THE BROOKINGS INSTITUTION

FALK AUDITORIUM

THE FENTANYL EPIDEMIC IN NORTH AMERICA AND THE GLOBAL REACH OF SYNTHETIC OPIODS

Washington, D.C.

Wednesday, December 4, 2024

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MALONEY: Good morning. I'm Suzanne Maloney, vice president and director of Foreign Policy here at the Brookings Institution. And I'm delighted to welcome you both here in our Falk Auditorium, as well as our online audience, to today's very critical discussion on the fentanyl epidemic in North America and the global spread of synthetic opioids. Over the past three decades, the United States has faced a devastating opioid crisis with synthetic opioids like fentanyl pushing overdose deaths to catastrophic levels. In 2022 alone, more than 100,000 lives were lost to drug overdoses. And fentanyl is now the leading cause of death for Americans aged 18 to 45. While recent data shows a slight decline in overdose rates, this crisis is far from over.

And the threat posed from fentanyl continues to grow both domestically and internationally. At Brookings, we are committed to help address the opioid crisis by providing in-depth research and actionable policy recommendations. Building on our multiyear work on opioids and illicit drugs. This new initiative, the fentanyl epidemic in North America and the global reach of synthetic opioids, examines the drivers of drug lethality. The impact on vulnerable communities, shifts in global drug markets, and the effectiveness of current policies. This project has been led by my colleague Vanda Felbab-Brown, who's a senior fellow at Brookings Foreign Policy and the director of our Initiative on Non-State Armed Actors. Through 12 comprehensive research and policy papers, which will be released beginning today and over the coming weeks, as well as our companion podcast series, The Killing Drugs, Vanda and the experts with whom she has collaborated and who are here with us today offer clear evidence-based recommendations for both domestic and global drug policies.

With an upcoming transition in the United States, today's conversation will focus on the critical challenges and opportunities for America and global drug policy. Before I turn the floor over to Vanda Felbab-Brown, a quick reminder that we are live and on the record. If users would like to submit questions, please do so via email to events@Brookings.edu or via social media using the hashtag #FentanylEpidemicForum and tagging @BrookingsFP. Vanda, congratulations and thank you for this very important work. The floor is now yours.

FELBAB-BROWN: Well, good morning. Thank you all very much for coming. Thank you, Suzanne, for your stellar leadership at Brookings. As my colleague Dr. Maloney mentioned, the opioid crisis is a

devastating issue for the lives of people in the United States and for people increasingly in other parts of the world. Canada and Mexico are also badly affected and synthetic opioids are emerging elsewhere. How to deal with this issue is fundamental for US policy, for public health, for international relations, relations with countries such as China, Mexico, India and many others. And so I'm enormously thrilled that in addition to the project that we have been doing with two terrific prominent experts, I am able today to have as our guest of honor, Mayor Bill de Blasio. Thank you so much and welcome to Brookings.

DE BLASIO: Thank you so much. And I want to thank you for the work you're doing. I just want to say to everyone, to say the least, this is a broader issue. The challenge that this country and many countries have had with drugs and specifically with fentanyl has been one of the most difficult to grapple with and takes so many forms as there are so many elements of policy, so many elements of human reality that come into play. I really appreciate the work that's being done here to try and untangle it and make sense of it. Find some actionable pieces. And I want to thank you for your leadership, but really thank you for everyone who's here who cares to try and find the solution. I would like to say we're trying to crack the code, but that might be presumptuous because it might not be trackable, but we can. I truly believe this is my entire experience in public life. We can find at least pieces that we can act on in the near term and save lives in the process. So thank you for what you're doing.

FELBAB-BROWN: And I look forward to having our conversation about how you were cracking the code, how you were decoding the code. But before that, let me offer just a very brief introduction. I mean, there is an inverse correlation between the prominence of the speaker and the length of the introduction. And I'm very tempted to simply say, Mayor Bill de Blasio.

DE BLASIO: Please do.

FELBAB-BROWN: But let me just little bit highlight some of the issues you are grappling with as a mayor, of which opioids. But of course, and fentanyl were one thing, but there were very many other issues on your plate. You were then you were mayor in New York City between 2014 and 2021. You

were dealing with the COVID-19 epidemic. You focused on transforming the city through one of the epicenters of COVID-19 to a place that was much safer. You were keenly focused on issues having to do with education, Pre-K, through-K education, as well as housing affordability and housing preservation in the city. Other aspects of health care inequality. And on top of that, there were opioids.

DE BLASIO: Yeah.

FELBAB-BROWN: And so you would.

DE BLASIO: I feel tired.

FELBAB-BROWN: As you were approaching the situation. When did you realize what was this drug situation like and when did you realize this was something the many issues you had to focus on that you had to deal with?

DE BLASIO: You know, it's amazing to think about where this is in our public discussion because one could argue in the context of 2020 for opioids and specifically fentanyl was sort of front and center in the national discussion in some way. I'm not sure the most productive way, but in some way. But when I go back to when I ran for mayor in 2013, honestly it was not a public topic, front burner topic. Everyone knew we had a problem and it was a problem that cut across demographics in an unusual way because much of what we experienced previously in terms of social ills kind of traced the poverty map of New York City.

But the history of the opioid crisis had a kind of unnerving ability to be strong and present in communities of all different demographics and without, you know, a sort of discernible enough pattern. Everyone knew about it. Everyone was concerned about no one was making it a front burner issue. If I if I could sort of speak in broad strokes. It took several years of, unfortunately, the growth of the crisis to sort of bring it forward, but still never as a burning public issue. More as a matter of my team, my health team in particular, saw the growth, saw the problem. And then, of course, the pandemic put everything into overdrive.

FELBAB-BROWN: And there are many reasons why I am so delighted that you were able to join us today. One is really your ability to speak about balancing and prioritizing many issues that we just started talking about. But the other is your truly pioneering work in the drug space. So there are folks in the audience, our esteemed authors, who have been advocates of harm reduction policies, policies that have been taboo. And it's one thing to advocate for them in research. On paper, it's quite a different proposition to translate some of those findings into actual on the ground implementation, especially in the U.S. context, where, as I mentioned, the policies, these approaches were taboo and even legal to some extent.
Please tell us about the range of options you considered. When opioids, fentanyl hit the radar screen and how you worked with the harm reduction aspects of it?

DE BLASIO: Well, look, first of all, I think it's important to say another thank you to everyone for doing this work, because some of this is I hate to use a simplistic phrase, but its consciousness raising the human cost, the human reality. I mean, this is a different kind of crisis. Many of our public policy challenges present themselves very physically. This crisis is strangely quiet, given its massive human ramification. And I would say to people, when we got to the point of overdose prevention centers that we just had to be honest about the reality in our city. There were people of all ages. It was not just a young person thing, which also kind of shocked me that it was such a spread across the ages, but that on a human level there were people dying in their bedrooms, of their family homes, of overdose.

There were people in a McDonald's bathroom dying of an overdose. There were people on, you know, somewhere in a park. But. When you stopped and took in the humanity of it. It was painful. It was terrifying that this was happening sort of on all of our watch, that this was happening as a strange norm, but something that wasn't seen and felt the way some of the other issues are. So that was part of what that that growing recognition, listening to the families, you know, the families who lost loved ones, listening to their stories and listening to their sense of powerlessness. And confusion was part of what opened my mind to the fact we have to do things very differently. Now, to the question of, you know, where we were before we got to overdose prevention centers. I'd say we were not in a place

that anyone could feel good about. I believe it's a true statement about substance misuse and about mental health.

That until we have some version of universal health care in this country, we're kind of kidding ourselves that we can make the impact we need to make. And some people may agree or disagree with that statement, but my point being from the local level, we often felt like we had very paltry tools to deal with a problem of this magnitude, of the sheer number of human beings, but also the nature of it. Like trying to if I was being simplistic, I would say trying to find an enemy you can't see. And we tried it obviously, to educate people. We tried to provide multiple treatment options. We tried to make Naloxone more widely available to avoid, you know, deaths that could be avoided. We did peer counseling. We would try and reach someone, ended up in a hospital, for example, to immediately connect them to a peer counselor in hopes that that would get them on the road to treatment. These were all fine policy initiatives. They had some impact.
I'm not doubting it. They were directionally correct. But none of them could fundamentally. Address the fullness of the problem in the absence of universal health care. We actually created our own version of a guaranteed health care system in New York City, where we came up with and intensified a kind of public health insurance option on the one hand, and for folks who could do that option, but for many, many undocumented people and others, that was not viable. So we created what we call them. I see care. We create a health care card that allowed anyone to go to our public hospitals and clinics, get assigned a primary care physician and have consistent care. These kind of approaches are helpful.

They're helpful in terms of physical help, the health, they're helpful in terms of mental health and substance misuse as well. But again, it all felt profoundly insufficient. And we kind of even in the meetings to discuss it, we couldn't pretend to each other that we had some holistic solution. We were only getting pieces of the equation. So finally along came and due to some wonderful activists, I want to give activists and advocates a lot of credit in this equation. And they were loud and persistent and from time to time would chain themselves to the front door of City Hall, which is a good way to get attention, not recommending it. But I will admit I will admit we would be in the middle of some other

kind of policy meeting and we'd hear their chanting because they were so close that it was kind of like you kind of had to ask the question, what are they chanting about?

And a group called Housing Works in particular was leading that effort in New York. And it helped me to start thinking of my team, to start thinking because this was not on our radar. And, you know, there's a circularity here. Overdose prevention centers were not on our radar because they had never been established in the United States. So there was no track record or no testimony, as it were, to understand them. So I'll finish. I don't want to belabor the question. I will say. It was powerful to learn there was sort of another frontier and again, not a solution writ large, but a powerful piece of the equation that could save a lot of lives and help people towards treatment. But the complexities of it were 100% obvious from the beginning. And I think a lot of what is helpful to discuss is how to help policymakers through those challenges, those honest challenges, the honest, deep questions that the public could have about something like this. It is a process. It took us years to get through that process, to get to a point of comfort.

My one profound contribution I can make to this conversation that should be lasting and deeply felt is that when people originally talked about the concept of supervised injection facilities, one of my first comments was never support a policy with the word injection in it. Is that, just not a message, a winning message. You know, no one likes injections. So, you know, I said, could we talk about what we're trying to achieve? And of course, we all came to the simple conclusion we're trying to stop overdoses. And we called them overdose prevention centers to get the core concept across, which were, unsurprisingly, a more appealing option to people. But from that first revelation that we had to even rethink the name years preceded in which we had to sort of piece by piece answer the questions and get our community to a point where it was actually viable to do this.

FELBAB-BROWN: Wonderful. You know, the messaging is certainly so core and applies to other injections, not just.

DE BLASIO: Yes.

FELBAB-BROWN: For overdose prevention...

DE BLASIO: As we learned during the pandemic.

FELBAB-BROWN: And of course, the overdose prevention. And to do much more than being places of safe injection. They connect or ideally, they should be connecting users to medical systems. And really, your efforts to provide medical accessibility to undocumented people is enormously admirable and also crucial during the pandemic, but also during the COVID-19 pandemic, but also, of course, responding to opioids. But all of this was radical, was revolutionary. And one of your great successes and something that I think is very impressive and will be one of my last few comments, I do want to make sure that we have enough space for questions from you. So please start thinking about what you would like to ask the mayor. Is your ability to work with law enforcement and your ability to build bridges between the health community and the law enforcement community? How did you do it?

DE BLASIO: Well, it's important to recognize from the beginning, you know, I got steeped in the cultural realities of different agencies and their histories and their worldviews and how it's just not easy for them to meet each other. And I came to understand that is something not to condemn or not to feel bad about, but to see the naturalness of it. So expecting the NYPD to immediately embrace this notion, I did not have that illusion and I thought it actually would be productive to go through the journey to see if we could get them to a place of relative comfort, because that would also mirror what we'd have to do with the public and the communities involved directly.

And I want to just do a really quick aside, special, honorable mention, a pioneer in this area who did not succeed and to use a political science term, got his ass kicked in the process was Mayor Jim Kenney in Philadelphia. He tried to go down this road and really struggled, but he did incredible service to New York City. And I would say to the nation, by schooling me, you know, I called him up and said, what happened? And he's like, here's what you should not do. And I got to tell you, when a colleague, policymaker says, I'm going to be real with you about what I did wrong and you know I want it. I want you not to make the mistakes I made. That's actually particularly powerful. And a lot of it was understanding how people had to be brought along and how much you have to listen to their concerns.

So I remember very vividly the first meeting with the NYPD leadership on this topic. And if I were to describe the look on their faces, dubious would not be a strong enough term. They to their credit and obviously, you know, one thing I will say about the many smart police leaders I've come across and they have extremely clear understanding of the human condition of what's happening in our communities. So they did not need to be told about the extent of the opioid crisis and the human cost. And they were concerned and they, too, had a deep interest in anything that might change the trajectory. But being told like, look, you know, here's a situation where people will be using drugs in a facility with medical support in some form or another, the government's going to be connected to it. It was hard for them to take in, just like it was hard for me to take in the first time.

It really was hard for a lot of elected officials and community leaders. I, two. But where everyone literally everyone I ever had the conversation with started to turn was when they heard about the track record from Canada, from Europe, from parts of the world that had used this approach. And they heard the simple notion that no one had died in these centers, you know. For many, many years, hundreds of thousands of people going through the doors and every overdose that happened was reversed. You know, that's we don't have any statistics like that in public policy and in life. So that was the eye opener of that for them, for me, for everyone. And the question actually for them was, okay, let's imagine we believe that there is a bigger merit in this.

We have to believe it can be done safely in terms of the community. We have to believe it will not encourage criminality writ large or create a whole host of additional problems. So I said not only is that fair, I need you to get those answers because we shouldn't proceed until we have those answers. And the easiest way to do it was for them to send a senior delegation to Toronto and to Vancouver and not just to meet with the advocates and the health care providers and the mayors, but to meet with their colleague police leadership. And obviously, every field has that sense of honor and connection and mutual respect that they can never find with people outside their field or not the same at least. And they went to Toronto and Vancouver, and I came back and said, look, yes, there is a way to make this work. We have to say, as professionals, notwithstanding our concerns. We saw it. We understand what's working, what's not. We can see how we would do things. And also, there's a

wonderful thing. I think everyone's seen this in different institutions. You know, there's a little bit of that.

Okay, we see the problems and we see how other people are doing it. But we're the NYPD. We can do it better. And I was kind of like, go with that pride. You know? And they're right. I mean, there are some amazing institution with tremendous capacity. I'm like, yes, please. So, they became convinced that they could keep the surrounding community safe. And their words, you know, look very simple, compelling arguments like, would you like, you know, if you're deeply troubled on every level by someone shooting up on the street or, God forbid, you know, dying in the park. Is there not an immediate argument that says, okay, let's try and bring some order to this and some possibility of change? And again, I think the police leadership of New York City did see that and embraced that sufficiently. Not perfectly, perhaps, but sufficiently.

But they needed to be convinced there was not an unintended consequence, a big, you know, crime multiplier effect of a different kind. And they did become convinced of that. And actually the outcome in the surrounding communities where we have the overdose prevention centers, New York City has been, I think, a good news story. I think it's perfect and it's a good news story. And it's an encouragement. And these are not, you know, communities with no problems. Right. We didn't do this in some leafy suburb. So when the day comes community by community where we're this is really getting to the point that might happen. The beautiful thing is we have examples. From neighborhoods that did this effectively, organizations that did this effectively. We also have the nation's largest police force that can say, yeah, we actually can help you understand how to do this.

FELBAB-BROWN: Let me continue exploring the law enforcement dimension with you, Bill, because we are thinking of stalking through lessons that can be applied. So, you know, after your work in New York, we end up with the Pacific Northwest, ended up moving toward the criminalization opening. Also, overdose prevention centers and a lot of street criminality becomes associated, very visible street use. And there is significant backlash, including in blue cities that rolled back many of the policies and some of them start voting red. What is the right balance between law enforcement concerns about order disorder, harm reduction policies? What is the magic that you had in New York

that could help if other communities, regardless of their political orientation, were to pursue such initiatives?

DE BLASIO: Well, it helps to have 35,000 officers. I mean, it's I mean, the size and capacity. NYPD is a kind of positive, special piece of this equation. And the also the depth of experience that the harm reduction groups had with the community. So we had you know, there was sort of a lot of veteran talent on the health side and the policing side of this, and that really affected the outcome and the collaboration with the district attorney, with the local city council member. All of these pieces add up to how you get to some version of success. But to your bigger point. You know, they say this on job sites and in many parts of life, safety first. You know, and I think the 2024 election and I won't delve into it only say as a Democrat and a progressive, I would say to everyone, safety first. Like people are looking for safety and security. It's totally human. It's totally appropriate. And what happened?

The Pacific Northwest, from what I could see from afar, was they forgot to put safety first in a way that was both sufficiently tangible and sufficiently visceral to the people of those jurisdictions. So, I think it's. It's 100% clear that. The general public. If we could take a very, very big category here and stereotype productively. The general public wants to know their safety and security. And that is, as I learned many times, New York City, that is one-part reality, one-part perception. And public leaders have to account for both. If you can sufficiently account for both, it's amazing what you then can do. If you cannot account for both. All other policy areas will be compromised. And I mean all it is literally the foundation. And if you think back to all our ancestral villages, we all come from whatever generations ago. You know, everyone want to know in the night there would never be an intruder who came in from outside the village.

It is like this is just part of our human coding. We need to know we are safe. So one of the things that we benefited from in terms of the creation of overdose prevention centers was that long period of time in which we were developing the idea, which obviously was in part because the Trump administration was in power and it was quite clear it would not be a viable time to act frontally. That time helped us build a foundation where we could show that we could do it more safely. And to make the argument

that the absence of overdose prevention centers create a different time type of insecurity and lack of safety.

That there was a different kind of criminality that was actually being strangely not enabled because of the absence of overdose prevention centers, but could not be addressed without them. If we could not get people to come in, we were allowing a certain anarchy. So, in fact, there was a, you know, law and order. I think it's really important. This is one of the things that kept being revelatory for me as I went on my journey as mayor. Law and order are two different things. People respond to both. And the reality of opioids in this country is there is no order. There's chaos and people don't like chaos. I don't blame them for not liking chaos. You can actually argue the pieces help reduce the chaos and bring more order while trying to get some people at least to a bigger solution. And I think that argument actually was successful with a number of our citizens.

FELBAB-BROWN: Wonderful. Any questions for the mayor.

FELBAB-BROWN: Please? Yeah. And you can if you can introduce yourself and ask a question.

DE BLASIO: Are we doing microphones? Here comes a microphone.

AUDIENCE MEMBER: My name is Doctor Filner. I practice anesthesiology for 19 years and pain medicine for 32 years practicing pain medicine. I had not a single patient develop addiction. I think while it's really important to talk about dealing with the result of addiction and trying to treat patients who have problems, I think in the long run, the demand side is the only way to resolve this problem. First of all, fentanyl is not an opioid. It's a synthetic narcotic. Opioids are derived from opium and the plants. Second of all, I would think there's not a single medical school in the United States that educates students about the use of narcotics or pain medicines and chronic pain. Not a single one.

FELBAB-BROWN: Thank you. Do you have a question, sir?

AUDIENCE MEMBER: Yeah. The question is how to deal with the demand side? Yeah.

DE BLASIO: Look, I'm very, very quick. Just so I know a lot of people want to ask for. Let me just pick up on that real quick. The I think on the policy level, we have to acknowledge I agree the demand side is where the first focus should be. And I would say from my vantage point as a recent policymaker, the whole medical establishment is still noticeably behind on reducing its own addiction to over subscription of opioids.
Again, do I have a study to show you? No. I'm basing on everything I've heard working with communities around my city. I think that's still an area where we could do a lot. I agree. I think that's part of the inference of the question. But also say since as Vonda said, the entire concept of my administration was to address inequality. You know, this is a decades long project for all of us to try and reduce inequality and give people a greater sense of belonging and opportunity where that directly relates to the extent of the opioid crisis. Know honest hopelessness, which I hope and believe no one in this room is experiencing because everyone in this room has succeeded in a variety of ways.

But there are so many people in this country who do not see a path forward for themselves, and that is fertile territory for the development of opioid use. So I think we need to get to the demand side on many levels. I actually think there are actionable steps we can take on the demand side. But I would also say as a policymaker, it's a bit I was not in the military, but I think the analogy will hold like we're in the middle of a battle right now. And the frontline troops in this battle, like the folks who work in the overdose prevention centers like we need that work right now. You know, those lives on the line right now. Bigger picture 100%. We got to move a lot of the policy discussion to the demand side.

FELBAB-BROWN: Gentlemen over there.

AUDIENCE MEMBER: Name is. Karl Bartholomeus. I'd like to. Ask a question about interruption on the supply side. There was an article in the. Journal. About a week ago about Morgan Stanley's investment advisory business. And they have 6 trillion with a t dollars of. Of assets. Invested. 25% of their accounts by their own internal metrics have been determined to be dirty money, money laundering. Are we making a big enough effort to interrupt the supply of money? And that's what the dark business. Is really at the end of the day about. Should we be focusing a lot more on enforcement

and banks as also a significant source of potential revenue in terms of confiscation of assets that could be applied to some of the, you know, the other parts of the problem.

DE BLASIO: This is much more Vanda's specialty than mine. But I just want to I love the question. And there's a great quote from Bob Dylan. He said, Money doesn't talk. It swears. Yeah. Yes, of course. It's all about money. And let's be very honest, among friends, there's no serious effort to interrupt these realities. From what I can tell. Again, you're much more expert than I. I think it's a little laughable that, you know, everyone who is being sent forward, including, you know, folks in law enforcement whose lives are on the line to make a case, is trying to address this issue, why the larger financial structure is merrily allowing these crimes, in effect, you know, financial crimes to take place all the time. So I would love to have a public policy discussion. I would love to have the public of this country start to examine how this money flows, who benefits, who's looking the other way, because that actually might disrupt some of the current troubled status quo, in my humble opinion. Again, you're the expert.

FELBAB-BROWN: Well, let me just add a little bit. You know, I think there is a great and growing recognition that going after a criminal money illicit proceeds, money that supports hostile actors is a crucial component of U.S. policies. And I see some folks in the audience who have been deeply involved in going after criminal money. And thank you. Thank you for doing that. But it's a big challenge. And there's a challenge that's both complicated because of regulation or the regulation in banking and financial sectors, and also because there are very many ways to launder money these days, including not just cryptocurrencies, but trade-based money laundering that is really excruciatingly difficult to get at. I'll take more questions, but since you're talking about law enforcement, you know, let me bring it back down to the street and NYPD cops. What, in your view, is the right role for law enforcement in dealing with drug dealing, the drug markets or large organizations? Your thoughts on that?

DE BLASIO: Well, you know, one of the things that's interesting, when you talk to police officers about their work, it's a variation on what you were just talking about, trying to trace the money laundering and how frustrating it is. I mean, imagine if every day you're confronted with the results of

the opioid crisis and you want to take action and you want to do something tangible and tangible can feel like. Arresting people involved. Now, what we, of course, move towards was don't arrest the addicted individual. They need treatment. But 100% go after the dealers and the suppliers and that whole chain. I think the point in that is there's a good conversation to have with law enforcement. I think a lot of people in law enforcement can get their say.

Let's separate that concept of sort of who's the victim and who's the perpetrator and really focus our energies on the perpetrator. But at the same time, I want to sort of citizen empathy with people at the front line doing this work. They can see these superstructures of finance and everything. They're not missing the fact that a lot of pieces are enabling this. And I think that builds a sort of sense of, you know, a myth of six of us. If you're out in the street trying to fight it, because the sense that the real players are never touched. Back to overdose prevention centers and approaches like this.
What I did find was extremely productive and a general thing I would recommend to everyone in public policy is putting the different viewpoints in one room and letting people start to understand each other. Because, you know, I found some folks in the health care field. Had an almost a religiosity about overdose prevention centers and they were so obviously right. What's wrong with the rest of you? And then law enforcement folks are like, wait a minute, you're opening Pandora's box here in terms of the potential of creating a criminal atmosphere. And there's all sorts of legal and other challenges. And we are. Law enforcement. We can't just ignore the law. So these were good conversations. I would note very importantly, our law department, which, you know, the New York City Law Department, if it were a standalone entity, would be one of the largest law firms in America, its vast and sophisticated.

At the beginning of this process, they bought fully the notion that we were stymied by federal law, and there was this was a very imperfect solution. By 2021, they actually gotten to the view that the laws governing drug trafficking. Did not apply if something was a medical context. And they. It was like they had to get acclimated to and again this is sort of I'm a proselytizing here about the beauty of dialog and people learning over time and sort of changing their views. Our law department by 2021 was like, wait a minute, this is entirely different than what the federal law is going at. An entirely defensible because these are all medically supervised facilities. It's a different construct entirely and defensible in

court. That is very, very important. If they're right. And I think they are. I hope they are. That's very important to what's going to happen in the next 5 or 10 years in this country because of it is provable in the legal context that the federal government actually doesn't have the ability to disrupt.

That, of course, opens the door for a lot of states and localities to act. But even while it's debatable, last thing I'll say, and I did wonder and I talked about this, I really want to hopefully contribute something in this discussion that could be lasting for folks who care about this topic. Federalism is a remarkable thing. And I will tell you, I thought I knew government. I thought I knew politics until I became mayor of New York City and understood the limits of the federal government, because sometimes I felt in my role, affronted by the federal government. Sometimes I wanted to know why the federal government couldn't help more. I had all these experiences that beg questions, and it became clear structurally, the federal government is a hell of a lot less powerful than we thought it was. And the founders wanted it that way. You know, they did not want a king and they did not want a concentration of power. So they threw all these monkey wrenches in.

Now, we all probably if I said to most of you in this room. You know, does that sound like federalism to you? You'd say, Yeah, that sounds right. In practice, it's striking how much power resides in the States. And one of the things I'd say is any state that would pass a law enabling overdose prevention centers would immediately have the commanding heights of the federal government. Even though we can say that our federal laws that are a real issue here. You know, the minute a state says this is the policy, the state and now the federal government is trying to fight that back and overcome that power, that federalism gives that state and cities and counties and all our creatures and derivatives of states.

So, you know, when New York City acted, we had we did not have the umbrella of support I would have liked from the state of New York. We did not have opposition from the state of New York, but we knew the state of New York actually could give us another layer of protection, even against a federal administration that wanted to disrupt. Not a perfect equation. I am not saying like, that solves all the problems. I'm saying kind of game on. There's actually more to this than who's in the White House.

FELBAB-BROWN: This gentleman might be the last question.

AUDIENCE MEMBER: My name's the way a scientist with a six-year grounded patent on opioids. We need to send the right messages across the country. Antonio Guterres is not. Overdose death is poison deaths. When does to attract and kill. For illegal trafficking of fentanyl. For illegal use. So as a whole country. From the government agency to social media and mainstream media, we should not use overdose deaths. Should be poison test, period.

FELBAB-BROWN: Thank you. So I will take a question, but it will be a question on the statement. So. So anyone. Okay. Okay.

AUDIENCE MEMBER: I'm just I'm just trying to put it out pretty out there. Sorry. Dave Anspach, just putting out there. Should we if we if approached by beggars on the street, give them money or anything, do you think you lot of them beg because they see the drug habit or. More legitimate reasons. I'm just wondering whether. A good deal of the pain comes. From. Getting money to feed. Addiction or not. I'm just wondering. Thank you.

DE BLASIO: 'll give my real-world view. And then I want one more question, because we still have time. I question I think it's both. I think it's the simple answer. Yeah, there's some people are going to use it for drugs. And again, they're addicts. They didn't necessarily sign up to be an addict. It's their reality. There's a lot of people it is for food and basic necessities. I think you have to call him as you see him case by case.

FELBAB-BROWN: So I'm actually going to take the last picture question. And you know, we just had some important positive results. And people like Brian Mann, who will be our moderator for the panel following us, have been alerting us that overdose deaths have gone down and they are overdose deaths in 2023, in 2024. But there are many moving pieces. We don't know whether this will plateau. The declines continue. Will they be disrupted? Very many issues and many dimensions of the very different policies that have been attempted are explored in our papers that will go online. They are online already. Some of them are online already evaluating and assessing every possible domestic and international dimension of synthetic opioid, such as fentanyl. And so I highly recommend that you

go and utilize those papers. Nonetheless, we are in a at best mid-stage, and we don't know how drug markets will change, how they evolve. What can we do from a policy makers perspective, someone who is arriving to be a mayor in a big city? How do you approach the issue of drug use and changing drug use? So it just doesn't catch you off guard? What can you do on the on the front end the moment you walk into the office?

DE BLASIO: Yeah, I think well, first thing to say is when you're the mayor of a big city, the biggest challenge is time and energy. I look back on now and I don't quite understand how any of us did the work we did because, you know, you're dealing with literally every issue and it's overwhelming all the time and exhausting all the time. And you know it. But it's I will also say I would strongly recommend it to everyone because it's amazing and powerful and beautiful. But the point I'm making is what really matters in policy making is whether something becomes a priority and whether it gets the time and energy. So my confessional point is when I came in, the door of this was not an issue. I would put in the sort of core, the top of the line because of its amorphous ness as experienced in communities, because it wasn't what people were bringing forward as their concerns.

And there were these gaping, huge policy areas that were big and tangible and actionable that took up most of my energy. And then just to make matters more interesting, incessant crisis and sort of being thrown off your strategic game all the time by current events. And that's long before COVID. COVID was that on many steroids?
So what I would say now that anybody coming into office now would have to say this is a clear and present danger. It has become much deeper than it was a decade ago. And yes, there is a difference, of course, between the overdose itself and the presence of fentanyl. They are both profound problems and they've both grown. So it has to be higher up your priority scale. And the simple answer is, it's do something. But not saying that in this sort of stereotyped way. Dig down to where you have the best resources you can apply that are meaningful. I do believe the things I talked about previously, like making Naloxone more widely available or peer counseling, you know, obviously overdose prevention centers, these are all viable, valuable pieces that any locality in theory could utilize, although with OpEx, obviously many, many questions about the political environment, the state government, etc., etc.

But there's actually tools, there's number of tools. And I think it's also fair to say to the very good point about the demand side, I think all levels of government should be working with the medical community. To put maximum pressure to keep reducing that over prescription reality, I think. Refocusing law enforcement on the dealers and the suppliers. And, you know, obviously many parts of the country where the addicts themselves are still being arrested, that's not productive. And I think that's an honest conversation that could be had with law enforcement. Like one, it's not productive. They're addicts. That's not changing. This is not where you're going to win the game. Move your resources over here. You can have a practical and moral argument with law enforcement. I think you can get somewhere. So wrapping the pieces together, I would say if a local leader or a state leader or even a federal leader said we have to do something, we're going to make it a priority, we do have tools right now.

They need to be deepened. We need to find better ones and we need to go after the money, unquestionably. But we do have tools right now, and I think it's fair to say in the United States, relatively few jurisdictions are utilizing even most of their tools, let alone all of their tools. And that means there's a there's a frontier there to be approached. There's something we can all do to get more focus on the issue and to get the things that work to be applied locality by localities, state by state in this country. And by the way, last point, thank you for your patience. Yeah, there was a national election. So much of what matters in the United States of America has no reference point to the national election. I mean, I know I'm in Washington, but policing is largely determined locally. Education is determined locally. Health care. You know, in the end, so much of what we're trying to do here depends on the policy choices and implementation choices at the local level, at the state level. And if Washington's a little unavailable, shall we say, then go where the possibilities are. Go where the action is. Keep innovating for the day where bigger national change is possible.

FELBAB-BROWN: Mayor de Blasio, thank you so much for sharing your thoughtfulness, your lessons and having this extraordinarily honest conversation. We are very grateful for your being here. I am very appreciative of the work you did as a mayor. I am delighted to hear your alerting our audience to the policy tool that you were using and that are part of the panoply of both national and

local level policy. Those tools are also something that our project has been examining. That's what the papers are about. That's what the podcasts are about. So please continue engaging with them. Please give a round of applause to Mayor Bill de Blasio. And please stay seated as the mayor departs. Our first panel, our esteemed authoress, Mr. Brian Mann, will take the seats and we will continue the conversations about where we are in the US with the rules and with the drug market. Mayor, thank you so much.

MANN: Hi, everybody. I guess we'll try to keep this going to time. Anybody want to give me a high sign that we're good to go and broadcasting and doing all the things? Okay. I see a thumbs up there in the back. My name is Brian Mann and I'm addiction correspondent for National Public Radio and based in upstate New York. But I travel all over the world kind of looking at how addiction and the fentanyl crisis in particular have affected our communities. And I want to thank Vanda and Brookings for having me here today. It's a real honor to be part of this conversation. The panelists have all agreed we'll keep it pretty informal here. But let me do just a very quick series of introductions. I want to start with Philomena Kebec who is a Bloomberg fellow at Johns Hopkins Bloomberg School of Public Health, also Chief Judge. In. The Chippewa community. Thank you so much for being here.

KEBEC: Yeah, the Mole Lake Chippewa Community. I also work for the Bad River Band. That's my that's my community.

MANN: Sounds great. Thank you for clarifying and giving us that additional frame of reference. Dr. Peter Reuter is distinguished professor at the School of Public Policy, University of Maryland. And Dr. Beau Kilmer is co-director of the Drug Policy Research Center at the Rand Corporation. Thanks to the three of you. I want to. Say that I've. Had the opportunity to read the papers. That they've prepared for. This conversation. And so I do hope that all of you, we're going to have a very conversational kind of. Chat about. What they're seeing out there in the world, in their communities. But please do burrow down and go deeper. Let me know. I actually want to start in your community, if that's okay. I want to talk first kind of about the human dimension of this.

You know, in your paper you talk about the fact that your office is actually in a harm reduction space in your community. You also talk about the fact that since 2019, there have been 45 community

members who've been lost to the fentanyl overdose crisis. Can you just talk about a little bit about the cost that you think this is bringing to your community in particular and what you're seeing in your research there?

KEBEC: That's a that's a hard question to start out with. And, you know, I just want to. Note the emotional, you know, depth that this crisis has carried within our community. You know, I'm just flooded with all the all the people in our community who have who we lost. And oftentimes people who have died of overdose are villainized. Their communities and families are stigmatized. And what's overlaid when we're talking about American, Indian, Alaskan Native communities is a stereotype that we suffer greater rates of substance use disorder because of some genetic issues. And you know, what my research is really focused on is that there's really no genetic predisposition to substance use disorder among American-Indian, Alaska natives. That's a fallacy. That's a stereotype. That's racism.

What we have is a series of bad policies that have that are that are targeted towards us because of the racism and the structural inequalities within the American system. And that has led to the death of so many of my friends, so many of my relatives. What is happening within our communities is many, many children have lost both parents. Many parents have lost more than one child to this. We have lost people from overdose within jail. They have died within the jail. We have you know, we have lost people because they have been cut off from their medication for opioid use disorder due to incarceration. And what you know, what we're seeing is it's not simply the fact that we have the lowest payment for health care within the federal system. But it's also this overlay of the criminal legal system. So we have lots of people to incarceration. And then due to incarceration, we're losing them permanently to overdose. And so it's you know, it's been devastating.

But I can also say that like many of the other crises that we've dealt with as a tribal nation, we're using this to inspire change very globally within our tribal system. And so often people have been disconnected because of drug use. They're disconnected from their families. They're disconnected from society in general. And what we're doing in our harm reduction program is reconnecting people rekindling their, you know, their social relationships and also connecting people back in to their culture

and spirituality. We have a monthly healing session that happens at our, within our harm reduction program, and we're really trying to change the dialog within tribal communities about drug use. People who have people who use drugs in our communities don't need to be disconnected from spirituality and culture and connection and their community. They're part of our families and really interrupting that and bringing people back in is what is going to solve the crisis for us.

MANN: I want to thank you for doing. I know that's hard to talk about and that's a lot to lift and carry, but I think it helps to ground this conversation in what's really happening in a human way. Often, we're talking statistics, we're talking data and research. And as all of us who've been out in communities know, there's a lot of real harm being done. And Peter, I want to I want to go to you next. One of the things that's so challenging about your research paper is you talk about this increase in drug overdose deaths. It's just been relentless, not only in the fentanyl crisis, but long before. And you raise this really troubling question about the efficacy of policy. And I think we're going to challenge this with our conversation today. But do you and again, I want to ask kind of a human question. Do you ever feel despair? Do you feel like we come to conferences like this? We have conversations like this. How much agency do we have?

REUTER: That's a very personal question. I know I don't feel despair, but I am pessimistic. I. To pick up on, Brian said. If you go back to 1978 and sort of draw a line mapping the number of fatal overdoses from all drugs, it rises, as Brian says, relentlessly for 45 years. It came down last year. First time in that period that it's come down by any substantial amount and that precedes the fentanyl crisis. Not only is it relentless, it's been very steady 7% per annum, roughly speaking, doubling every ten years. So, you know, the decline last year maybe brought the figure down to 90 somewhere in the early low 90 thousands. It's important to remember that 20 years ago it was probably more like 20,000. We get used to these things. And so we see something cheering in what are really catastrophic numbers. So pessimism rather than despair.

MANN: Great. We're going to keep burning down. Beau, I want to go to you, again slightly human spin on this conversation just to start. A lot of your research that we're going to be talking about today focuses on law enforcement. And that's really the topic of our panel and really the need for very

nimble, thoughtful interventions by law enforcement. Right now, we're at a moment where there feels like something of a backlash moment. A lot of people talking re criminalization, tougher sentencing policies. The president elect is using very severe language about death penalties for drug dealers. People are talking about poisoning rather than overdose. How do you feel when you look at the research you're doing and the tone of the conversation right now? What does your gut tell you about this moment?

KILMER: Well, in the chapter, we spend time kind of looking at a number of different criminal justice indicators with respect to what's happening in terms of drug possession, drug sales, incarceration, arrests. So we spend a lot prices. We spend a lot of time looking at the data. But then we also spend a fair amount of time looking at a number of noteworthy changes that have happened in the criminal legal space over the past ten, 15 years. And, you know, some of them are encouraging. But I do have to say the one that I find most discouraging is the increased application of what we would call drug induced homicide laws. Typically, when someone gets arrested for selling or sharing drugs, there can be very long sentences.

What drug induced homicide laws do, as they sometimes can be a sentence enhancement, or it can be an additional charge where if you share or sell drugs to someone and they die, there could be a big increase in the sentence. Now, this is concerning to me from a theoretical perspective, but also an empirical perspective, because when we know what we know about deterrence, if we want to deter people from dealing drugs or deterring them from violating, you know, some other law, we know it's the certainty in the swiftness of the sanction that matters more than the severity. So what do these drug induced homicide laws do? One, they bump up the severity and two, the add this whole level of uncertainty into it.

So from a theoretical perspective, this absolutely makes no sense to me from an empirical perspective. I'm not aware of any evidence that suggests that these drug induced homicide laws make any positive difference. There was one study published in a peer reviewed journal that did find that the application of these laws did reduce opioid overdose deaths, but the study ended up being so flawed it had to be retracted. There were a number of problems with that study. So theoretically, it

doesn't make sense. There's no empirical basis. Third, there are also reasons to be concerned that if you implement these drug induced homicide laws, that it could create disincentives for people to call the authorities when there is an overdose rate. You might be worried about getting arrested.

And so and so I know there isn't much evidence on that, but anecdotally, I think that's something that you have to, you know, that we have to consider. But stepping back, I understand politically why politicians are passing these laws. When you have parents coming up to you saying, my child died and this happens, you know, on a weekly basis, you want to take some type of action. You want to take something quickly. It's really easy to ratchet up sanctions. But don't fool yourself in terms of thinking that this is actually going to make a difference or that in that there's a possibility that it could actually make things worse. And I'd say the other part about this, which is frustrating, is it makes it seem like something is being done.
We're passing this law here. And that can be discouraging. But I do want to make it clear, though, and we talk about this in the paper. This isn't to say that there isn't a role for criminal legal actors in terms of reducing the harm related to opioid and other drug overdoses. We spent a lot of time talking about other options. In the paper. But we have to be thoughtful about how we use the criminal legal system when addressing these issues.

REUTER: Actually. So Beau and I are very close collaborators. So if I say something critical about him, about what he just said, it's not because we're not very close friends. So if you look at I want to go back to this sort of very uniform rise in overdose deaths. This covers a period in which there was an intensification of law enforcement in the 80s and 90s, and then a substantial decline in the intensity of drug enforcement is certainly represented by drug related incarcerations in the, you know, in the 21st century. Thousands and tens. You just don't see any effect of these changes in what I think is the most important indicator of the drug problem. Overdose deaths keep rising. It points when you ask about despair. No, but it really is depressing to see how little enforcement, how little policy changes, including expansion of treatment, naloxone, etc., how modest have been their effects undetectable in terms of overdose.

MANN: So we're seeing this roughly, according to the CDC, about a 14.5%. Drop. In overdose mortality. So let me ask a kind of a lightning round question here. Do you think law enforcement played if we broke down, what contributes that 14.5% drop? What chunk of that would be law enforcement, in your view?

KILMER: No idea.

REUTER: No, absolutely. I don't think anybody has any. But not should. I don't think I know nobody has any basis for assigning a cause to that drop where we had the unexpected increase during COVID. We can certainly explain that. What's the surprise that when the pandemic ends and the lockdown ends and all that, we go back in effect, go back to the curve? So we're just we're just now on the curve again.

KILMER: And Brian, to get to your question, one of the problems is we have a really weak data drug policy data infrastructure here in the United States That makes it hard to answer that question. The United States used to be a leader. We are not we are no longer leader. We have no idea how many people are using that, nor methamphetamine. To answer your question about, well, how much of this reduction in overdose deaths could be attributed to supply.
We'd really want to know, you know, what's happening to supply and how do we do that? We look at what's happening with market prices. And it's not just the price per gram. You know, a dime bag will always be $10 is the purity adjusted price. And it used to be the case that my colleagues at Rand 25 years ago developed an algorithm to do this. It was adopted by ONDCP every year when the National Drug Control Strategy would come out and have all this detailed information about the purity adjusted prices. That series ended in 2012. And so we've cut data programs. And so it makes it hard to answer the question that you're asking, Brian.

KEBEC: I'd like to address this as well. We. I agree that the data is just terrible. And the data with respect to American Indian Alaskan natives is also very problematic. We oftentimes the race is delineated in maybe 2 or 3 categories that do not include American, Indian, Alaskan native. But, you know, data that we do have indicates that American Indian, Alaskan Native people experience higher

rates of incarceration. And we're also experiencing higher rates of overdose fatality. And, you know, within some states, you can look at patterns related to high incarceration rates are translating into high overdose rates or else at least there's an association between these things.

What I see in my community is, again, people are people in my community are incarcerated in jails and prisons at a much higher rate than the non-native population. And I mean, I think that's true for a lot of northern areas. And these high rates of incarceration means that folks go through a period of reduction in use. But then when they're when they're released from their incarceration periods, they're not provided any kind of support with a with a lower tolerance, they're at much higher risk of overdose. And so, I mean, I think we were using a very blunt instrument when we're talking about treating the overdose crisis in this country simply with law enforcement tools. They're not designed in a scientific or targeted manner to address this crisis. I would posit that it is contributing in a very large way to what we're seeing on the ground.

MANN: So let's stay with you. One of the things that I hope everybody will go and read following his paper. You talk a lot about the relationship between law enforcement and native communities and the relationship between federal, state and local law enforcement. Can you think out loud about, you know, if we were to do some reforms to law enforcement at this point of the fentanyl crisis that could save lives, that could shift that a little bit, at least meaningfully? What would it be? What would what would some of the big ideas be that you would put on the table?

KEBEC: I mean, for tribes, we need to take control of our criminal legal systems. There's a policy called public law 280, of which was imposed by a very regressive Congress in 1953 that just wholesale had counties and states take over law enforcement within tribal communities. What we're seeing within our community is it's a very predatory system where there is a whole ecosystem that has been created with the court and prosecution and parole and probation that are creating value from extracting our people and people who are experiencing illness within our community that is exhibited through chronic and problematic drug use. And instead of providing these people with help and assistance, it's often just running them through these systems. We need to end public law 280 and retro cede from public law 280 to have additional resources for our own community to take care

of these problems and address them in the way that is culturally centered and is actually going to promote health and wellness.

MANN: Let me ask one follow up question then, Peter, I'll come to you. I've spent time in the Cherokee community looking at some of the projects they're doing. Some of it seemed really progressive and interesting. Are there other communities that you think that you can point to that say they are kind of grabbing hold of some of this? What would be some examples of hopeful cases?

KEBEC: Absolutely. I mean, that the work that's being done at the Northwest Indian Health Board is absolutely amazing. And they're igniting these communities in conversations related to addressing the maternal health crisis that has come from high rates of participation within the within the child welfare system and, you know, a criminalization of maternal health. The work that they're being they're doing is absolutely amazing. Jessica Langston is one of the researchers there, and she's really focused on improving outcomes for maternal health, which is just critical for the future of our nations. The Grand Ronde community has in COVID, during COVID they created a mobile methadone unit that provides access to buprenorphine and methadone on a in a rural area in Oregon. Oftentimes the work that tribal communities are doing in this area is not just to benefit ourselves, but it's also to outreach to non-tribal people who are also afflicted, because frankly, the states and the counties and the settler colonial system has oftentimes ignored their own people.

MANN: Peter, I want to turn to you. This panel is about law enforcement and the intersection between this and the fentanyl crisis. I know your paper concludes to some extent that treatment is the place where most of the traction will come. But if you had to say, here's one thing that my research has led me to think about in terms of law enforcement, is there anything we can be doing smarter and better insertion points now, or is it really about treatment?

REUTER: Can I take the Fifth? I mean, it's an awkward question. Much of my research over long period of time has been about drug law enforcement. And I'm not in principle against it. It's just it's so hard to find evidence that it has done much more than you get just from a so lightly enforced prohibition. And prohibition has enormously important consequences. A little bit of enforcement may

be sort of what you need to get those good and bad consequences. And more enforcement is just expensive and inhumane. I, I, I do not have a I do not have a clear idea. And I don't I mean, it's not that there are a set of clever ideas out there. I mean, one of the if I might make political for the moment, I mean, one of the striking things is that there isn't a Democratic position or a Republican position about the drug problem. There's no agreement. It's a terrible problem. We should, you know, have more treatment, maybe more, and maybe there's a difference on the intensity of penalties for sellers. But there's a dearth of innovative ideas here. I'd like to hear someone name one that really would make a difference. I certainly. Can't.

MANN: One of the ideas that I've heard floated not new, but with a little bit more emphasis recently has been the idea of focusing law enforcement on the collateral damage of the crisis, on public order, on creating safe spaces. Is that a place if you were talking to law enforcement, would you say that might be a more productive.

REUTER: Absolutely. I mean, I think that what we what we might infer from 40 years of sort of varying intensities and enforcement is that going after the markets just for the purposes of deterrence and raising prices isn't very effective. On the other hand, police can do a lot to affect the behavior of the markets. And there are lots of damages that are not just from drug use, but from the markets and the corruption of the violence around that. And that should play certainly play a larger role in decisions about policing.

MANN: I'd like for you...

KILMER: I would just add. Yeah, when you're it depends on what you're trying to address. You know, as Peter mentioned, if you're trying to shut down an open-air drug market because you want to give the community their space back, there are some really innovative strategies. David Kennedy has pioneered a lot of this work. Now, it isn't that that's necessarily going to reduce drug use, but it can restore order in those communities. You just have to be clear about what you're looking at. But Brian, getting to your question with respect to other things that law enforcement can be doing. One section of our paper focus on what was called police led deflection or diversion programs. This is why when

police come into contact with someone who's using drugs as opposed to arresting them and booking them and taking down to the station, they may make a referral to treatment or a referral to services, maybe connect them with a case manager. Now, there are hundreds of these deflection programs that have really kind of increased, I'd say, over the past ten years. And so as part of this volume, we spent some time tonight starting to dig into the research. And I would say overall, the research on these diversion or deflection programs is positive, but the methodologies used aren't very strong.

So I would say. It's I would say overall, if you were to look at this, it's potentially encouraging. But what we end up doing in the chapter is saying that we do think that local law enforcement officials should consider some of these deflection and diversion programs, but it should also be tied in with a rigorous evaluation. And when you think about the evaluation of these programs, I mean, obviously anything what's the outcome? Is it just going to be overdose deaths? Is it going to be the number of people entering treatment? But then also, you have to realize that when you're evaluating these innovative programs, you know, a lot's going to depend on this service infrastructure in that community. If you don't have high quality services in that community, well, what are the police going to refer people to? So you have to be thoughtful about how you think about this. But I do I do think there's a lot more room for many other agencies to give this a try, but also evaluate it to see what works and what doesn't.

MANN: I want to talk, you know, one of the big inflection points right now is there is this unexplained drop in overdose deaths. Another inflection point we're at now is that we do have President elect Donald Trump coming back to office. Mayor de Blasio made the point that a lot of this stuff will happen at the local level, but the federal agencies, the Justice Department, the DEA, the relationship, the local law enforcement, all of this is going to have a profound trickle-down effect. Donald Trump has been a disrupter in many ways. And in this case, what he's saying is, I want to fix this. He's saying I want to end the fentanyl crisis. So let me ask you this. When it comes to how this is going to play out, is this helpful to have fresh thinking and sort of very muscular let's really go at this? Or is or are these ideas dangerous? How do you think these could affect the search for solutions coming down to the levels you're looking at? Peter, you want to go first?

REUTER: I think using the term fresh thinking and President Trump in the same sentence is questionable. And I would not say they was new ideas. They're slogans. I have no reason to think that the slogan makes a difference. The notion that we should be penalizing Canada for importing, for exporting fentanyl to the U.S., I mean, I'm sure it has happened, but I mean, that's just fantasy. So I wouldn't I mean, I'm not saying that that a Trump Justice Department and Department of Homeland Security won't do something different, but I don't think the slogans give us any indication of what they are.

MANN: We're going to go. But let me know. What do you think?

KEBEC: So I'd like to uplift the state opioid response grants. And this was an innovation of the Trump administration, which was incredibly helpful for infusing much needed funds to start the experimentation in communities about what are the what are the targeted and tailored needs of a particular state. You know, I I'm from the Bad River tribe and we've had a little bit of a back and forth about the equitable distribution of state opioid response funding. Our tribe is experiencing much greater rates of overdose risk than non-tribal communities. And so, you know, we've been collaborating on how can we how can we create programs that are funded through these super funds that are interrupting some of these trends so that so that we can, you know, we can see a lowered risk.

This is a really great program and it's at risk right now. So authorizing the Support Act through this lame duck session is really critical to making sure that states continue to have lifelines to address the things that they need. I mean, I think I think another really positive thing that we're seeing from this administration is Vice President elect JD Vance's support for the Reentry Act. And this is about providing funds for county jails to provide health care services which are incredibly deficient within this nation, providing some federal funding to address to shore up the deficiencies that counties are seeing, especially when they're being inundated by many, many people with really high needs, people who need access to medication for opioid use disorder and induction, which is complicated. I mean, this is really important. And I'm hopeful that, you know, some of the things that are that are coming out

of this administration that are, you know, based in providing that necessary localized community support come to fruition.

MANN: But what do you think?

KILMER: If I could just add. We've spent a lot of time talking about overdoses and overdose deaths. Obviously, it's important. It's also very easy to measure. But we need to step back and also think about the other outcomes associated. Obviously, those who are suffering from substance use disorder. But I also want us to spend some time thinking about.
And this is when we talk about policy options, thinking about the families and loved ones of those who are suffering from addiction or have overdosed and died. We did some research that came out last year where we surveyed all Americans 18 and older and found that more than 40% of all-American adults, about 125 million people personally know someone who's died from a drug overdose. But then we asked them additional questions about how did that drug overdose or how did that death affect you? And found that 40 million American adults had said that a drug overdose death had disrupted their lives. And so when we start thinking about this problem, it's not just overdose. It's not just addiction. It's also how it influences family and friends. And I think when we think about the problem that way, it opens us up to thinking about other different policy interventions.

Now, obviously, we need to be doing more in terms of increasing access to treatment and making sure. And when we talk about that, it's not just about increasing funding for treatment. We need to make sure that it's actually high-quality treatment and we're giving it to people. But so treatment obviously is an important piece to this. But I think there's more that we could be doing to be providing services and help to the family members. I mean, ranging from teaching them how to use naloxone to then, you know, potentially providing them with services and support when they're trying to deal with a loved one who's suffering from addiction. I think there's a lot of potential there in terms of policy that I know. And I think for a Trump administration that focuses on the family, I think this is this is a potential avenue where they can make a big difference.

MANN: I'm going to ask one last question and then we're going to open it to the audience for questions. And we are going to really look for questions. So be thinking about things you want our panelists to think out loud about. I'm going to close on what may seem like a bit of a wonky question given all the places we've gone, but I think it's really important to emphasize this. In all three of your research papers, you all point to the fact that data on this devastating public health crisis is garbage.

We are decades into this overdose crisis. You know, we had you know, this is kind of a cliché that people say, but it's the truth that when COVID hit, we had granular data within months. We are now decades into this crisis. And, you know, as a journalist, it feels like a bit of a shell game. It's a bit of a tell that that academics, government officials, law enforcement, we can't track and understand the types of drugs on the streets, the quality of care, all of these different things. And so I want to ask each of you to point to this and you talk about this very granularly in your paper about how this is hurting native communities. Why don't we have better public health data after all of these years? What's going on? Why hasn't that happened?

KEBEC: I mean, oftentimes I feel like tribes are the redheaded stepchild. And we just don't, like oftentimes we're forgotten in these policy conversations. And it's really a missed opportunity because we have so much to contribute to the solutions. Right. And so investing in higher quality data, I mean, I think. Here's one very specific example. So the death records. Are uniformly within this country, produced by counties. And so often the counties and the coroners do not take care in determining the tribal status of an individual. I am. I don't look like a tribal member. Right. Look at me. I am an absolute tribal member. My grandmother was an original Apache of the Bad River Indian Reservation. But if I died here in Washington, DC today, would they. Would they figure that out? That's the problem.

And that needs to be addressed. What we're seeing is the we have very high rates of overdose fatality within this country. And in some states, it's enormous. But what we need is an adjustment of those numbers to account for the tremendous amount of misclassification of race. And that's a huge project. And that's a project that is really worth doing to even just figure out the, you know, how we do that mathematically and statistically. And then we can apply that across many, many different, you know,

like many different areas where, you know, where we where we see these disparities because we need the data in order to get the research and get the funding and get the support to start interrupting these trends.

MANN: Well, you want to go next?

KILMER: Yeah, I would say we have cut and discontinued important data programs. We've been slower to adopt new approaches for monitoring markets such as wastewater testing. We've also made it harder to access the data that are already being collected. So three concrete recommendations. One, let's bring back some version of the Arrestee drug abuse monitoring program. This is by far the best source of information we had about what was happening with local drug markets. And this information was then also used to estimate the total number of people who are using drugs in the United States. That program was cut in 2013. Let's bring some version of that back. Second, it's not as if we don't have wastewater testing for detecting illegal drugs in the United States, but we don't have a network. When we created the network for COVID.

Why not just add on to that and start taking more samples so we can then be able to detect what's been used in different communities? Because not only would give us help, help us get a sense about, you know, the variation in drugs used in different places.
But also you could think about this as an early warning system. So that would be my second recommendation. My third recommendation would be for law enforcement to make it easier for researchers to access the data that they're collecting on seizures and undercover buys. That's how we were able to figure out the purity adjusted prices so we could actually monitor what was happening with supply. It's that the DEA has made it much harder to access those data. And I mean, and this is across multiple administrations, this has been going on for some time. And it's not just the DEA. But I do think there's a lot more that we could be doing with the data that are already collected. So we have a better sense of what's happening in these markets. And you know, and Brian, getting back to original question, if we had those data, we'd have a much better sense about what's driving this decrease in overdose deaths.

REUTER: So let me take up why public health community hasn't done a lot better in this respect. And I'll tell a story from my own experience. Friend of mine had at one stage in his career being head of the Framingham Study. That's a long-time longitudinal study of the health of an of the population. And I said to him. And this was at a time by which half of every high school cohort for 20 years had said that they'd tried marijuana at least once. I said, why don't you ask about drug use? And his response was, Well, that would sort of imperil the rest of the study. They'd regard that as too intrusive. Now, you know, half of people have already been using an illegal drug. It's not that sensitive a question sensitive to question to an elderly researcher, but not to the population he's dealing with.

And I think that there is a kind of there are some real barriers to studying an illegal behavior. That's the that's, I think, the label that troubles health researchers about getting too much into this. And there's this sort of underlying fear and it sort of reflects something Mayor de Blasio said earlier, that, you know, are you are you helping enforcement by. And we wouldn't want to be doing that. So I think that there are some sort of deep attitudinal issues that make the law, make medical and public health researchers reluctant to collect a lot of these data.

MANN: Thanks to all of you. And so now let's do some questions here. I'm going to start kind of middle back there. If you could bring the microphone up, keep your hand up so they know where to go. And remember, we're looking for questions.

AUDIENCE MEMBER: Hi, everyone. Juhu Park from Brown University. Thank you so much for all of these insights. I just wanted to touch on a couple of points that have been made. One being that there don't seem to be many innovative ideas or public health solutions out there. I think we do need to do a better job of bringing public health professionals to the table and also communities who are directly impacted to these policy debates, because I can guarantee that some of my friends and colleagues who are listening today are probably thinking, well, there are actually many ideas that communities have raised that, you know, some of them have worked. Some of them had faced many barriers. And if only, you know, there were folks out there to listen. And I'm talking about federal agencies, even, you know, media, police departments, drug policy experts. So I would just say that that is a really important part. Also.

MANN: We have such a tiny time to ask a quick question.

AUDIENCE MEMBER: Yes, I my question is from the federal policy level. Do you think that harm reduction interventions have been adopted as far as they could be? For example, drug checking programs. Thank you.

MANN: Thank you for that. Sorry to cut you off. Any thoughts about that?

KILMER: Yeah, I'd say that. I mean, when we talk about harm reduction, I mean, there are a number of different interventions. And I actually think if we're having policy conversations about this, we need to be specific about the intervention because some people think about it just as administering naloxone. Some people think about it as legalizing drugs. I think it's really important to be careful about that. But with respect to drug tracking, it's really interesting. So many people know about the fentanyl test strips where, you know, you can test or powder your pill and figure out it's a binary yes or no. Is there fentanyl then there? But what we're seeing, you know, kind of emerge in a number of places, especially in in Canada, but also in different parts of the United States is actually drug checking where people can go. And within, you know, ten, 15 minutes know kind of what's in that pillar, what's in that powder.

And I suspect you're going to see that being adopted in more places. However, in a number of states, that's considered drug paraphernalia. So it's prohibited. I think there have been changes over time. I think you're going to see more with respect to drug tracking. And I think an interesting thing with drug check in a potential I haven't seen this done yet, but, you know, when people go in and they test their drugs, you know, obviously that provides information to them. But what if at the same time when they did that, you ask them, hey, how big was the bag or how many pills did you buy when you got this and how much did you pay?

I think it's a really interesting place where we can actually begin collecting data on the economics of drug markets. And so I think as these expand in different places, I would hope that we could get some

of that information because as I said, it's really tough to understand what's happening with prices in these markets. And getting that information from the people who use drugs just makes a lot of sense.

MANN: I think we've got time for one more. Do you write down here in front? And again, I'm going to twist your arm for a question.

AUDIENCE MEMBER: I'll ask the question. My name is Paul Martin. I'm the founder and president of United Against Fentanyl. And we interrupt the use of illicit funding of innovative, bold and effective initiatives. Next year, on September. 20th, we'll have the largest federal awareness event. In the world. We have 150 parents leading walks across cities, rural and suburban and urban. And I'll answer your question. It seems to me that keeping it real. A lot of experts get really shy when we come to enforcement. Just it doesn't work. And I'm frustrated because there seems to be a lack of urgency. Fentanyl is not like meth. It's not like heroin. It's not like cocaine. It kills people like that, including 15-year old's who buy a Percocet. And we know that the fear of sanction does work. That's why we have laws. Mothers Against Drunk Driving did this with the Wagner admonishment, or. They read to everyone that got a DUI. If you kill someone again, you could be charged with murder. I'm not saying. That we go lock up people who have addiction problems, but this drug seems to be. Different.

KEBEC: This drug is different. And part of the difference is the fact that people cannot stop using it once they once they become, you know, chronically using it. And that is the crux of the matter, because when we start interrupting supply, people have to switch supply and then they're going into a new situation with less information and that's higher risk. And when we're talking about fentanyl, risk is death. And so we cannot simply address this with supply side issues. What we see within tribal communities, when we see what I'm seeing in tribal communities is that we have a lack of access to effective medications. We do not have access to methadone in my community. We need that. We need all forms of FDA approved medication. But the regulatory system in this country, the nanny state, has made that impossible. So my women who are using fentanyl, if they want methadone, they have to go to Duluth where they're subject to trafficking. All right. And so and they are oftentimes targeted by police. All right. And so there's a lot of complexity to this. The law enforcement solutions are not working for us.

MANN: I would say. Hold on. Just there. He said. Do either of you have thoughts about this? Clearly, there is some demand in the country. There are some people who say it's time to look at arrests and a tougher response to fentanyl in particular. Is there data to show that that might be effective? Let me put the question to the two of you very quickly that way.

KILMER: Once again, it depends on the goal. We're at a point now where fentanyl is just entrenched in a lot of different areas. So the idea that law enforcement is going to be able to reduce supply enough to raise the prices to lead to a reduction in consumption, not seen as impossible at this point, that seems unlikely. Here's the thing. Five, six years ago. You know, before especially before fentanyl spread west, I think there was an opportunity for law enforcement. It wouldn't have prevented it. But even if you could have slowed down the transition of fentanyl, you know, you know, from becoming saturated in these markets, even a couple of years, you would have saved thousands of lives.

And so I think when we talk about the roles of law enforcement, it depends on where we are in this kind of epidemic. And so, Peter, Peter in John Calkins had a great piece in Scientific American last year talking about when we think about the role of law enforcement, we need to think about, you know, especially in places where we're fennel is really entrenched, maybe focusing less on supply reduction there, but more on the dealers who are committing violence. Focusing on the corruption. And so the takeaway is it's not that there isn't a role for criminal legal agencies, but being thoughtful about where they allocate their resources.

MANN: Okay. Okay. Briefly.

REUTER: Yes, Rebecca, about that. I mean, again, you know, my good friend Bo is going to be I'm going to disagree.

KILMER: I was quoting your paper.

REUTER: But I don't think that was actually responsive to the question, which is, look. So the question I asked was, can law enforcement make a substantial have a substantial effect in reducing the availability of fentanyl? You know, your argument is we should be very much focused on the fatal overdoses.

And there I just I, I fail to see that we have any evidence that tougher local enforcement or federal law enforcement can substantially restrict supply. I mean, the attraction, the great attraction of heroin for of fentanyl for drug dealers is precisely the ease with which it can be manufactured and replaced. It is we did an estimate that at the very high level, you know, in Mexico, traffickers pay, in effect, 1% as much for fentanyl as they do for heroin, taking into account. Difference in the potency of the two of the two drugs. And so and it can be produced endlessly, cheaply. It's an it's I mean the case for supply reduction is hard to make.

MANN: On that note, I want to thank the three of you. And it's a hard discussion. And this is a challenging moment to be talking about it. But I thank you for your thoughts. And I again encourage all of you to go and read their papers, dig in further than we could go today. We're going to Take a break now for a coffee and everybody stretch your legs and then a lot more conversation to come. And again, I'm grateful to you very much. Thank you.

OVALLE: Good morning. Good morning. Thank you all for joining us on the second panel. It is Fentanyl, United States Treatment, Harm reduction and Decriminalization. My name is David or I am a health writer with The Washington Post. I'm very, very excited to be here with such amazing speakers. So I'm two quick, brief introductions and then we'll just open it up. First off, we have Dr. Harold Pollack, a professor. Of public health sciences, University of Chicago, Regina LaBelle, former White House drug policy advisor and the director of the Addiction and Public Policy Initiative at Georgetown University Law. And of course, Keith Humphreys, also former White. House drug policy advisor and professor of psychiatry at Stanford University. Welcome all. I guess. We'll just start with you, Harold. Maybe you can talk a little bit about your paper and the importance of Medicaid in dealing with this crisis.

POLLACK: So I'll be really short and sweet. So we have I'll be really short and sweet. So we have lots of time for conversation. Medicaid is the cornerstone of everything we're trying to do. If you want to do something that's financially sustainable, you know, Medicaid is just is just the ball game. And for several different reasons. One is that many, many people with substance use disorders also have other health problems, as Keith and others have written about quite importantly.

So we need to deal with the totality of people's mental physical health needs, but also, we need to make substance misuse treatment, the human experience of that accessible evidence based and so on and met and state Medicaid programs are in a position to implement that and to make sure that that's done in a in a widespread way for all the people who need it. I'm doing a randomized trial right now in Illinois of people leaving jails and prisons who have opiate use disorders. And more than two thirds of our, of our folks are Medicaid recipients. And so a lot of the innovations in Medicaid that have been actually both political parties have supported have been to try to provide Medicaid more effectively to people leaving jails and prisons and to deal with all the populations that are on Medicaid that have great need.

OVALLE: Great. Regina, do you want to talk a little bit about your paper?

LABELLE: Sure. First, I want to thank Brookings and Vanda Felbab-Brown for this really important discussion. It's I love the overview of the complexity of the issue is really important. And so our paper I worked on this with David Holt grave who is now with the state of New York, previously was the translational research director at the Office of National Drug Control Policy, where I served as acting director in 2021 and then served through the entirety of the Obama administration. And in 2021, we are drug policy priorities included harm reduction for the first time. And when I talk about harm reduction, when we talk about in the paper, we look at the complexity of the issue from naloxone, which reverses an overdose all the way to drug checking. And then what Mayor de Blasio was talking about this morning with overdose prevention centers.

And the reason we talked about this in 2021 was very simple, is that we knew that we were about to reach and we did reach the 100,000-overdose death point. And so that calls for an urgent response

where you can't leave anything on the table across the continuum of care and also on the supply reduction side. So the interventions that bring people in that meet people where they are critically important to getting people the help that they need to reduce the harms associated with substance use disorder. This doesn't mean increasing drug use. It means reducing harms. And so that's what our paper is about. We have a, you know, an overview of all the array of various harm reduction programs that that city states and the federal government are funding.

OVALLE: And Keith, tell us a little bit about your paper.

HUMPHREYS: So my papers about the rise and fall of Pacific Northwest drug policy reform. And what that refers to is what happened from 2020 to 2024 in San Francisco, which is very close to where I live, up through Oregon, Washington and British Columbia. And it was extraordinary changes in policy around drugs and policing decriminalizing use both in private and in public, largely decriminalizing dealing as well, a great embrace of harm reduction and a sort of turning over of a lot of public spaces to drug scenes. And these were popular policies passed through ballot initiative or through elected representatives had great support for about 18 to 24 months. And then there was a turn, as first off, overdoses kept going up. Treatment did not become more accessible and crime went up. And you saw this reversal of the voters and elected and their elected officials turning the other direction. And the paper ends with where we are right now. And just asking the question I think we all need to ask is so we don't want the war on drugs and we don't want to have a completely laissez faire policy either. So what is the next step for that region but also for the country?

OVALLE: I'm staying on that topic. What do you think, what concerned you about the messaging that came along with those that decriminalization effort? I think you and I had talked about this at some point. I think maybe you had seen a billboard that that kind of almost made it seem that drug use was condoning it. But maybe talk to us a little bit about that.

HUMPHREYS: Yeah. So there was a different kind of thinking among the advocates who changed policy in 2020 to 2022. So in traditional public health might say, well, drug use is a risky behavior we'd like to minimize. We want to reduce the harms so that we have better population health. There's had

more of a drug use as a right, and drug use should not be either legally constrained or even criticized. And we need to stop stigmatizing it. In the most remarkable expression of this was in the city of San Francisco, where there were billboards up all over the city put up by the health department that showed people having fentanyl parties and young, attractive, healthy, successful looking people. Fentanyl do it with friends. It looked like beer, beer ads, basically.

Now, the idea was that that would destigmatize, that people would be more comfortable using together and then they could do overdose rescue. That was the reasoning. But at the same time, if a tobacco company or an alcohol company had put those kinds of billboards up about their products, the health department would have pitched a fit and said, you're promoting this, you're glamorizing it, you're minimizing risk, you're going to be tempting kids. But this in this sort of new framework, this much more positive view of drug use, including even fentanyl use, had become dominant, at least as I said briefly for a year or two.

OVALLE: Because you know what what's your take on the on the messaging and sort of how we disentangle or balance those sort of friction points between harm reduction and drug use, but also sort of more of the getting people into treatment.

LABELLE: So harm reduction is, you know, it's both say an approach. So meeting people where they are as well as a set of tactics. And I think that sometimes the messaging about it can kind of overtake what the techniques are, what the tactics are. When we talk about meeting people where they are, I feel very strongly that it needs to be meeting everyone where they are. That means law enforcement, as Mayor de Blasio said this morning, you know, that meant bringing them in to discuss what the issues are, that might how that might affect public safety. Know, I was the mayor of Seattle's legal counsel for eight years. And, you know, I left in 2009 to join the Obama administration and the and today's Seattle versus 2009 Seattle is very different.

And it is it's like people hit a tipping point where they were even I talked to my very liberal friends about harm reduction, and they see it in a very different way. So what we call for in our piece, in the recommendation is to make sure we're sitting down with everybody and have those conversations

with law enforcement. One of the first discussions that we had and Gil Kerlikowske was the ONDCP director, the drug czar in the first Obama admin, first part of the Obama administration, former police chief. And we went to a lot of law enforcement folks constantly to talk to them about naloxone because it wasn't it's widely accepted now. It was not widely accepted then. And so that was the first one of the first groups we reached out to was to talk to them about how Naloxone is going to help them. It's going to save lives and it's good for communities. So, you know, again, meeting people where they are, meeting everyone where they are is really important.

OVALLE: Herold You want to share your thoughts and on this space?

POLLACK: Yeah. I think that a lot of the issues have been put on the table. It's interesting. A lot of the backlash is actually unfair. Like people were blaming some of the legal reforms out in the West Coast for things where the evidence is that, you know, did not worsen overdose and crime, things like that. But we as we in the public health community have I think we have stumbled in how to and how to address the pain and community that's caused by widespread substance use.

You know, imagine that you're a 60-year-old mom and you have a 28-year-old son who's living in your apartment in Chicago Housing Authority, and he's selling drugs out of your apartment, you know, to finance his drug use. Of course, you're going to be angry and in pain over that because it's affecting you and it's affecting the entire community. And one of the things that we need to do is we need to we need, as Beau mentioned earlier, we need to engage the issues that families and friends are confronting, that communities are confronting. And to have a conversation that to say, you know, you stated that, son, you have a personal responsibility to engage treatment and the things that are that that could help you not be selling drugs out of that apartment and to deal with your heroin use. At the same time, you mom, you have a responsibility to do your homework and understand what are the treatment interventions that are most likely to be effective.

Don't tell your son that getting on methadone is substituting one addiction for another when we know that there's a lot of very positive things about getting engaged properly in medication treatment. But it's but it's completely legitimate for you to say here are some things that you can't do if you're going to

be living, you know, in my apartment. And I think that that that we in the public health community, we have not figured out how to fully engage all communities as part of some of the work that I've done that some of which is in our is in our paper. We surveyed communities about attitudes, about harm reduction and so on and a lot of communities of color. We found a lot of ambivalence about evidence informed interventions like syringe exchange, because people felt that it was not addressing the sort the pain that we are feeling about other issues around people's substance use.

So I think there's a lot of legitimacy. And I do think that that there is an unfairness to some of the backlash because we do know that a lot of the harm reduction tactics and approaches are really important and valuable, but we have to figure out how to do them in partnership with community and to address whatever issues communities have. So if you when I started my work in New Haven, sorry, I'm bloviating. I'll be done in just one second. The there was a mobile syringe exchange unit and they actually talked with some of the local merchants about, you know, one of the McDonald's said, yeah, please don't park right in front of our McDonald's. We think what you're doing is fine, but if you park in that spot, people are going to go and do syringe exchange and they're going to our restroom and they're going to and they're going to use their heroin there. And that causes a problem for us. So can you. Is there a place where you can be located, where, where that's less likely to happen, that then that kind of give and take is actually important. And so I'll stop there.

OVALLE: Herold You talk in your in your paper about the importance of linking harm reduction to medication assisted treatment and the practical challenges of it. Walk us through that and what are those challenges?

POLLACK: Yeah. So one of the things we would really love to do is to use syringe exchanges and other harm reduction intervention services as a way to help people get into treatment and to say, you know, while are you interested in buprenorphine treatment so we can so we can deal with the other aspects of your, of your substance use that that this clean syringe is not going to deal with. It has been a real uphill battle in a lot of ways. And. There's some really interesting work being done in Chicago and elsewhere where people are saying if we bring if we have mobile medication sites. So

maybe what we do is some of the traditional messaging is this is clinic we want you to go to and we're going to give you the sales pitch for that clinic.

And a lot of people with substance use disorders, they're just not going to go between 9 and 5 to that physical location to get their treatment. And it's much better if we can figure out ways to bring the medications to them and to figure out, you know, what are the practical obstacles that you are facing in your life. You know, you're living in a tent encampment, you know, on the west side of Chicago. How can we come to you and address your issues and get you connected to medication maybe where, maybe where you're living rather than asking you to come to a site and things like that. And there's some my colleagues at the University of Illinois at Chicago, for example, and at Chestnut Health Systems are doing some really excellent work, just figuring out how do we practically connect people to treatment given their very challenging life circumstances.

HUMPHREYS: And yeah, so what Harold's articulating is the classic public health understanding of the role of those services, and that's also my understanding. But interesting wrinkle during the sort of reform period that was rejected by a lot of people working in harm reduction actively. My job is not to get anybody in treatment. That would imply if I if I even mentioned that, that would be implying there's something wrong with their continued drug use. And I'm here to support their right to use drugs, not to, you know, give them all this moralistic treatment talk. That was a real shift. And it was amazing interaction between a journalist who came out, Herman Lopez from New York Times and we met in the Tenderloin, which is where a rough neighborhood where I volunteer.

And he said he had asked a harm reduction worker, what would you do if someone said to you today, I'd like to quit using drugs and get in treatment? And he was really surprised. The worker said, Well, I would discourage them from that. They need to set more realistic goals. That's new. Now, whether you think it's right or wrong. That's new. But that was part of the argument of supporting the right. And if you look at the practically like we're spending went for Measure 110, hardly any of it went to what is understood as treatment. 99% of it was harm reduction, although the promise was sold to the public. This will help, you know, your loved one get into recovery. That's not what it was. And as I quote in

the paper, when the person responsible for that was challenged, she said, the money's going right where it's supposed to go, not to traditional treatment. That's new.

LABELLE: So, you know, there's been some research done in Washington State. New York State has like drug user health hubs, basically. And they look to the research that's been done in Seattle actually, and syringe services programs by Kilburn-Green asked people, do you want to reduce your drug use. And this is where we need to also respect people. They said, yes, I want to reduce my drug use. And so the drug user health hubs, the low barrier programs that they have in Washington State that they have in New York State, there's actually legislation on the Hill that would allow for more pilots of that allow for an array of services for people. And, you know, so it could be treatment and it could be other services.

They might be unhoused. It also, you know, we need to look at the total totality and the total complexity of the individual and make sure that all of the services that we have, there's a lot of barriers. I don't know if, you know, many of you probably have had experiences just with the health care system. Imagine if you were unhoused trying to figure out how to get, I don't know, an X-ray. These are not simple things for people who have law degrees, never mind unhoused people. So the drug user health hubs that are beginning in, you know, in Washington state in think there are some other places. New York obviously are places where, again, there are locations for people to seek the type of complex for their complex needs.

POLLACK: One of the things that the Biden administration is focused on and I think has done some good and I think and I'm hoping that the Trump administration will continue in this is to try to improve the human experience of addiction treatment. One of the things that is really striking is there's a lot about the way addiction treatment is provided that is very, very forbidding to people and very predictably leads people to disengage. And then there's the substance abuse Mental Health Services Administration put out this thing called the final rule, where they really went through a lot of practices that addiction treatment providers are doing and saying and saying, here's some ways that you need to be more embracing of people and less punitive in the way that addiction treatment is provided.

And I think there's a lot we can do to make that experience more accessible to people. And, you know, if we had a bunch of diabetes patients who just showed up a couple of times for treatment and then stopped coming, we would say, hey, to the providers, we would say, hey, what are you doing that is chasing away the patients and how are you treating people? Are you, are you making people feel like they are respected and that their well-being is being, you know, is the priority? And very often that's not the way we the public discourse around addiction treatment goes. It is very often if someone stops showing up their anon, their non-compliant patient and there's much we can do, I think. I think one of the nice things about buprenorphine and having it available from primary care providers is that you can at least it broadens the range of options so that people can find a way to get the help that they need in a dignified way that, you know, there's more organic to them.

OVALLE: Walk us through the differences between for those in the audience that don't know the nuances of it all the differences between buprenorphine and methadone, the restrictions, how it's been expanded in recent years and what and how it can be expanded more.

POLLACK: I mean, I maybe I'll let our Co panelists who are in some ways have more expertise on this than I do to jump on that one.

LABELLE: So I'm a trained lawyer. I'll let the actually the social scientists.

HUMPHREYS: Okay. So they're both opioid called opioid agonist therapies. Methadone is a full agonist and buprenorphine is a partial agonist that that makes the experience of taking them somewhat different. It has. They have different retentions and how long people stay in. But anyway, they're both working on the same theory. If you're filling up that they're sort of think of like the hungry, the hungry receptor in the brain, it's being filled up with a with an opioid reduces craving, creates biological stability, and then people can do other things in their lives, whatever that is, get a job or reconnect with a family, all that sort of thing. They've been around a very long time as it owns, been around, what, 50, 60 years? They're FDA approved, meaning they're safe and they're effective. They're not always easy to get, though, particularly not methadone. So when methadone came out, it

was very controversial. It was particularly controversial in African-American communities who looked down on it.

As you know, the white man's heroin, government, heroin, taking over, you know, our neighborhoods, including right here in Washington, D.C. And so lots and lots of regulations got out on it. And then, you know, drug enforcement also piled more regulations on it because they sometimes methadone would get diverted and sold. And so now that you can if you're running a methadone clinic, there was one study that showed if you're a physician, you could literally spend more than 100% of your time just doing all the forms you have to do to run a methadone clinic. And that makes it much, much harder to access because you're spending all that time doing that. There's only so many clinics. You can't really give it anywhere other than a designated federal clinic. So if you actually the last panel, you know, if you live way far away, you're just out of luck, really. You can't participate. So recently during COVID, both for methadone, buprenorphine, there was an opening up of the restrictions.

So, you know, this would be things like telehealth getting to your first consult, not actually having to come in, giving people more take-home doses. So, you know, if you're you know, you wouldn't have to come to the clinic every single day, which you can imagine a lot of people just get tired of doing. It's a real hassle to get to the clinic every day. Then the question was, would this be kept after COVID? And mostly it has been you. What is going to be the effect of that? I for you since it's a chance to promote Brookings to a piece that's on the Brookings site, first authored by Richard Frank that I co-wrote with Haiden Huskamp and about we have to just find the right balance.

There have been experiments like in Europe where methadone has been extremely available and lots of people have died from methadone, so that's no good. But on the other hand, if it's super, super restricted, we have lots of people dying for the absence of it. So we're going to have to keep monitoring this experiment. We've loosened things up a bit. We were so tight. I think it's going to be okay. Some people want to go further if we do that again, but we have to watch closely because at some point these are these are opioids. There can be risks from doing it. And that's where we are. I think anything else.

POLLACK: One thing I would say is it's really important to pay attention to the boring until it's not details of practical delivery of services. So one thing that with WIFI, we do a lot of work with people leaving jails and prisons and very often buprenorphine is the preferred way that people want to receive medication treatment. And one of the things that's really striking actually, during both the Trump and Biden administration, NIH has funded something called the HEAL Initiative.
And within that, there's something called the Justice Community Opioid Innovation Network, where there's a lot of studies being done with jails and prisons to try to connect people with treatment. And particularly in Massachusetts, for example, my colleague Pete Friedman, University of Massachusetts, they have found that that working with jail staff and prison staff on the practicalities of how we can connect people to treatment and figure out, especially when people leave, it's may have a good discharge plan when people leave, that we can really make a big difference. And they actually found lower levels of crime, better health outcomes because people were being effectively connected to treatment. And the thing that was really striking about it was a real attention to implementation.

You know, one of the things Bo in the earlier panel was talking about diversion and deflection programs and a lot of the how we really have to we really have to evaluate the practicalities of doing these things well. And I think a lot of what's happening, we often say there's this this whole debate treatment works or treatment doesn't work. Treatment is not an it. It depends a lot on how it's provided to people. And if we if we do if we're really very careful about the granular details with the particular groups of people we're trying to serve, we can design interventions to engage people in treatment and make it more likely to keep them in treatment. And I do think that there's a kind of practicality, particularly within the people that are running jails and prisons now. People are like, how can we do this? Well, come help us. And I think that's a real source for optimism in that.

OVALLE: Can you tell us a little bit about the Medicare Medicaid waivers that are being sought, why they're important? And do you have any concerns that under the Trump administration, some of those waivers that are still pending might not get done or at least get done in a timely way? And I guess also overall, what do you guys have any concerns about the de-emphasizing of the public health approach that the Biden Administration has made really a cornerstone of its drug policy in addition to the

enforcement, But that maybe might not be as politically, you know, appealing to people in the public or certainly not as catchy as, you know, let's bomb the cartels and in Mexico.

HUMPHREYS: And I'll start with the Medicaid waivers. And if you're thinking about Medicaid reentry for. Okay, so the challenges that that Herold described about people leaving carceral settings have been exacerbated in American history by the fact that when Medicaid was designed, there was a stipulation that the second somebody goes into a jail or prison, the federal share of Medicare turns off. So you're on your own, paying for their health care. And plenty of places just skimp and they don't give people health care, including mental health and addiction care. So Medicaid reentry, which was initially a bill but couldn't quite pass and almost passed, says you can turn Medicaid on before people leave, which would let you get them set up with care, not just while they are locked up, but you can contract with community providers. So when you know you leave the prison instead of here's a pamphlet, maybe you should go to a clinic. It would instead be, Hey, you remember, you know, Regina, She was that fabulous, you know, doctor you saw when you were in prison. She's still out there in the community. You can go see her today. And that makes it much, much easier for that connection to be made for a state to do this. Rhode Island dropped the death rate after prison by 60%, 66 overdose rate. So well done Gina Raimondo, who became the, you know, commerce secretary later.

So other states are now trying to do that because the bill didn't pass, which would have made it all 50. We're doing it through the 1115 waiver process. About 25 states have applied and proud to say California was the first to get one. And these experiments are running. I think they're going to continue even in a new administration. Why do I think that? Because, first off, it's a win. You get the public health benefit, but you also get an anti-crime benefit. It's many people might not care about one of those things too much, but there's hardly anybody who doesn't care about either of them. So that's the one thing. The second thing is, you know, we do point out that the first step Act, signed by then President Trump, expanded addiction treatment in the federal prison system with support. So within the president's history is some commitment in this area. So that makes me optimistic that these will this will continue in some form through the next administration.

POLLACK: A couple of things about the waivers. And one thing that I liked about the California waiver is it also and some of the other states, too, that they that they acknowledged some of the practical challenges with Medicaid. So a lot of health care providers do not want to deal with Medicaid. And we often want to criticize the providers because they're not taking Medicaid patients. And I actually think that's part of what we need to be doing, is telling medical providers, you need to be you need to be treating people. We also have to ask honestly, providers, why do not why do you not want to deal with Medicaid? And one answer is Medicaid reimbursement rates are too low, and the other is that the administrative burdens that Medicaid imposes on providers are too high. And of course, providers don't want to deal with Medicaid if they can avoid. And we see that in psychiatry. We see that in addiction treatment.

We see that in lots of other things. And the California waiver basically said you have to at least provide a reimbursement rate to this population. That's 80% of what Medicare provides. And I think that that was a practical acknowledgment of something important there. Now, because there's a lot about Medicaid that is that needs that's just not well implemented as a program in many states. I think that I am concerned about the new administration, about some of the public health issues you raise. I'm actually more optimistic about the issues that are below the fold in the newspaper, and there's a lot of potential for bipartisan cooperation, you know, to do this better. Now, there are there is a partisan divide in America.

The opioid epidemic is less racialized than, say, the crack epidemic was 30 years ago. But one thing we cite in our paper, there is a continuing partisan divide, particularly among actually ordinary voters, people who identify as Republican in surveys that we did were much less likely to support public funding for addiction treatment. We're much less likely to support harm reduction interventions. Things like that. So we still have we still have a partisan divide. I think it's actually less severe in Washington than it is on Main Street in some ways. But it is it is still there.

LABELLE: I want to go back to the 1115 waiver, which I obviously that it's good that the 1115 waiver is important to provide people with health care and medications for opioid use disorder if they have an opioid disorder 90 days prior to reentry. However, the Americans the Americans with Disabilities Act

covers people who have a substance use disorder and individuals who are incarcerated are the it's the only group that has a constitutional right to health care because they're incarcerated. So it doesn't that doesn't end only at the nine- it doesn't start only at the 90 days prior to reentry. It starts when they enter. And the majority of people in America who are who are incarcerated in jails are dying within the first 24 hours of entry.

So it's good, but not sufficient that the 1115 waivers are very important. Kudos to folks from CMS who are in the room who worked on it. Very important. But there's also legislation on Capitol Hill that would go further and would, there is a big dollar amount, but as Keith said, we also have to think of how much this will decrease recidivism, which it does decrease deaths, which it does. So again, we have to look at the at the totality of this and not give up and think that, you know, now we've done enough with 90 days prior to reentry. It's simply insufficient.

POLLACK: The other thing I would say is, boy, I really feel for people who run jails in America. You know, you have this very fluid population of people coming in and, you know, Cook County Jail in Chicago is one of the largest jails in the United States. You have people a lot of people come in. They stay for sometimes they stay for a couple of days or they stay for a week. And you have to figure out how to serve the needs of that person very, very quickly. And I think understanding how to bring in federally qualified health centers and other facilities into the jail setting in a way that allows for integrated care once they leave is really critical. The example that Keith gave is very much on point that. We can't let people slip through our fingertips in that in those moments when they have housing needs, they have addiction needs, their mental health needs. And a lot of those people, they're committing low level offenses, but they're still creating issues in the community.

And there's and we still have an opportunity to serve them. One of the things we have to do since we have we have we're putting fewer people in jail than we did pre-COVID, we have to figure out how to use things like bond courts and other ways that people interact with the criminal justice system to also link them to treatment if they're not going to be held in a secure facility. But we've identified they've mentioned, here's a person who's shoplifting, he gets arrested. We're not really going to incarcerate him, but we have an opportunity to say, hey, what's going on that's making you do these survival

crimes that that is causing harm in the community. And how can we connect you with some services to help deal with that?

OVALLE: One of the issues that struck me in in writing about the experience in Oregon was how difficult it was to find enough people to staff the addiction, workforce, addiction, treatment, workforce. Can Keith, maybe you could walk us through sort of what the challenges were there and what can government do or organizations do to try to get more people into that space, more doctors, more nurses, more practitioners that can help staff those treatment centers that that are desperately needed?

HUMPHREYS: Harold mentioned Medicaid being, you know, central to everything we're doing. Medicaid is the backbone of the public addiction treatment system in most states. Medicaid reimbursement rates aren't that great. So when reimbursement rates are low, that streams through to what people are paid. So the kinds of jobs you can get are just not as not as remunerative generally in the addiction field as they might be with something else with the same skills. Tom McClellan, who worked with Reggie and I and the Obama White House used to carry a help wanted ad from the Philadelphia paper, which said drug counselor, seven bucks an hour, no experience needed, which he clipped next to a McDonald's ad, which had the same pay rate and same demand. No experience needed. So if you're going to if that's the case, a lot of people going to say, look, I could I could make a lot more money and have a much easier life treating, you know, a different kind of condition than addiction.

So that's a fundamental thing. When it's under finance, it spreads. Second thing is treatment is stigmatized because addiction is stigmatized. Stigma spreads. So you just imagine how you would feel if your child said, I'd like to become an oncologist or I'd like to become a drug counselor. You know, what is your emotional reaction to say, I'd like to treat addicted people, I'd like to treat people with heart disease. And there's that natural kind of social thing of, you know, that's addiction is kind of bad somehow. And so there's that effect also people do care about, is my job respected? You know, is it something that, you know, my mom and dad will smile, my friends will congratulate me rather than go, boy, you know, you had a bad job search, So both those things, the financing and the status need to be raised for this to be something that more people would want to do. I mean, we're lucky we have

the people. There's many, many incredibly dedicated people who spend their lives doing it, but we don't have anywhere near enough.

LABELLE: I had a couple of things to add. First is that we actually worked on Model Workforce, State Workforce Act, Addiction Policy, Workforce Act that was just released today. And what it does is we figured we couldn't like solve the entirety of the workforce problem overnight, but we proposed that states set up an initiative to look at the needs of the state workforce addiction workforce. And we go from, you know, the peers who are incredibly underpaid, not necessarily certified and don't necessarily have a certificate in every state all the way to addiction medicine doctors. So what does the team have to look like? So that would just release and we're hopeful that states will take the addiction workforce really seriously as part of the solution to the issue.

And the other thing, if I may, I just want to point out that at Georgetown, we started an addiction policy master's program. So my students are here, some graduates. The whole point of that is because not only do we have a problem with the clinical workforce, we have a problem with the policy workforce as well, that we have too many people who, as my old boss, Michael Botticelli, would say, have the I knew a guy approach to addiction. And so there's science and evidence behind all of this. And so our little our little part of the world is churning out people 12 at a time every year trying to build an addiction policy workforce that's rooted in science and evidence.

OVALLE: Open up for questions. Anybody? Very.

AUDIENCE MEMBER: Kevin So about here. Thank you for that. It was a great one. I just want to point out a couple of things about Oregon. One of the things that we found, which I think we touched on briefly and Keith talks about in his paper that I think is profound, is the public, especially among communities of color, how they turned on something like decriminalization or even this notion of treatment instead of incarceration. In Oregon, we ran the campaign to repeal Measure 110. We run a lot of campaigns. It was the easiest thing we've ever done because we didn't really have to convince people. The 80% of people started by saying, We want to decriminalize drugs. And it wasn't, you know, all the right-wing folks in Portland. It was actually, you know, liberal white liberals as. Well as

people of color that use that term decriminalize. When we asked, well. You know, would you go for more treatment. And why do you use that term? We sort of probed and focus groups, the term re criminalization.

The overwhelming response. Was that, you know, we don't see this as diabetes. So diabetes does not, you know, force maybe somebody to do something or steal. From their mom to buy to buy money, you know, to buy insulin. Diabetes doesn't, you know, cause violence. Meth does. And it was a real interesting pushback, you know, against some of the messaging that, you know, I think we're all on the same page of treating this primarily like a health issue, which we all want to do. And it was just fascinating to see. How easy the dominoes fell there. The other issue about connecting with treatment, because we also probed that issue of, well, what if these services could connect with treatment, even if we could convince them that that was the motivation?

When you looked at, for example, the early data from their own data from the New York supervised injection site or supervised drug use site, whatever you want to call it, their own data shows that the single digits in terms of the number of people every year that they actually refer to treatment. So a lot of these. Kinds of messages that we're trying. To, you know, sort of talk about when you talk to the folks in Harlem where this is, they say, listen, we're surrounded by methadone clinics. The last thing. We want is an injection site here. This is where the dealers congregate and sort of you all are sort of out of touch. We would like to go back to some of the criminalization. It was a very interesting wake up call, that whole thing. And I think it just speaks to the sort of pendulum. And now we're going to see if people will use it sort of politically now in the next four years. But I thought that was really interesting.

HUMPHREYS: So thanks for that, Kevin. I want to pick up on the point about race is something I say in the paper, Where do we go next? One of the things that was striking about the decriminalization and defund the police generally, and you have to remember, this was an era where it wasn't just that drug enforcement was declining.

Enforcement of everything, you know, was kind of off the table for a while, is that those policies were very popular among white, college educated progressives who lived in neighborhoods where they did

not have to deal with the consequences of those policies, and they were unpopular with working class and lower income communities, many of them majority minority communities that had to live with the consequences. So if you want to frame policies in terms of racial justice, which is obviously a very important thing to pursue, it is important that the conversation include the people who live in those communities and actually have to deal with these problems. You know, the Tenderloin in San Francisco, the, you know, the roughest neighborhood in the city, which is majority minority, is suing the city for more police. Meanwhile, out in like, you know, the sea cliffs, the white neighbors, they're probably still saying, you know, defund the police is awesome and please pass the chardonnay. Right. So you got to listen to the people what they're saying. And it starts there. And when you have that as your base, you're much more likely to produce a racially just solution than when those communities are not included. Really. They're just the they're on the posters, but they're not actually allowed into the discussion.

POLLACK: I mean, if I could just add to that. I mean, the politics are complicated. And there's also a large generational divide in this. When you talk to younger people in communities of color, you get you get very different answers on a lot of these issues than when you talk to people over the age of 50. And we need a portfolio of things that we do need. We do need harm reduction. We syringe support programs are good. There's overdose prevention sites when well-implemented do not increase local crime, things like that. And there and at least it's something that we need to evaluate and figure out how to how to do well. And we need and we need we need policing, but we need police to be operating in a way that is consistent with public health and social justice values. And the idea that being addiction is one thing. Stealing from a mom is another thing.

And if someone is addicted, we need to say, how can we help you to get into treatment and deal with the issues that you have? It's your responsibility not to be doing these things that we're talking about, and it's our responsibility to help you and not to demonize you because you have this addiction as opposed to some concrete behavior you're doing that may be harming other people. Where it is appropriate for us to say, hey, you know, you shouldn't be doing that. And I do. I don't want to, I don't want to caricature the harm reduction community. A lot of people that I work with on the ground are very well aware of these issues and are actually members of the communities.

They're not you know, there's certainly white liberals like myself who are not members of those communities. But there's a lot of people who are who are living on the west side of Chicago who are living in the south side of Chicago, who are who embrace harm reduction and who are and who do experience this community harms. And they say, hey, what's the full portfolio of things we can do that that can be helpful? You know, one of the challenges we don't want to oversell any one thing because, you know, effective policing is good, but it's not going to solve the whole problem. Treatment is good, but it's not going to solve the whole problem. Harm reduction is good. It's not going to solve the whole problem.

OVALLE: I think we have time for 1 or 2 more questions, I guess first. Front. Row and then we'll get if you have.

AUDIENCE MEMBER: Success in getting a patient who's addicted to be not addicted anymore, what's done afterwards, assuming that they got addicted because of overprescribing, they had chronic pain. What programs are set up to get them into some sort of a pain treatment program, otherwise they might get addicted again?

HUMPHREYS: I think the experience in that area is that pain and addiction have to be treated together and the best programs do those things and both in terms of how they prescribe, but also the other psychosocial supports, they wrap around people.

OVALLE: It's time for one more.

OVALLE: Question here and.

AUDIENCE MEMBER: I'm from Canada and Vancouver and Toronto, and certainly Vancouver was the experimental site for some of the modeling that was done in the United States. I'd like to deal with an elephant in the room, and that is about safe supply being redirected into the community. Having Canada Supply a study just came out last in November. 25% of the safe supply is going back into the criminal networks exchange for opioids at the federal. And the cycle continues. And kids in our high

schools are getting addicted to the dillies, etc. Hydromorphone And they're dying. I'd like to talk about what you're seeing in the United States and how to address that issue.

HUMPHREYS: Thanks for that question. So I talk about safe supply in the paper in British Columbia as sort of taking this a step further. So same reasoning. So, you know, if I agree this is a right. To the extent people do it out of distress, that is society's fault. So not only is it wrong to forbid drug use, but you have a positive obligation to support drug use. And so tax dollars are used in British Columbia to distribute hydromorphone, which is pretty close to heroin. So it's pretty strong opioid. And there was a proposal during this period to expand that to include crystal meth, to include benzodiazepines and anything else that people wanted. The irony to all of this is this is how this all started in the first place. You know, British Columbia successfully sued Purdue Pharma for flooding communities with OxyContin 20 years ago.

Purdue Pharma sells hydromorphone to British Columbia to distribute in the hopes of reducing the problem. So that is sort of amazing a chain of events. And you could see the last point in the paper when I talk about how the politics really shifted up and down the coast. The people, virtually everybody who supported these policies is unemployed in politics, you know, the Vancouver ABC Party, you know, the mayor wiped out all the city councils, the ruling party of the province, just by the skin of their teeth, survived this last election after progressively distancing themselves from that. And so I think those the extreme part of those policies, the way they're going to disappear, is not really because they defeated by the right. But the people on the left say like, this is too much for me. I don't want it. I don't want to champion this anymore.

POLLACK: I would say also that there's we have to I think this also gets to the importance of really understanding the practical implementation of any particular thing. So people often say is safer supply good. And the answer is, well, it depends on, you know, what, what do you actually how are you actually implementing that? And it may be that there's the way that that these programs are implemented. We are learning we have to do it differently. And there may be there may be that we have to learn from the practical experience to figure out what is feasible, what are the costs and benefits and tradeoffs of different ways we could do this. I think when you have people who have

chronic substance use are not going to seek treatment and they are at serious risk of overdose, the idea that that we offer some way to prevent them from dying in a harm reduction intervention, I can see the I can see the potential value of that. It also seems to me that, boy, there's a lot under the hood and how to do that well and how to deal with some of the predictable potential unintended consequences that could come from an intervention like that. And I think harm reduction is always the right question. But any particular harm reduction intervention isn't always the right answer.

LABELLE: We cover safe supply in our piece. And, you know, talk about the Canadian experiment. There's also been, you know, heroin assisted treatment that has been longstanding in other European countries. But as Harold says, it is in the implementation. And what is going to work and what are what are the outcomes that we're seeking as well. Most importantly, and I would contend that all of everything we do has to really look beyond just making sure that people don't die. That's a minimal issue. There's a lot more that we need to do and that goes also to recovery supports.

OVALLE: Thank you, we are a few minutes past the time. So I want to thank this wonderful panel and thank you all. Stay in your seats for the next speakers.

AHMED: Sorry. Good morning, everybody. Thank you for coming. I'll be moderating the panel today. My name is Azam Ahmed, I'm from the New York Times and I we just get started. All right. So, Vanda, you've done a lot of work in both Mexico and focused on China. And your review of the past administration in Mexico is quite harsh that they've done very little and in fact, in some ways edged closer to a narco state in the last centennial. How will Trump change Mexico's response to the fentanyl epidemic? And is there something that Mexico can do given its limited law enforcement capacity?

FELBAB-BROWN: Well, certainly President elect Trump also, as you know well, having been in Mexico for many years as a New York Times bureau chief, has issued very blanket the very strong threats that he will impose, his administration will impose tariffs specifically linked to fentanyl, as well as to migration on Mexico, Canada and China as a way to force the countries, particularly Mexico and China, to stop the flow of fentanyl. Mexico is the predominant source of fentanyl for the United States.

The Lopez Obrador administration often claimed fantastically so that no fentanyl was produced in Mexico or consumed in Mexico. It is produced in Mexico, it is consumed there, and it is trafficked to the United States by groups like the Sinaloa Cartel and Cartel Erosion. So the threat from President elect Trump, I think, needs to be taken very seriously.

This is not just bluff and bluster. I think that is a very serious policy intention behind it. And this also is part of a larger set of very coercive tools that the circles around President Trump during his candidacy and after he was elected, unveiled, such as potentially unilateral military airstrikes into Mexico. Look, I don't think the tariffs in this simplistic form or unilateral strikes are a good idea. I think they are a bad idea. They will not accomplish objective and they will jeopardize other important dimensions of the relationship.

But it is also clear that not just for U.S. interest, but for Mexico's own national security interests, societal interests, quality of democracy, rule of law. The Mexican government needs to find the wherewithal once again to start pushing back against the criminal groups. And I think this is about common position can start taking place between the administration that had indicated in its October plans they wanted to be much more robust, much more multifaceted in the law enforcement response with cooperation with the US. Now, it's not easy, right? We know that there is tremendous level of corruption in Mexico. Law enforcement is very weak. It has been dismantled actively. The cartels are present in many aspects of life in legal economies. They are very politically powerful. And it's also crucial for the U.S. to recognize that we cannot be indifferent to deaths from violence in Mexico. We need to devise strategies with the Mexican government that will bring this down. But this notion of just backing off doing nothing hasn't helped Mexico and has not helped the United States.

FELBAB-BROWN: Thank you. Dr. Mejía. I'm curious, the Global South has often looked at the United States and U.S. drug policy with a somewhat skeptical eye. And there's been some efforts in other places to push at the U.N. to change some of the legalization regimes in in thinking through kind of what what's impacting and affecting South America right now. What do you what role does the U.S. play in that and where do you see policy and enforcement going?

MEJÍA: Thank you. Thanks for that for inviting us to write these chapter or chapters on South America. Not it doesn't take into account Mexico that's on this chapter. To respond your question, I think the U.S. has always played a huge role in Latin America and especially in illegal drug markets in Latin America, bit, but mainly focused on cocaine markets. In the past it was at some point some production of heroin in Colombia, but it is mostly on cocaine markets. What we found in this in this in this paper is that as of now, the incidence of fentanyl production, illicit fentanyl production and trafficking in Latin up in South America, sorry, is minimal or no. Exist. And most of what we've seen in that in South America. And we focused on Chile, Argentina, Brazil and Colombia. Most of what we've seen is diversion from of fentanyl, from medical facilities. And there are rising concerns so far, a huge increase this year In 2024 of seizures of illicit fentanyl diverted from medical facility facilities.

But this is done by a small a groups not related to drug trafficking organizations or criminal groups in Latin America. Not so far. That's a rising concern that we that we point out in the in our paper. But so far, large criminal organizations are not the PCC in Brazil or drug trafficking organization. And criminal groups in Colombia are not yet involved in in illicit fentanyl trafficking and production and trafficking. I think the point here, the main point here is that in my view, I've studied the illicit cocaine markets largely, but I don't think we have a comparative advantage relative to Mexico in the production and trafficking of fentanyl.

AHMED: That's a I think that's an important point. Why would fentanyl destined for the U.S. market be produced farther south when it can be produced in Mexico? But you mentioned cocaine, which is interesting because I think we were speaking earlier. Europe has seen a large rise in imports of cocaine and cocaine abuse and violence associated with drug trafficking. Can you talk to us a bit about what's happened vis a vis cocaine markets coming from South America to the U.S. in the now, instead to Europe?

MEJÍA: Well, cocaine markets are thriving. What has changed in the in the in the past, I would say 8 to 10 years is the composition of demand has changed. The U.S. the consumption of cocaine in the U.S. and North America has decreased. But there is there is an increase in in cocaine consumption in some European countries in the southern part of South America, in Uruguay, Argentina and Chile,

and some parts of southern Brazil on a huge increase, although from our very low baseline in Australia. Where were prices on profits associated with a with a cocaine trafficking are huge and this is one of the reasons why not the only one, but this is one of the reasons why we have seen a huge increase in violence in Ecuador. This is because the route to export cocaine from Colombia, Peru or Bolivia. A most of the points where were that are used for exporting cocaine to Australia are in Ecuador.

AHMED: John. I wanted to move back to fentanyl and ask sort of a big, impossibly large question, which is what is the appropriate response to this? We've seen recently that some of the overdose deaths have gone down and, you know, the various agencies have taken a bow. But what do you think it looks like going forward? Sort of as we passed this epidemic that feels so completely new and foreign. What is the right blend of law enforcement harm reduction? Or how is it that the United States should be thinking about this? And what do you expect from a Trump administration in terms of the range of policy possibilities?

CAULKINS: Fantastic question. I'm going to not. Do the last I don't know what's going to happen with the current administration, but what should happen. Almost everybody thinks this problem. Is so enormous that it's an all hands-on deck sort of thing. We should be doing things on prevention, on treatment, on harm reduction, law enforcement. I think that makes sense. Let me take up the law enforcement side, because other panels have talked about treatment and harm reduction. There tends to. Be this. Bifurcated view about drug law enforcement.
Either it's useless, in fact, maybe always been useless or at least is useless now that it's a synthetic and too easily replaced. So let's just rely on treatment, harm reduction prevention, Or there's this great optimism that if only. We redouble. Our efforts, if only we take it seriously, we'll be able to put fentanyl back in the bottle and be back to like countries that don't have it, or at least put the prices back up. But there are intermediate views about law. Enforcement's potential role. One is as a partner for treatment and say treatment will be the key. But a lot of people who medically need treatment don't volunteer to show up. And law enforcement can partner. But I am.

Particularly like to have us think about. Drug law enforcement's second role, not as trying to constrict. Supply, which is so difficult now, but to protect us from all the collateral damage and harm that's created by the markets and the supply chains. Never mind the metric tons delivered. The markets are also highly destructive. They're violent. They're corrupting. They create disorder. And I think we make a mistake when we. Say to drug law enforcement, your only job is to quixotic, impossible to achieve objective of shrinking supply because it distracts them from many practical things they can do to address the violence and the corruption and the disorder.

AHMED: Thank you. Vanda, I wanted to ask you a broader question. That is something that's puzzled me and you and I have talked about a lot, which is why has the fentanyl crisis not really struck anywhere else and certainly not to the degree it struck the United States. Drug markets are pretty adaptable and, you know, it just makes a lot more sense if you're a trafficking organization to sell fentanyl than it does to sell heroin. And yet Europe has not seen anywhere near the rates the United States has seen. Latin America has not seen it. Asia has not seen it. Why? What's stopping that continuum from moving along in other nations?

FELBAB-BROWN: Well, it's a very important question, and I think that one better. We don't have any definite answer. So let me put forward opinions which are, in my view, informed opinions, but opinions. So one way to phrase the question, Azar, is why not? Or another way would be why not yet. And this is where I really think we need to be focused on. So the world is, in fact, going through a synthetic drugs revolution around the world. Some form of synthetic drugs is spreading and expanding very significantly. Even in a place like Middle East that is methamphetamine, that is not simply smuggled through the Middle East. And it's not just Captagon, a mixture of amphetamine and caffeine, but its meth hitting the Middle East.

Certainly Australia and New Zealand. Yes. Are grappling, grappling with the push by trafficking groups to bring cocaine in Australia just so it's a larger seizure. But you have a tremendous amount of meth markets that have been dominant and continue to be dominant or at least very significant. Meth is emerging in Europe, which is dealing with little seen. So even in Europe, there are at least 22 countries. When I last look, which I was October that have had fentanyl on it, I seen some sort of

synthetic opioids and the inside. It ends of detections and seizure is rising now, is rising from very low baseline and it's not rising equally everywhere. Some places like the Baltics and Estonia and the Nordic countries head for considerable amount of time already synthetic opioids and might not be going through a crisis in other places like the United Kingdom.

The incidence is spreading quite rapidly and it's leading to overdose deaths. But why is that difference? Why is it not happening simultaneously? Just like in United States, Canada and Mexico and you have different opinions, right? So you will have people in Europe who will say, well, we don't have synthetic opioids because we have such robust markets in plant-based opioids in heroin. Why would our users be using dangerous synthetic opioids that overdose? Is it possible where there is plenty of heroin and there is plenty of stimulant cocaine? So in this view, it's the market is saturated with other stuff. So why would users go to another drug? Another opinion is, well, in Europe we have harm reduction and treatment. We have universal health care. So even if you get synthetic opioids, it won't be a big deal because there is so much more protection of the user than it is in the US.

But all of these views assume that the market is driven by demand by what the users are asking for. But there is a strong possibility that what shapes what is being used on the street is driven far more by supply. And it really has to do with decisions by organized crime group as to what they will be funneling into the market. So back in the 80s, there was plenty of cocaine available in production in India and countries to be supplying in Europe. And you had this vastly bifurcated market between North America, the U.S. and Europe with the U.S. market going through cocaine and crack cocaine and Europe just sticking to heroin. And at the time, you would have conversations where our users want heroin, they want opiates, they don't want cocaine. And then one day in the mid-1990s, drug trafficking groups decided they would start funneling cocaine into Europe. And we see a big explosion of cocaine. But it was a lag of ten, 15 years where it was the most incredible choices like innovation, other constraints on drug trafficking groups. But it was the supply that changed the demand.

And I think we need to be really, really careful about the possibility that the wide spectrum of organized crime groups in Europe, some of which are new, some of which are very violent, will simply

say synthetic opioids are so easy to smuggle, they're so powerful, they make it so easy to evade law enforcement, we'll start bringing them.

AHMED: And there's another place.

CAULKINS: Yeah, you're right. It's a fantastic question. That's a great answer. But just want to add something that I have to attribute to Peter Reuter. You got to listen to you on the last panel. But Peter's observation is that drug markets and drug suppliers are conservative, which is not a statement about how they voted last month, but rather that when you're in a business where there's high risk of getting arrested. If you can still do. What worked last week, you're inclined to keep doing that because that's the cautious strategy. So until there's some disruption or until there's some reason that forces in innovation, a market may stay in its past place, which is why Vanda's comment about not about yet. Why hasn't it happened yet? If the conditions are right and it may just be an idiosyncratic choice, some exhaustion of shock, that will tip us to that. And it may just not have happened yet, because as Vonda pointed out on the cocaine side, it took something like 15 years. We're only ten years into the North American fentanyl crisis.

AHMED: One of the components of that that I think is potentially germane to the exigence, in fact, is the heroin supply coming out of Afghanistan. We all know the Taliban has banned opium in having spent a lot of time there in the last two years. I can tell you it's accurate. There is almost no poppy anywhere. They're working through these supplies. But early indications are from at least Iran that prices are starting to rise and people are using that as a metric to try and assess when that supply will run out, because that is the supply that Europe is relying on. What happens then?

AHMED: It's a prime moment for synthetic opioids to expand. They are in Europe. They are funneled to Europe from China and from India. They are currently directly going that they being synthetic opioids from producers, brokers to retailers. But if we have a big heroin drought that. And it's an opportunity for Balkans, criminal groups, for Turkish criminal groups, for Italian criminal groups and Mexican criminal groups that have expanded presence in Mexico to start bringing in synthetic opioids. And in fact, the origin of synthetic opioids in Europe, in Estonia, in the Baltics, was on the heels of the

Taliban opium poppy ban in 1999 that went into 2000 and ultimately 2001. And the bets that supply there was coming out of Russia, the former Soviet space was not connected to the same networks like the Mexican groups, the Turkish groups. But all of them already have extensive connections with Chinese criminal networks and Indian or can easily develop it.

AHMED: Daniel, I wanted to ask, we're talking a lot about fentanyl in North America. Maybe we can step back to that and you can tell us a bit about what the primary concerns are in the Southern Cone in South America, because it doesn't seem like fentanyl yet is a primary concern in the organized crime groups. There don't seem to be immensely focused on it. What are the. If we don't take a kind of U.S. centric view, what are the concerns that are predominant in in that region?

MEJÍA: That this is a point that we discussed with Vanda, and with other authors in the in the report, which is in my initial view, was that we didn't have a fentanyl crisis in Latin in South America due to the fact that we don't have a baseline consumption of medical opioids. Right. But that's not that necessarily is not necessarily a necessary condition for the emergence of a fentanyl consumption epidemic. Because I think one that said it correctly, which is small drug dealers might induce this demand, might create this demand by lacing, by mixing commonly consumed drugs with fentanyl to induce that demand, create that demand and expand a profit, which is, I think and this gets me to your to your question, which is what is the greatest the greatest risk that we identified in the chapter is this is precisely these one not given that we don't have this baseline demand for medical opioids.

The greatest risk is that a small trafficking groups or large trafficking groups and start trying to mix by mixing a commonly consumed drug such as synthetic drugs or cocaine with fentanyl, they induce the demand. They create that demand. And this starts to expand rapidly. And this, of course, leads to a policy recommendation of a strengthened monitoring systems in the streets of what is being a. Produced and trafficked in other markets, in cocaine markets, in synthetic. And drug markets. And to have like an early warning system for it, for tracking this this substance, this industry.

AHMED: I think the question of adulteration is on the minds of a lot of people these days that you don't have to be looking for an opioid to get hooked to an opioid because of the supply side. You

know, in Australia I recently heard that he vapes have started to contain small trace amounts of nitazenes and other, in other instances, you're seeing these sorts of opioids appear fentanyl and cocaine. How do you deal with that from a policy perspective? I

mean, it's so first off, is something like that. Is there a precedent for that? And if so, what's the way to how does one go about preventing a would-be populace of addicts that don't even know they're going to be addicted?

CAULKINS: I am so glad you inserted that. Is there a precedent? Because that lets me just talk about what's happened and ducked the question about what to do about it, because I think it's very hard to know. So, no. You're on to something. Really important. Up until not that long. Ago, when you bought a bag of street drugs, it was just that drug plus a bunch of junk that wasn't that important. I'm not saying that the bag was 100% pure and properly labeled, but the diligence and adulterants tended to be relatively unimportant things like mannitol or caffeine. What we have seen a lot. Of in the last 5 or 10 years for the first time, is that there is a bag that has two very potent drugs in it. Simultaneously, an opioid and a benzodiazepine, for instance, is a particularly bad combination. Or xylazine starting to be. So, yes, this is one of the relatively new phenomenon that we're dealing with, and it's extraordinarily dangerous.

So I can. Speak specifically. To the fentanyl story because that's the prime thing that's bringing us here. Originally, fentanyl illegally manufactured fentanyl as opposed to the diverted pharmaceutical fentanyl arrived in North America and in the United States as an adulterant in heroin. So people who had been using heroin were going out and buying a bag. And it was no longer only heroin, it was heroin and fentanyl. And then that saved so much money for the suppliers. The supplier started leaving the heroin out of it. But that's only phase one. At that point, you're just serving an existing pool of users with a cheaper opioid. But the two subsequent waves are the ones where it's expanding markets. One subsequent wave is the one that you're referring to and Daniel did, which is you take a stimulant and you add an opioid to it, which is extraordinarily dangerous because the person who's only been using stimulants has not yet built up tolerance. The only weirdly good news here is that. That is such a fatal situation.

That the actual volume is lower than it appears. Right. It's a certain percentage of the deaths. And you think, wow, that's that percentage in the market. But actually it's smaller than that because the small amount of cocaine and meth and then amphetamine that's adulterated produces a large number of deaths. And then the third wave, which is scary to the average parents, are the counterfeit pressed pills that contain that know. And that's a big. Expansion in the market because there's a lot of people who have no interest in injecting a drug, but they perceive of the pill as safer. So when fentanyl starts to show up in counterfeit pills, it's accessing a much larger pool of potential users than when it was just replacing heroin.
So now I've successfully described why this is a very complicated situation, and I'll let the other to answer the question what to do about it.

AHMED: Fantastic. Dodge. Your turn.

FELBAB-BROWN: Well, I think that the entire conversation applies something that several of our papers emphasize. They are online. More of them will be coming online. But do go look up the papers beyond the event, which is that countries around the world, including the United States, need to invest far more in monitoring drug markets. Whether this includes they waste water testing, something that has become fairly standard in various parts of Europe, but it's not yet in the United States something that's part of the conversation or should be part of the conversations with Mexico's, whether it's other forms of monitoring. I mean, you know, we often say we don't have fentanyl outside of North America and Europe, but the reality is that you have essentially no testing for fentanyl across East Asia.

You have no testing for fentanyl in Africa and you have very, very limited testing for fentanyl in Latin America. Daniel identified how fentanyl is being mixed already into other drugs. Now, you know, it might not be fentanyl, it might be netizens. A challenge of devising, testing and monitoring also has to do with how rapidly the markets are evolving, what new synthetic drugs is being pumped out. There is a lot of new psychotropic drugs being cooked in places like India are being sent around the world. But in the absence of having this better real time or close to real time data. Policymakers and communities will continue being very much on the backfoot as the drugs are much more potent. You know, one of the big differences in the synthetic drugs revolution from the old drugs is not only are

they so much easier to produce and smuggle, but they are so much more potent. And this is not just true about sending opioids like fentanyl and other things, but as you heard on the first panel, also the potency of meth and the lethality of my life has gone up a lot.

AHMED: I think that's a should I open it up for questions now? No. Okay. We still have some time. One of the questions I wanted to ask well, first, let me ask you, Daniel, when it comes to regulatory regimes and when it comes to knowing what's actually happening. I mean, I think Europe might be more advanced than the United States, but South America is still not necessarily aware of what's being consumed on the streets and that framework that exists to kind of test and assess.
Is there a movement to change that? Is there an awareness that we need to figure out what people are using and how it's being used and what sorts of substances are passing through our populations?

MEJÍA: This has been almost all done by NGOs and civil society and local governments. I worked in the local government of Bogota a few years ago. National governments are not creating the tracking systems in of what is being consumed in the street. This is mostly done by NGOs and civil society and people in the streets helping drug users to test and tell them what they are consuming, what the risks are. And the I would say something I will say something that is that might be controversial, but a given the history of South America with drug, mostly drug production and trafficking. We have no prevention. No the public sector, the health sector is not prepared to handle an epidemic of fentanyl consumption or I think such as are dangerous drugs such as fentanyl. So I think this is something that we say in the in the in the paper that the that this is completely different from what we have seen in the past, Fentanyl. So the health sector should be prepared and should not leave that to only NGOs and civil society organizations in the streets trying to help drug users.

AHMED: Okay. I would like to open it up for questions from the audience. Please.

AUDIENCE MEMBER: Josh Wagner coming here from San Francisco. I really appreciated this panelists discussion. We've heard a lot of discussion today throughout. The morning about. This issue being. Either law enforcement or public health or maybe supply. Is there anyone on the panel willing to comment about what efforts. Should be made to look at this problem holistically from a larger scale

geopolitical and from national security standpoint as well? Like this? Solving the problem at the local level is only really treating the solution. Or treating symptoms. It's not going to remove the problem by providing health care or by. Stopping drug dealers on a. Small scale. How are we looking at this from a strategic level to actually remove the problem, not just treat the symptoms?

CAULKINS: Thank you. Thank you. Should go first and then I'll follow up.

FELBAB-BROWN: Sure. So, you know. First of all, U.S. policy across multiple administration has not been looking at drugs solely by dealing at a local level. But the domestic level, the United States has invested tremendous efforts over many decades to be dealing with supply.
And this has continued through fentanyl, from the Biden administration, across the Trump administration, from the Obama administration, across the Trump administration and Biden administration, engaging principal suppliers of fentanyl, synthetic opioids and precursor to the U.S. has been a central feature of policy, and it needs to remain so. Not because we can be easily in the world, but supply is stopped, as John spoke about, I assume will speak more about stopping supply is very difficult, but because of law enforcement cooperation, it's denial. Its effectiveness affects many other aspects of security. In Mexico, U.S. economic interests are at stake. U.S. lives of U.S. citizens are at stake. The safety of supply chain is at stake as Mexican criminal groups have expanded into legal economies and control over larger territories. People have political influence, affect institution with China.

What is at stake in the relationship is the power of Mexico, of Chinese criminal groups, their connections to other forms of criminality, to money laundering, the possibility that they could be instrumentalized for hostile actors. So it's not just about the supply. And there needs to be a concerted as there is effort to be inducing countries to be suppressing a dangerous organized crime. But the stopping supply as. Been extraordinarily difficult and has become extraordinarily more difficult. So we should really far more broadly conceptualize in what we want to achieve with law enforcement efforts directed outside of the United States. Now, look, the administrator of the Drug Enforcement Administration, Alvin Graham, announced about two weeks ago that the purity of fentanyl had gone down. And that's a very strong sign that there is something happening with supply, that either supply

is reduced or that is an even more intriguing possibility that the Mexican criminal groups, as a result of U.S. pressures, have finally realized they cannot get away with sending very potent fentanyl that's killing people.

And then they send they themselves are sending more adulterated, less potent fentanyl. I don't know whether it is the case. The U.S. has three of the big Mexican bosses in prison or video like him in Ohio. U.S. law enforcement can ask that. But if the answer was yes because of U.S. actions, we finally made the choice to be sending a less potent drug. That would be a really big win for U.S. law enforcement. And so this is why I'm going to hand over to John. Law enforcement is very much about shaping the behavior of organized crime groups and reducing the greatest threats and harms they pose.

CAULKINS: Excellent. So what is this. National security crisis? Is the national. Security crisis that about 100,000 Americans are dying in an overdose every year? If that's the. National security crisis. That I think. What you've heard is exactly the right analysis.
It was hard enough when the drug problem was cocaine coming from only a few countries in South America was grown from plants. And we had great collaborative relations with those countries. And it's ten times harder now. Ergo, that's why you hear so much about treatment and harm reduction and so on because of the pessimism about the ability to shrink supply enough to consider. I mean. The price per morphine equivalent dose has dropped by like 90% over the last ten years. Even if we made it go up by a factor of ten, we're only back to baseline. But if your national security definition is there, are these powerful criminal organizations making $1 billion a year who are undermining democratic institutions and important partner countries, then 100%. There's a lot of opportunity to address that. And I think the message that I would give is let's not distract law enforcement with the impossible task of shrinking the number of overdose deaths. Leave that to the treatment and harm reduction mission, and let's therefore free up the energies to pursue these other threats that come from the existence of these powerful criminal organizations.

AHMED: Great answers, please.

AUDIENCE MEMBER: I wanted to give. The opportunity for the panel to comment. I've heard a lot of. Some rightfully, some, I would argue with bashing of supply reduction today. What if we think about the counterfactual, which is actually what most of the NGOs, Daniel, you talked about are arguing for in a very organized manner and international forum around the world on a regular. Basis, which is let's. Just get rid of supply reduction. Then what maybe some. Folks could comment on if we just. You know, stop. Spending that money. What would happen with the dynamics of the drug market?

CAULKINS: Can you clarify whether to stop spending money but retain the laws? Or are you talking about getting rid of the laws against supply and therefore allowing.

AUDIENCE MEMBER: The latter.

CAULKINS: businesses in...

AUDIENCE MEMBER: The latter.

CAULKINS: Yeah. Okay. In my, above the words water supply reduction. In my opinion, legalization would be an unmitigated disaster and the limited effect of variation of law enforcement within a prohibition regime tells us essentially nothing about the consequences of a regime change. And legalizing drugs as deadly as the opioids or as compelling as cocaine, crack and meth, amphetamine would be a disaster.

MEJÍA: This is this is somehow what's being happening in Colombia in the last 2 or 3 years, which is an it's still illegal, but the government, A, decided not to fight against illegal coca crops by not by suspending the aerial eradication campaigns back in 2015. In the last two years, a manual eradication has gone down to almost zero and interdiction efforts have gone down dramatically. From three years ago, we were interdicting about 42% of potential cocaine production. Now it's 2528. It has gone down to almost half. And we are reaching a record high, record high of a coca crops cocaine, a potential cocaine production. But we haven't seen our reduction in drop in cocaine prices yet. We have a natural experiment going on. I think I'm not sure if this is a natural experiment, but a few hours ago,

the Mexican government announced the largest seizure of fentanyl, a historically one ton, one ton of fentanyl, which is, they said 20 million doses. I will see if that impacts. Fentanyl markets are not. But I think this is. This is a mistake. But they said yesterday this is three times what the whole Pena Nieto administration seized in terms of fentanyl. We'll see what happens.

FELBAB-BROWN: But let me add one comment here, and that is that I think that is a great folly in a lot of analysis that assumes that legal economies do not require law enforcement. They absolutely do. You can have a lot of violence. You can have a lot of criminality, underhanded behavior, tax evasion, money laundering in legal economies. And so the issue of how one designs policies to particular forms of illegal economies, to particular forms of contraband, very naively falls on if only it's legal, then we won't have crime all over, or if only we just throw as much law enforcement, then the crime will disappear. And you need to really think about what is the specific role for law enforcement. We need to realize that it's not a one time, one-win situation. You will need law enforcement and that you need good, smart, adaptable policing both in the legal economists and the legal ones. And this is all the more important as there's many of the most dangerous criminal groups around the world, like the Mexican cartels, like Chinese organized crime groups, are robustly involved in legal economies and are causing great harms in that entry, in that space. From national security perspective, from a rule of law, from democracy, and as well as with connections to hostile powers.

AHMED: You've had your hand up before.

AUDIENCE MEMBER: Hi. My name's Elish. One of my questions was, given that we've spoken about how important law enforcement would be in terms of limiting sort of fentanyl in the Mexican context, and given that cartels in Mexico are so involved in like sort of societal legal processes, I guess, what specific law enforcement mechanisms would you recommend in the Mexican context that wouldn't obviously sort of violate the autonomy of Mexico and also not be sort of the bad ideas of bombing cartels and things like that?

FELBAB-BROWN: Well, I think that the need to get away from obsession with Led busts and high value arrests. Look, it's important to be arresting top criminals. They should not be given carte

blanche. They should not be given a pass. They need to be brought to accountability from justice perspective, rule of law perspective. But that cannot be the dominant sole dimension of it. What law enforcement in Mexico, in cooperation with the United States on the U.S. side, should be focusing on is dismantling the complexity of the structures. I have often argued for going after the middle operational level. You know, arresting the Haqqani's on the street in masses will also not have very dramatic effect. But you have a set of operators who are the logisticians, who are the core money launderers, who have the international connections, who have the corruption capacities.

That needs to be a critical component. And the shine behind the ministration in the security plans that it released in October emphasized that and said they're interested in doing this and the dark cloud of the tariff threats, we should come in. We want to work with you on this. I think in Mexico it's important to get tough on the corruption and pervasive infiltration of organized crime into politics and into law enforcement institutions. Tough issue, as I'm you will know, for decades and decades, starting the 80s, every Mexican government set out an ambition or an agenda or claims they would reduce corruption. And the next administration finds itself stunned by the level of corruption and finds it difficult to deal with it because of how much integrated it this. But is this clearly what the U.S. should be inducing? And we also have to realize that after several years, including acutely after the Lopez Obrador success, Neal, we have absolutely decimated investigating capacities in Mexico. So not only have the issue of corruption, you don't have investigators.

Mexico passed very problematic legal constitutional changes in September that I am not fond of. But that is one aspect that I think is useful, which is now that the National Guard is in perpetuity being asked to be in law enforcement, it is. Cuban investigative mandates shine the shine. Obama administration had said they want to be building up investigators.
We should be supporting them, trying to do so in ways that preserve vetting, that we don't just build, investigate this and five years down the road, they're corrupt. But these are the aspects of what needs to be built into the judicial system and the law enforcement system. I am very concerned about judges being elected in Mexico because the narcos have such tremendous power over who can run for office and who is elected that the pressure on the judges from the criminal groups will be intense. So with

these laws, how is the Mexican government going to protect judges who will be running from office, from succumbing to the narcos?

AHMED: I mean, just to add to that, and then I'll ask your opinion on this. It's no surprise that Mexico just announced the biggest fentanyl bust in its history. They're trying to get out in front of what they know is going to be a terrifying next few years for them, whether it's tariffs or just broad-based insults. And so but it's also interesting that they did that in a matter of weeks. And I think, you know, sources within the Mexican government that I've talked to have indicated that there is going to be a lot of those bright, shiny things, you know, the dope on the table moments. I think on the one hand. Sure. That's great. You know, an engaged Mexico trying to rid the scourge of fentanyl from within its borders is good. On the other hand, is it is it just the dope on the table or is it just like, let's bust a couple of these folks and is it going to distract our neighbor to the north enough that they'll focus their ire somewhere else? Because it's not a simple thing to suddenly regenerate or generate period. The rule of law in Mexico is always had the capacity to crack down when it wanted to and take down kingpins. The more systemic investigative capacity has always kind of eluded it, and it's always been problematic for the United States in its partnership. Sorry, You go ahead.

CAULKINS: No, I can't top that we can take the next question.

AHMED: We we've got to wrap up here, so we'll do one more question in the back. Thank you so much you.

AUDIENCE MEMBER: My question is related to. What the next Trump. Administration going to demand from Mexico and Canada even before we get to the. Review process, especially when it comes. To fentanyl. Like, what sort of actions. Would you expect the next U.S. Government to demand from Mexico and Canada on this issue and how those actions might impact the review of the trade agreement in 2026? Thank you.

FELBAB-BROWN: Sorry, The review of your sense here.

AUDIENCE MEMBER: How those actions or how this narrative might impact the review of the agreement if we're not only talking about trade like these other issues are now in the discussion of the trade agreement.

FELBAB-BROWN: Thank you. Well, absolutely, Diego. So what has been put forward by the incoming administration, or at least President elect Trump, is the intense mixing of security and economic issues, tariffs. And, you know, I don't think that's such a bad thing because there was a lot of reluctance on the part of the Mexican government to have product, full conversation, meaningful conversation about what needs to happen online enforcement. And you have a lot of jubilation across the Lopez Obrador years that there is new shoring to Mexico, even as rule of law in Mexico was tanking dramatically. And I think that our real reasons on the U.S. side to be concerned about deepening, economically integrating with the narco economy, we don't want that.

We want Mexico to be a healthy, thriving economy with which we want to be integrating. But simply imposing tariffs on China and integrating with the economy that's deeply infiltrated by criminal groups would be dangerous and unhealthy for the United States. So now that these issues are on the table, I think this is stimulating conversation in Mexico about, well, maybe we cannot ignore rule of law. How do we work with the U.S. productively now on the U.S. side, we need to be realistic about what is it that you're asking for and we need to be wise about what is it we asking for? If our demand is to stop all fentanyl flows, stop all undocumented migrants else. All's USMCA is not renewed or that is a negative finding that I would suggest will put us in the situation when we achieve neither objective. So we have an opportunity that is realization in both country as shown by the administration has signaled, like with the fentanyl bust, that, you know, Mexico is back to understanding. It needs to focus on security issues. But I would say that what Mexico needs to realize is that it needs to focus on security issues and ongoing after criminal groups for its own sake, not just because here is the incoming Trump administration using it as a clubber, but because the narcos are imposing tyranny on Mexican society. They are weakening critically the capacity of the state. And you don't want to live in such a world either. With that, I will need to keep the last minute aside. And want to thank you so much for coming to moderate today.

I want to thank Daniel and John for being on the last panel with me today. To all of our authors for their extraordinary contributions. Please do go read the papers. But you also have the papers and the findings and other topics communicated through the podcast, the Killing Drugs that I have been hosting. Look up the podcast. You can get in any way that you access your podcast.

I want to thank you all very much for engaging with us this morning. This is not the end of our work on drugs, fentanyl, synthetic opioids, China, Mexico. This is an important misstep, but we have a lot more coming. So please stay engaged with that. And finally, I need to thank my extraordinary team, some of whom are here in the room. And I specifically want to highlight Natalie Britton and Diana Garcia, who were just indispensable, who are indispensable partners in the project into work and have done extraordinary work. So very many thanks to all of you. And thank you.