THE BROOKINGS INSTITUTION
BROOKINGS CAFETERIA PODCAST

"Opioids in America"

Washington, D.C.

Friday, July 10, 2020

PARTICIPANTS:

Host:

FRED DEWS
Managing Editor, Podcasts and Digital Projects
The Brookings Institution

Guests:

VANDA FELBAB-BROWN
Senior Fellow, Foreign Policy, Center for 21st Century Security and Intelligence

CAROL GRAHAM
Leo Pasvolsky Senior Fellow and Research Director, Global Economy and Development

KEITH HUMPHREYS
Esther Ting Memorial Professor and Professor of Psychiatry, Stanford University

BRYCE PARDO
Associate Policy Researcher, RAND Corporation

BRADLEY D. STEIN
Director, Opioid Policies, Tools, and Information Center (OPTIC); Senior Physician Policy Researcher, RAND Corporation

PAUL H. WISE
Senior Fellow, Freeman Spogli Institute for International Studies, Stanford University
Richard E. Behrman Professor of Child Health and Society, Stanford University

DEWS: Welcome to the Brookings Cafeteria, the podcast about ideas and the experts who have them. I'm Fred Dews.

Over the last two decades, more than 400,000 Americans have died from opioid-related causes. The epidemic has ravaged families and communities across the country, exposing weaknesses in drug policy, healthcare, and welfare systems. The crisis also has significant international dimensions as it intersects in myriad ways with US relations with countries ranging from Mexico to China.

To provide policy options and recommendations for addressing multiple dimensions of this epidemic, the Brookings Institution has brought together some of the United States' leading experts on drug policy in a project called The Opioid Crisis in America. For over a year, Brookings and external experts undertook a multidisciplinary collaboration to develop new insights and best practices for policy stakeholders at the local, state, and federal levels, as well as for members of the public who are on the front lines of the opioid crisis.

On this special episode of the Brookings Cafeteria podcast, you will hear from six of these experts, who will discuss findings and recommendations from their fields of specialty.

Carol Graham is a Brookings Institution scholar and a leading expert on the science of well-being and ill-being, as well as the role of despair in the opioid crisis. Keith Humphreys is a professor of psychiatry and behavioral sciences at Stanford University. Bryce Pardo is a researcher at the RAND corporation. Vanda Felbab-Brown is also a Brookings scholar and co-director of the Brookings series on opioids. Bradley Stein is director of the Rand-USC Schaffer Policy Center and a practicing psychiatrist. And Paul Wise is a physician who holds multiple professorships at Stanford University.

The entire set of papers can be found on the Brookings website, Brookings.edu/opioidcrisis.

You can follow the Brookings Podcast Network on twitter @policypodcasts to get information about and links to all our shows including Dollar and Sense: The Brookings Trade Podcast, The Current, and our events podcast.

And now, the opioid crisis in America.

GRAHAM: Since 1999, there've been over a million so-called deaths of despair. These are deaths, premature deaths, due to alcohol poisoning, opioid overdose and suicide. And roughly half of those deaths were due to opioids. In 2018 alone, about 70,000 people died of opiate overdose.

I'm Carol Graham. I'm Leo Pasvolsky Senior Fellow at the Brookings Institution.

DEWS: Carol Graham has long studied the economics of happiness, also called the economics of well-being, but also ill-being and deaths of despair. She observes that the United States boasts more opioids per capita than any other nation. Later in this episode, we'll focus on supply side issues, but here, Graham looks at the demand side.

GRAHAM: There really isn't enough discussion, in my view, of the demand side of the of the problem, the root causes of demand for drugs and the trends in premature mortality. And in our work, we've been looking at that. I didn't get into this work because of opioids, but it ended up linking directly to them. And what we find is that we are able to match the trends in CDC data on premature mortality, deaths of despair, at the level of individual race and place, county-level in US, and trends in well-being or ill-being. So reported worry, reported stress, hope or lack thereof, life satisfaction. And what we find is that our well-being metrics are good trackers of trends of deaths and despair.

So, what we find the starkest markers of these deaths are lack of hope and worry and stress. And if you look at a map, if we were able to put up a map, you would see that these same trends in ill-being match very closely with the places where there the most levels of opioid addiction and the highest levels of desperate despair.

A critical aspect of Graham's research is to try to understand *where* deaths of despair and opioid addiction are concentrated, and why they seem to be most prevalent among a certain group in the United States—less than college educated white males. She notes the coincidence between measured increases in despair among these men and the decline in manufacturing starting in the late 1970s—long before the opioid crisis started.

GRAHAM: Opioid addiction and deaths are most prevalent in places where manufacturing and other blue-collar jobs disappeared. Where less than college educated white males used to have stable jobs, the communities used to be roughly middle class. And since the late 70s, gradually those places have literally hollowed out. The jobs are gone. The families have disintegrated. And many people have moved out. And these tend to be the places where we have the highest level of deaths of despair and opioid consumption.

One of the side effects of the loss of jobs and the loss of community was the loss of purposeful employment and meaning and purpose in life in these places. People didn't have another narrative. You used to be the stable worker in the manufacturing or the mining plant … and that's that is gone. And that hopelessness is very much linked to despair.

I could say much more. But maybe as we as we talk further, later on, one group that is particularly toxic and worrisome and very related to these trends are a prime-age males who have simply dropped out of the labor force. They're not even unemployed because that assumes that they're looking for a job. They have simply dropped out. They're disproportionately spending

their time watching video games. And they're also the highest among the group that's among the highest opiate opioid addicts.

DEWS: Carol Graham took us through some of the key points in the demand side of the opioid crisis—why so many people—white men without college degrees in particular—were susceptible to opioids. But where did the drugs themselves come from. Who supplied all those pills? The next scholar points to the pharmaceutical industry.

HUMPHREYS: My name is Keith Humphreys. I'm the Esther Ting Memorial Professor at Stanford University School of Medicine. I'm a researcher who studies addiction, and I've also worked in policy around addiction.

So, in the 1990s, many people in medicine and many patients became concerned with the problem of untreated pain in America, which is a real problem, and it was a real problem then, and it is a real problem now. That humanitarian concern got co-opted by the opioid manufacturing industry into a different message, which is we need to prescribe many, many more opioids as the solution to pain. And they focused particularly on chronic non-cancer pain and particularly on people in primary care, where physicians generally have poor training, both in pain and in addiction.

And companies at that time, the most famous of which was Purdue Pharma, but others that did this, launched the most aggressive promotion effort in the history of the industry, and that included an enormous number of detailers, as they're called, going into doctors' offices and telling them that these long acting opioids were terrific and they would control pain and that they weren't addictive. And the doctors need to get over their opioid-phobia, as they call it, and just prescribe more.

And they also hired leaders in the field to give talks in favor of higher opioid prescribing. Oftentimes, these people didn't acknowledge that they were getting large payments from the opioid industry. They became a huge presence at scientific conferences, in state legislatures. And all the regulatory agencies pushing this message that we need to get over our fear of opioids and prescribe, prescribe, prescribe.

This was massively successful from simply an economic point of view. The volume of prescribing in the United States went up about 400 percent to the point that we were prescribing more than any other nation on a per capita basis had in the history of the world. And even now, today, with although prescribing has gone down in recent years, we are still by far the number one nation in the world. The only nation that comes even close to us is Canada, which also, not incidentally, has an opioid epidemic.

DEWS: Humphreys explains that as people became dependent on opioid pills, a market opportunity for a second wave of addiction—this time to heroin—arose, with cartels in Mexico driving the reestablishment of heroin markets in places where it had been prevalent, and creating new markets in places like Youngstown Ohio, and Huntington, West Virginia. And since heroin is cheaper than prescription pills, people started dying from it in addition to the pills. And then we moved to the third stage, as Humphrey's explains …

HUMPHREYS: And then the last stage comes in 2012 or so, which is the infiltration of an increasing amount of drugs in the United States with fentanyls, which are synthetic opioid analogs, most of them emerging from China, that were in the heroin supply and soon spread into the supply of stimulants as well. Those opioids were even more deadly than the previous two categories, and in the last few years they have been the chief killers in the United States,

although it's important to note that people are still dying from heroin and they're still dying from prescribed opioids.

DEWS: A key question in this history is, why didn't anyone—any regulatory or health agency of government—intervene to stop the over-prescription of pain killers in the first place? Keith Humphreys put it quite bluntly:

HUMPHREYS: Everybody who should have been protecting patients failed in the opioid crisis for a range of reasons.

DEWS: Humphreys explains that states control a lot of the medicine in the U.S., and at the same time, the pharmaceutical industry is a powerful lobbyist. He describes how at the state level, industry-funded patient groups advocated for opioid use and opposed restriction on them. These groups not only limited regulations, but also were able to get patients to focus on their pain in health system ratings, which then encouraged physicians to prescribe more opioids. And on top of that, the pharmaceutical industry has been, as Humphrey puts it, an enormously influential lobbyist in Washington, as Humphreys explains …

HUMPHREYS: They were also influential in the Congress and with the enforcement or lack of enforcement of over-shipments. So opioid manufacturers make these pills, but then they are shipped and due to some crusading journalism, it was revealed that companies like McKesson and Cardin Health were shipping hundreds of millions of pills to small towns that couldn't possibly have had that much legitimate use for them and failing in their reporting, which they're required to do in a case of suspicious payments.

Those companies intervened with by the Drug Enforcement Administration and basically brought their might to bear to (A) hire away a lot of the key DEA people and (B), go to their friends in Congress to make ample lobbying contributions and get them to essentially strip the

powers of the DEA to hold them responsible for what they're supposed to be responsible for when they get a license, become an opioid distributor.

So, there's very few white hats, sadly enough. I mean, it's a great example of how legal industries can capture regulators at all levels, federal, state and local. And in that process, you know, generate enormous wealth for themselves at enormous cost to the public.

DEWS: Keith Humphreys just laid out how the pharmaceutical industry acted in ways that allowed a flood of prescription pain pills to enter the market, which in turn opened the door for heroin and then synthetic fentanyl to come in.

This next scholar puts the fentanyl problem into perspective.

PARDO: My name is Bryce Pardo. I'm an associate policy researcher at the Rand Corporation.

In 2013, there were about 3,000 overdose deaths involving synthetic opioids like fentanyl. By 2018, that number had jumped to over 31,000. So, a tenfold increase in a little less than six years. Quite unprecedented.

These drugs now over have overtaken heroin and prescription opioids. They're largely coming from China, they're largely coming from Mexico. And are smuggled in through the traditional routes through the southwest border and direct to buyers through the mail system from China. And so, this in some ways is changing the nature of how the supply of illicit drugs are coming into the country and how law enforcement needs to be responding to them.

DEWS: Pardo explains that the traditional law enforcement response has been to focus on retail and wholesale distribution of these drugs in an attempt to reduce availability and raise the price.

PARDO: And so the focus has been on getting product off the street and raising the price. And we do know that drug prohibition can substantially increase the price of otherwise cheap or inexpensive commodities. Heroin is a plant-based substance. Cannabis is a plant-based substance. It's really prohibition that's elevated the price to make it worth more than gold per ounce.

DEWS But here's the problem when it comes to synthetics like fentanyl …

PARDO: And this is increasingly problematic as we transition away from these traditional drugs towards these newer drugs like synthetic opioids, including fentanyl and fentanyl analogs, these kind of generations of new chemicals that are manufactured by chemists in a lab.

And it's important to keep in mind two kind of two factors here. One is that synthetic opioids are very cheap. As I said, these are manufactured in labs. The drug cartels or drug suppliers don't need to wait months for a poppy harvest to ripen, to kind of come to harvest. You just don't have to pay the labor to extract the gum and then to process it into heroin. You can make a substantial amount of fentanyl in a lab, in a kind of domestic setting, fairly easily. And in addition to that, not only is it cheaper to manufacture, fentanyl and other synthetic opioids are very potent, orders of magnitude more potent than heroin. Some best estimates are about 25 to 50 times more potent than heroin.

So thinking about how the price is very inexpensive to produce, and because of its elevated potency, after you shake out and do the math, you kind of realize that per dose at wholesale, fentanyl is about 99 percent cheaper than heroin at the wholesale level, at the import level. So, this is really kind of an attractive alternative to drug dealers, given its price and given the availability of fentanyl. It's just too easy to make it. It's just too potent, too cheap.

DEWS: Pardo makes an important distinction here, one that is critical for better law enforcement practices. The introduction of fentanyl into illicit drug markets was not driven by user demand—users didn't want an opioid that was more potent than heroin. Instead, dealers started substituting fentanyl for heroin or even pain pills, packing the deadlier, synthetic drug into what looked like pharmaceutical products. And so here is where traditional law enforcement's approach to reduce supply and elevate price will be, as Pardo put it, increasingly problematic.

PARDO: The fact that any individual in this country can import a substantial amount of fentanyl direct from China to his or her doorstep really makes this problem a challenge for traditional law enforcement. Traditionally, law enforcement would have to build up cases through confidential informants. They would have to do surveillance operations and then take down some of these organizations through investigations. That's much harder to do when any individual anywhere can import a substantial amount of fentanyl without having any prior connection to organized crime or criminal history.

DEWS: Since 2013, China has been the principle supplier of fentanyl and fentanyl precursor agents—chemicals that are meant for legal purposes but can be used for the illicit production of drugs. As Bryce Pardo just explained, these substances can be shipped via mail direct from China, but they can also arrive into the U.S. from China via Canada or Mexico.

For more on the challenge of opioids coming from China, we turn now to another Brookings expert.

FELBAB-BROWN: I am Vanda Felbab-Brown, senior fellow at the Brookings Institution.

When synthetic opioids started emerging in about a decade ago or started emerging in new production techniques that made them very easily producible, the Obama and Trump administrations spent a lot of time trying to get China to tighten its regulation. Why was that? Because many of the synthetic opioids would be classified as illegal or illegal without special licensing in the United States, but not in China. So, you had several years of effort that focused supply policy on trying to get China to so-call schedule fentanyl and fentanyl analogues.

DEWS: Felbab-Brown explains that fentanyl has legal uses, including in surgery or intubating COVID-19 patients. Fentanyl requires special licensing for use and import … but China did not have such regulations until very recently. Moreover, there are also many analogs of fentanyl, similar at the molecular level to fentanyl. Many do not have legal uses but were long unregulated in China.

FELBAB-BROWN: These kinds of regulations for a long time did not exist in China, where the production was essentially unregulated and law enforcement made no effort to stop sales into the United States, even though they were causing massive devastation in the United States. So, in the latter part of both the Obama and Trump administrations spent a lot of effort trying to get China to classify fentanyl and precursor agents for fentanyl in the same way that the United States classifies them to reduce the amount of production facilities and amount of diversion. That finally happened in April of 2019, when China announced it was now doing what the United States has wanted.

DEWS: But until then, the fentanyl production market was largely unregulated in China, where, Felbab-Brown says, there are hundreds of thousands of facilities that can produce synthetic drugs, including, possibly, fentanyl. And now, after China has agreed to stricter

regulation of its drug market, production of illicit substances is shifting to other places, like India.

FELBAB-BROWN: Already synthetic drugs, including synthetic opioids, are robustly being produced in India, and there they are even far less regulated than in China. The regulatory environment in India overall tends to be much poorer. The pharmaceutical industry is very powerful, just like in China. But in the regime, that is, of course an electoral democracy, but the possibility of capture is very high. It's also one of the major industries, one of the major economic sectors in India delivering money and jobs. So the pharmaceutical industry in India tends to be very powerful, like all industry it hates regulation and tries to combat regulation. It's very poorly regulated.

DEWS: And Myanmar …

FELBAB-BROWN: It's very likely that if China does start cracking down on fentanyl production, Myanmar will rise as a source of production. It's not easy for the United States; it's a country in civil war, drugs are produced in areas that are either controlled by ethnic militant groups or militias that belong to the government. Both of them deeply trade in drugs, and both of them are dependent on drug trade for financial as well as political capital. And U.S. access to shape policy space there is limited.

And the last place worth mentioning, of course, is Mexico, right on the border with the United States. We get a large supply of all drugs going either through Mexico or being produced in Mexico. Fentanyl is being produced in Mexico from precursor agents that are imported from China and fentanyl is transshipped through Mexico. Now, one of the big things to happen is if the Mexican criminal groups will develop the capacity perhaps in liaising with some industries, some maquilas, in actually producing some kind of precursor agents themselves. So far, we

haven't seen that, but it's something to watch for and likely it will happen. And when that happens, there needs to be a priority for law enforcement.

DEWS: Later in this episode, we'll turn to policy solutions for this and so many of the challenges associated with the opioid epidemic. I'll also at this juncture offer another reminder about the new paper series from Brookings on the opioid crisis in America. The experts you're hearing from in this episode, along with others, contributed to the papers in that series.

No matter the relative balance between demand and supply, or cause and effect—federal, state, and local governments still have to respond in ways that not only try to stem the tide, but also provide treatment to people where they are now.

Here's a scholar who addresses how states have responded to the growing crisis.

STEIN: I'm Bradley Stein. I'm the director of the Rand-USC Schaffer Policy Center and a practicing psychiatrist.

So, I think as you think about the state response to this, there was really a number of different legs that it stood on. All of which were designed to increase access and at the same time hopefully improve the quality of care for individuals suffering from opioid use disorder with the recognition that many of these individuals historically haven't been able to get treatment. And in many cases, the treatments they've been able to receive have not really used some of the most effective interventions that we've had.

DEWS: Noting the flood of opioids described previously, he says that …

STEIN: We suddenly had a tremendous increase in the number of individuals with opioid use disorder, or what is sometimes called opioid addiction. And so, I think states recognizing the need to sort of provide treatment to these individuals responded in a number of ways.

DEWS: Stein explains what he calls three broad strategies, including: One, expanding insurance coverage and payment for treatment services for people suffering with opioid addiction; Two, expanding treatment access, with a focus on the most effective treatments; and three, Medicaid expansion under the Affordable Care Act, which allowed states to provide and reimburse for services that many people who had been previously uninsured could now get.

Here's Stein on the second item, on one way that states have expanded treatment access …

STEIN: So, one thing that states did is try to expand access to buprenorphine, which is a medication that can be prescribed for individuals with opioid use disorders and has been effective. Historically, oftentimes and historically, individuals would have to have to go to opioid treatment programs, to methadone clinics, to receive medications for opioid use disorder, and that required oftentimes going to those clinics daily.

And so for many individuals, this was very difficult. If you were geographically distant or if you were working a job or several jobs to be able to get there every day. And so, buprenorphine, when it was approved in 2002, greatly expanded sort of potential access to treatment because individuals didn't need to go daily.

Now to prescribe buprenorphine, clinicians have historically had to take a brief, eight-hour training to be waivered to prescribe, to receive permission to be able to prescribe buprenorphine. This eight-hour training really provides a very basic level of information about treating opioid use disorder. And as you heard Keith mention just a minute or so ago, this type of training in addiction was sadly often neglected in medical school curriculums. And so, one of the things states have been doing is supporting free training, increasing buprenorphine, increasing reimbursement for clinicians providing buprenorphine, supporting ongoing consultation for

clinicians who are first prescribing buprenorphine. And even in cases reimbursing clinicians for being trained, all with the goal of increasing the number of clinicians comfortable and able to prescribe buprenorphine and thereby increasing access.

DEWS: And so here we are, a nation grappling with an epidemic of opioid use, whether from over prescription of pain medication, or heroin abuse, or more recently, abuse of fentanyl the cheap, potent, and highly addictive synthetic drug.

What policies can treat the symptoms and the underlying disease? What combination of local, state, and federal responses, treatment plans, law enforcement approaches, and global policies are available to address the challenge?

As mentioned earlier, the experts in this special episode are contributors to the opioid crisis in America series, and along with a number of co-authors have laid out numerous policy approaches for the opioid crisis.

Let's start with a new voice in this episode, a medical doctor and professor whose work on addressing opioid addiction focuses on the most vulnerable people in our population—notably, women, children, and families.

WISE: I'm Paul Wise. I'm the Richard E. Behrman Professor of Child Health and Society at Stanford University. Also, professor of health policy and international studies at Stanford as well.

The societal responses to women, children, and families affected by the opioid crisis have to confront the intersection of three troubled policy arenas. First, they have to confront the profound challenges inherent in mitigating the impact of a national opioid epidemic.

However, there are two other domains of policy that have made opioid use in pregnancy and families particularly troubled, that give this set of issues a distinct character worthy of

special attention. In addition to mitigating the impact of national opioid epidemic, there's also a second arena of complexity, which are the policies directed at the impact of opioid use on pregnancy and children that have to navigate the fraught landscape of women's reproductive well-being and childbearing—domains of public policy that have long been complicated by deep ideological divisions and legal controversy.

The third area that is worthy of attention are the policies concerned with opioid use and the well-being of pregnant women and children, and how they directly engage the public mechanisms designed to protect children from mistreatment and provide safe alternatives to the family when the family cannot provide adequately for the care and nurturance of their children.

DEWS: Wise says there are five sets of recommendations for how to deal with the complex intersection of these three policy domains. The first is to follow the evidence, and not ideology.

WISE: The central strategy to mitigate the adverse effects of opioids before, during, and after pregnancy is the sustained provision of efficacious medications, and the ideologically-based approaches tend to diminish the provision of these essential interventions. So, follow the evidence, not the ideology is a crucial first step.

DEWS: Second, expand what Wise calls the constrained focus on the health needs of newborns exposed to opioids in pregnancy from just after birth to the larger well-being of women, children, and families.

WISE: And the tight focus on neonatal abstinence syndrome, or NAS, can distract from a much broader sense of concern and a much broader capability and set of opportunities to address the issues in a constructive way. The focus on in utero exposure has at times, overshadowed the

long-term impact on children of having a parent go without treatment for opioids. This is a much broader set of concerns with a much broader set of opportunities to do good.

DEWS: The third recommendation Wise offers has to do with guaranteeing comprehensive health services to women throughout their reproductive lifespan.

WISE: We only care about women's health during the prenatal period. And our programs are initiated the moment of conception, and then we throw women off the programs the moment they deliver or soon thereafter. And this is not constructive, and we see this in the arena of opioid approaches as well.

DEWS: Wise emphasizes that access to high quality contraception is a crucial factor in women's reproductive health care, noting that about 85 percent of pregnancies in women using opioids are unintended.

WISE: And so a commitment to enhance access to contraception for women who want to use contraception is critical.

DEWS: Wise's fourth recommendation is to adopt what he calls supportive interventions, not punitive ones.

WISE: Policymakers are charged with developing effective approaches to opioid pregnancy, and they are faced with a central dilemma. There is a powerful public impulse to protect the fetus and child from the harms of opioid exposure. We get that. However, most of the most effective ways to actually do this depend upon improving the health and well-being of the mother.

And so we get, not surprisingly, a set of policies that try to do both and often are frankly contradictory. Punitive policies are less effective in reducing drug use and pregnancy than they are in reducing engagement with prenatal care and drug treatment services. There's a remarkable

consensus among all the medical and public health authorities that the emphasis has to be strong, supportive strategies and not strategies that try to coerce, reduce drug use and pregnancy through reporting to child protective services, civil commitment, or even in some states, criminal prosecution of women who are using opioids in pregnancy.

DEWS: And finally Wise says that …

WISE: The last arena is to provide support to preserve family unity. The only alternative to the family in most jurisdictions, [for] families cannot take adequate care of kids, is the state. And the issue with Child Protective Services can be very real and create deep disincentives to engage in medical care and social services. However, policies that emphasize supportive services and empowerment for families confronting opioid use have been shown to be far more effective than coercive or impulsive policies that bring that basically ultimately lead to family dissolution.

WISE: And just to end, it's important to remember that children are the poorest segment of our society. And kids are poor because the parents are poor. And the impact of COVID on the finances of young families are only likely to exacerbate this and exacerbate this troubled reality. So as we consider opioid policies that affect pregnant women and families, it's also important to remember that the structural inequalities that are affecting young families, such as poverty, will also need to be addressed, particularly as the social claims of children and young families are deliberated in public policy concerns over the next few years.

DEWS: What kinds of new policing policies might better address the crisis? Recall that Bryce Pardo from RAND earlier described how the traditional law enforcement approach to opioids has been to reduce the supply and raise the price, but this fails to stem the tide of cheap, potent, synthetic fentanyl.

Pardo says that instead, law enforcement should focus on strategies instead that reduce the toxicity of these drugs and increase the transparency of drug markets.

PARDO: Users, at least initially, aren't demanding fentanyl. They're demanding heroin. They're looking for prescription pills. They're not looking for fentanyl. Sort of the dealers who are moving that. They're not telling the users what they're selling.

So trying to get law enforcement to help shape the markets, to reduce the toxicity and increasing transparency. There are a couple ideas we can put forward. But basically that means that means that we would need to have law enforcement try to use what we call focused deterrence, which is a which is which is basically an idea of a pragmatic approach to reducing the it's been used to reduce violence and drug dealing markets. So, in markets that are really violent in terms of how drug retail is occurring, what would focused deterrence does essentially, it focuses police efforts on the most violent actors, aggressively pursues and prosecutes those individuals, while really not doing much about those that are nonviolent retail distributors.

The focus here is that they want to minimize the violence, not so much minimize the distribution of drugs. And if we could adopt a similar approach, law enforcement could adopt a similar approach with regard to the distribution of synthetic opioids, we think it might yield some results. So here, the shift in thinking is not to reduce the overall distribution of drugs, but to reduce the distribution of drugs that are the most toxic of the most dangerous.

DEWS: Pardo calls this focused deterrence—focus on the dealers who are pressing fentanyl into tablets to hide the fact that they are selling fentanyl. But also law enforcement needs to pay attention to the uneven geographic spread of these markets.

PARDO: Not all areas have really been hit by the same level of distribution of synthetic opioids. So, where we see synthetic opioids in these markets is largely in parts of Appalachia,

New England, eastern half of the United States, not so much in the western half. So, this this this bifurcation of the market, this difference in how synthetic opioids are distributed is important for law enforcement. So, keeping it out of markets where there's still a good portion of the heroin being distributed in cities like out west in, say, San Francisco or Seattle, trying to alert drug users to the arrival of synthetic opioids is going to be increasingly important. So, law enforcement will need to continue to do routine seizures and buys and testing these samples to determine if synthetic opioids are present in the drug supply, alerting users as to when it when it does arrive, and then telling drug dealers that, look, we will investigate and prosecute the most flagrant of fentanyl distributors. Not really going after so much the heroin distribution networks.

DEWS: So how can law enforcement do this? Go read Pardo's paper with the University of Maryland's Peter Reuter for a detailed enforcement strategy for synthetic opioids, including fentanyl. But for now, here's what he has to say on this podcast:

PARDO: Thinking about how synthetic opioids are arriving in these markets through online retail, one policy recommendation that that the federal government can take into account here would be to try to spoof fake websites that purport to sell fentanyl or other synthetic opioids to potential buyers here in United States just to create kind of confusion in the online sourcing, because right now it is very easy to go online and to find an online vendor through the surface web who will sell you fentanyl. So, using law enforcement resources to kind of dissuade individuals by creating fake websites to kind of sow confusion in the online sourcing of fentanyl will be would be one kind of low hanging fruit here when it comes to deterring and dissuading or disrupting the supply of synthetic opioids.

So, going forward, we do think that the law enforcement efforts will have to adapt to a new reality of fentanyl distribution.

DEWS: Earlier, you heard Keith Humphreys of Stanford University's School of Medicine explain how over prescription of pain pills and lax regulation were contributing factors in the explosion of opioid addiction in the United States. So, from the perspective of the supply side within the medical profession, what can be done? Humphrey's emphasizes that we can't generalize from lessons of the past. The opioid epidemic, he says, is just different than other drug epidemics in this country.

HUMPHREYS: And that certainly applies in terms of supply control. Sweeping up large numbers of street corner crack cocaine dealers, for example, was not a successful policy. That doesn't mean that supply control won't work for the opioid epidemic because we still have the main suppliers are professionals, health care professionals.

Likewise, on the prevention side, the fact that ads aimed at adolescents to try to get them to stop smoking marijuana generally did not work, and maybe even we're antigenic (?) in their effects doesn't mean we can't do different types of prevention messaging today, for example, like encouraging parents to make sure that their opioid prescriptions are locked up in their home or telling people who use opioids, street opioids, about the prevalence of fentanyl and its effects.

The key things we can do in the health care system are a mixture of carrots and sticks. So, physicians do need to be monitored. No one likes to be monitored. But states that have implemented prescription drug monitoring—these are programs where physicians or other pharmacists check to make sure that the person doesn't, for example, have three or four or five other doctors writing them opioid prescriptions—states that have set up those systems and mandated that that those checks be made have seen drops both an opioid prescribing, but more importantly, in opioid poisoning and overdosing.

DEWS: Along with his paper co-author Jonathan Caulkins, Humphreys describes a range of policy interventions aimed primarily at the supply coming from prescribers and pharmacists, including lowering the number of pain pills prescribed by default to changing the incentives for physicians to get good customer satisfaction ratings from patients based not on their current pain but on their overall health outcome.

Recall that earlier Bradley Stein, a psychiatrist and director of the Rand-USC Schaffer Policy Center, described how governments—primarily state governments, responded to the growing opioid epidemic by expanding insurance coverage, expanding treatment access, and expanding Medicaid coverage for people who previously could not get drug treatment services.

And yet, Stein notes that despite these efforts, most of the people who need treatment for opioid use disorders still don't get it.

STEIN: And I think the other thing that's critically important to recognize at this time is the data suggests that access to that treatment isn't equitable, that individuals who are white and wealthy and living in communities with fewer people of color are far more likely to get access to that treatment than people of color. And so I think states really continue to try to address this question.

So, we certainly need more clinicians prescribing buprenorphine, but we need to make sure that it's not just about prescribing buprenorphine. They need to know enough about addiction to overcome the stigma often associated for caring for these individuals and families and really provide quality of care for the entire patient, not just focus on the opioid use disorder.

DEWS: In his Brookings paper with Rosalie Liccardo Pacula, a professor at the University of Southern California, Stein details these kinds of policy interventions. In our discussion for the podcast, Stein emphasized that clinical services for patients with opioid use

disorder need to consider a wide range of social structures, including housing and mental health, so that clinicians treat patients as whole individuals with a range of needs.

STEIN: I think the other thing that we need to consider as a policy is the recognition that opioid use disorder is a chronic episodic disorder affecting thousands of people and their families, many of whom have significant comorbidities. And we really need to make sure that we have the funding and infrastructure in place to treat this as a chronic illness that ebbs and flows and not just the acute events. We need to have sort of the ongoing support and effective care to be able to support these individuals and their families as the illness ebbs and flows. And that really is a very different rethink of how we structure our healthcare system to address the needs of individuals with opioid use disorder.

DEWS: Earlier in this episode, Brookings Senior Fellow Vanda Felbab-Brown explained how China's poor enforcement of its own drug market let opioids flow into the United States, and then when it did start cracking down, production shifted to countries like India, Myanmar, and Mexico. Her description of the problem highlights the difficulty of addressing it, especially when the U.S. relationships with global powers like China and India are concerned.

FELBAB-BROWN: One of the things that synthetic drugs did is radically change the role of narcotics policy with respect to geopolitical issues. Until the arrival of, really, fentanyl, the United States had to contend with counternarcotics in countries like Colombia, like Mexico, like Peru, like Bolivia that were either weak countries, sometimes in civil war, that were not either peer competitors or peer allies. That is not the case with China and India. So, in India, although India's regulatory environment and enforcement are bad and are bad for the United States, the United States seeks to cultivate India as a major geostrategic partner against China. So, it's not

easy for the U.S. then to demand with the same heft that it could demand from China that India improves its regulatory and enforcement practices.

So, the geopolitical dimension of fentanyl and synthetic opioids makes it even more difficult to design effective supply side measures. And under the best of circumstances, they've struggled. But many of the traditional tools, however effective or ineffective, are not even applicable when we think of countries like China or India. Ideally, the United States would be able to have joint task forces with China that would involve U.S. personnel on the ground in China to investigate leads on when illicit production or diversion of fentanyl is taking place. I am, unfortunately, very skeptical that in the current state of relations between the two countries, something like that will be available.

DEWS: Felbab-Brown, here and in her paper for the project—recommends a four-pronged approach the US government should take when it comes to China's regulation of and enforcement against its domestic opioid industry. Among the strategies is delinking counter-narcotics policy from the global US-China rivalry that plays out in other spheres.

FELBAB-BROWN: Such delinking is always hard to do, but there are certainly precedents—during Cold War with the United States where some policies were delinked at various times from the global competition and global rivalry. Investing in the delinking, emphasizing to China its embrace, its pride in being diligent on cracking down on narcotics markets, using other governments in Asia to deliver that same message and to delink is worthwhile attempting even if not easy to achieve.

DEWS: Felbab-Brown also recommends focusing on Chinese pharmaceutical companies directly.

FELBAB-BROWN: Chinese pharmaceutical companies are big sources of legal drugs, including legal fentanyl, for the United States. So, the United States could, for example, target them in its policies by mandating that only companies that adopt CCTV monitoring or other control system that China routinely uses to spy on its people are implemented in its production facilities. That will not eliminate the problem of finding the illegal supply, but can potentially simplify it, as there is actually some certainty or some hint that particular production facilities are not guilty of that.

DEWS: Other strategies include a database of Chinese pharmaceuticals that would provide a forensic signature on chemicals that Chinese companies want to sell in the U.S.; and also developing what Felbab-Brown calls individual packages of leverage against prominent individuals in the Chinese industry. Felbab-Brown calls for a similar delinking approach to India. But a major question remains: while China did agree in 2019 to U.S. demands to classify fentanyl and precursor agents the same way the U.S. does, will it enforce these new regulations and crack down on diversion to other countries that supply the drug to the United States?

FELBAB-BROWN: So, does China now have the capacity to monitor and inspect all the facilities that exist to prevent diversion is one issue. The second issue is whether China will have the will to do so. And both issues are complicated. China is a highly, tightly controlled society that has the capacity for all kinds of monitoring and enforcement. It monitors its citizens through crowd sourcing, data mining in ways that are unprecedented in the world.

It does not monitor its facilities in the same way, its production, chemical production facilities. But there are some ways to think about how monitoring could take place. So right now, only a very small amount of facilities are being inspected in China.

The second question is then, if China can overcome the capacity problem, does it have the will to start enforcing in ways that the United States wants? And that is not a straightforward issue at all. So, on the one hand, China is very focused on its international role as a global counternarcotics police officer. The United States long relished the role—for decades and decades the U.S. was the principal architect of the existing counternarcotics regime and its chief policeman.

So about 20 years ago, as China was entering the global system as an important and rising power, it has also decided that one of its hallmarks, one of its central tenets of identity in international relations, will be to present itself as another global counternarcotics police officer. And it has adopted often very doctrinaire, arguably backward and even inappropriate, counternarcotics policies, both at home but also in the neighborhood.

DEWS: However, the policy options are different when it comes to U.S. drug policies in other non-global powers like Mexico. There, Felbab-Brown says, the United States has a wider scope of policy. As she puts it …

FELBAB-BROWN: The United States is very thickly involved in the design and conduct of counternarcotics policies in Mexico.

DEWS: Conditions in Mexico have changed, however, under the current administration of Andres Manuel Lopez Obrador, as compared to his predecessor Felipe Calderon. As Felbab-Brown explains, the AMLO government has chosen to address violence and criminality in Mexico not primarily through law enforcement but through focusing on inequality and economic opportunity. This has, she explains, caused difficulties in counter narcotics policies for the U.S.

FELBAB-BROWN: And although many of the previous counternarcotics approaches were problematic and often driven by faulty US suggestions such as high-value targeting,

nonetheless saying essentially no more law enforcement or very weak and meek law enforcement is throwing the baby with away with the bath water.

DEWS: So, Felbab-Brown asks, what can we do with Mexico?

FELBAB-BROWN: That, too, has become challenging when the most important, the most violent criminal group, called Cartel de Jalisco Nueva Generacion, moved into the production and smuggling of fentanyl several years ago. There was a unique opportunity to combine effort in the United States and Mexico to go after this group, to go after the Jalisco Cartel. That had a chance to deter others, particularly its principal rival the Sinaloa cartel that dominates the heroin market, from moving into fentanyl. That failed. Now, fentanyl is traffic not just by Jalisco, but that approach actually didn't fail, that approach was never undertaken. And so as a result, Jalisco Cartel ... is producing fentanyl and shipping into the United States. Sinaloa Cartel is, and a whole variety of smaller groups are. It's hard now to imagine how that could be turned off.

So the next policy focus then can be at least preventing the production of fentanyl precursor agents in Mexico. One of the potential risks of collaboration is tightening control systems in Mexico, Mexican ports. The ports are very corrupt. And one of the areas that is of interest to President Lopez Obrador is reducing corruption so that [in my view, it is] of trying to reduce the level of fentanyl flowing to corrupt Mexican ports and the level of control that criminal groups have over port authorities and over the ports themselves.

But overall, I am rather skeptical that at this point we will be able to very much shape the Mexican market that is enormously violent, out of control, and where policy is simply affecting individuals or individual groups, but is really not having any kind of shaping the deterrence effects right now at all.

DEWS: But, Felbab-Brown cautions, the same issues apply to heroin and the poppy production that underlies it. Even if a large portion of fentanyl users in the U.S. switch to heroin, that drug is still produced widely in Mexico and, as Felbab-Brown points out, those same criminal groups would have an opportunity to employ a lot of people in the poppy fields. — especially those displaced during this COVID-19 crisis.

And then they'll still smuggle it across the border … over it or under it. Felbab-Brown explains the challenge and a policy opportunity.

FELBAB-BROWN: And I would also hope to see much more innovation in what's happening with the drone smuggling, not because I believe that if we get rid of drone trafficking—I don't think we can—that would any way eliminate supply to the U.S. Drugs are supplied through the wall that President Trump is wasting money on. Traffickers are already cutting holes through the new bollard system that has gone up. It's supplied by tunnels. But there is particular dangers in the drone supply as well. The dispersion, and anyway for other counterterrorism reasons, developing a robust anti-drone capacity, such as geofencing and drone capture is a worthwhile investment that will also have some beneficial side effect on drug supply.

DEWS: In this episode, we started with the economic changes in America over the past few decades that have contributed to deaths of despair, and the rise in opioid addiction. We've walked through some of the reasons why opioid use disorder has skyrocketed in the US, government and law enforcement responses, and the international dimensions. We've heard from a series of experts on possible interventions, from changing law enforcement practices, to more effective clinical treatments, to the challenges of global coordination on drug interdiction.

And so now I wanted to return, full circle, to how we address those deaths of despair, to those root causes underlying the *demand* side, rather than supply side, of the opioid crisis in America.

And for expert insight on this, we return to Brookings senior fellow Carol Graham.

GRAHAM: There really is not a comprehensive policy approach for addressing the root causes of this sort of despair of the population that is demanding opioids. And that's not an easy policy to come up with. Understanding differential resilience is even further away from current policy discussions. But if you think about the root causes of much of these ... driving addiction in much of these populations, what you have is the decline of the white working class, the erosion of families, communities, and social capital, and an inadequate public health care system, which certainly does not do a good job of providing access to mental health care, among other things, and also obviously very uneven access to health insurance at all.

And these things are not going to go away. They're going to and already are spilling over into the next generation. And now enter COVID, which is an exponential shock on this whole system. So, we really need to think about the pain and suffering and just lack of real work and connections for a lot of this population that's only getting more disrupted by COVID.

DEWS: Graham asks here, and explores in detail in her paper, on the role of deaths of despair in the opioid crisis, how we can restore hope and teach resilience for the people affected in the communities hit by the opioid crisis. How can the science of well-being measurement inform interventions that, as she explains, reduce isolation, and get people involved in meaningful activities in their communities even if they are unemployed?

GRAHAM: The U.S. actually has a burgeoning number of local level efforts to enhance community well-being, to try and help opioid addicts. But they're all really bottom-up efforts.

~~there.~~ There's some at the city level like the City of Santa Monica's wellbeing index and policy, the City of Louisville in Kentucky as a whole community healing effort. There are others. The Maryland Behavioral Health Administration is very active in helping children of opioid patients learn resilience skills so that they can have a hope at a better life, growing up with addicted parents.

There are a number of these efforts. And as I said, with COVID the need for them is only going to grow. But it's hard for these for these efforts to go to scale because there really isn't anything at the central level that supports them, even as an information clearinghouse, something as simple as that. That could at least serve to connect all of these, you know, local efforts with each other and increase learning.

And the last point I'll make is now with COVID I think we're going to have to be much more innovative about telecommunications involved in the whole thing there. There have been some changes in regulations. So, for example, doctors can see opioid patients now in video conferences and attempt to treat them as possible.

We're gonna need more and more of this. We're also going to need to develop technol technological systems to provide some of the social support that these local level efforts have been doing in-person at a point in an in time where we don't know when full social distancing will stop—it may maybe with us, at least in some forms for quite a while. And so, we're going to have to harness technology to start to think about how we can reach out again to vulnerable, isolated cohorts that are very vulnerable to addiction, as well as to both depths of despair and now also to COVID.

DEWS: Episodes like this are possible only with the collaboration of a very large team. I'd like to thank: Gaston Reboredo, audio engineer for the Brookings Podcast network, who

skillfully stitched the whole thing together. Claire Doire, intern in the Office of Communications at Brookings, who found all the news clips. Brad Porter, Security and Strategy project manager in the Foreign Policy program at Brookings, who arranged all the interviews and developed the themes. Anna Newby, communications director and managing editor of Foreign Policy, who oversaw production of the Opioids in America project. And Camilo Ramirez, who manages the podcast creation team in the Office of Communications.

My special thanks to all the scholars who took time out of their schedules to be interviewed. Carol Graham, Bryce Pardo, Keith Humphreys, Bradley Stein, Paul Wise, and Vanda Felbab-Brown, who co-directed the project and provided essential editorial direction for this episode.

Remember that you can find all the papers by these scholars and those of all the other scholars in the Opioids in America project on our website, brookings.edu/opioidcrisis.

The Brookings Cafeteria is brought to you by the Brookings Podcast Network, which also produces Dollar & Sense, the Current, and our events podcasts.

Email your questions and comments to me at BCP@Brookings.edu. Follow us on Twitter @PolicyPodcasts. You can listen to the Brookings Cafeteria in all the usual places. Visit us online at Brookings.edu.

Until next time, I'm Fred Dews.