And Rural Homelessness*. https://www.hud.gov/press/press_releases_media_advisories/HUD_No_23_079

[82] The White House. (2021, December 16). *READOUT: White House, HHS Host National Harm Reduction Summit*. https://www.whitehouse.gov/ondcp/briefing-room/2021/12/16/readout-white-house-hhs-host-national-harm-reduction-summit/

[83] Substance Abuse and Mental Health Services Administration. (2023). *Harm Reduction Framework.* https://www.samhsa.gov/find-help/harm-reduction/framework.

[84] The White House. (2023, June 20). *Statement from ONDCP Director Dr. Rahul Gupta Regarding White House Meeting on Increasing Access and Affordability of FDA-Approved Overdose Reversal Medications*. https://www.whitehouse.gov/ondcp/briefing-room/2023/06/20/statement-from-ondcp-director-dr-rahul-gupta-regarding-white-house-meeting-on-increasing-access-and-affordability-of-fda-approved-overdose-reversal-medications/

[85] Abdul-Quader, A. S., Feelemyer, J., Modi, S., Stein, E. S., Bricenco, A., Semaan, S., Horvath, T., Kennedy, G. E., & De Jarlais, D. C. (2013). Effectiveness of Structural-Level Needle/Syringe Programs to Reduce HCV and HIV Infection Among People Who Inject Drugs: A Systematic Review. *AIDS and Behavior, 17*(9), 2878-92. https://doi.org/10.1007/s10461-013-0593-y

[86] Centers for Disease Control and Prevention. (2019, May 23). *Syringe Services Programs (SSPs) FAQs*. https://www.cdc.gov/ssp/syringe-services-programs-faq.html

★ ★ ★ ★ ★ ★

[87] Legislative Analysis and Public Policy Association. (2021). *Model Syringe Services Program Act*. https://legislativeanalysis.org/model-syringe-services-program-act/

[88] Legislative Analysis and Public Policy Association. (2023). *Model Fentanyl Test Strip and Other Drug Checking Equipment Act*. https://legislativeanalysis.org/wp-content/uploads/2023/04/Model-Fentanyl-Test-Strip-and-Other-Drug-Checking-Equipment-Act-FINAL.pdf

[89] Substance Abuse and Mental Health Services Administration. (2021, April 7). *Federal Grantees May Now Use Funds to Purchase Fentanyl Test Strips*. https://www.samhsa.gov/newsroom/press-announcements/202104070200.

[90] Frost, T., Deutsch, S., Brown, S., Lemien, E., Cunningham, C. O., & Fox, A. D. (2021). "We'll be able to take care of ourselves"–A qualitative study of client attitudes toward implementing buprenorphine treatment at syringe services programs. *Substance Abuse*, *42*(4), 983-9.

[91] Corneli, A., Perry, B., Des Marais, A., Choi, Y., Chen, H., Lilly, R., Ayers, D., Bennett, J., Kestner, L., Meade, C. S., & Sachdeva, N. (2022). Participant perceptions on the acceptability and feasibility of a telemedicine-based HIV PrEP and buprenorphine/naloxone program embedded within syringe services programs: a qualitative descriptive evaluation. *Harm Reduction Journal*, *19*(1), 1-1. https://doi.org/10.1186/s12954-022-00718-1

[92] Bartholomew, T. S., Andraka-Cristou, B., Totaram, R. K., Harris, S., Doblecki-Lewis, S., Ostrer, L., Serota, D. P., Forrest, D. W., Chueng, T. A., Suarez, E., & Tookes, H. E. (2022). "We want everything in a one-stop shop": acceptability and feasibility of PrEP and buprenorphine implementation with mobile syringe services for Black people who inject drugs. *Harm Reduction Journal, 19*(1), 133. https://doi.org/10.1186/s12954-022-00721-6

[93] Ijioma, S. C., Pontinha, V. M., Holdford, D. A., Carroll, & N. V. (2021). Cost-effectiveness of syringe service programs, medications for opioid use disorder, and combination programs in hepatitis C harm reduction among opioid injection drug users: a public payer perspective using a decision tree. *Journal of Managed Care & Specialty Pharmacy*, *27*(2), 137-46. https://doi.org/10.18553/jmcp.2021.27.2.137

[94] Bernard, C. L., Owens, D. K., Goldhaber-Fiebert, J. D., & Brandeau, M. L. (2017). Estimation of the cost-effectiveness of HIV prevention portfolios for people who inject drugs in the United States: a model-based analysis. *PLoS medicine*, *14*(5), e1002312. https://doi.org/10.1371/journal.pmed.1002312

[95] Adams, J. W., Savinkina, A., Fox, A., Behrends, C. N., Madushani, R. W., Wang, J., Chatterjee, A., Walley, A. Y., Barocas, J. A., & Linas, B. P. (2022). Modeling the cost-effectiveness and impact on fatal overdose and initiation of buprenorphine–naloxone treatment at syringe service programs. *Addiction*, *117*(10), 2635-48. https://doi.org/10.1111/add.15883

[96] Centers for Disease Control and Prevention, Viral Hepatitis, Funded Partners and Programs: Strengthening Syringe Services Programs (SSPs), https://www.cdc.gov/hepatitis/policy/FO-CDC-RFA-PS22-2208.htm

[97] https://www.whitehouse.gov/wp-content/uploads/2024/03/FY-2025-Budget-Highlights.pdf

[98] National Institute on Drug Abuse. (2022, December 16). *NIH launches harm reduction research network to prevent overdose fatalities*. https://nida.nih.gov/news-events/news-releases/2022/12/nih-launches-harm-reduction-research-network-to-prevent-overdose-fatalities

[99] Drug Enforcement Administration; Diversion Control Division. Registrant Population by Business Activity Web Search using Business Activity term "Mobile Narcotics Treatment Programs" and Cycle "06-2023". https://apps.deadiversion.usdoj.gov/RAPR/raprRegistrantPopulationByBusinessActivity.xhtml

[100] Binswanger, I. A. (2019). Opioid Use Disorder and Incarceration - Hope for Ensuring the Continuity of Treatment. *N Engl J Med, 380*(13), 1193-1195. https://doi.org/10.1056/nejmp1900069

[101] The White House Executive Office Of The President Office Of National Drug Control Policy. *Substance Use Disorder and Pregnancy: Improving Outcomes for Families*. https://www.whitehouse.gov/wp-content/uploads/2021/10/ONDCP_Report-Substance-Use-Disorder-and-Pregnancy.pdf

[102] Legislative Analysis and Public Policy Association. (2023). *Model Substance Use During Pregnancy and Family Care Plans Act*. https://legislativeanalysis.org/wp-content/uploads/2023/03/Model-Substance-Use-During-Pregnancy-and-Family-Care-Plans-Act.pdf

[103] Consolidated Appropriations Act, 2023 (P.L. 117-328) https://www.congress.gov/117/bills/hr2617/BILLS-117hr2617enr.pdf

[104] Consolidated Appropriations Act, 2023 (P.L. 117-328) https://www.congress.gov/117/bills/hr2617/BILLS-117hr2617enr.pdf

[105] Milgram, A. (2023, January 12). Drug Enforcement Administration, Department of Justice. [Dear Registrant Letter]. https://www.deadiversion.usdoj.gov/pubs/docs/A-23-0020-Dear-Registrant-Letter-Signed.pdf

★ ★ ★ ★ ★ ★

[106] Substance Abuse and Mental Health Services Administration & Drug Enforcement Administration, 2023. SAMHSA DEA Webinar on the Consolidated Appropriations Act of 2023 (MATE Training Video/Webinar). https://www.youtube.com/watch?v=Yhhuzy5625Q

[107] Registration Requirements for Narcotic Treatment Programs With Mobile Components, 21 CFR Parts 1300, 1301, and 1304 (2021). [Docket No. DEA–459] https://www.govinfo.gov/content/pkg/FR-2021-06-28/pdf/2021-13519.pdf

[108] Drug Enforcement Administration; Diversion Control Division. Registrant Population by Business Activity Web Search using Business Activity term "Mobile Narcotics Treatment Programs" and Cycle "06-2023". https://apps.deadiversion.usdoj.gov/RAPR/raprRegistrantPopulationByBusinessActivity.xhtml

[109] Delphin-Rittman, M. E. (2021, August 4). Letter to State Substance Abuse Director on the adoption of mobile medication units from Miriam Delphin-Rittmon, Assistant Secretary for SAMHSA. https://www.samhsa.gov/sites/default/files/2021-letter-state-authorities-mobile.pdf

[110] Dephin-Rittmon, M. E. (2021, August 4). Letter to State Substance Abuse Director on the adoption of mobile medication units from Miriam Delphin-Rittmon, Assistant Secretary for SAMHSA. https://www.samhsa.gov/sites/default/files/2021-letter-state-authorities-mobile.pdf

[111] Expansion of Induction of Buprenorphine via Telemedicine, 21 CFR Parts 1300, 1304, 1306 (2023). [Docket No. DEA–948] https://www.govinfo.gov/content/pkg/FR-2023-03-01/pdf/2023-04217.pdf

[112] Internal Veterans Administration data reported to ONDCP on 09-0212023.

[113] Binswanger, I. A., Stern, M. F., Deyo, R. A., Heagert, P. J., Cheadle, A., Elmore, J. G., & Koepsell, T. D. (2007). Release from prison — a high risk of death for former inmates. *N Engl J Med, 356*(2), 157-165. https://doi.org/10.1056/NEJMsa064115

[114] Binswanger, I. A. (2019). Opioid Use Disorder and Incarceration - Hope for Ensuring the Continuity of Treatment. *N Engl J Med, 380*(13), 1193-1195. https://doi.org/10.1056/nejmp1900069

[115] BOP Health Services Database, June 2023, Shared directly with ONDCP Staff.

[116] Chatterjee, A., Weitz, M., Savinkina, A., Macmadu, A., Madushani, R., Potee, R. A., Ryan, D., Murphy, S. M., Walley, A. Y., & Linas, B. P. (2023). Estimated Costs and Outcomes Associated With Use and Nonuse of Medications for Opioid Use Disorder During Incarceration and at Release in Massachusetts. *JAMA Netw Open*, *6*(4), e237036. https://doi.org/10.1001/jamanetworkopen.2023.7036

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

[118] Social Security Act Amendments of 1965, Pub L No. 97, 42 USC §1396d (April 9, 1965)

[119] Medicaid and CHIP Payment and Access Commission (MACPAC). (2021). *Access in Brief: Health Care Needs and Use of Services by Adolescents Involved with the Juvenile Justice System*. Washington, DC: MACPAC https://www.macpac.gov/wp-content/uploads/2021/08/Access-in-Brief-Health-Care-Needs-and-Use-of-Services-by-Adolescents-Involved-with-the-Juvenile-Justice-System-1.pdf

[120] Medicaid and CHIP Payment and Access Commission (MACPAC). (2021). *Access in Brief: Health Care Needs and Use of Services by Adolescents Involved with the Juvenile Justice System*. Washington, DC: MACPAC https://www.macpac.gov/wp-content/uploads/2021/08/Access-in-Brief-Health-Care-Needs-and-Use-of-Services-by-Adolescents-Involved-with-the-Juvenile-Justice-System-1.pdf

[121] Tsai, D. (2023, January 26). Letter from CMS to California State Medicaid Director Approving Medicaid Demonstration Project "CalAIM Demonstration" through December 31, 2026. https://www.medicaid.gov/sites/default/files/2023-01/ca-calaim-ca1.pdf

[122] Tsai, D. (2023, June 23). Letter from CMS to Washington State Medicaid Director Approving Medicaid Demonstration Project Washington State Medicaid Transformation Project 2.0 through June 30th 2028. https://www.medicaid.gov/sites/default/files/2023-06/wa-medicaid-transformation-ca-06302023.pdf

[123] Tsai, D. (2023, April 17). Letter from CMS RE: Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated. https://www.medicaid.gov/federal-policy-guidance/downloads/smd23003.pdf

★ ★ ★ ★ ★ ★

[124] Substance Abuse and Mental Health Services Administration. *FY 2022 State Opioid Response Grants (Short Title: SOR) (Modified Announcement) Notice of Funding Opportunity (NOFO) No. TI-22-005 Assistance Listing Number: 93.788*. https://www.samhsa.gov/sites/default/files/grants/pdf/fy-22-sor-nofo.pdf

[125] Department of Health and Human Services Substance Abuse and Mental Health Services Administration FY 2022 Tribal Opioid Response Grants Short Title: TOR (Initial Announcement) Notice of Funding Opportunity (NOFO) No. TI-22-006 Assistance Listing Number: 93.788 https://www.samhsa.gov/sites/default/files/grants/pdf/fy-22-tor-nofo.pdf

[126] Ranson, J. M., Kuźma, E., Hamilton, W., Lang, I., & Llewellyn, D. J. (2018). Case-finding in clinical practice: An appropriate strategy for dementia identification? Alzheimers Dement (N Y), 4, 288-296. https://doi.org/10.1016/j.trci.2018.04.011

[127] Agency for Healthcare Research and Quality. *Warm Handoffs: A Guide for Clinicians*. https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patient-family-engagement/pfeprimarycare/warm-handoff-guide-for-clinicians.pdf

[128] Dennis, M. L., & Davis, J. P. (2021). Screening for more with less: Validation of the Global Appraisal of Individual Needs Quick v3 (GAIN-Q3) screeners. *J Subst Abuse Treat, 126*, 108414. https://doi.org/10.1016/j.jsat.2021.108414

[129] Mitchell, S. G., Fletcher, J. B., Monico, L. B., Gryczynski, J., Fishman, M. J., O'Grady, K. E., & Schwartz, R. P. (2023). Comparing outcomes of extended-release naltrexone in adolescents and young adults with opioid use disorder. *J Subst Use Addict Treat*, 209162. https://doi.org/10.1016/j.josat.2023.209162

[130] De Crescenzo, F., Ciabattini, M., D'Alò, G. L., De Giorgi, R., Del Giovane, C., Cassar, C., Janiri, L., Clark, N., Ostacher, M. J., & Cipriani, A. (2018). Comparative efficacy and acceptability of psychosocial interventions for individuals with cocaine e and amphetamine addiction: a systematic review and network meta-analysis. *PLoS Med, 15*(12), e1002715. https://doi.org/10.1371/journal.pmed.1002715

[131] Substance Abuse and Mental Health Services (2023). SAMHSA Advisory. *Digital Therapeutics for Management and Treatment in Behavioral Health*. https://store.samhsa.gov/sites/default/files/pep23-06-00-001.pdf

[132] Kiluk, B. D., Nich, C., Buck, M. B., Devore, K. A., Frankforter, T. L., LaPaglia, D. M., Muvvala, S. B., & Carroll, K. M. (2018). Randomized Clinical Trial of Computerized and Clinician-Delivered CBT in Comparison With Standard Outpatient Treatment for Substance Use Disorders: Primary Within-Treatment and Follow-Up Outcomes. *Am J Psychiatry, 175*(9), 853-863. https://doi.org/10.1176/appi.ajp.2018.17090978

[133] Tetrault, J. M., Holt, S. R., Cavallo, D. A., O'Connor, P. G., Gordon, M. A., Corvino, J. K., Nich, C., & Carroll, K. M. (2020). Computerized Cognitive Behavioral Therapy for Substance Use Disorders in a Specialized Primary Care Practice: A Randomized Feasibility Trial to Address the RT Component of SBIRT. *J Addict Med, 14*(6), e303-e309. https://doi.org/10.1097/ADM.0000000000000663

[134] Marsch, L. A., Campbell, A., Campbell, C., et al. (2020). The application of digital health to the assessment and treatment of substance use disorders: The past, current, and future role of the National Drug Abuse Treatment Clinical Trials Network. *J Subst Abuse Treat, 112S*, 4-11. https://doi.org/10.1016/j.jsat.2020.02.005

[135] Tetrault, J. M., Holt, S. R., Cavallo, D. A., O'Connor, P. G., Gordon, M. A., Corvino, J. K., Nich, C., & Carroll, K. M. (2020). Computerized Cognitive Behavioral Therapy for Substance Use Disorders in a Specialized Primary Care Practice: A Randomized Feasibility Trial to Address the RT Component of SBIRT. *J Addict Med, 14*(6), e303-e309. https://doi.org/10.1097/ADM.0000000000000663

[136] Wyoming does not have any Opioid Treatment Programs. (https://dpt2.samhsa.gov/treatment/directory.aspx).

[137] Jones, C. M., Compton, W. M., Han, B., Baldwin, G., & Volkow, N. D. (2022). Methadone Involved Overdose Deaths in the US Before and After Federal Policy Changes Expanding Take-Home Methadone Doses From Opioid Treatment Programs. *JAMA psychiatry*, e221776. Advance online publication. https://doi.org/10.1001/jamapsychiatry.2022.1776.

[138] https://www.samhsa.gov/medications-substance-use-disorders/statutes-regulations-guidelines/42-cfr-part-8

[139] Medications for the Treatment of Opioid Use Disorder, 42 CFR Part 8 (2022). RIN 0930–AA39 https://www.govinfo.gov/content/pkg/FR-2022-12-16/pdf/2022-27193.pdf

[140] Department of Health and Human Services, Center for Medicare and Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Payment for Intensive Outpatient Services in Hospital Outpatient Departments, Community Mental Health Centers, Rural Health Clinics, Federally Qualified Health Centers, and Opioid Treatment Programs; Hospital Price Transparency; Changes to Community Mental Health Centers Conditions of Participation, Changes

to the Inpatient Prospective Payment System Medicare Code Editor; Rural Emergency Hospital Conditions of Participation Technical Correction. Final Rule (November 22, 2023), Federal Register Volume 88 no. 224 CMS–1786–FC RIN 0938–AV09. Page 81540. CMS–1786–FC https://www.govinfo.gov/content/pkg/FR-2023-11-22/pdf/2023-24293.pdf

[141] Department of Health and Human Services, Center for Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Final Rule (November 11, 2023), Federal Register Volume 88, No 220. CMS-1784-F RIN-AV07. Page 78818. https://www.federalregister.gov/documents/2023/11/16/2023-24184/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other

[142] Office of Justice Programs. *BJA and NIC announce the publication of the Guidelines for Managing Substance Withdrawal in Jails: A Tool for Local Government Officials, Jail Administrators, Correctional Officers, and Health Care Professionals*. https://www.cossup.org/Topics/CourtsCorrections/JailResources/Guidelines

[143] Substance Abuse and Mental Health Services Administration. (2015). *Federal Guidelines for Opioid Treatment Programs*. HHS Publication No. (SMA) 01-2015. Rockville, MD: Substance Abuse and Mental Health Services Administration. https://store.samhsa.gov/sites/default/files/d7/priv/pep15-fedguideotp.pdf

[144] Substance Abuse and Mental Health Services Administration. Core Curriculum Elements on Substance Use Disorder for Early Academic Career Medical and health Professions Education programs. https://www.samhsa.gov/sites/default/files/core-curriculum-report-final.pdf

[145] Registration Requirements for Narcotic Treatment Programs With Mobile Components, 21 CFR Parts 1300, 1301, and 1304 (2021). [Docket No. DEA–459] https://www.govinfo.gov/content/pkg/FR-2021-06-28/pdf/2021-13519.pdf

[146] CODAC Behavioral Healthcare. (2021, July 18). *CODAC Announces Mobile Medical Unit Able to Dispense Methadone as Part of Full MAT*. https://codacinc.org/news-articles/codac-announces-mobile-medical-unit/

[147] Substance Abuse and Mental Health Services Administration. "2021 National Survey on Drug Use and Health." 2022. Detailed Tables - Table 5.7A Substance Use Disorder in Past Year: Among People Aged 12 or Older. https://www.samhsa.gov/data/sites/default/files/reports/rpt39441/NSDUHDetailedTabs2021/NSDUHDetailedTabs2021/NSDUHDetTabsSect5pe2021.htm

[148] Parsley, I. C., Dale, A. M., Fisher, S. L., Mintz, C. M., Hartz, S. M., Evanoff, B. A., & Bierut, L. J. (2022). Association Between Workplace Absenteeism and Alcohol Use Disorder From the National Survey on Drug Use and Health, 2015-2019. *JAMA network open*, *5*(3), e222954. https://doi.org/10.1001/jamanetworkopen.2022.2954

[149] Substance Abuse and Mental Health Services Administration. "2021 National Survey on Drug Use and Health." 2022. Detailed Tables - Tables 2.28B, 2.29B, 5.6B, 1.24B, 1.25B, 5.5B. https://www.samhsa.gov/data/report/2021-nsduh-detailed-tables

[150] Bush, D. M., & Lipari, R. N. (2015). *Substance Use and Substance Use Disorder by Industry*. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/sites/default/files/report_1959/ShortReport-1959.pdf

[151] Substance Abuse and Mental Health Services Administration. "2021 National Survey on Drug Use and Health." 2022. Detailed tables.

[152] Miech, R. A., Johnston, L. D., Patrick, M. E., O'Malley, P. M., Bachman, J. G., & Schulenberg, J. E. (2023). *Monitoring the Future national survey results on drug use, 1975–2022: Secondary school students.* Monitoring the Future Monograph Series. University of Michigan Institute for Social Research: Ann Arbor, MI. https://monitoringthefuture.org/wp-content/uploads/2022/12/mtf2022.pdf

[153] Welsh, J. W., Shentu, Y., & Sarvey, D. B. (2019). Substance Use Among College Students. *Focus (Am Psychiatr Publ)*, *17*(2), 117-127. https://doi.org/10.1176/appi.focus.20180037

[154] Patrick, M. E., Schulenberg, J. E., Miech, R. A., Johnston, L. D., O'Malley, P. M., & Bachman, J. G. (2022). *Monitoring the Future Panel Study annual report: National data on substance use among adults ages 19 to 60, 1976-2021.* Monitoring the Future Monograph Series. University of Michigan Institute for Social Research: Ann Arbor, MI. https://files.eric.ed.gov/fulltext/ED623992.pdf

[155] Substance Abuse and Mental Health Services Administration. (2021). Key substance use and mental health indicators in the United States: Results from the 2021 National Survey on Drug Use and Health. (HHS Publication No. PEP22-07-01-005, NSDUH Series H-57). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.

★ ★ ★ ★ ★ ★

[156] Jones, C. M., Noonan, R. K., & Compton, W. M. (2020). Prevalence and correlates of ever having a substance use problem and substance use recovery status among adults in the United States, 2018. *Drug and Alcohol Dependence*, *214*,108169. https://doi.org/10.1016/j.drugalcdep.2020.108169
[157] Substance Abuse and Mental Health Services Administration. *SAMHSA's National Model Standards for Peer Support Certification*. https://www.samhsa.gov/about-us/who-we-are/offices-centers/or/model-standards
[158] Department of Labor. *Recovery-Ready Workplace Resource Hub*. https://www.dol.gov/agencies/eta/RRW-hub
[159] Legislative Analysis and Public Policy Association. Model Recovery Ready Workplaces Act. https://legislativeanalysis.org/wp-content/uploads/2023/10/Model-Recovery-Ready-Workplaces-Act.pdf
[160] https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2673378 https://www.research.va.gov/currents/0218-Individual-Placement-and-Support-more-effective-than-transitional-work.cfm
[161] Substance Abuse and Mental Health Services Administration. *Best Practices for Recovery Housing*. https://store.samhsa.gov/sites/default/files/pep23-10-00-002.pdf
[162] The White House. (2023, July 6). *The White House Announces Nine Newly Designated Counties Across America Are Joining the High Intensity Drug Trafficking Areas Program*. https://www.whitehouse.gov/ondcp/briefing-room/2023/07/06/the-white-house-announces-nine-newly-designated-counties-across-america-are-joining-the-high-intensity-drug-trafficking-areas-program/
[163] Department of Homeland Security. (2023). *U.S. Customs and Border Protection Drug Seizure Statistics*. https://www.cbp.gov/newsroom/stats/drug-seizure-statistics
[164] United States Postal Inspection Service. (2023). *The Opioid Epidemic*. https://www.uspis.gov/the-opioid-epidemic
[165] United States Customs and Border Protection. *CBP: America's Front Line Against Fentanyl.* https://www.cbp.gov/frontline/cbp-america-s-front-line-against-fentanyl
[166] United States Customs and Border Protection. (2023, May 31). *Statement from Acting Commissioner Troy Miller on CBP's Successful Fentanyl Interdiction Efforts During Operation BLUE LOTUS.* U.S. Department of Homeland Security. https://www.cbp.gov/newsroom/speeches-and-statements/statement-acting-commissioner-troy-miller-cbp-s-successful.
[167] Office of the U.S. Intellectual Property Enforcement Coordinator. *Annual Intellectual Property Report to Congress*. https://www.whitehouse.gov/wp-content/uploads/2024/04/IPEC-FY-23-Annual-Report_Final.pdf
[168] High Intensity Drug Trafficking Area (HIDTA) Program Summary. https://www.hidtaprogram.org/summary.php.
[169] HIDTA National Directors Association. (2024). *2023 National HIDTA Program Effectiveness*.
[170] Department of Justice. *Justice Department Announces Charges Against Sinaloa Cartel's Global Operation.* https://www.justice.gov/opa/pr/justice-department-announces-charges-against-sinaloa-cartel-s-global-operation
[171] Department of Justice. *DEA Operation Last Mile Disrupts Fentanyl Trafficking Fueled by the Sinaloa and Jalisco Cartels.* https://www.justice.gov/opa/pr/dea-operation-last-mile-disrupts-fentanyl-trafficking-fueled-sinaloa-and-jalisco-cartels
[172] Department of Justice. *Justice Department Announces Charges Against China-Based Chemical Manufacturing Companies and Arrests of Executives in Fentanyl Manufacturing.* https://www.justice.gov/opa/pr/justice-department-announces-charges-against-china-based-chemical-manufacturing-companies
[173] Organized Crime Drug Enforcement Task Forces. *FY 2025 Congressional Justification* https://www.justice.gov/d9/2024-03/ocdetf_fy_2025_presidents_budget_narrative_2.27.24_final_1.pdf
[174] High Intensity Drug Trafficking Area. (n.d.). *PMP Data Sharing*. https://www.hidta.org/resources/pmp-data-sharing/
[175] United States Postal Inspection Service. (2023). *United States Postal Inspection Service Annual Report 2022*.
[176] United States Postal Inspection Service. (2023). *United States Postal Inspection Service Annual Report 2022*.
[177] United States Postal Inspection Service. (2024). The Opioid Epidemic – United States Postal Inspection Service (uspis.gov).
[178] 2022 United States Interdiction Coordinator Award Citation.
[179] Department of Justice. (2023, April 14). *"Chapitos" Charged in Department's Latest Actions to Disrupt Flow of Illegal Fentanyl and Other Dangerous Drugs.* https://www.justice.gov/usao-ndil/pr/chapitos-charged-departments-latest-actions-disrupt-flow-illegal-fentanyl-and-other

★ ★ ★ ★ ★ ★

[180] U.S. Embassy and Consulate in Mexico. *U.S. SHARES PERSONAL PROTECTIVE EQUIPMENT WITH MEXICAN AUTHORITIES TO SUPPORT FIGHT AGAINST ILLICIT DRUGS*, https://mx.usembassy.gov/u-s-government-shares-personal-protective-equipment-with-mexican-authorities-to-support-fight-against-illicit-drugs/

[181] Department of Justice. *Deputy Attorney General Lisa Monaco Announces New Crime Gun Intelligence Center in Chicago.* https://www.justice.gov/opa/pr/deputy-attorney-general-lisa-monaco-announces-new-crime-gun-intelligence-center-chicago

[182] The White House. (2023, November 11). *Seventh Meeting of the North American Drug Dialogue.* https://www.whitehouse.gov/ondcp/briefing-room/2023/11/11/seventh-meeting-of-the-north-american-drug-dialogue/

[183] Department of the Treasury. *READOUT: Secretary of the Treasury Janet L. Yellen's Bilateral Meeting with the Leadership of the U.S.-People's Republic of China Economic and Financial Working Groups.* https://home.treasury.gov/news/press-releases/jy2257

[184] Department of State. (n.d.). *Global Coalition to Address Synthetic Drug Threats.* Global Coalition to Address Synthetic Drug Threats - United States Department of State

[185] United Nations Office on Drugs and Crime. (2023, March 17). *Seven new substances/chemicals placed under international control; four resolutions passed at 66th Session of the Commission on Narcotic Drugs.* https://www.unodc.org/unodc/en/frontpage/2023/March/seven-new-substances-chemicals-placed-under-international-control-four-resolutions-passed-at-66th-session-of-the-commission-on-narcotic-drugs.html

[186] The White House. (2023, September 9). *FACT SHEET: Delivering an Ambitious Agenda for the G20.* https://www.whitehouse.gov/briefing-room/statements-releases/2023/09/09/fact-sheet-delivering-an-ambitious-agenda-for-the-g20/

[187] The White House. (2023, June 22). https://www.whitehouse.gov/briefing-room/statements-releases/2023/06/22/joint-statement-from-the-united-states-and-india/

[188] The White House. (2021, December 15). *Executive Order on Imposing Sanctions on Foreign Persons Involved in the Global Illicit Drug Trade.* 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/

[189] Consolidated from multiple sources. Department of the Treasury press releases, https://home.treasury.gov/news/press-releases.

[190] NRP information https://www.state.gov/inl-rewards-program/narcotics-rewards-program/

[191] Colombia Land for Prosperity Activity. (2022). *Quarterly Performance Progress Report (April 1 – June 30, 2022).* United States Agency for International Development.

[192] U.S. Embassy & Consulate in Ecuador. (2024, January 16). *Message for U.S. Citizens Nationwide State of Emergency.* https://ec.usembassy.gov/message-for-u-s-citizens-nationwide-state-of-emergency-2/

[193] The White House. (2024, February 19). *White House Drug Control Policy Director Travels to Ecuador to Meet with President Noboa and Senior Officials to Discuss Ongoing U.S. Support and Efforts to Disrupt Global Illicit Drug Trafficking.* https://www.whitehouse.gov/ondcp/briefing-room/2024/02/19/white-house-drug-control-policy-director-travels-to-ecuador-to-meet-with-president-noboa-and-senior-officials-to-discuss-ongoing-u-s-support-and-efforts-to-disrupt-global-ill/

[194] Carson, E. A. (2022). *Prisoners in 2021--Statistical Tables*. U.S. Department of Justice Bureau of Justice Statistics. https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/p21st.pdf.

[195] Zeng, Z. (2022). *Jail Inmates in 2021--Statistical Tables*. U.S. Department of Justice Bureau of Justice Statistics. https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/ji21st.pdf

[196] National Center on Addiction and Substance Abuse at Columbia University. (2010). *Behind Bars II: Substance Abuse and America's Prison Population*. https://www.casacolumbia.org/articlefiles/575-report2010behindbars2.pdf

[197] National Center on Addiction and Substance Abuse at Columbia University. (2010). *Behind Bars II: Substance Abuse and America's Prison Population.* https://www.casacolumbia.org/articlefiles/575-report2010behindbars2.pdf

[198] Binswanger, I., Stern, M., Deyo, R., Heagerty, P. J., Cheadle, A., Elmore, J. G., & Koepsell, T. D. (2007). Release from prison—a high risk of death for former inmates [published correction appears in N Engl J Med. 2007 Feb 1;356(5):536]. *N Eng J Med*, *356*(2), 157-165. https://doi.org/10.1056/nejmsa064115

★ ★ ★ ★ ★ ★

[199] Carson, E. A., & Kluckow R. (2023). *Prisoners in 2022—Statistical Tables*. U.S. Department of Justice Bureau of Justice Statistics. https://bjs.ojp.gov/document/p22st.pdf

[200] Vestal, C. (2018, April 4). *New Momentum for Addiction Treatment Behind Bars*. Stateline. https://stateline.org/2018/04/04/new-momentum-for-addiction-treatment-behind-bars/

[201] Weizman, S., Perez, J., Manoff, I., Baney, M., & El-Sabawi, T. (2021). *National Snapshot: Access To Medications For Opioid Use Disorder In U.S. Jails And Prisons*. O'Neill Institute for National and Global Health Law at Georgetown Law Center. https://oneill.law.georgetown.edu/wp-content/uploads/2021/07/A-National-Snapshot-Access-to-Medications-for-Opioid-Use-Disorder-in-U.S.-Jails-and-Prisons.pdf

[202] NORC at the University of Chicago. (2023). JCOIN's National Survey of Substance Use Services in Jails: Describing U.S. Jails and Their Screening, Treatment, Recovery, and Re-entry Practices. https://jcoinctc.org/MAT-results-from-JCOIN-national-jail-survey/ on Dec. 12, 2023.

[203] Marsden, J., Stillwell, G., Jones, H., Cooper, A., Eastwood, B., Farrell, M., Lowden, T., Maddalena, N., Metcalfe, C., Shaw, J., & Hickman, M. (2017). Does exposure to opioid substitution treatment in prison reduce the risk of death after release? A national prospective observational study in England. *Addiction*, *112*(8), 1408-1418. https://doi.org/10.1111/add.13779

[204] Department of Justice, Office of Public Affairs. (2023, September 22). *Associate Attorney General Vanita Gupta Delivers Remarks at "The Case for Second Chances: A Conversation About Criminal Justice, Collateral Consequences and Clemency."* https://www.justice.gov/opa/speech/associate-attorney-general-vanita-gupta-delivers-remarks-case-second-chances

[205] Centers for Medicare & Medicaid Services. (2023, February 16). California CalAIM Demonstration. No. 11-W-00193/9. www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ca2.pdf

[206] Centers for Medicare & Medicaid Services. (2023, June 30). Medicaid Transformation Project 2.0. https://www.medicaid.gov/sites/default/files/2023-06/wa-medicaid-transformation-ca-06302023.pdf

[207] Office of Justice Programs's Comprehensive Opioid, Stimulant, and Substance Abuse Program. https://www.cossapresources.org.

[208] Office of Justice Programs, Drugs & Substance Use topics page. https://www.ojp.gov/topics/drugs-substance-use

[209] Registration Requirements for Narcotic Treatment Programs With Mobile Components, 86 FR 33861. (2021). https://www.federalregister.gov/documents/2021/06/28/2021-13519/registration-requirements-for-narcotic-treatment-programs-with-mobile-components

[210] Medications for the Treatment of Opioid Use Disorder. Substance Abuse and Mental Health Services Administration. Notice of Proposed Rule Making. RIN 0930-AA39. December 16, 2022. https://public-inspection.federalregister.gov/2022-27193.pdf

[211] Consolidated Appropriations Act of 2023. https://www.congress.gov/117/bills/hr2617/BILLS-117hr2617enr.pdf

[212] National Institutes of Health. *Justice Community Opioid Innovation Network.* https://heal.nih.gov/research/research-to-practice/jcoin

[213] Department of Veterans Affairs. *Health Care for Re-Entry Veterans Services and Resources*. VA Homeless Programs. https://www.va.gov/homeless/reentry.asp

[214] Department of Veterans Affairs. *Veterans Justice Outreach Programs*. VA Homeless Programs. https://www.va.gov/homeless/vjo.asp

[215] NORC at the University of Chicago. (2023). JCOIN's National Survey of Substance Use Services in Jails: Describing U.S. Jails and Their Screening, Treatment, Recovery, and Re-entry Practices. https://jcoinctc.org/MAT-results-from-JCOIN-national-jail-survey/ on Dec. 12, 2023

[216] Department of Justice Office of Justice Programs. (2023). *Drug Treatment Courts*. https://nij.ojp.gov/library/publications/drug-courts

[217] Legislative Analysis and Public Policy Association. (2022). *Model Law Enforcement and Other First Responder Deflection Act.* https://legislativeanalysis.org/model-law-enforcement-and-other-first-responder-deflection-act/

[218] Legislative Analysis and Public Policy Association. (2022). *Model Substance Use During Pregnancy and Family Care Plans Act*. http://legislativeanalysis.org/wp-content/uploads/2023/03/Model-Substance-Use-During-Pregnancy-and-Family-Care-Plans-Act.pdf

[219] Legislative Analysis and Public Policy Association. (2022). *Good Samaritan Fatal Overdose Prevention and Drug Induced Homicide: Summary of State Laws*. http://legislativeanalysis.org/wp-content/uploads/2022/12/Good-Samaritan-Fatal-Overdose-Prevention-And-Drug-Induced-Homicide-Summary.pdf

★ ★ ★ ★ ★ ★

[220] American Civil Liberties Union. (2021). *A Tale of Two Countries*. https://www.aclusd.org/sites/default/files/field_documents/marijuanareport_03232021_0.pdf
[221] Brown, K. (2022, November 21). *Pardon*. https://www.courts.oregon.gov/forms/Documents/GovernorKateBrownsMarijuanaPardonExecutiveOrder.pdf
[222] HF 100 (Minnesota 2023), https://www.revisor.mn.gov/bills/bill.php?b=house&f=hf100&ssn=0&y=2023.
[223] U.S. Sentencing Commission, data provided to Department of Justice as of June 21, 2021.
[224] Department of Justice, Office of Public Affairs. (2023, September 22). *Associate Attorney General Vanita Gupta Delivers Remarks at "The Case for Second Chances: A Conversation About Criminal Justice, Collateral Consequences and Clemency."* https://www.justice.gov/opa/speech/associate-attorney-general-vanita-gupta-delivers-remarks-case-second-chances
[225] American Bar Association. (2018). *Collateral Consequences of Criminal Convictions Judicial Bench Book 5*. https://www.ojp.gov/pdffiles1/nij/grants/251583.pdf
[226] Jacobs, L. A., & Gottlieb, A. (2020). The effect of housing circumstances on recidivism: Evidence from a sample of people on probation in San Francisco. *Crim Justice Behav*., *47*(9), 1097-1115. https://doi.org/10.1177/0093854820942285
[227] Skardhamar, T., & Telle, K. (2012). Post-release employment and recidivism in Norway. *J Quant Criminol*., *28*, 629-649. https://doi.org/10.1007/s10940-012-9166-x
[228] National Center on Addiction and Substance Abuse at Columbia University (2010). *Behind Bars II: Substance Abuse and America's Prison Population.* https://www.casacolumbia.org/articlefiles/575-report2010behindbars2.pdf
[229] Marsden, J., Stillwell, G., Jones, H. E., Cooper, A., Eastwood, B. J., Farrell, M., Lowden, T., Maddalena, N., Metcalfe, C., Shaw, J., & Hickman, M. (2017). Does exposure to opioid substitution treatment in prison reduce the risk of death after release? A national prospective observational study in England. *Addiction, 112*(8), 1408-1418. https://doi.org/10.1111/add.13779
[230] Volkow, N. D., Frieden, T. R., Hyde, P. S., & Cha, S. S. (2017). Medication-Assisted Therapies — Tackling the Opioid Overdose Epidemic. *New Eng. J. Med., 370*, 2063, 2064. https://doi.org/10.1056/nejmp1402780
[231] The White House. (2023, January 11). *Fact Sheet: Biden-Harris Administration Announces New Actions to Advance Open and Equitable Research*. https://www.whitehouse.gov/ostp/news-updates/2023/01/11/fact-sheet-biden-harris-administration-announces-new-actions-to-advance-open-and-equitable-research/
[232] The White House. (2023, May 18). *Release: Dr. Rahul Gupta Releases Statement on CDC's New Overdose Death Data*. https://www.whitehouse.gov/ondcp/briefing-room/2023/05/18/dr-rahul-gupta-releases-statement-on-cdcs-new-overdose-death-data-3/
[233] Centers for Disease Control and Prevention. DOSE Dashboard: Nonfatal Overdose Syndromic Surveillance Data. May 22, 2023. https://www.cdc.gov/drugoverdose/nonfatal/dose/surveillance/dashboard/index.html
[234] Centers for Disease Control and Prevention. SUDORS Dashboard: Fatal Overdose Data. December 8, 2022. https://www.cdc.gov/drugoverdose/fatal/dashboard/index.html
[235] Centers for Disease Control and Prevention. DOSE Dashboard: Nonfatal Overdose Discharge Data. May 8, 2023. https://www.cdc.gov/drugoverdose/nonfatal/dose/discharge/dashboard/index.html
[236] Centers for Disease Control and Prevention. Fentalog Study Dashboard: Nonfatal Opioid Overdoses. March 27, 2023. https://www.cdc.gov/drugoverdose/nonfatal/fentalog/dashboard/index.html
[237] Gupta, R., Levin, R. L., Cepeda, J. A., & Holtgrave, D. R. (2022). Transforming Management of Opioid Use Disorder with Universal Treatment. *N Engl J Med, 387*, 1341-1344. https://doi.org/10.1056/nejmp2210121
[238] Gupta, R., Wright, N. F., & Holtgrave, D. R. (2023). A 2023 Agenda for Substance Use Prevention and Treatment in the US. *JAMA, 329*(9), 707-708. https://doi.org/10.1001/jama.2023.1090
[239] Tanz, L. J., Jones, C. M., Davis, N. L., Compton, W. M., Baldwin, G. T., Han, B., & Volkow, N. D. (2023). Trends and Characteristics of Buprenorphine-Involved Overdose Deaths Prior to and During the COVID-19 Pandemic. *JAMA Netw Open, 6*(1), e2251856. https://doi.org/10.1001/jamanetworkopen.2022.51856
[240] Jones, C. M., Compton, W. M., Han, B., Baldwin, G., & Volkow, N. D. (2022). Methadone-Involved Overdose Deaths in the US Before and After Federal Policy Changes Expanding Take-Home Methadone Doses From Opioid Treatment Programs. *JAMA Psychiatry, 79*(9), 932-934. https://doi.org/10.1001/jamapsychiatry.2022.1776
[241] Jones, C. M., Shoff, C., Hodges, K., Blanco, C., Losby, J. L., Ling, S. M., & Compton, W. M. (2022). 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, 79*(10), 981–992. https://doi.org/10.1001/jamapsychiatry.2022.2284

[242] Jones, C. M., Shoff, C., Blanco, C., Losby, J. L., Ling, S. M., & Compton, W. M. (2023). Association of Receipt of Opioid Use Disorder-Related Telehealth Services and Medications for Opioid Use Disorder With Fatal Drug Overdoses Among Medicare Beneficiaries Before and During the COVID-19 Pandemic. *JAMA Psychiatry*, e230310. https://doi.org/10.1001/jamapsychiatry.2023.0310

[243] Tanz, L. J., Dinwiddie, A. T., Mattson, C. L., O'Donnell, J., & Davis, N. L. (2022). Drug Overdose Deaths Among Persons Aged 10–19 Years — United States, July 2019–December 2021. *MMWR Morb Mortal Wkly Rep, 71*, 1576–1582. http://dx.doi.org/10.15585/mmwr.mm7150a2

[244] Dinwiddie, A. T., Tanz, L. J., & Bitting, J. (2022). Notes from the Field: Antihistamine Positivity and Involvement in Drug Overdose Deaths — 44 Jurisdictions, United States, 2019–2020. *MMWR Morb Mortal Wkly Rep, 71*, 1308–1310. http://dx.doi.org/10.15585/mmwr.mm7141a4

[245] Bitting, J., O'Donnell, J., & Mattson, C.L. (2022). Notes from the Field: Overdose Deaths Involving Para-fluorofentanyl — United States, July 2020–June 2021. *MMWR Morb Mortal Wkly Rep, 71*, 1239–1240. http://dx.doi.org/10.15585/mmwr.mm7139a3

[246] Casillas, S. M., Pickens, C. M., Stokes, E. K., Walters, J., & Vivolo-Kantor, A. (2022). Patient-Level and County-Level Trends in Nonfatal Opioid-Involved Overdose Emergency Medical Services Encounters — 491 Counties, United States, January 2018–March 2022. *MMWR Morb Mortal Wkly Rep, 71*, 1073–1080. http://dx.doi.org/10.15585/mmwr.mm7134a1

[247] Kariisa, M., Davis, N. L., Kumar, S., Seth, P., Mattson, C. L., Chowdhury, F., & Jones, C. M. (2022). Vital Signs: Drug Overdose Deaths, by Selected Sociodemographic and Social Determinants of Health Characteristics — 25 States and the District of Columbia, 2019–2020. *MMWR Morb Mortal Wkly Rep*. http://dx.doi.org/10.15585/mmwr.mm7129e2

[248] Maras, M., Logie, K., Arsovska, J., Wandt, A., & Barthuly, B. (2023). Decoding hidden darknet networks: What we learned about the illicit fentanyl trade on AlphaBay. *J Forensic Sci., 68*(5), 1451-1469. https://doi.org/10.1111/1556-4029.15341

[249] Beaman, J., Bolinger, C., Runde, L., & Hartwell, M. (2023). The intersection of methamphetamine and violence in the United States: a county-level assessment of methamphetamine overdose mortality and violent crime. *J of Substance Use*. https://doi.org/10.1080/14659891.2023.2217247

[250] Ott, C., Burns, A., Sisco, E., & Arroyo, L. (2023). Targeted Fentanyl Screening Utilizing Electrochemical Surface-Enhanced Raman Spectroscopy (EC-SERS) Applied to Authentic Seized Drug Casework Samples. *Forensic Chemistry, 34*, 100492. https://doi.org/10.1016/j.forc.2023.100492

[251] Office of National Drug Control Policy. (2023, January 9). Criteria for Designating Evolving and Emerging Drug Threats. Dir. No. 2022-002. https://www.whitehouse.gov/wp-content/uploads/2023/05/Emerging-Threats-Criteria-Directive-Final.pdf

[252] The White House. (2023, April 12). *Press Release: Biden-Harris Administration Designates Fentanyl Combined with Xylazine as an Emerging Threat to the United States*. https://www.whitehouse.gov/ondcp/briefing-room/2023/04/12/biden-harris-administration-designates-fentanyl-combined-with-xylazine-as-an-emerging-threat-to-the-united-states/

[253] Office of National Drug Control Policy. (2023). *Fentanyl Adulterated or Associated with Xylazine Response Plan*. https://www.whitehouse.gov/wp-content/uploads/2023/07/FENTANYL-ADULTERATED-OR-ASSOCIATED-WITH-XYLAZINE-EMERGING-THREAT-RESPONSE-PLAN-Report-July-2023.pdf

[254] Drug Enforcement Administration, Diversion Control Division. Schedules of controlled substances: Temporary placement of isotonitazene in schedule I, 21 CFR Part 1308, Docket no. DEA-631. Federal Register 2020; 85 (118).

[255] Office of National Drug Control Policy. (2023). *Plan for Utilizing and Improving Data to Support the National Drug Control Strategy*. https://www.whitehouse.gov/wp-content/uploads/2023/05/2022-Drug-Data-Plan_Final_April-2023.pdf

[256] Gupta, R., & Holtgrave, D. R. (2022). A National Tracking System for Nonfatal Drug Overdoses. *JAMA, 328*(3), 239–240. https://doi.org/10.1001/jama.2022.10815.

[257] Johnson, C., Catlin, M., Sinow, L., Gupta, R., & Holtgrave, D. R. (2023). States' Methods for Capturing and Reporting Local Responses to Suspected Nonfatal Drug Overdoses. *JAMA, 329*(9), 761–763. https://doi.org/10.1001/jama.2023.0169

★ ★ ★ ★ ★ ★

[258] Centers for Disease Control and Prevention. National Center for Health Statistics. Division of Analysis and Epidemiology. (2022). *The Linkage of the National Center for Health Statistics Survey Data to United States Department of Veterans Affairs Administrative Data: Linkage Methodology and Analytic Considerations*. Hyattsville, Maryland. https://www.cdc.gov/nchs/data/datalinkage/NCHS-VA-Linked-Data-Methodology-and-Analytic-Considerations.pdf

[259] Department of Justice. Office of Justice Programs. Bureau of Justice Statistics. (2023). *FY2023 Survey of Prison Inmates Data Linkage Program.* https://bjs.ojp.gov/funding/awards/15pbjs-23-gk-00381-bjsb

[260] Durose, M. R., & Antenangeli, L. (2023). *Arrest History of Persons Admitted to State Prison in 2009 and 2014*. U.S. Department of Justice. Office of Justice Programs. Bureau of Justice Statistics. https://bjs.ojp.gov/document/ahpasp0914.pdf

[261] Office of the Chief Statistician of the United States. (2023). *Recommendations on the Best Practices for the Collection of Sexual Orientation and Gender Identity Data on Federal Statistical Surveys*. https://www.whitehouse.gov/wp-content/uploads/2023/01/SOGI-Best-Practices.pdf

[262] National Science and Technology Council. (2023). *Federal Evidence Agenda on LGBTQI+ Equity.* https://www.whitehouse.gov/wp-content/uploads/2023/01/Federal-Evidence-Agenda-on-LGBTQI-Equity.pdf

[263] Executive Office of the President, Office of Management and Budget. Initial Proposals For Updating OMB's Race and Ethnicity Statistical Standards. 88 FR 5375: 5375-5384. https://www.federalregister.gov/documents/2023/01/27/2023-01635/initial-proposals-for-updating-ombs-race-and-ethnicity-statistical-standards

[264] Substance Abuse and Mental Health Services Administration. *SAMHSA 2023-2026 Data Strategy*. https://www.samhsa.gov/sites/default/files/2023-2026-data-strategy.pdf

[265] National Institutes of Health. (2022, September 21). HEAL Initiative: Health Data2Action – Innovation and Acceleration Projects, Phased Awards (R61/R33, Clinical Trial Optional). Funding Opportunity Announcement. https://grants.nih.gov/grants/guide/rfa-files/RFA-DA-23-057.html

[266] Centers for Disease Control and Prevention. (2023, March 17). Apply for Overdose Data to Action (OD2A) Funding. https://www.cdc.gov/drugoverdose/od2a/funding-announcements.html

[267] National Institute on Drug Abuse. A novel robotic wastewater analysis system to quantify opioid exposure and treatment in residential communities. Project Number 5R44DA051106-03. https://reporter.nih.gov/search/SnwAPa8bWUSXwNpOQlEqeg/project-details/10328984

[268] National Institute of Justice. Wastewater Epidemiology to Examine Stimulant Trends. Award # 2020-R2-CX-0013. https://nij.ojp.gov/funding/awards/2020-r2-cx-0013

[269] New Castle County Delaware. New Castle County Wastewater High-Risk Substances Dashboard. https://ncco-high-risk.pages.dev/data/fentanyl#content

[270] University of Florida. State and National Overdose Web (SNOW) Interactive Dashboard. https://public.tableau.com/views/StateandNationalOverdoseWebdashboard/Homepage?%3Alanguage=en&%3Adisplay_count=y&%3Aorigin=viz_share_link%3A&%3AshowVizHome=no%3Aembed&%3Atoolbar=no

[271] Tempe, Arizona. Wastewater BioIntel Program. https://wastewater.tempe.gov/pages/biomarker-opioids

[272] Biobot Analytics. Sewer Authority Mid-Coastside: Monitoring of High Risk Substances in Wastewater. March 2023. https://samcleanswater.org/vertical/sites/%7B1307B359-C05A-436D-AC1C-9EB8D6FFB4A3%7D/uploads/BioBot_Presentation_4-10-23.pdf

[273] Halstead R. Marin County Wastewater Tests Detect 'Tranq' Drug. Marin Independent Journal. 15 May 2023. https://www.marinij.com/2023/05/15/marin-county-wastewater-tests-detect-tranq-drug/

[274] Price D. Biodesign Engineer Rolf Halden's Lab to Identify Concentrations of Opioids, Other Substances, in Samples From Sewage Lines. Arizona State University News. 24 May 2018. https://news.asu.edu/20180524-solutions-asu-tempe-partner-wastewater-monitoring-system-opioids#:~:text=The%20Tempe%20City%20Council%20announced,threatening%20substances%20in%20the%20city%27s

[275] European Monitoring Centre for Drugs and Drug Addiction. Wastewater-Based Epidemiology and Drugs Topic Page. https://www.emcdda.europa.eu/topics/wastewater_en

[276] Australian Criminal Intelligence Commission. National Wastewater Drug Monitoring Program Report 18. 15 March 2023. https://www.acic.gov.au/sites/default/files/2023-03/NWDMP%20Report%2018_1.PDF

[277] National Highway Traffic Safety Administration. Nonfatal Drug Overdose Surveillance Dashboard. https://nemsis.org/nonfatal-drug-overdose-surveillance-dashboard/

★ ★ ★ ★ ★ ★

[278] Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. National Survey on Drug Use and Health, 2022.
[279] Office of National Drug Control Policy. *National Drug Control Budget, Funding Highlights, FY 2024*, March 2023. https://www.whitehouse.gov/wp-content/uploads/2023/03/FY-2024-Budget-Highlights.pdf
[280] Milliman Research Report, How do individuals with behavioral health conditions contribute to physical and total health care spending?, 2020, https://www.milliman.com/-/media/milliman/pdfs/articles/milliman-high-cost-patient-study-2020.ashx
[281] Milliman Research Report, How do individuals with behavioral health conditions contribute to physical and total health care spending?, 2020, https://www.milliman.com/-/media/milliman/pdfs/articles/milliman-high-cost-patient-study-2020.ashx
[282] Stanojlović M, Davidson L. Targeting the Barriers in the Substance Use Disorder Continuum of Care With Peer Recovery Support. *Substance Abuse: Research and Treatment*. 2021;15. doi:10.1177/1178221820976988; Targeting the Barriers in the Substance Use Disorder Continuum of Care With Peer Recovery Support - Milena Stanojlović, Larry Davidson, 2021 (sagepub.com)
[283] Hawkins JD, Catalano RF, Miller JY. Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: implications for substance abuse prevention. Psychol Bull. 1992 Jul;112(1):64-105. doi: 10.1037/0033-2909.112.1.64. PMID: 1529040. https://pubmed.ncbi.nlm.nih.gov/1529040/
[284] Centers for Disease Control and Prevention, Promoting Mental Health and Well-Being in Schools | CDC: an Action Guide for School and District Leaders. https://www.cdc.gov/healthyyouth/mental-health-action-guide/index.html#print
[285] Centers for Disease Control and Prevention (2019). Adverse Childhood Experiences (ACEs) Prevention Resource for Action: A Compilation of the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/pdf/ACEs-Prevention-Resource_508.pdf
[286] 42 CFR 441.56(b)(1) and 441.58. Periodicity Schedule; https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html
[287] Centers for Disease Control and Prevention (2019). Adverse Childhood Experiences (ACEs) Prevention Resource for Action: A Compilation of the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/pdf/ACEs-Prevention-Resource_508.pdf
[288] Friedman, J, et.al., Trends in Drug Overdose Deaths Among US Adolescents, January 2010 to June 2021, JAMA. 2022;327(14):1398-1400. doi:10.1001/jama.2022.2847, https://jamanetwork.com/journals/jama/fullarticle/2790949?guestAccessKey=c6551d85-8488-4716-887d-a598dae6d048
[289] Jones CM, Clayton HB, Deputy NP, et al. Prescription Opioid Misuse and Use of Alcohol and Other Substances Among High School Students—Youth Risk Behavior Survey, United States, 2019. MMWR Suppl, 2020;69(Suppl-1): 38-46). DOI: http://dx.doi.org/10.15585/mmwr.su6901a5.
[290] Centers for Disease Control, Youth Online: High School YRBS - Questions | DASH | CDC
[291] SAMHSA, Coding for Screening and Brief Intervention Reimbursement, https://www.samhsa.gov/sbirt/coding-reimbursement
[292] The Commonwealth Fund. Understanding the US Behavioral Health Workforce Shortage. 2023. https://www.commonwealthfund.org/publications/explainer/2023/may/understanding-us-behavioral-health-workforceshortage#:~:text=As%20of%20March%202023%2C%20160,to%20ensure%20an%20adequate%20supply
[293] Panchal, Nimrita, Recent Trends in Mental Health and Substance Use Concerns Among Adolescents, Kaiser Family Foundation, 2022; https://www.kff.org/mental-health/issue-brief/recent-trends-in-mental-health-and-substance-use-concerns-among-adolescents/
[294] VADM Jerome M. Adams, MD, MPH and Nora D. Volkow, MD, *AMA J Ethics. 2020;22(8):E702-708. doi: 10.1001/amajethics.2020.702.*
[295] Navas C, Wells L, Bartels SA, Walker M., Patient and Provider Perspectives on Emergency Department Care Experiences among People with Mental Health Concerns. Healthcare. 2022; 10(7):1297. https://doi.org/10.3390/healthcare10071297. University of Kentucky News, UK's First Bridge Clinic Offers

★ ★ ★ ★ ★ ★

Immediate Access to Opioid Treatment, April 2019, https://uknow.uky.edu/research/uks-first-bridge-clinic-offers-immediate-access-opioid-treatment

[296] Binkley, Mandy, et al, Bridge to Life: Connecting Individuals Presenting to the Hospital with Complications from Opioid Use Disorder to Evidence-based Care. Presentation at 2019 RX Summit; https://www.eventscribe.com/2019/RxSummit/fsPopup.asp?efp=SU1ESlhPV1I4MzY3&PresentationID=491212&rnd=0.9485711&mode=presinfo

[297] SAMHSA, Advisory: Low Barrier Models of Care for Substance Use Disorders, December 2023; Advisory: Low Barrier Models of Care for Substance Use Disorders (samhsa.gov)

[298] National Archives, Federal Register, Requirements Related to the Mental Health Parity and Addiction Equity Act, Aug. 3, 2023, https://www.federalregister.gov/documents/2023/08/03/2023-15945/requirements-related-to-the-mental-health-parity-and-addiction-equity-act

[299] Jackson Lewis, Benefits Law Advisor, What Employers Need to Know about the Mental Health Parity Proposed Regulations, July 31, 2023; https://www.benefitslawadvisor.com/2023/07/articles/mhpaea/what-employers-need

[300] American Psychiatric Association, Psychiatric News, Ghost Networks' Put Patients at Risk of Becoming More Ill; May 26, 2023; https://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2023.07.7.10

[301] Section 1262 of the Consolidated Appropriations Act, 2023 (also known as Omnibus bill), removes the federal requirement for practitioners to submit a Notice of Intent (have a waiver) to prescribe medications, like buprenorphine, for the treatment of opioid use disorder (OUD). With this provision, and effective immediately, SAMHSA will no longer be accepting NOIs (waiver applications) from providers. https://www.samhsa.gov/medications-substance-use-disorders/waiver-elimination-mat-act

[302] Barbara Andraka-Christou,a,b Olivia Golan,c Rachel Totaram,a Maggie Ohama,d Brendan Saloner,e Adam J. Gordon,f,g and Bradley D. Steinh , Prior authorization restrictions on medications for opioid use disorder: trends in state laws from 2005 to 2019, Ann Med. 2023; 55(1): 514–520. Published online 2023 Feb 1. doi: 10.1080/07853890.2023.2171107. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9897778/

[303] Kevin O'Reilly, Bills in 30 states show momentum to fix prior authorization, AMA News, May 10, 2023: https://www.ama-assn.org/practice-management/prior-authorization/bills-30-states-show-momentum-fix-prior-authorization

[304] Saunders, H, Rudowitz, Robin, Will Availability of Over-the-Counter Narcan Increase Access? Kaiser Family Foundation, September 2023; https://www.kff.org/policy-watch/will-availability-of-over-the-counter-narcan-increase

[305] Dadiomov D, Bolshakova M, Mikhaeilyan M, Trotzky-Sirr R. Buprenorphine and naloxone access in pharmacies within high overdose areas of Los Angeles during the COVID-19 pandemic. Harm Reduct J. 2022 Jun29;19(1):69. doi: 10.1186/s12954-022-00651-3. PMID: 35768817; PMCID: PMC9241266. Buprenorphine and naloxone access in pharmacies within high overdose areas of Los Angeles during the COVID-19 pandemic (nih.gov)

[306] Barbara Andraka-Christou,[a,b] Olivia Golan,[c] Rachel Totaram,[a] Maggie Ohama,[d] Brendan Saloner,[e] Adam J. Gordon,[f,g] and Bradley D. Stein[h] , Prior authorization restrictions on medications for opioid use disorder: trends in state laws from 2005 to 2019, Ann Med. 2023; 55(1): 514–520. Published online 2023 Feb 1. doi: 10.1080/07853890.2023.2171107. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9897778/

[307] Chan B, Hoffman KA, Bougatsos C, Grusing S, Chou R, McCarty D. Mobile methadone medication units: A brief history, scoping review and research opportunity. J Subst Abuse Treat. 2021 Oct;129:108483. doi: 10.1016/j.jsat.2021.108483. Epub 2021 May 16. PMID: 34080541; PMCID: PMC8380675., https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8380675/

[308] Duncan, Alexandra, Mobile Medication Units Help Fill Gaps in Opioid Use Disorder Treatment, Online article, PEW Charitable Trusts, 2021. https://www.pewtrusts.org/en/research-andanalysis/articles/2021/11/22/mobile-medication-units-help-fill-gaps-in-opioid-use-disorder-treatment

[309] American Association of Medical Colleges, AAMC News, 12/18/2019. https://www.aamc.org/news/21-million-americans-suffer-addiction-just-3000-physicians-are-specially-trained-treat-them

[310] National Archives, The Federal Register, Centers for Medicare and Medicaid Services, Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program, November 16, 2023.

https://www.federalregister.gov/documents/2023/11/16/2023-24184/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other

[311] National Archives, The Federal Register, Centers for Medicare and Medicaid Services, Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program, November 16, 2023. https://www.federalregister.gov/documents/2023/11/16/2023-24184/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other

[312] Dixon, B., et. al., Impact of event notification services on timely follow-up and rehospitalization among primary care patients at two Veterans Affairs Medical Centers, Journal of the American Medical Informatics Association, Volume 28, Issue 12, December 2021, Pages 2593-2600, https://doi.org/10.1093/jamia/ocab189.

[313] National Institute on Drug Abuse. TAPS, Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS) Tool, (nih.gov)

[314] National Institute on Drug Abuse. Instrument: Drug Abuse Screening Test (DAST-10) | NIDA CTN Common Data Elements (nih.gov)

[315] National Institute on Drug Abuse. Screening and Assessment Tools Chart, https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/screening-tools-adolescent-substance-use

[316] Department of Health and Human Services, HealthIT, Interoperability Standards Advisory, United States Core Data for Interoperability (USCDI) | Interoperability Standards Advisory (ISA) (healthit.gov)

[317] American Association of Medical Colleges, AAMCNEWS, 21 million Americans suffer from addiction. Just 3,000 physicians are specially trained to treat them, 12/18/2024, https://www.aamc.org/news/21-million-americans-suffer-addiction-just-3000-physicians-are-specially-trained-treat-them

[318] Drake, R., et.al., Individual Placement and Support for People with Co-occurring Substance Use Disorders A Brief for States, Territories and Organizations, Westat, 2023; https://www.dol.gov/sites/dolgov/files/ODEP/pdf/IPS-ForPeopleWithCo-Occurring-SUD.pdf

[319] SAMHSA, National Model Standards for Peer Support Certification, 2023. https://store.samhsa.gov/sites/default/files/pep23-10-01-001.pdf

[320] Association of Recovery Schools, What is a Recovery High School, https://recoveryschools.org/what-is-a-recovery-high-school/

[321] Samuels EA, Baird J, Yang ES, Mello MJ. Adoption and Utilization of an Emergency Department Naloxone Distribution and Peer Recovery Coach Consultation Program. *Academic Emergency Medicine*. 2019;26(2):160-173. doi:10.1111/acem.13545

[322] Ramdin C, Guo M, Fabricant S, Santos C, Nelson L. The Impact of a Peer-Navigator Program on Naloxone Distribution and Buprenorphine Utilization in the Emergency Department. *Substance use & misuse*. 2022/02/16 2022;57(4):581-587. doi:10.1080/10826084.2021.2023187

[323] National Council for Behavioral Health, Peer Support Workers in Emergency Departments: Engaging Individuals Surviving Opioid Overdoses – Qualitative Assessment; https://pcssnow.org/wp-content/uploads/2018/07/Peer-Support-Workers-in-EDs-Issue-Brief-1.24.19.pdf

[324] Waye KM, Goyer J, Dettor D, et al. Implementing peer recovery services for overdose prevention in Rhode Island: An examination of two outreach-based approaches. *Addictive Behaviors*. 2019/02/01/ 2019;89:85-91. doi: https://doi.org/10.1016/j.addbeh.2018.09.027

[325] Scott CK, Grella CE, Nicholson L, Dennis ML. Opioid recovery initiation: Pilot test of a peer outreach and modified Recovery Management Checkup intervention for out-of-treatment opioid users. *Journal of Substance Abuse Treatment*. 2018/03/01/ 2018;86:30-35. doi: https://doi.org/10.1016/j.jsat.2017.12.007

[326] Scott, C. K., Dennis, M. L., Grella, C. E., Kurz, R., Sumpter, J., Nicholson, L., & Funk, R. R. (2020). of Substance Abuse Treatment, 108, 75–81. doi: 10.1016/j.jsat.2019.07.001; https://www.recoveryanswers.org/research-post/peer-outreach-actively-link-individuals-opioid-use-disorder-medication-treatment/

[327] Gupta R, Levin RL, Cepeda JA, Holtgrave DR. Transforming Management of Opioid Use Disorder with Universal Treatment. N Engl J Med 2022; 387:1341-1344. DOI: 10.1056/NEJMp2210121

[328] Gupta R, Wright NF, Holtgrave DR. A 2023 Agenda for Substance Use Prevention and Treatment in the US. JAMA. 2023;329(9):707-708. DOI:10.1001/jama.2023.1090.

★ ★ ★ ★ ★ ★

[329] Tanz LJ, Jones CM, Davis NL, Compton WM, Baldwin GT, Han B, Volkow ND. Trends and Characteristics of Buprenorphine-Involved Overdose Deaths Prior to and During the COVID-19 Pandemic. JAMA Netw Open. 2023 Jan 3;6(1):e2251856. DOI:10.1001/jamanetworkopen.2022.51856.

[330] 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 Sep 1;79(9):932-934. DOI:10.1001/jamapsychiatry.2022.1776.

[331] 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;79(10):981–992. DOI:10.1001/jamapsychiatry.2022.2284.

[332] Jones CM, Shoff C, Blanco C, Losby JL, Ling SM, Compton WM. Association of Receipt of Opioid Use Disorder-Related Telehealth Services and Medications for Opioid Use Disorder With Fatal Drug Overdoses Among Medicare Beneficiaries Before and During the COVID-19 Pandemic. JAMA Psychiatry. 2023 Mar 29:e230310. DOI: 10.1001/jamapsychiatry.2023.0310.

[333] Agency for Healthcare Research and Quality. Injuries and External Causes: Reporting of Causes on the HCUP State Inpatient Databases (SID), 2016-2019. September 29, 2021. https://hcup-us.ahrq.gov/reports/ataglance/HCUPanalysisInjuryReporting.pdf

[334] Agency for Healthcare Research and Quality. Injuries and External Causes: Reporting of Causes on the HCUP State Emergency Department Databases (SEDD), 2016-2019. September 29, 2021. https://hcup-us.ahrq.gov/reports/ataglance/HCUPanalysisInjuryEDReporting.pdf

[335] Goldman-Mellor S, Olfson M, Lidon-Moyano C, Schoenbaum M. Mortality Following Nonfatal Opioid and Sedative/Hypnotic Drug Overdose. Am J Prev Med. 2020 Jul;59(1):59-67.

[336] Schoenbaum M. Survival As a Patient-Centered Outcome of Mental Health Care. Psychiatr Serv. 2019 Jun 1;70(6):512-513.

[337] Casillas SM, Pickens CM, Stokes EK, Walters J, Vivolo-Kantor A. Patient-Level and County-Level Trends in Nonfatal Opioid-Involved Overdose Emergency Medical Services Encounters — 491 Counties, United States, January 2018–March 2022. MMWR Morb Mortal Wkly Rep 2022;71:1073–1080. DOI: http://dx.doi.org/10.15585/mmwr.mm7134a1.

[338] Applebaum KM, Asfaw A, O'Leary PK, et al. Suicide and Drug-Related Mortality Following Occupational Injury. Study of severe workplace injuries impairing workers' long-term health and well-being, with drug related deaths and suicides important contributors to excess mortality of injured workers. Am J Ind Med 2019 Sep;62(9): 733-741.

[339] Shaw WS, Roelofs C, Punnett L. Work Environment Factors and Prevention of Opioid-Related Deaths. American Journal of Public Health. August 2020. 110: 1235-1241.

[340] Rosen J, Zelnick JR, Zoeckler J, Landsbergis P. Introduction to the Special Issue: Opioids and the Workplace - Risk Factors and Solutions. NEW SOLUTIONS: A Journal of Environmental and Occupational Health Policy. 2021;31(3):201-209.

[341] Le AB, Rosen JD. It Is Time to Implement Primary Prevention in the Workplace to Ameliorate the Ongoing U.S. Opioid Epidemic. NEW SOLUTIONS: A Journal of Environmental and Occupational Health Policy. 2021;31(3):210-218.

[342] Dinwiddie AT, Tanz LJ, Bitting J. Notes from the Field: Antihistamine Positivity and Involvement in Drug Overdose Deaths — 44 Jurisdictions, United States, 2019–2020. MMWR Morb Mortal Wkly Rep 2022;71:1308–1310. DOI: http://dx.doi.org/10.15585/mmwr.mm7141a4.

[343] Bitting J, O'Donnell J, Mattson CL. Notes from the Field: Overdose Deaths Involving Para-fluorofentanyl — United States, July 2020–June 2021. MMWR Morb Mortal Wkly Rep 2022;71:1239–1240. DOI: http://dx.doi.org/10.15585/mmwr.mm7139a3.

[344] Tanz LJ, Dinwiddie AT, Mattson CL, O'Donnell J, Davis NL. Drug Overdose Deaths Among Persons Aged 10–19 Years — United States, July 2019–December 2021. MMWR Morb Mortal Wkly Rep 2022;71:1576–1582. DOI: http://dx.doi.org/10.15585/mmwr.mm7150a2.

[345] Kariisa M, Davis NL, Kumar S, Seth P, Mattson CL, Chowdhury F, Jones CM. Vital Signs: Drug Overdose Deaths, by Selected Sociodemographic and Social Determinants of Health Characteristics — 25 States and the District of Columbia, 2019–2020. MMWR Morb Mortal Wkly Rep. ePub: 19 July 2022. DOI: http://dx.doi.org/10.15585/mmwr.mm7129e2.

★ ★ ★ ★ ★ ★

[346] Midgette G, Davenport S, Caulkins JP, Kilmer B. What America's Users Spend on Illegal Drugs, 2006-2016. Santa Monica, CA: RAND Corporation, 2019. https://www.rand.org/pubs/research_reports/RR3140.html
[347] Department of Justice. National Institute of Justice. NIJ's Drugs and Crime Research: Arrestee Drug Abuse Monitoring Programs. 6 May 2012. https://nij.ojp.gov/topics/articles/nijs-drugs-and-crime-research-arrestee-drug-abuse-monitoring-programs
[348] Office of National Drug Control Policy. Arrestee Drug Abuse Monitoring Program. https://obamawhitehouse.archives.gov/ondcp/arrestee-drug-abuse-monitoring-program
[349] New Castle County Delaware. New Castle County Wastewater High-Risk Substances Dashboard. https://ncco-high-risk.pages.dev/data/fentanyl#content
[350] University of Florida. State and National Overdose Web (SNOW) Interactive Dashboard. https://public.tableau.com/views/StateandNationalOverdoseWebdashboard/Homepage?%3Alanguage=en&%3Adisplay_count=y&%3Aorigin=viz_share_link%3A&%3AshowVizHome=no%3Aembed&%3Atoolbar=no
[351] Tempe, Arizona. Wastewater BioIntel Program. https://wastewater.tempe.gov/pages/biomarker-opioids
[352] Biobot Analytics. Sewer Authority Mid-Coastside: Monitoring of High Risk Substances in Wastewater. March 2023. https://samcleanswater.org/vertical/sites/%7B1307B359-C05A-436D-AC1C-9EB8D6FFB4A3%7D/uploads/BioBot_Presentation_4-10-23.pdf
[353] Halstead R. Marin County Wastewater Tests Detect 'Tranq' Drug. Marin Independent Journal. 15 May 2023. https://www.marinij.com/2023/05/15/marin-county-wastewater-tests-detect-tranq-drug/
[354] Price D. Biodesign Engineer Rolf Halden's Lab to Identify Concentrations of Opioids, Other Substances, in Samples From Sewage Lines. Arizona State University News. 24 May 2018. https://news.asu.edu/20180524-solutions-asu-tempe-partner-wastewater-monitoring-system-opioids#:~:text=The%20Tempe%20City%20Council%20announced,threatening%20substances%20in%20the%20city%27s
[355] Millennium Health. Definitive Urine Drug Testing with Millennium UDT. https://www.millenniumhealth.com/services/urine-drug-testing/
[356] University of Maryland. Center for Substance Use, Addiction, & Health Research. National Emergency Department Drug Surveillance. https://cesar.umd.edu/landingtopic/about-edds
[357] National Institute on Drug Abuse. Rapid Assessment of Illicit Drugs in Wastewater. Project Number 2R44DA051105-02. https://reporter.nih.gov/search/zctCnZ0hZkajA2JfSP1Cfw/project-details/10397306
[358] National Institute of Justice. Wastewater Epidemiology to Examine Stimulant Trends. Award # 2020-R2-CX-0013. https://nij.ojp.gov/funding/awards/2020-r2-cx-0013
[359] European Monitoring Centre for Drugs and Drug Addiction. Wastewater-Based Epidemiology and Drugs Topic Page. https://www.emcdda.europa.eu/topics/wastewater_en
[360] Australian Criminal Intelligence Commission. National Wastewater Drug Monitoring Program Report 18. 15 March 2023. https://www.acic.gov.au/sites/default/files/2023-03/NWDMP%20Report%2018_1.PDF
[361] National Institute on Drug Abuse. Screening for Drug Use in General Medical Settings Resource Guide. https://nida.nih.gov/sites/default/files/resource_guide.pdf
[362] Dezman Z, Schwartz B, Billing A, et al. Notes from the Field: High Prevalence of Fentanyl Detected by the Maryland Emergency Department Drug Surveillance System — Baltimore, Maryland, 2019. MMWR Morb Mortal Wkly Rep 2020;69:724–726. DOI: https://dx.doi.org/10.15585/mmwr.mm6923a3external icon
[363] Centers for Disease Control and Prevention. The Fentalog Study: A Subset of Nonfatal Suspected Opioid-Involved Overdoses with Toxicology Testing. 27 March 2023. https://www.cdc.gov/drugoverdose/nonfatal/fentalog/dashboard/index.html
[364] Shrestha S, Bayly R, Pustz J, Sawyer J, Van Handel M, Lingwall C, Stopka TJ. Methods for jurisdictional vulnerability assessment of opioid-related outcomes. Preventive Medicine. March 2023. 170. DOI: https://doi.org/10.1016/j.ypmed.2023.107490.
[365] Centers for Disease Control and Prevention. State-led Vulnerability Assessments. 31 August 2021. https://www.cdc.gov/pwid/vulnerable-state-assessments.html
[366] White House Council on Environmental Quality. Climate and Economic Justice Screening Tool. 22 November 2022. https://screeningtool.geoplatform.gov/en/#3/33.47/-97.5
[367] Centers for Disease Control and Prevention. Agency for Toxic Substances and Disease Registry. CDC/ATSDR Social Vulnerability Index. 16 November 2022. https://www.atsdr.cdc.gov/placeandhealth/svi/index.html

★ ★ ★ ★ ★ ★

[368] United States Census Bureau. Community Resilience Estimates. 30 May 2023. https://www.census.gov/programs-surveys/community-resilience-estimates.html

[369] Centers for Disease Control and Prevention. Data from the Drug Overdose Surveillance and Epidemiology (DOSE) System are Used for Action. https://www.cdc.gov/drugoverdose/nonfatal/pdf/22_DOSE_FS_508.pdf

[370] Office of the Chief Statistician of the United States. Recommendations on the Best Practices for the Collection of Sexual Orientation and Gender Identity Data on Federal Statistical Surveys. January 2023. https://www.whitehouse.gov/wp-content/uploads/2023/01/SOGI-Best-Practices.pdf

[371] Office of National Drug Control Policy. Criteria for Designating Evolving and Emerging Drug Threats. Dir. No. 2022-002. January 2023. https://www.whitehouse.gov/wp-content/uploads/2023/05/Emerging-Threats-Criteria-Directive-Final.pdf

[372] This serves as an update to the 2022 *Northern, Southwest, and Caribbean Border Counternarcotics Strategies* that further refine the *Strategy* by articulating an approach to prevent the trafficking of illicit drugs across the Northern, Southwest, and Caribbean Borders, as mandated by Congress in the SUPPORT for Patients and Communities Act. Pursuant to 21 U.S.C. § 1705(c)(3)(C), see the 2022 Northern Border Counternarcotics Strategy for discussion on National Drug Control Program agency roles and responsibilities, illegal trafficking of drugs to or through Indian reservations, and other requirements that carry over and are incorporated herein by reference. Pursuant to 21 U.S.C. § 1705(c)(3)(B), see the 2022 Southwest Border Counternarcotics Strategy for discussion on National Drug Control Program agency roles and responsibilities, tunnels and subterranean passages that cross the international border, recommendations for criminal penalties, and other requirements that carry over and are incorporated herein by reference. Pursuant to 21 U.S.C. § 1705(h)(7) and H.R. Rep. No. 116-122 (2019), see the 2022 Caribbean Border Counternarcotics Strategy for discussion on agency roles and responsibilities and other requirements that carry over and are incorporated herein by reference.

[373] Customs and Border Protection. *CBP Releases January 2024 Monthly Update.* https://www.cbp.gov/newsroom/national-media-release/cbp-releases-january-2024-monthly-update

[374] Customs and Border Protection. *CBP: America's Front Line Against Fentanyl.* https://www.cbp.gov/frontline/cbp-america-s-front-line-against-fentanyl

[375] The FY 2025 Budget Summary contains information on the FY 2025 Drug Control Budget, provides a description of each agency's mission, program descriptions, resources, and significant changes in the requests. Additional resources, such as those requested in the President's October 2023 supplemental request, would enhance border security efforts and both are incorporated herein by reference.

[376] The *Northern, Southwest, and Caribbean Counternarcotics Strategies* align with the Congressionally mandated *National Interdiction Command and Control Program*, which lays out the overall approach to the broader "border regions," and focuses on outlining a high-level approach. The *NDCS* sets policy goals and objectives that ONDCP considers as projections for policy and budget priorities, which indicate to the NDCPAs the Administration's long-term priorities expected to be funded.