to repeal certain obsolete requirements, and for other purposes.

The Clerk read the title of the bill.

The text of the bill is as follows:

S. 3499

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. REPEAL OF OBSOLETE DHS CONTRACTING REQUIREMENTS.

The Post-Katrina Emergency Management Reform Act of 2006 (Public Law 109–295; 120 Stat. 1394) is amended by striking section 692 (6 U.S.C. 792).

The SPEAKER pro tempore. Pursuant to the rule, the gentlewoman from the District of Columbia (Ms. NORTON) and the gentleman from Illinois (Mr. RODNEY DAVIS) each will control 20 minutes.

The Chair recognizes the gentlewoman from the District of Columbia.

GENERAL LEAVE

Ms. NORTON. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and include extraneous material on S. 3499.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from the District of Columbia?

There was no objection.

Ms. NORTON. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, this bill will repeal a section of the Post-Katrina Emergency Management Reform Act of 2006 to conform the act with government-wide Federal acquisition regulation changes to subcontracting limits.

The National Defense Authorization Act of 2009 directed the Federal Acquisition Regulatory Council to institute a government-wide limitation on excessive subcontracting. This change put the Department of Homeland Security-specific requirements established by the Post-Katrina Emergency Management Reform Act in conflict with government-wide rules. This bill simply repeals the Department of Homeland Security's obsolete requirement.

Mr. Speaker, I urge my colleagues to support this bill, and I reserve the balance of my time.

Mr. RODNEY DAVIS of Illinois. Mr. Speaker, I yield myself such time as I may consume.

I also rise in support of S. 3499, which amends the Post-Katrina Emergency Management Reform Act of 2006. This bill repeals outdated Department of Homeland Security contracting requirements that set a limit of 65 percent for subcontracting costs.

The National Defense Authorization Act of 2009 established a subcontracting cost limit at 70 percent. Unfortunately, these conflicting limits have just created confusion for contractors in emergency response and recovery efforts since then.

Repealing this obsolete provision will make subcontracting cost limits consistent with the rest of the Federal contracting regime.

Mr. Speaker, I remind you that these are not issues that are going to make the 24-hour news cycle, but it is fixing broken pieces of the bureaucracy right here in this institution that can actually help communities recover faster.

If we don't address issues that aren't newsworthy according to the media experts, then we waste taxpayer dollars, we don't help communities recover, and we don't make government work for the people. I am proud to stand here and say I am a conservative when it comes to fixing government bureaucracy, and this is one of those fixes that we are putting forth today, in conjunction with the other side, in conjunction with the Senate.

In closing, Mr. Speaker, again, this fixes the Federal bureaucracy that was broken back post-Katrina. I was a congressional staffer in 2005 when we all watched in horror what happened to Louisiana and the Gulf Coast because of that tragic storm.

Provisions that were put in place post-Katrina in 2006, during the Bush presidency and into the Obama administration in 2009, long before I ever got here to the House floor, we are now fixing the inconsistencies, making government work for the people, and making government work for every single American who is going to be affected by a future disaster. That is everywhere. That is Montana, that is Illinois, and that is D.C. Every single place in the United States and our territories will be impacted positively by this consistent change to the bureaucracy through the procurement process that needed to be done years ago and is going to be done today because of the leadership of our Senate sponsors and also the leaders on the Committee on Transportation and Infrastructure and my colleague, Ms. NORTON.

Mr. Speaker, I urge support of this piece of legislation, and I yield back the balance of my time.

Ms. NORTON. Mr. Speaker, I yield myself the balance of my time for closing.

S. 3499 is a simple example of good governance with bipartisan support. I support this legislation, and I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentlewoman from the District of Columbia (Ms. NORTON) that the House suspend the rules and pass the bill, S. 3499.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mr. ROSENDALE. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this motion will be postponed.

□ 1530

RURAL OPIOID ABUSE PREVENTION ACT

Ms. JACKSON LEE. Mr. Speaker, I move to suspend the rules and pass the bill (S. 2796) to amend the Omnibus Crime Control and Safe Streets Act of 1968 to provide for the eligibility of rural community response pilot programs for funding under the Comprehensive Opioid Abuse Grant Program, and for other purposes.

The Clerk read the title of the bill.

The text of the bill is as follows:

S. 2796

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Rural Opioid Abuse Prevention Act''.

SEC. 2. ELIGIBILITY OF RURAL COMMUNITY RESPONSE PILOT PROGRAMS FOR FUNDING UNDER THE COMPREHENSIVE OPIOID ABUSE GRANT PROGRAM.

Section 3021 of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (34 U.S.C. 10701) is amended—

(1) in subsection (a)(1)—

(A) in subparagraph (F), by striking ''and'';

(B) in subparagraph (G), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(H) a pilot program for rural areas to implement community response programs that focus on reducing opioid overdose deaths, which may include presenting alternatives to incarceration, as described in subsection (f).''; and

(2) by adding at the end the following:

''(f) RURAL PILOT PROGRAM.—

''(1) IN GENERAL.—The pilot program described under this subsection shall make grants to rural areas to implement community response programs to reduce opioid overdose deaths. Grants issued under this subsection shall be jointly operated by units of local government, in collaboration with public safety and public health agencies or public safety, public health and behavioral health collaborations. A community response program under this subsection shall identify gaps in community prevention, treatment, and recovery services for individuals who encounter the criminal justice system and shall establish treatment protocols to address identified shortcomings. The Attorney General, through the Office of Justice Programs, shall increase the amount provided as a grant under this section for a pilot program by no more than five percent for each of the two years following certification by the Attorney General of the submission of data by the rural area on the prescribing of schedules II, III, and IV controlled substances to a prescription drug monitoring program, or any other centralized database administered by an authorized State agency, which includes tracking the dispensation of such substances, and providing for interoperability and data sharing with each other such program (including an electronic health records system) in each other State, and with any interstate entity that shares information between such programs.

''(2) RULES OF CONSTRUCTION.—Nothing in this subsection shall be construed to—

''(A) direct or encourage a State to use a specific interstate data sharing program; or

''(B) limit or prohibit the discretion of a prescription drug monitoring program for interoperability connections to other programs (including electronic health records systems, hospital systems, pharmacy dispensing systems, or health information exchanges).''.

The SPEAKER pro tempore. Pursuant to the rule, the gentlewoman from

Texas (Ms. JACKSON LEE) and the gentleman from Ohio (Mr. JORDAN) each will control 20 minutes.

The Chair recognizes the gentlewoman from Texas.

GENERAL LEAVE

Ms. JACKSON LEE. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and insert extraneous material on S. 2796.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from Texas?

There was no objection.

Ms. JACKSON LEE. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, let me acknowledge that this legislation is from Senator JON OSSOFF. I know how important these issues are to him. At the very beginning, I thank him for his leadership. We have worked together as members of the Judiciary Committee, he in the Senate and myself in the House. I applaud him and look forward to more work on this constructive approach to drug use.

S. 2796, the Rural Opioid Abuse Prevention Act of 2022, is bipartisan legislation that would establish a pilot program for rural communities within the Comprehensive Opioid Abuse Grant Program.

The pilot program would make grants to rural areas to implement community response programs in order to reduce opioid overdose deaths. These community response programs would involve collaborations between public safety, public health, and behavioral health systems. The program will seek to identify gaps in current treatment availability and establish treatment programs to reduce opioid overdoses in rural areas.

Data from the Centers for Disease Control and Prevention's National Center for Health Statistics indicates that in 2021 there were an estimated 107,622 drug overdose deaths. The data also shows overdose deaths, including opioids, increased from an estimated 70,029 in 2020 to 80,816 in 2021.

Mr. Speaker, what compounds this, as I proceed in my debate here today, is that, just this morning, I read an article that says Texas rural hospitals are closing by the dozens, impacted by the pandemic and lack of personnel. We have an emerging, surging, if you will, synergism of default: individuals who need care, can't get care, and hospitals in rural communities that are closing.

With more than 200 Americans still dying of drug overdoses each day, it is even more important that we pass this critical legislation to get in the way, if you will.

In my hometown of Houston, overdose deaths have been exacerbated by strained access to treatment caused by the COVID–19 pandemic. Opioid overdose deaths have increased throughout the State of Texas, rising from 4,154 deaths in 2020 to 4,831 deaths in 2021.

When we wanted to get the antidote to opioid, unfortunately, we couldn't get State funding. Police officers and recovery entities, they just couldn't get it because there was a philosophical disbelief that that had anything to do with some of the dangerous drugs out there to be able to help some of those who are in need.

S. 2796 would enable local communities and community organizations to develop and expand initiatives targeting rural and low-resource communities. Eligible applicants of the grant program would be required to have a documented history of providing services in rural communities or regions highly impacted by substance use disorder.

The programs supported by this legislation would be able to identify gaps in treatment access for rural communities, leverage Federal resources to expand treatment options, and ensure rural and remote communities are not forgotten in our effort to address the ongoing impact of opioid abuse disorder across the country. The point that should be made is that rural communities are north, south, east, and west.

Building on the successful Comprehensive Opioid Abuse Grant Program, this bipartisan bill would expand it to include a pilot program targeting rural communities.

Mr. Speaker, I thank Congressman LAMB and Senator OSSOFF for introducing this important legislation. I urge all of my colleagues to support the bill, and I reserve the balance of my time.

Mr. JORDAN. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, this bipartisan legislation codifies into law an existing Department of Justice pilot program known as the Rural Responses to the Opioid Epidemic initiative, established during the Trump administration.

In 2020, the Trump administration created the new initiative to improve the opioid response and to reduce opioid overdose deaths in America's high-risk rural communities. The initiative enables 21 rural communities to receive existing Department of Justice funding to develop responses in opioid prevention treatment and recovery services.

While this work is important, it is also critical that we not lose sight of the dangerous drugs like fentanyl that are so easily trafficked across our southern border.

The Biden border crisis is making America's drug crisis worse. We have seen record numbers of drug seizures like fentanyl, encounters of illegal aliens, and apprehensions of suspected terrorists at the southern border.

For example, in fiscal year 2022, Customs and Border Protection seized over 14,000 pounds of fentanyl at the border and up to 10,000 pounds in fiscal year 2021 and 4,500 pounds in fiscal year 2020.

Oh, by the way, these drugs are only what CBP officers catch. We do not know the amount of dangerous drugs that have slipped through the gaps due to President Biden's open border policies, but there is no mistake that drug cartels and illegal aliens are taking advantage of the crisis at our border.

Meanwhile, our drug crisis continues to spiral out of control. We have seen the sad reality that overdose deaths in America reached an all-time high last year. An estimated 107,000 Americans died from drug overdoses in 2021, an increase of approximately 15 percent from the previous year.

Overdose deaths involving both opioids and synthetic opioids like fentanyl sharply increased in 2021 compared to the year before. These dangerous drugs are killing Americans at record levels and destroying families and communities across America. Communities in rural America have been particularly hard-hit by the opioid crisis.

While passage of this legislation will continue the important work started by President Trump's administration to help rural communities combat this crisis, we must do more. We must also take actions to address the Biden border crisis and stem the flow of illicit drugs flowing into our country.

Mr. Speaker, I reserve the balance of my time.

Ms. JACKSON LEE. Mr. Speaker, I yield myself such time as I may consume.

Let me, first of all, again acknowledge Senator OSSOFF and Congressman LAMB. This is an important piece of legislation, but my good friend knows that I am going to have to add to this discussion by saying that, again, the question of fentanyl, no one wants to see that proliferated and causing the disastrous conditions that we have.

But listen to the story of Ms. Alfaro, who was 19 years old. She lived in Appleton, Wisconsin, and ''was a recent high school graduate raising a toddler and considering joining the Army when she and a friend bought what they thought was the antianxiety drug Xanax in December 2020.''

The pills were fake and contained fentanyl, an opioid that can be 50 times more powerful.

One of the things that we should understand is fentanyl is everywhere, and it has been determined that most of the fentanyl that comes across the border is brought over by U.S. citizens.

The other aspect that is very important that doesn't specifically cover this bill, but at least this bill provides what the mother indicated, she didn't know anything about these drugs. She wished she could have helped her daughter. Yes, her daughter did lose her life.

The point this legislation is making is let's provide information to these rural communities, but also let's understand some of the techniques that some States and local communities were not providing law enforcement or anyone else. Certainly, that is the fentanyl test strips and Narcan. That

certainly was a problem and continues to be a problem in the State of Texas.

We have to look at this holistically, and I think this legislation focuses, certainly, on getting families information, particularly in the rural areas. This was Appleton, Wisconsin. At least, minimally, there would have been information about this, maybe in a broader way, because the mother of the 19-year-old said, ''Two years ago, I knew nothing about this.''

We have to do a better job of telling the facts about fentanyl that we all want to see be extinguished from causing the loss of life.

I think this legislation for rural communities is a very good start, but we need to make sure that our facts are accurate as we talk about this deadly drug, which we want to get off the streets of this Nation. We need to find ways that can be very effective, and we need to keep working.

Mr. Speaker, I reserve the balance of my time.

Mr. JORDAN. Mr. Speaker, I yield such time as he may consume to the gentleman from Iowa (Mr. FEENSTRA), my good friend.

Mr. FEENSTRA. Mr. Speaker, I rise today in support of this Rural Opioid Abuse Prevention Act.

I am from rural America. I am from rural Iowa, and I have seen the effects of opioids. It affects all ages. Those that are in high school that get hurt, that have a knee go out or a shoulder, they get affected by taking opioids.

This bipartisan legislation, which I introduced with my colleague, CONOR LAMB, will help prevent opioid abuse and overdoses in rural America.

In 2021 alone, nearly 100,000 Americans died from some drug overdose. This is unacceptable. This bill can do something about it.

My legislation will help the most vulnerable in rural America, in rural communities, recover from addiction and provide our first responders with the support they need to save lives.

There are too many barriers to rural healthcare right now, and we need to ensure that our Federal programs can efficiently reach communities in rural America that can make a difference when it comes to opioid abuse, and that is exactly what this bill does.

I urge my colleagues to support this important program because too many families have lost loved ones to the opioid epidemic, and they have also been affected by a family member's addiction. That needs to change.

Mr. Speaker, I ask my colleagues to support this bill.

Ms. JACKSON LEE. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I would like to offer a number of articles that speak to the importance of this legislation. I thank the gentleman from Iowa for his comments in support, and I know that the gentleman from Ohio will likewise, hopefully, join us.

It is important to speak the obvious. U.S. overdose deaths in 2021 increased half as much as in 2020 but are still up. We know that we need legislation specifically in communities in rural areas that would close or identify the gaps in prevention, treatment, and recovery services for individuals who interact with the criminal justice system in rural areas and create new efforts to address the opioid crisis.

Mr. Speaker, I include in the RECORD an article from the Centers for Disease Control's National Center for Health Statistics.

[From the Centers for Disease Control and Prevention, May 11, 2022]

U.S. OVERDOSE DEATHS IN 2021 INCREASED HALF AS MUCH AS IN 2020—BUT ARE STILL UP 15 PERCENT

Provisional data from CDC's National Center for Health Statistics indicate there were an estimated 107,622 drug overdose deaths in the United States during 2021, an increase of nearly 15 percent from the 93,655 deaths estimated in 2020. The 2021 increase was half of what it was a year ago, when overdose deaths rose 30 percent from 2019 to 2020.

The data is featured in an interactive web data visualization. The 2021 data presented in this visualization are provisional—they are incomplete and subject to change.

The new data show overdose deaths involving opioids increased from an estimated 70,029 in 2020 to 80,816 in 2021. Overdose deaths from synthetic opioids (primarily fentanyl), psychostimulants such as methamphetamine, and cocaine also continued to increase in 2021 compared to 2020.

The biggest percentage increase in overdose deaths in 2021 occurred in Alaska, where deaths were up 75.3 percent, while overdose deaths in Wyoming did not increase at all in 2021 and deaths in Hawaii declined 1.8 percent from the same point in 2020. The visualization includes:

Reported and predicted (estimated) provisional counts of deaths due to drug overdose occurring nationally and in each jurisdiction.

U.S. map of the percentage changes in provisional drug overdose deaths for the 12-month period ending in December 2021 compared with the 12-month period ending in December 2020, by jurisdiction.

Reported and predicted provisional counts of drug overdose deaths involving specific drugs or drug classes occurring nationally and in selected jurisdictions.

NCHS releases both reported and predicted provisional drug overdose death counts each month. They represent the numbers of these deaths due to drug overdose occurring in the 12-month periods ending in the month indicated. These counts include all seasons of the year and are insensitive to variations by seasonality. Deaths are reported by the jurisdiction in which the death occurred.

Ms. JACKSON LEE. Mr. Speaker, I think it is important to emphasize that, really, treatment works, and this is an example. ''Thomas Gooch has spent more than 30 years struggling with illegal drugs. The 52-year-old Nashville, Tennessee, native grew up in extreme poverty. He was first incarcerated in 1988 and spent the next 15 years in and out of jail for using and selling narcotics. 'Until 2003,' Gooch says. 'That was the first time I went to treatment and the last time I used.'''

This has to also be a component, which is the treatment of individuals whose conditions put them in this way.

Mr. Speaker, I include in the RECORD ''The Opioid Epidemic Is Surging Among Black People Because of Unequal Access to Treatment.''

[From Scientific American, Dec. 1, 2022]

THE OPIOID EPIDEMIC IS SURGING AMONG BLACK PEOPLE BECAUSE OF UNEQUAL ACCESS TO TREATMENT

(By Melba Newsome and Gioncarlo Valentine)

In one way or another, Thomas Gooch has spent more than 30 years struggling with illegal drugs. The 52-year-old Nashville, Tenn., native grew up in extreme poverty. He was first incarcerated in 1988 and spent the next 15 years in and out of jail for using and selling narcotics. ''Until 2003,'' Gooch says. ''That was the first time I went to treatment and the last time I used.'' Since then, for most of 19 years, Gooch has been trying to get others into recovery or just keep them alive. He handed out clean needles and injection-drug equipment—which reduce injuries, infections and overdose deaths—in Nashville's hardest-hit communities. In 2014 he founded My Father's House, a transitional recovery facility for fathers struggling with substance use disorder.

But despite Gooch's long experience, the opioid epidemic recently has brought a level of devastation to the Black community that has shocked him. ''I had never seen death the way I've seen death when it comes to opioid addiction,'' he says. ''There's been so many funerals, it doesn't even make sense. I personally know at least 50 to 60 individuals who died from overdoses in the last 10 years.'' That staggering body count includes Gooch's recently estranged wife in 2020 and a former partner in 2019.

A million people in the U.S. have died of opioid overdoses since the 1990s. But the face—and race—of the opioid epidemic has changed in the past decade. Originally white and middle class, victims are now Black and brown people struggling with long-term addictions and too few resources. During 10 brutal years, opioid and stimulant deaths have increased 575 percent among Black Americans. In 2019 the overall drug overdose death rate among Black people exceeded that of whites for the first time: 36.8 versus 31.6 per 100,000. And with the addition of fentanyl, the synthetic opioid that's 50 to 100 times more powerful than morphine, Black men older than 55 who survived for decades with a heroin addiction are dying at rates four times greater than people of other races in that age group.

The reasons for this dramatic change come down to racial inequities. Research shows that Black people have a harder time getting into treatment programs than white people do, and Black people are less likely to be prescribed the gold standard medications for substance use therapy. ''If you are a Black person and have an opioid use disorder, you are likely to receive treatment five years later than if you're a white person,'' says Nora D. Volkow, director of the National Institute on Drug Abuse at the National Institutes of Health. ''Treatments are extraordinarily useful in terms of preventing overdose death so you can actually recover. Five years can make the difference between being alive or not.'' Black people with substance use problems are afraid of being caught up in a punitive criminal justice system and are less likely to have insurance good enough to allow them to seek help on their own. And the COVID pandemic disrupted many recovery and harm-reduction services, particularly for people of color.

Gooch blames straight-out racial discrimination in the health-care system, too. ''When we call different places to try to get people into treatment, the question they ask is 'What drug do they use?' '' he recounts with

exasperation. ''If you say 'crack,' all of a sudden they ain't got no bed available. If you say opioids and heroin, they will find a bed because that's the demographic they want. A couple of times I told patients that the only way they're going to get help is to get drunk and turn themselves into Vanderbilt Hospital because Vanderbilt will hold them for five days, and that'll get them into treatment.''

Gooch is one of the people trying to improve access to therapies for addiction and change the overall dysfunctional dynamic. Other groups are bringing more effective addiction treatments within prison walls, reducing the chances of recidivism on release. A proposed federal law would make therapy with the commonly used addiction medication methadone less onerous for an impoverished population, as well as less stigmatizing. And Volkow is using her platform at the NIH to highlight the overwhelming research-based evidence for better ways to understand and treat addiction.

ACCESS TO TREATMENT

The nation's historic reluctance to treat addiction as a health-care issue rather than a criminal justice one has resulted in a health-care system where too few people of any race—just 10 percent—receive treatment for substance use disorder. Several factors, such as stigma and an inability to afford or access care, make the numbers considerably more dismal among people of color. Even after a nonfatal overdose, Black patients are half as likely to be referred to or access treatment as non-Hispanic white patients, according to federal government data.

A growing recognition that criminalization and incarceration do little to curb illegal drug use or improve public health or safety has led to harm-reduction policies such as Good Samaritan laws—statutes that provide limited immunity for low-level drug violations and increase availability of naloxone, a drug that can reverse overdose. But racial disparities have emerged in the application and effectiveness of both measures. A study from RTI International found that Black and Latino intravenous drug users have inequitable access to the medication.

Loftin Wilson, program manager for the NC Harm Reduction Coalition in Durham, N.C., who has worked in the field for more than a decade, says the problems with inequality lead to distrust in the system, which creates a vicious cycle in which people who need help won't go to institutions that can provide help. People entering treatment worry, with good reason, that dealing with the social service system can cause them to lose their employment, housing or even custody of their children. ''That's another example of the negative experiences people who use drugs have. They definitely don't land equally on everybody, and people don't experience them all the same way. It is a vastly different experience to be a Black drug user seeking health care than for a white person,'' Wilson says

University of Cincinnati psychologist Kathleen Burlew notes, as Volkow does, that when Black patients enter treatment, they are more likely to do so later than white people and are less likely to complete it. In addition to mistrust, she says, the less favorable outcomes result from factors such as clinician bias and lack of racial and ethnic diversity among treatment providers.

Federal resources, such as grants to support local opioid use disorder clinics and programs, also tend to favor white populations. According to 2021 data from the Substance Abuse and Mental Health Services Administration, 77 percent of the clients treated with grant funding were white, 12.9 percent were Black and 2.8 percent were Native American. The disparity is even more pronounced in some states. For example, in 2019 North Carolina announced that white people made up 88 percent of those served by its $54-million federal grant, compared with 7.5 percent for Black people. Native Americans accounted for less than 1 percent of those served.

MEDICATION INEQUALITY

Research has shown that there is a bias among health-care providers against using medication-assisted treatment (MAT), which combines FDA-approved drugs with counseling and behavioral therapies. Substance use specialists consider it the best approach to the opioid use problem. Yet a study published in JAMA Network found that about 40 percent of the 368 U.S. residential drug programs surveyed did not offer MAT, and 21 percent actively discouraged people from using it. Many addiction treatment programs are faith-based and see addiction as a moral problem, which leads to the conclusion that relying on medication for abstinence or sobriety simply trades one form of addiction for another. Many general practitioners who lack training in addiction medicine have this misconception.

The three medications approved by the FDA are buprenorphine, methadone and naltrexone. Buprenorphine and methadone are synthetic opioids that block brain opioid receptors and reduce both cravings and withdrawal. Naltrexone is a postdetox monthly injectable that blocks the effects of opioids. Very few insurance providers in the U.S. cover all three medications, and according to the Centers for Disease Control and Prevention, the full range of medications is far less available to Black people.

Research suggests that economics and race influence who receives which medications. Buprenorphine, for instance, is more widely available in counties with predominantly white communities, whereas methadone clinics are usually located in poor communities of color.

To use methadone, patients must make daily visits to a clinic to receive and take the medication under the supervision of a practitioner. This requirement makes it difficult to do things that build a normal life, such as attending school and obtaining and maintaining a job. There is also the stigma of standing in a public line known to everyone passing by as a queue for addiction treatment. ''The treatment model was developed [during the Nixon administration] based on racism and a stigmatized view of people with addiction without any thought of privacy or dignity or treating addiction like a health problem,'' says Andrew Kolodny, medical director of the Opioid Policy Research Collaborative at Brandeis University. The stigma is made worse by methadone's classification as a Schedule II controlled substance, which is defined as a substance with a high potential for abuse, potentially leading to severe psychological or physical dependence. This categorization pushed the medication into a quasicriminalized status and the clinics into minority communities.

Buprenorphine, however, is a completely different story. When opioid use problems increased in white communities, Congress acted to create less stigmatizing treatment options. The Drug Addiction Treatment Act of 2000 (''DATA 2000'') lifted an 86-year ban that prevented treating opioid addiction with narcotic medications such as buprenorphine, which today is sold under the brand names Subutex and Suboxone. The majority of doctors who got special federal licenses to prescribe it accept only commercial health insurance and cash, so the drug is usually offered to a more affluent population, which in the U.S. means white people. About 95 percent of buprenorphine patients are white, and 34 percent have private insurance, according to a national study of data through 2015.

John Woodyear is an addiction treatment specialist in Troy, a small rural town in south central North Carolina where the epidemic is exacting an increasingly heavy toll on the Black and Native American populations. Overall overdose death rates increased 40 percent from 2019 to 2020, but death rates among those two groups in particular went up 66 and 93 percent, respectively. Yet Woodyear, who is Black and practices in a town that is 31 percent Black, says his patients are 90 percent white. People come to the clinic through word of mouth or referrals from friends. As long as Woodyear's patients are mostly white, new patients will be mostly white as well, he says.

One exception to this racial pattern is Edwin Chapman's clinic in the Northeast neighborhood of Washington, D.C., one of the district's predominantly Black and most impoverished communities. Chapman, a physician, often prescribes buprenorphine to his patients with opioid use problems, and the overwhelming majority of them are Black. He says that to prescribe the drug, physicians like him must get past certain roadblocks. ''The insurance companies in many states put more restrictions on patients in an urban setting, such as requiring prior authorization for addiction treatment,'' he says. Further, ''to increase the dose above 16 or 24 milligrams, you may have to get a prior authorization. The dosing standards were based on the white population and people who were addicted to pills. Our surviving Black population often needs a higher dose of buprenorphine.''

Chapman says few physicians in private practice are willing to treat these patients. ''They don't really feel comfortable having these patients in their office, or they aren't really prepared to deal with the economic and mental health issues that come with this population,'' he explains; those disorders include bipolar disorder and schizophrenia, among others.

People have their own biases that keep them away from medication such as buprenorphine, Wilson says. Many view it as simply trading one drug for another. ''They think, 'If I'm going to take this step, why not just go to detox and not take any medications at all' '' he says. ''There's a big cultural misunderstanding about the fact that [these] medications are the only evidence-based treatment for (opioid use disorder. Short-term detox isn't the most appropriate intervention for most people.''

Gooch agrees that the bias is real. He facilitates recovery groups at a program operated by a group from Meharry Medical College, a historically Black institution. Yet ''I haven't seen one Black person yet,'' Gooch says. ''Some think it's a setup. There's so much distrust, they have a hard time thinking it's legal. It's just the culture of Black people. Many are religious and think [taking the drug] is wrong.''

''Those [misconceptions] are holdovers from our having been miseducated from the outset,'' Chapman says. ''Whites have done a tremendous job educating their community that this is a medical problem, a disease. In the African American community, drug addiction has always been and continues to be seen as a moral problem, and incarceration was the treatment.''

HOPE FOR CHANGE

In the November 2021 issue of Neuropsychopharmacology, Volkow argued that it is long past time for a new approach to drug addiction that would address these misconceptions within the most affected populations

and biases among providers. ''We have known for decades that addiction is a medical condition—a treatable brain disorder—not a character flaw or a form of social deviance,'' she wrote.

Volkow argues that treatment reform should start with prison and the criminal justice system. Even though there is no difference along racial lines in who uses illegal drugs, Black people nonetheless were arrested for drug offenses at five times the rate of white people in 2016. The racial disproportionality in incarcerated drug offenders does not reflect higher rates of drug law violations, only higher rates of arrest among racial and ethnic minorities. Currently the number of arrests for heroin (which more Black people use) exceeds the arrests for diverted prescription opioids (which more white people use), even though the latter is more prevalent.

These unequal arrests and incarcerations add to the racial inequalities in drug treatment and survival rates. An estimated two thirds of people in U.S. correctional settings have a diagnosable substance use disorder, and approximately 95 percent will relapse after their release. In the two weeks postrelease, the risk of overdose increases more than 100-fold, and the chances of death increase 12-fold.

Paradoxically, that makes prisons and jails—institutions with the most obvious and overt racial disparities—the places with the greatest potential to bring about effective change. Volkow points to a recent NIH study as proof that starting substance disorder treatment during incarceration lowers the risk of probation violations and reincarcerations and improves the chances of recovery. But only one in 13 prisoners with substance use problems receives treatment, according to a Pew data analysis.

Some local programs have started to tackle some of these issues. In Pittsburgh, the Allegheny Health Network's RIvER (Rethinking Incarceration and Empowering Recovery) Clinic opened in May 2021. Its goal is to reduce recidivism among people with addictions by providing care for the formerly incarcerated immediately on their release from jail, regardless of their ability to pay. Since opening, the clinic's caregivers have engaged with hundreds of people.

New York City recently became the first municipality in the country to sanction overdose prevention centers where people with substance use disorder can use drugs under medical supervision. Two sites, one in East Harlem and the other in Washington Heights, opened in December 2021. They have had more than 10,000 visits and prevented nearly 200 overdoses by administering the medication naloxone.

There are other signs of change, too. California signed a law that requires every treatment provider in the state to provide a ''client bill of rights'' to notify patients of all aspects of recommended treatment, including no treatment at all, treatment risks and expected results. And federal authorities loosened methadone regulations during the pandemic. Instead of daily in-person visits, more patients were allowed to use telehealth consultations and take doses home. Senators ED MARKEY of Massachusetts and RAND PAUL of Kentucky have introduced a bill that would make that change permanent. Among other programs and initiatives across the country, these are an indication that drug treatment policy may be headed in a more equitable, evidence-based direction.

Ms. JACKSON LEE. Mr. Speaker, I also include in the RECORD the article regarding the tragic young lady who died in Appleton, Wisconsin, and even now give sympathy to that family and make sure that we have the basic facts.

''Advocates warn that some of the alarms being sounded by politicians and officials are wrong and potentially dangerous. Among those ideas: that tightening control of the U.S.-Mexico border would stop the flow of the drugs, though experts say the key to reining in the crisis is reducing drug demand.''

She was looking for Xanax. Someone made phony Xanax, and then fentanyl was in it. That is just heartbreaking. It is tragic. We have to know where to spend our resources.

Mr. Speaker, I include in the RECORD this article: ''Myths about fentanyl persist as opioid continues to cause overdose deaths.''

[From the PBS News Hour, Oct. 28, 2022]

MYTHS ABOUT FENTANYL PERSIST AS OPIOID CONTINUES TO CAUSE OVERDOSE DEATHS

Lillianna Alfaro was a recent high school graduate raising a toddler and considering joining the Army when she and a friend bought what they thought was the anti-anxiety drug Xanax in December 2020.

The pills were fake and contained fentanyl, an opioid that can be 50 times as powerful as the same amount of heroin. It killed them both.

''Two years ago, I knew nothing about this,'' said Holly Groelle, the mother of 19–year-old Alfaro, who lived in Appleton, Wisconsin. ''I felt bad because it was something I could not have warned her about because I didn't know.''

The drug that killed her daughter was rare a decade ago, but fentanyl and other lab-produced synthetic opioids now are driving an overdose crisis deadlier than any the U.S. has ever seen. Last year, overdoses from all drugs claimed more than 100,000 lives for the first time, and the deaths this year have remained at nearly the same level—more than gun and auto deaths combined.

The federal government counted more accidental overdose deaths in 2021 alone than it did in the 20-year period from 1979 through 1998. Overdoses in recent years have been many times more frequent than they were during the black tar heroin epidemic that led President Richard Nixon to launch his War on Drugs or during the cocaine crisis in the 1980s.

As fentanyl gains attention, mistaken beliefs persist about the drug, how it is trafficked and why so many people are dying.

Experts believe deaths surged not only because the drugs are so powerful, but also because fentanyl is laced into so many other illicit drugs, and not because of changes in how many people are using. In the late 2010s—the most recent period for which federal data is available—deaths were skyrocketing even as the number of people using opioids was dropping.

Advocates warn that some of the alarms being sounded by politicians and officials are wrong and potentially dangerous. Among those ideas: that tightening control of the U.S.-Mexico border would stop the flow of the drugs, though experts say the key to reining in the crisis is reducing drug demand; that fentanyl might turn up in kids' trick-or-treat baskets this Halloween; and that merely touching the drug briefly can be fatal—something that researchers found untrue and that advocates worry can make first responders hesitate about giving lifesaving treatment.

All three ideas were brought up this month in an online video billed as a pre-Halloween public service announcement from a dozen Republican U.S. senators.

A report this year from a bipartisan federal commission found that fentanyl and similar drugs are being made mostly in labs in Mexico from chemicals shipped primarily from China.

In New England, fentanyl has largely replaced the supply of heroin. Across the country, it's being laced into drugs such as cocaine and methamphetamine, sometimes with deadly results. And in cases like Alfaro's, it's being mixed in Mexico or the U.S. with other substances and pressed into pills meant to look like other drugs.

The U.S. Drug Enforcement Agency has warned that fentanyl is being sold in multicolored pills and powders—sometimes referred to as ''rainbow fentanyl''—marketed on social media to teens and young adults.

Jon DeLena, the agency's associate special agent in charge, said at the National Crime Prevention Council summit on fentanyl in Washington this month that there's ''no direct information that Halloween is specifically being targeted or young people are being targeted for Halloween,'' but that hasn't kept that idea from spreading.

Joel Best, an emeritus sociology professor at the University of Delaware, said that idea falls in with a long line of Halloween-related scares. He has examined cases since 1958 and has not found a single instance of a child dying because of something foreign put into Halloween candy—and few instances of that being done at all.

''If you give a dose of fentanyl to kids in elementary school, you have an excellent chance of killing them,'' he said. ''If you do addict them, what are you going to do, try to take their lunch money? No one is trying to addict little kids to fentanyl.''

In midterm election campaigns, fentanyl is not getting as much attention as issues such as inflation and abortion. But Republicans running for offices including governor and U.S. Senate in Arkansas, New Mexico and Pennsylvania have framed the fentanyl crisis as a result of Democrats being lax about securing the Mexican border or soft on crime as part of a broader campaign assertion that Democrats foster lawlessness.

And when Democrats highlight the overdose crisis in campaigns this year, it has often been to tout their roles in forging settlements to hold drugmakers and distributors responsible.

Relying heavily on catching fentanyl at the border would be futile, experts say, because it's easy to move in small, hard-to-detect quantities.

''I don't think that reducing the supply is going to be the answer because it's so easy to mail,'' said Adam Wandt, an assistant professor at John Jay College of Criminal Justice.

Still, some more efforts are planned on the U.S.-Mexico border, including increasing funding to search more vehicles crossing ports of entry. The bipartisan commission found those crossings are where most fentanyl arrives in the country.

The commission is calling for many of the measures that other advocates want to see, including better coordination of the federal response, targeted enforcement, and measures to prevent overdoses for those who use drugs.

The federal government has been funding efforts along those lines. It also publicizes big fentanyl seizures by law enforcement, though it's believed that even the largest busts make small dents in the national drug supply.

The commission stopped short of calling for increased penalties for selling fentanyl. Bryce Pardo, associate director of the RAND Drug Policy Research Center and a commission staff member, said such a measure would not likely deter the drug trade. But, he said, dealers who sell the products most likely to cause death—such as mixing

fentanyl into cocaine or pressing it into fake Xanax could be targeted effectively.

One California father who lost his 20–year-old daughter is pushing for prosecutors to file murder charges against those who supply fatal doses. Matt Capelouto's daughter Alexandra died from half a pill she bought from a dealer she found on social media in 2019, while home in Temecula, California, during a college break. She was told the pill was oxycodone, Capelouto said, but it contained fentanyl.

The dealer was charged with distributing fentanyl resulting in death, but he reached a plea deal on a lesser drug charge and will face up to 20 years in prison.

''It's not that arresting and convicting and putting these guys behind bars doesn't work,'' Capelouto said. ''The fact is we don't do it enough to make a difference.''

While some people killed by fentanyl have no idea they're taking it, others, particularly those with opioid use disorder, know it is or could be in the mix. But they may not know how much is in their drugs.

That was the case for Susan Ousterman's son Tyler Cordiero, who died at 24 in 2020 from a mixture that included fentanyl after years of using heroin and other opioids.

For nearly two years, Ousterman avoided going by the gas station near their home in Bensalem, Pennsylvania, where her son fatally overdosed. But in August, she went to leave two things there: naloxone, a drug used to reverse overdoses, and a poster advertising a hotline for people using drugs to call so the operator could call for help if they become unresponsive.

Ousterman is funneling her anger and sorrow into preventing other overdoses.

''Fentanyl is everywhere,'' she said. ''You don't know what's in an unregulated drug supply. You don't know what you're taking. You're always taking the chance of dying every time.''

Ms. JACKSON LEE. Mr. Speaker, I reserve the balance of my time.

□ 1545

Mr. JORDAN. Mr. Speaker, I thank Mr. FEENSTRA for his work on the legislation. We support the litigation, and I yield back the balance of my time.

Ms. JACKSON LEE. Mr. Speaker, I yield myself the balance of my time.

I thank the gentleman from Ohio for his work on this bill and indicate that we are pleased to, likewise, support and thank Congressman LAMB and the gentleman from Georgia, Senator OSSOFF, for introducing this legislation.

I urge all of my colleagues to support this bill, as well, and to ensure that we provide really deep collaboration in our rural communities to help people who don't have access either to this kind of treatment, knowledge or prevention, and then, as I indicated, to medical care because hospitals are closing.

This is an important legislative initiative. I am hoping that we will support the Rural Opioid Abuse Prevention Act because it is bipartisan legislation. It is time for our Nation to face the increased overall overdoses and deaths in everyday communities large and small.

With more than 200 Americans dying of drug overdoses each day, Congress must act to support small and rural communities in addressing this crisis.

Mr. Speaker, S. 2796, the ''Rural Opioid Abuse Prevention Act of 2022,'' is bipartisan legislation that would establish a pilot program for rural communities within the Comprehensive Opioid Abuse Grant Program.

The pilot program would make grants to rural areas to implement community response programs in order to reduce opioid overdose deaths. These community response programs would involve collaborations between public safety, public health, and behavioral health systems. The pilot programs would seek to identify gaps in current treatment availability and establish treatment programs to reduce opioid overdoses in rural areas.

Data from the Center for Disease Control and Prevention's National Center for Health Statistics indicates that in 2021 there were an estimated 107,622 drug overdose deaths. The data also shows overdose deaths involving opioids increased from an estimated 70,029 in 2020 to 80,816 in 2021.

With more than 200 Americans still dying of drug overdoses each day, it is even more important that we pass this critical legislation. In my hometown of Houston, overdose deaths have been exacerbated by strained access to treatment caused by the COVID–19 pandemic. Opioid overdose deaths have increased throughout the state of Texas, rising from 4,154 deaths in 2020 to 4,831 deaths in 2021.

S. 2796 would enable local governments and community organizations to develop and expand initiatives targeting rural and low resourced communities. Eligible applicants of the grant program would be required to have a documented history of providing services to rural communities or regions highly impacted by substance use disorder. The programs supported by this legislation would be able to identify gaps in treatment access for rural communities, leverage federal resources to expand treatment options, and ensure rural and remote communities are not forgotten in our efforts to address the ongoing impact of opioid abuse disorder across the country.

Building on the successful Comprehensive Opioid Abuse Grant Program, this bipartisan bill would expand it to include a pilot program targeting rural communities.

I want to thank Congressman LAMB and Senator OSSOFF for introducing this important legislation. I urge all of my colleagues to support the bill.

Mr. Speaker, I urge my colleagues to support this bill, and I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentlewoman from Texas (Ms. JACKSON LEE) that the House suspend the rules and pass the bill, S. 2796.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mr. ROSENDALE. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this motion will be postponed.

PROVIDING RESOURCES, OFFICERS, AND TECHNOLOGY TO ERADICATE CYBER THREATS TO OUR CHILDREN ACT OF 2022

Ms. JACKSON LEE. Mr. Speaker, I move to suspend the rules and pass the bill (S. 4834) to reauthorize the National Internet Crimes Against Children Task Force Program.

The Clerk read the title of the bill.

The text of the bill is as follows:

S. 4834

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Providing Resources, Officers, and Technology to Eradicate Cyber Threats to Our Children Act of 2022'' or the ''PROTECT Our Children Act of 2022''.

SEC. 2. REAUTHORIZATION.

Section 107(a)(10) of the PROTECT Our Children Act of 2008 (34 U.S.C. 21117(a)(10)) is amended by striking ''2022'' and inserting ''2024''.

The SPEAKER pro tempore. Pursuant to the rule, the gentlewoman from Texas (Ms. JACKSON LEE) and the gentleman from Ohio (Mr. JORDAN) each will control 20 minutes.

The Chair recognizes the gentlewoman from Texas.

GENERAL LEAVE

Ms. JACKSON LEE. Mr. Speaker, I ask unanimous consent that all Members have 5 legislative days in which to revise and extend their remarks and include extraneous material on S. 4834.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from Texas?

There was no objection.

Ms. JACKSON LEE. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in support of S. 4834, the PROTECT Our Children Act of 2022, a critical piece of bipartisan legislation that would reauthorize the Internet Crimes Against Children Task Force, or ICAC, which has worked tirelessly for 14 years to protect our children from online predators.

It is no exaggeration to say the internet today is one of the most dangerous places for our Nation's children, many of whom spend hours online each day. Predators use social media and other online resources to groom and entice children to commit sexual acts.

The internet makes it easy for sex and labor traffickers to gain clandestine access to children and teens, recruit them into their organization, and exploit them. The internet is also the primary vehicle for distributing child sex abuse material and committing criminal acts of extortion against minors. It also provides an open forum for cyberbullying and online harassment, which can lead victims of such conduct to withdraw, become depressed, and even commit suicide.

To combat these monstrous crimes and to protect our youth from exploitation, ICAC task forces work with Federal, State, and local law enforcement to develop an effective holistic response to cybercrimes against children. Their programs include forensic and investigative components, training and technical assistance, victim services, and community education.