

Written Submission of Professor Keith Humphreys to the Senate Caucus on International Narcotics Control for July 20, 2021 hearing entitled “The Federal Response to the Drug Overdose Epidemic”

I am grateful to Chairman Whitehouse, Co-Chairman Grassley, and their fellow members of the Senate Drug Policy Caucus for the opportunity to submit testimony related to our nation’s tragic crisis of addiction and overdose. My analysis of the crisis reflects my decades of work as an addiction researcher at Stanford University and my experiences serving as a White House drug policy advisor in the Administrations of Presidents Obama and Bush. I focus on five key areas where the federal government can make fundamental improvements in the national response to addiction and overdose in the era of COVID-19.

Invest in State of the Art Data Science

COVID-19 has obviously been traumatic for our country, but it has also shown what our nation and government can do when they make a commitment to respond to a major public health challenge. One concrete indicator of that commitment is that any of us can look on our computer or phone right now and find out exactly how many Americans in every state tested positive for COVID-19 or died of it as recently as 24 hours ago. Contrast that achievement with our decades-long failure to do anything comparable for addiction and overdose. Overdose fatality data from around the country take 6-12 *months* to arrive in Washington. Our current survey tools cannot provide credible estimates of how many Americans use heroin and fentanyl, how many are addicted to these drugs, or what percentage of the addicted population receives treatment.¹ The ADAM program, which was our best source of data on the link between drug use and crime and provided vital information on illicit drug markets, was defunded. Similarly, the White House Office of National Drug Control Policy’s capacity to assemble and analyze data on drug epidemics has withered in recent decades.

As a result, Congress and The White House cannot design policy based on the status of the epidemic today because they don’t know what it is. Even data that it is only a few years old can be misleading, as we can see in the recent and rapid expansion of fentanyl into the Western United States.² Nor can policymakers tell whether new policies are working until years after the fact when the data finally come in. Data collection can seem like a low priority in comparison with providing direct public health and safety services, but without it we are literally blind and lost in the opioid crisis.

Given that technology companies have extraordinary capacity to know about so many domains of American behavior in real time and that the Internet fora with which humans constantly interact produces an avalanche of data on drug use, attitudes, and intentions, this would be an ideal moment for federal drug control officials to partner with the private sector to develop an opioid-related epidemiological monitoring system. It is also a propitious moment to create a national infrastructure in a representative sample of locations regularly monitoring the content of wastewater for the presence of known and emerging drugs. As part of this overall effort, Congress should fund a small team of data scientists at White House ONDCP to integrate all available data sets and to provide timely and user-friendly reporting to state, local, non-profit, and private sector organizations working to address the drug problem. The COVID experience with real-time, accurate data collection shows that if we make the commitment we can develop a system that accurately estimates how many Americans use opioids, how many are addicted to them, and how many are dying from them in a dashboard based on recent data.

Mainstream the Financing of Addiction Treatment

Another success of the U.S. COVID response was how rapidly health services were established within the existing health care system. We would benefit enormously from copying this model in our approach to addicted patients.

The addiction treatment system includes many dedicated staff members and volunteers who save many lives. It is also segregated from the rest of health care, unstably funded, and of inconsistent quality. There are many reasons this is so, but the fundamental one is that addiction treatment is financed differently than the rest of the health care system. My time in the White House convinced me that when funding for addiction-related care is placed in a silo with no connection to mainstream financing mechanisms like Medicaid and Medicare, that same segregation is reflected in American communities, creating a fragmented, difficult to access care system. Quality of care also suffers because addiction treatment has more difficulty attracting skilled providers and is not subject to the more rigorous quality assurance systems of the rest of health care. Put simply, if we want a quality addiction care system that is a seamless, enduring, part of medical practice, we need to finance it adequately through the same mechanisms as everything else in health care. Over the past 15 years, Congress and successive administrations have made strides in this area, but more work remains to be done.

On the public financing side, this can be best accomplished by ensuring that addiction treatment benefits in Medicaid and Medicare are comprehensive in scope and offer adequate reimbursement. This should be the goal whether the benefits are provided by the government directly or a participating private insurer.

On the private financing side, Congress passed “parity” legislation by an overwhelming bipartisan majority in 2008 and expanded it in 2010. It strengthened the law further only 6 months ago (Public Law 116-260). The principle that insurance benefits for addiction and psychiatric problems should be comparable to those for other disorders is settled policy and is also popular with the public. But it is not consistently adhered to in practice. Congress has given the executive branch critical tools to implement the principle of parity and should now provide both the resources and the oversight to ensure these tools are fully utilized. Specifically, the Departments of Labor, Treasury, and HHS should be encouraged to embark on a major campaign of education of insurers, employers, and the public to explain the requirements of the law coupled with stricter enforcement where it is not followed.

Foster an Explicit, Sensible Division of Responsibility Between Law Enforcement and Public Health

COVID-19 has co-occurred with a national debate about the role of police in American life, and both of these forces shape the national response to the worsening opioid epidemic. There is now substantial disagreement and confusion about what role law enforcement should play regarding drugs and what role public health should play. In any complex, multi-sector endeavor – and the response to the opioid crisis is certainly one – confusion and disagreement about who is capable of and responsible to do what substantially lessens the likelihood of success.

The idea, dominant in the 1980s and 1990s, that enough enforcement would suppress drug problems without significant collateral damage, was wrong. Equally wrong is the idea which is getting popular out where I live, namely that if we just get the police out of the way and offer extensive health and human services, the drug problem will wane. Some people who say, correctly, that “We cannot

arrest our way out of drug problems” believe that we can treat our way out of them, which is also untrue. The opioid crisis illustrates this with painful clarity. When supply control is absent, as was the case when the health care system was churning out a quarter billion opioid prescriptions a year, increases in addiction and death always follow no matter how much is spent on health services for addicted people.

One of the most useful things anyone with a platform – certainly including Members of Congress and officials in the Biden Administration – could do is to articulate a clear division of responsibility between law enforcement and health professionals that honored both of their missions, respected their capacities, and did not ask them to do things they cannot do well. This would then have to be matched in policy design and programmatic decisions. The division I would propose goes something like this.

For the individual experiencing addiction and not committing non-drug felonies (e.g., assault), health professionals should be in the lead and law enforcement should be available as backup. Addiction is a legitimate medical disorder to which our first response should be an offer of treatment, not punishment. Yet we still need law enforcement to be available as backup because addicted individuals can pose threats to public safety (e.g., intoxicated driving, family violence) that health professionals cannot handle on their own.

For the production and distribution of illegal drugs, the roles are reversed: Law enforcement is in the lead and health care professionals are available as backup. Disrupting drug trafficking, money laundering, and transnational criminal organizations for whom drugs is just one line of business can only be done by law enforcement. Such enforcement is a major contributor to public safety and to public health. That said, sometimes health care professionals are needed as backup. For example, when the DEA shuts down a pill mill, hundreds of addicted individuals may respond to having their supply of pills cut off by seeking opioids in heroin and fentanyl markets. Coordinated action making treatment immediately available for such individuals can lower the adverse short-term side-effects of disrupting drug supply.

Stop the Opioid Epidemic from Spreading Abroad

COVID-19 has re-taught us the painful lesson that one nation’s health problems can spread throughout the globe. One of the global public health tragedies of my lifetime was that as wealthy countries like ours finally started to adequately regulate the tobacco industry, we let them pivot to expanding their business to low and middle income countries, where they have been dealing death ever since. We are at risk of making the same mistake with opioid manufacturers.

Federal officials -- including members of the Senate Drug Policy Caucus – have managed to expose the role in the opioid crisis of people like the Sackler Family and their company Purdue Pharma³. Fines have been levied and more are to come, along with constraints on various fraudulent practices that were used to promote opioid drugs like OxyContin in the United States.

However, like the tobacco industry, some opioid manufacturers have now shifted to expanding opioid prescribing abroad. For example, investigative journalists have documented that the Sackler family is expanding opioid markets through a mirror company of Purdue Pharma -- known as Mundipharma -- using the same tactics as they employed in the U.S. In an ongoing criminal investigation in Italy for example, two Mundipharma executives have been sentenced for involvement

with a leading physician who promoted opioids allegedly in exchange for laundered large cash payments from Mundipharma and another opioid manufacturer.⁴

Most of opioid manufacturers' expansion efforts are targeted at developing nations. Among the countries where Mundipharma is attempting to promote OxyContin for example, according to a *Los Angeles Times* investigation, are Brazil, China, Colombia, Egypt, Mexico, and The Philippines.⁵ Investigative journalists at The Guardian document that Mundipharma is one of many Western companies promoting opioids in India using tactics pioneered in North America.⁶

We have a responsibility to our friends around the world to not be satisfied simply by bringing our own prescription opioid problems under control. I urge the caucus to investigate the international activities of U.S. opioid manufacturers, to warn our allies against their conduct, and to do everything possible to ensure that constraints on fraudulent and corrupt practices apply not only in our own country, but in other countries in which these corporations are active.

Rethink Drug Policy in Light of the Increasing Prevalence of Synthetic Drugs

The increasing availability of fentanyl and of methamphetamine are only the two most prominent demonstrations that global illicit drug markets are increasingly able to produce drugs that are entirely synthetic, meaning their production is not dependent on agriculture. The advantages to traffickers of not having to grow drug-producing plants in politically volatile regions and secure peasant labor to farm them are enormous. Eliminating the risks of drought, crop blight, and bulk shipment interdiction are also attractive to drug traffickers. These economic advantages of synthetic drugs, coupled with the Internet spreading the needed information and technology to synthesize drugs, and facilitating their covert purchase, raise questions about the basic assumptions of global drug control strategies.⁷

As drug production moves increasingly from something that depends on agriculture to something that any chemist can accomplish in their sink, some long-standing policies and programs have diminishing returns, e.g., trying to reduce drug crops in poor countries through eradication or alternative livelihood programs. Transnational drug trafficking itself may also diminish as domestic retail sellers can make their own drugs rather than rely on large criminal organizations to import them in bulk. This has substantial implications for where law enforcement directs energy, including on our strategy for border control.

I can't predict all the ways the expansion of synthetic drugs will change drug use, addiction, and drug policy, but I am quite sure it's enormously important. I have some ideas about how to proceed and so do some other people in the field, but fundamentally this change is so profound that we can be safe in saying that any one person who thinks they have a simple answer is wrong. Dealing with this new world is going to take sustained thought, study, and discussion. If the Senate Caucus on International Narcotics Control wishes to use its convening power to lead that process, I know I am only one of many drug policy analysts who would be pleased to assist it in formulating an approach to drug policy that measures up to the challenges posed by synthetic production.

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