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BU SCHOOL OF PUBLIC HEALTH
A Conversation with Rahul Gupta
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>> SANDRO GALEA: Hello, my name is Sandro Galea, Dean of the Boston University School of Public Health. Welcome to this conversation. These conversations are meant as spaces where we discuss how to create a healthier world by shaping a foundation of ideas to generate healthier populations. We aim to do so through a process of conversation and debate guided by expert speakers. Thank you for joining us.

Thank you to our cohost, the Grayken Center for Addiction. Thank you to the Dean's Office, without whose efforts these conversations without not take place. The United States is in the midst of an epidemic of drug overdose. Drug 2021, there were close to 200,000 overdose deaths in the country. We must engage at the policy level and support health. Today we are privileged to be joined by someone at the forefront of the response, Dr. Rahul Gupta. Here to introduce Dr. Gupta is Dr. Miriam Komaromy, Medical Director of the Grayken Center for Addiction, at the School of Medicine.

She leads programs focused on expanding access to scare and engaging with care for patients who have substance abuse disorders, particularly those from marginalized populations.

Dr. Komaromy, welcome.

>> MIRIAM KOMAROMY: Thank you so much, Dean. I'm an addiction specialist leading the Grayken Center for Addiction at Boston Medical Center, the principal teaching hospital of Boston University. The Center oversees all aspects of addiction-focused work. This includes more than a dozen programs providing clinical treatment for substance use disorders, fellowships in addiction medicine and psychiatry. And we have an ambitious agenda.

We're delighted to collaborate with the School of Public Health to sponsor Dr. Gupta's visit. He's the first physician to lead the Office of National Drug Control Policy. His work demonstrates a strong focus on harm reduction and overdose prevention and we're so excited to have a clinical leader with this focus working in such a powerful and influential role to shape U.S. drug policy.

At the Grayken Center, our top policy priority is overdose prevention. We're particularly interested in the potential for overdose prevention through legalization of overdose prevention centers, previously known as supervised consumption facilities. We're interested in hearing Dr. Gupta's reflections on harm reduction and the potential for prevention centers to be legalized at the national level as well as the state level.

And now to formally introduced Dr. Gupta, the first medical doctor to serve as director of ONDCP. And he leads the Office of National Drug Control Policy, a component of the Executive Office of the President, which coordinates the drug budget and federal policies including prevention, harm reduction, treatment, recovery support and supply reduction. Through his work as a physician, a state and local leader, an educator and a senior leader on a national nonprofit organization, Dr. Gupta has dedicated his career to improving public health and safety.

He served as a local public health official. He brought together public health, law enforcement, healthcare, faith-based, business, and other community partners to solve local problems in novel and innovative ways. As the state's chief health officer, he led the opioid crisis response and launched a number of public health initiatives. He's held academic appointments throughout his career, including as a clinical professor in the Department of Medicine As Georgetown University School of Medicine, and Visiting Faculty at Harvard University School of Public Health.

He's been recognized for his career of public service by the American Medical Association, the American Public Health Association, and by Governing Magazine, which named him their Public Health Official of the Year 2018. He will speak for ten minutes and then Dr. Gupta and Dr. Galea will engage in a --

>> Recording in progress.

>> MIRIAM KOMAROMY: Also taking questions from the audience. Welcome, and thank you for joining us, Dr. Gupta. Dr. Gupta, over to you.

>> RAHUL GUPTA: Thank you, Dr. Komaromy. I appreciate the opportunity to have this conversation. I also want to thank Dean Galea for the invitation as well. What I want to do is take a few minutes to talk through some slides, both the work we do, the importance of the work, and the current epidemic, as well looking forward of where we all can partner to make an impact.

So, if we could get the slides, I'd appreciate it. So, the next slide, basically, we can move to. If you see the challenge over the last several years, the slide that demonstrates from 1999 to the most recent data, you can clearly see on your left-hand side that the synthetic drugs like fentanyl have been largely responsible for the overdose deaths in the United States.

On the right-hand side, equally important is the fact that if you look at the age groups, it's those between 25 and 49 years old that are bearing the brunt. That's the workforce in this country at a time when we have some of the lowest work rates ever on record in this country. And a lot of economy -- that loss has happened to the tune of $1.5 trillion a year, that's with a T, trillion. Next slide, please.

And one of the things we have done in this office is to work with our Department of Transportation colleague who put together a near real time data dashboard. This data comes from all the 911 calls at a ZIP code and county level for opioid overdoses. This can be a really important policy, but also a first responder action tool and a research tool that allows us to look at this from a demographic standpoint, from a response standpoint, as well as where the resources need to go.

Very similar to the pandemic, this allows us to look at opioid overdoses right now in near real time. there's a two-week lag. But we're working very quickly and soon to put other overdose circumstances, non-opioid as well on there. So, this is going to be really important to have an assessment that has not existed for the last few decades. Next slide, please.

And then we'll talk about expanding treatment is critical, because what is not surprising, I guess, but really critical is of the 8 million people that suffer from opioid use disorder, of the 46 million people with substance use disorder, hardly about 288,000 are actually receiving MOUD. So, what that means is if you look at the total percentages of people, 8 million, a fraction of people are actually getting the treatment.

And this analysis is and was important for us to highlight because we must know where and how much we need to move forward

in this area. Next slide, please. If you look at Massachusetts, about 2500 or 2600 drug overdose happened in 2021, which is up from significant double digits. And a large percentage of those involved fentanyl. And obviously a third almost involved psychostimulants. Xylazine increased about 103% in only a year in terms of being found in deaths. Next slide, please.

And so this is kind of a statement of the problem so far. How do we address this comprehensively? One of the ways we do it is Congress created this office. I'll talk about it in a minute. The primary job is to create a national drug control strategy, the President's strategy, and implement it with a budget. When we put this out in this administration, we saw the two biggest drivers of the academic being untreated addiction, and drug trafficking. Next slide, please.

And the office, of course, as I mentioned, it does not only the strategy, but it has the $44 billion that is split across and managing that budget across 19 agencies, which you'll see on the next slide. So these agencies -- next slide, please. You'll see that they range anywhere from the Department of Health and Health and Human Services to Homeland Security to Department of Defense, Department of Justice, Postal Services. There's a wide range from demand to supply side, including education. Next slide, please.

So when we look at addressing driver number 1, which is untreated addiction, it becomes important to make sure that OUD treatment is more widely available. One of the things we've done is to, sort of, move forward the telehealth component of this so more people in marginalized communities, rural areas, and incarcerated settings are able to get the treatment.

Second is to make sure we understand that of the 2 million people in custody any given day in America, two thirds of them are there because they have an SUD. But that doesn't get treated and we see more overdose fatalities post-release and we see a lot of re-incarceration because of untreated SUD. It becomes really important to make sure we're working right now to expand access to treatment in prisons and jails across the country.

We have states where applying for 1115 waiver, allowing Medicaid to turn the switch on 90 days before release from custody so that these folks can be treated. And it has been demonstrated to produce significantly improved results. Next slide, please.

One of the problems has been we've had this issue of not only having a license to treat, but having an X waiver. Late last year, Congress passed on the urging of the President a bill to change the law in a way that from 128,000 prescribers, now we have almost 2 million prescribers who have DEA license who can now prescribe OUD treatment. It's a big step forward, a historic

one that will allow us to have so much more workforce included to treat. Next slide, please.

And then along with OUD comes the life-saving drugs like naloxone. One of the things that we know, while we distribute about 9 million doses of naloxone last year, we had about a half a million life-saving episodes where they were used. Now, naloxone, we worked really hard to make it over-the-counter available in most pharmacies. It's important because it helps -- naloxone is a drug that not only is a reversal drug for opioid overdose, but it's one that has been found largely to be safe and effective.

And there's a significant amount of resource from the federal government where this could be purchased at almost no cost or no cost to the person. We're working to make sure we believe that we have additional naloxone doses to the tune of 7 million. We will be able to save an additional 26,500 lives.

So the whole idea here is for us to push, make sure that naloxone is available just like a fire extinguisher or AAD device. We want to see it in schools, in college campuses, in malls and other public areas. Next slide, please.

And then one of the best strategy is preventing use before it begins. We have a program called Drug-Free Community Support Program that covers 67 Americans across the country. It's an evidence-based program, multifaceted that has been shown to delay or prevent drug use. Working with the Federal Department of Education to provide messaging to K-12 school systems and providing resources to educators Prevention is really an important key. Next slide, please.

And then about over 23 million Americans today are in recovery. And if we're successful with the 46 million people with substance use disorder, we will have more people in recovery. It becomes critical that businesses look at this and we start to build a recovery-ready nation through developing a recovery-ready workforce and workplaces. Recently, we did a press event with the governor and the Chief Medical Officer of Google.

Google has now become a recovery-friendly workplace. We have a number of people in recovery in my office and in the White House at large. Again, it is really important that we also try to move from treatment to recovery, because recovery is a lot more than treatment. It's about all of those wraparound services like housing, like food security, transportation, economic opportunities, education, that help people not just survive, but thrive into long-term recovery.

A really important piece that we're leading the work here. Next slide. And then as I mentioned, we've got to make sure that we are investing into advancing addiction medicine in terms of

not only what we have, but more research and development. Then looking at other ways, where it's methadone or others, how do we find ways to expand treatment. Next slide, please.

And I'll talk a little bit about the second driver just a bit, which is the drug trafficking piece. You can see pictures of drug tunnels. You can see the border there. You can see the meetings of the Mexico delegation and a number of aspects. This becomes important as well because the efforts here allow us to create this space for public health efforts to take root.

So we're working closely to ensure that these nonintrusive inspection technologies exist on the border. We want to make sure that there's appropriate mechanisms in global supply chain with China and Mexico. We're partnering with nations and really making them understand the threat of global -- the global threat of synthetics, which is not limited to the United States any longer, unfortunately.

And we've also then put out -- actually we have declassified this picture, which is the entire supply chain of fentanyl. We're sharing this with foreign governments, policy-makers and others to understand that we need to work in a very coordinated, evidence-based, data-driven mechanism in order to disrupt the commerce of drug trafficking as opposed to putting and incarcerating individuals for their drug use.

So this is a shift that's happening in policy after almost 50-60 years in the United States which is shifting to ensuring that on the supply side we're going after the very commerce, the lifeline, the blood that feeds the trade, but at the same time, we're making sure the people who are suffering from SUD are getting the help they need in lieu of incarceration. Next slide, please.

And then drugs like xylazine -- understand that in some ways, it's Whac-A-Mole. We still have to ensure that we're taking action. So we've announced earlier this year to have xylazine be designated an emerging threat, which allows more resources and ensuring we take action before it becomes a further threat. Next slide, please.

And then what we've done is, when I was a state health commissioner, we had to reinvent the wheel every time we wanted to think about how do we help people. One of the great things about the office is we're now able to provide model acts, literally a frame of how do you create overdose review teams, how do you treat substance use in correction settings, how do you help pregnant people with SUD.

So, we're using the best evidence and the experts to create these model state acts and sharing those with state legislatures and policy-makers in states to help them make the best decisions. Next slide, please.

And one of the things that you'll find that we're really concerned about moving forward is the workforce challenge. If you just look at the behavioral health workforce, I've circled some of these. We are looking at in the next five years 12,000 plus shortages in psychiatrists, similarly with counselors. It's really important that we think about a cascade of care. We speak about curricula in medical schools and schools, all of the health-affiliated schools so there's an interest in having a workforce of the future in behavioral health that is able to actually address and help take care of the people, which is quite a number. Next slide, please.

And then during the pandemic we've had obviously the burnout for physicians and providers has been a big issue. Congress past and present signed into law the protection act which provides resources in training for healthcare professionals, suicide prevention, as well as ensuring that we're breaking the stigma. Next slide, please.

I put this slide out there almost in conclusion because it's important to note that almost $400 million are being -- going to the state of Massachusetts. The idea here is for the commonwealth to think about and look at how best programs get implemented. And, of course, I know the university and the school have big equity in that. Next slide, please.

And I'll just say this as the second-to-last slide. Our priorities for the next year coming up is first, it's almost like triage. We have so many people dying. If there are big items, we believe that two of the biggest items is to expand the use of naloxone, or Narcan, or overdose reversal drugs. And if we do, we've done the analysis here.

If we expand to 7 million doses, we can save 26,000 lives. If every correction facility had access to treatment, we'd be able to save an additional 20,000 lives. And then, we have to aggressively drive forward on prevention, treatment, recovery, and multilateral engagements. Next slide, please.

The last slide -- second-to-last, I'm sorry -- is -- basically shows that if we do this, what we will start to see is a significant decline in American lives lost. Next slide, please. And what we can all do, what you can do to end this crisis is very similar. Carry naloxone. There is fentanyl.com, resources on college campus, they talk about the dangers of fentanyl and carrying naloxone.

As we develop policies that continue to be based on evidence and data. With that, I'll end. Thank you, and I'll turn it back to Dean Galea.

>> SANDRO GALEA: Thank you for that presentation. So, just for everybody in the audience, I'm going to ask Dr. Gupta 15 minutes of questions and then we'll have some questions in the

Q&A. So, Dr. Gupta, let me start with a softball easy question. Can you tell us a little bit about your path? How you came to be doing what you're doing?

>> RAHUL GUPTA: Well, thank you, Dean. Of course I am only the first physician, but also someone who is an immigrant. I studied medicine in New Delhi in India and I trained in Chicago. I spent quite a bit of time understanding from a master's of public health as well as administration. And the issue has been for me, how do you have the greatest impact as a physician leader.

Of course I have a lot of love for the practice of medicine, but my love is even greater for figuring out how to have the largest impact on population health. And that's how my career has sort of taken the track, is to always looking at where are the biggest impacts at a time when we have an American dying every five minutes, 110,000 per year, which is only the tip of the iceberg of people who suffer. This has been my passion.

>> SANDRO GALEA: Thank you. Let me build on something you just said. Let's talk a little bit, the administration -- let's call it public health approach to substance abuse and substance use disorders. You mentioned in your presentation the removal of the X waiver and all that, and the access to naloxone. Can you guide us through where did the public health approach come in into this administration? Obviously it's much stronger than the previous administration, but it's stronger than previous administrations. How did that come about?

>> RAHUL GUPTA: Thank you for that question. A few weeks ago, we on the 35th anniversary of the inception of this office brought together all of the former directors all the way from the Nixon era. And they all sat down on a stage. You could tell the evolution of the office, because we had everybody from a four-star military general to a police chief to a person who had spent a life being a leader in recovery.

And I think it's an evolution that not only has here in this administration but our country has gone through, where now we recognize that this is a public health crisis first and foremost. To address the public health crisis, we must take an evidence-based public health approach that includes harm reduction for the first time in the history of the United States government. We have three elements in naloxone programs as well as drug checking as part of that harm reduction, but also expanding treatment and recovery as well as prevention.

So this public health approach is unique in this administration because it really signals the change in the direction of the policy this office and previous administrations have had in a way that is hopefully going to be long-lasting and

hopefully also going to be impacting people's health and survival in a way it hasn't been in the past.

>> SANDRO GALEA: So, it's interesting that you comment, which I agree with, that this administration in some respects is actually where the growing understanding in the general public is in terms of approaches to substance use disorders. But let me build on that and ask a harder question. Let's talk about the tension between harm reduction approaches and abstinence-based approaches. We've seen it just in the persons of the directors, let alone in their philosophies.

In my read of your work, you've navigated that line. You've had to the deal with the different philosophies. Can you comment a little bit about where you think that tension is at today and how we consider harm reduction and abstinence-based approaches, trying to take the best of both to create the healthiest possible population?

>> RAHUL GUPTA: That's a great question. Thank you for that. When I went to medical school, we didn't know anything literally about addiction. We did not understand the various chemistry that occurs in our brains. We didn't understand it was a brain disease. It was often labeled as a moral failing. Today, when my son is in medical school it's a very different understanding.

And it's -- we must adapt to the learning of science and evolution that occurs as human beings. What we try -- what I try to accomplish and talk about is the science side of this, which is on one hand, we have to treat this as no different than a disease like diabetes and hypertension. That's the first aspect of this.

The second, harm reduction approach is important because this is about triage in some ways. We have to meet people where they are and help them get through to the next level. Harm reduction is not unique to addiction medicine. It is not unique to medicine or public health. If you think about it, even today we have a 28 Summit happening in Dubai. What people are talking about, you can term it as harm reduction, because people are talking about alternatives to fossil fuels.

That's literally harm reduction. So the idea and the notion of harm reduction is about saving lives first and foremost, meeting people where they are, understanding people and helping them move to the next level. If we take an approach which is we know best, this is a moral failing, it gets us in a dark area where we have been. And we tell other countries now to not go there because we've had this negative experience over decades where we've lost more people than we should have and it has obviously impacted communities of color and marginalized populations a lot more than the rest of us.

>> SANDRO GALEA: Let me ask a question from the audience, because it ties into this. A question from Dr. Steve Jones about the pending legislation to allow addiction specialist physicians to prescribe methadone to treat opioid use disorders without requiring physicians be part of the opioid treatment program and to allow pharmacists to dispense methadone to treat OUD. Can you comment on that?

>> RAHUL GUPTA: I can comment in a limited way. Less than a million people were getting treatment when 8 million people are suffering from OUD, opioid use disorder. The OTPs today that exist largely treat about a half a million people, give and take. We have an approach -- we can take two approaches. We could say we want to build an OTP in every nook and cranny and get on that on a hundred-year plan.

Or we could say the idea here is to help people get treatment when and where they need it as opposed to a particular special interest. When we take that approach, we have to start to look at all the tools and the science available to us, turn that into good policy, and move forward. So we're looking at those things. We're looking very carefully at does methadone need to be treated in the same way it has been treated for the last 30-40 years, especially at a time when people are dying from fentanyl?

Which some people may benefit from buprenorphine, others might need methadone, a pure agonist to be helpful. So it's really important that we let the science and the data guide policy-making.

>> SANDRO GALEA: Thank you. Let me ask about data. Let me do a bit of a deep dive on the data question. Can you talk about progress we're making on data? The CDC monthly provisional numbers have been a big improvement, but there remains a lot more to be done. Can you talk a little bit more about your assessment of where we are and give us some thoughts about how we can get better, assuming we can get better?

>> RAHUL GUPTA: That's a really good question. And here's what my thoughts are. When the pandemic came, you could look at your phone and tell how many cases in your county were yesterday of COVID. Today, we still are not able to do that 20 years and 1 million lives lost later.

So that was a challenge. And that's why when I showed the data dashboard we built that up to understand the burden of disease on a daily basis. The fact today is if you look at the numbers first, we had a double-digit rise in overdose deaths from 2019-2021. Now we're starting to see a flattening in the last year. That flattening is important because in any epidemiological curve, as we all know, things change.

The rate of increase has to go down before you start to see

a pure flattening and decline after that. That's where we are. It also indicates our policies and work seems to be working. We do have to -- in the next year -- double down on a few of those things that I highlighted today in order to get even greater benefit in saving lives. I think there's a lot more that can be done through data.

I think -- look. For every death that happens from overdose, there's a number of nonfatal overdoses that happen and that number varies, 15:1 to more or less per state. We don't keep that data very well. We're publishing -- it's in publication, it shows state by state that ratio. Now, years ago when someone came with a TIA, an attack, we used to send them home, maybe give an aspirin.

We recognize a large percent of people would have a stroke in the next two weeks and we changed the way we do business. Every nonfatal overdose is a cry for help. We have to stop in so many ways the concept of treat and street people and we really need to look at that as a cry for help and start to understand every overdose and make sure that people do not have a second overdose which might be fatal.

So there's a lot of data that needs to happen behind that to enable first responders, hospital ERs and others to take the first event of an overdose extremely seriously and prevent that from progressing further and capture and get those people the help they need.

>> SANDRO GALEA: Thank you. Let me ask you two more questions. As you know, our School of Public Health is located in Boston, which lately has been in the news locally and nationally because we are at the epicenter of an area where a lot of people who are struggling with homelessness, substance use disorders, are living. Can you talk us through what role the ONDCP plays in helping with challenges like this and how you intersect with state and municipal governments?

>> RAHUL GUPTA: Absolutely. So, the dollars we talked about, Congress appropriates the money across various grants and programs and we oversee the policy and the implementation of those dollars through various agencies.

Now, those dollars often will go to the Department of Health in Massachusetts, Department of Housing and Urban Development, Transportation, and others. Our role is to coordinate that work in a way that it can be effective. So when it comes to particular areas it becomes very important to take an approach that addresses both the supply side but also the demand side.

We often see -- we've seen data in the areas of Chicago where the heat maps overlap, which means gang activity and overdoses. That allows us to say that we can prevent a number of

overdoses by surging naloxone into those areas. That goes back to understanding the data in particular areas and working to remove whether it's the unhoused population, whether it's the other challenges in treatment and get people that help.

So we work with both city mayors as well as governors and administrations across the country. And really are there to support any initiatives, plans, but also to share the data in a way that it could be helpful. I'm aware of the maps. I have two children who have graduated from Boston, so I understand a lot of that. I think it's important, because these are the challenges that we face in cities all across the nation. And that's why a comprehensive approach is so critical.

>> SANDRO GALEA: Let me ask you a question, you mentioned children graduating. Let me ask you a question about workforce. You hinted about this in your presentation. We are tremendously under-resourced in the workforce that is able to deal with substance use disorders. When I talk to my colleagues running clinical institutions, they're always running dozens and hundreds of people short who are able to provide services.

What's ONDCP's role, what's ONDCP doing to address that? What should we be doing, those of us who are in the academic public health space to try to address this challenge?

>> RAHUL GUPTA: It's a real challenge. And I think one of the things we have to look at is, you know, we've expanded the loan repayment programs, the fellowships to HRSA. But the challenges are greater than just providers, it's about counselors, social workers, the entire teams. Some of that will be helped by telehealth and other aspects of this.

But Congress and the federal government are going to have to figure out how to expand the workforce piece. That's the first piece. We're working on something called the cascade of care model right now to understand how can we first of all get people to have some version of a universal screening for addiction and then help them get into a primary care problem. I think the schools can do a great bit by introducing consistently addiction curriculum or SUD curriculum into health-related professions, because that gets more and more students interested in following career paths that could be not only rewarding, but also important to the workforce of the nation when it comes to being able to help.

>> SANDRO GALEA: Thank you. Let me go to some questions from the audience. We have about 30 questions. There's a few questions, all complimenting you and ONDCP for the work that you've done to make methadone treatments more available in Black and Brown communities and asking the question around stigma. Your thoughts and also any actions that are taken, can be taken to reduce the issue of stigma for these medications,

particularly in minoritized communities.

>> RAHUL GUPTA: That's an important question. That is exactly right that in some ways, stigma prevails in communities, in families, and also in healthcare. Healthcare systems. I think it's going to be important. That's why we're relooking at the methadone aspect of this. That's why the removal is important, of the X waiver. Part is policy, but part has collateral benefits, which is it helps to mainstream disease and its treatment, not unlike what we have done with other diseases in the past, whether it's cancer, HIV, or others.

It is really important that we work both with the healthcare system when it comes to stigma, education and curricula when it comes to stigma, and then, of course, walking the talk. One of the things that in the present budget that is right now in Congress is working to remove the name -- stigmatizing names like National Institute for Drug Abuse or SAMHSA, Substance Abuse Mental Health Administration. Some of those terms we're working to remove so they send a clear signal to us in the country and outside the country that we are serious about this.

Stigma is a deep thing that winds up killing people, preventing them from getting treatment.

>> SANDRO GALEA: Thank you. I couldn't agree more about language and stigma. For anybody who's interested, Rich, our late Chair Cough Community Health Science, wrote key papers around stigma around language. Let me take another cluster of questions. This one is harder. A number of people challenge the assumption that disrupting supply chain and reducing supply actually will have much of an impact on substance use and substance use disorder, making the argument, a reasonable argument, that you block supply chain on one drug, it will result in other drugs that enter the drug supply. I'm wondering about your thoughts on that.

>> RAHUL GUPTA: I've spent a lot of time looking at this, and a lot of information and data, and perspectives. What it comes down to is that people -- oftentimes Americans, because this is not always a problem elsewhere -- think with one pair of glasses only oftentimes. There are people that are on the supply side, or there are those who are exclusively on the demand side.

And just like any complex problem, this is one that we should look at it as two sides of the same coin. Not that we need to -- it's been said before, we need to be able to walk and chew gum, which is not, sort of, put ourselves in a position that if we do that, the other will be defeated.

To give an example, ONDCP's budget used to be 90% supply and 10% demand. The President has proposed $46 billion, 57% is demand side. And the rest of it is supply side. It's important

to show money where you are making your investment. A lot of those investments are going into the demand side part, it saves lives. At the same time, we must understand it is not about supply. It's about why this is happening.

That's not about a particular drug, it's about why that is happening. And when you cut through all of the, sort of, you know, products and you understand, it's actually in commerce. It's a business. That business will not stop. You have to figure out how to disrupt that business, that commerce, because it's about profit and it's about operating capital.

So that's why our shift in supply side now has moved and focused more of disrupting the commerce rather than exclusively locking people up. And that's where I think it's really important to understand. The people who have had an aversion to the supply side is because we've had an approach of locking people up for substance use disorder. That is not what we're advocating for.

>> SANDRO GALEA: That's a helpful distinction. A question talking about the WHO, UN methadone treatment goals, more than 50% of people treated with methadone. Most European countries have surpassed this. We're in the 25% range. Can you comment on why that discrepancy and what you can see us doing to actually get to where many other Western European country are?

>> RAHUL GUPTA: So I think we are far behind for a good reason. Part of this has been our approach to substance use disorder. Part has been our policies towards this issue. Part of it has been our healthcare system not being resourced enough to get people the help. And we showed the data for that. What we have to do now is to move forward. And that's why I say a data-driven approach, because if that's where our data is taking us, that we need to get people the help whenever they need it, meaning that if someone at 2:00 a.m. feels that they need to get into a treatment center and they call and we give them an appointment three months later, it doesn't work that way.

That's a harm reduction approach. We have to find a way to help that person right then and there. And with those medications that they need. We're thinking from that lense moving forward. And I think we're going to probably end up getting closer. Maybe not surpassing the European model, but getting closer than we've been in the past in terms of expanding treatment and getting people real-time help when they need it.

As I said, we can't afford not to do that any longer, because as I mentioned we're losing a trillion and a half dollars, the equivalent of Russia's economy every year. We're losing workforce. We have some of the lowest work rates on record. It's all of these things coming together when you look at it beyond a four-year cycle. We have to get treatment to

people. We have to develop recovery-friendly workplaces and we have to support the recovery journey of people through a holistic wraparound service approach.

>> SANDRO GALEA: All right. Let me shift to another difficult question. I'm trying to balance more straightforward with harder questions. There's a question about where are we at on having a national conversation about legalization and management of the drug market? It's a really difficult issue, I think. Given the fact that we've talked about harm reduction, it seems worth asking. Where do you think that conversation is at? Where do you think the conversation is headed?

>> RAHUL GUPTA: I think first of all, we're -- as I mentioned, at a stage where we have so many Americans dying. And we know how we can stop. If you just look at the data I provided today, we can save about 46,000 of the 110,000 lives by knowing what to do and doing it. So, this is to me, when it comes to as a physician saving lives, this is not about we don't know what to do. We have evidence and data supporting how we can save 30 to 40% of those at least by just two policy changes.

So that's the first piece. We've got to understand we know what works. We have to ensure and implement it with a sense of urgency. Now, I will say that last fall the President has asked the Department of Justice and the Department of Health and Human Services to use evidence, data and science, to take another look at the scheduling of marijuana and provide the report back.

The reason -- he's done that. That's one part. Second what he did was pardoned people with simple possession of marijuana offense in the federal system. And third, he asked state governors to do the same. Why is that important? Because there's so much disproportionate impact on marginalized communities, communities of color from simple possession of marijuana charge that prevents those individuals from getting an education loan, housing, so many other things.

So we're actually looking at this from, once again, an approach that is passionate. It's evidence-driven. But it's one that we are working with it through science to make best decision possible.

>> SANDRO GALEA: Thank you. Changing track, how are people with lived experience of substance use disorder being centered in the decision-making process at ONDCP and nationally?

>> RAHUL GUPTA: Very significantly. We have people with lived experiences working in my office for maybe the first time. We have people with lived experiences working in the White House. We have regular meetings with stakeholders that includes people with lived experiences to help us. We have done significant and extensive consultations on the strategy that I highlighted with people with lived experiences before we

published it.

So, it's really important to center around that, because a lot of the work we do is informed by folks that have lived experiences, because it's so important to do that.

>> SANDRO GALEA: A different question, Dr. Rosenbloom. We know that buprenorphine in the emergency department saves lives. How can the federal government use this leverage to make treatment initiation in the emergency room a standard of care, for example, as a condition for patients with Medicare and Medicaid?

>> RAHUL GUPTA: Yeah, if there was a way to do this overnight, I would do it.

(Laughter)

>> RAHUL GUPTA: We are working to do everything. We encourage emergency departments. We are working with the leaders who are leading this in some states. Massachusetts, of course, is one of those. And we are doing everything possible to encourage low-threshold induction. And those who are leading the path obviously, we're highlighting the examples. We've also put out a state model law about ED induction so that more and more states can look at that, think about it, and maybe make it part of their policy.

As I said before, it's live-saving. It's the difference between life and death for a lot of people. And while 110,000 people die, there's probably a couple of million people who go through a nonfatal overdose that come through the ED or urgent care that we can capture early and not wait until they have a fourth overdose happen again.

>> SANDRO GALEA: Let me go to a difficult question again from Joe. There's an underlying assumption in your presentation that those who have opioid use disorders want treatment. And I think there is increasing evidence that is not always the case. The Portland experiment suggests that strongly. So, how do we deal with it? How do we think about that? What measures would one think about to help those who do not necessarily want treatment?

>> RAHUL GUPTA: So, let me just expand the lense a little bit. There's literally, you can put folks into three categories. Those who are perhaps casual users and they feel that it's not an SUD but they have things under control. There are those who order online what they think is Xanax or Adderall and actually end up overdosing, sometimes fatally because it's a counterfeit pill. And then there are those who have true SUD, we can all agree with the DSM criteria.

So, now let's move to the ones that have just SUD through the DSM criteria. I think it's important to educate, inform, and engage people with SUD. We would not do this for people with

diabetes, people with heart condition, or hypertension. I wouldn't be fulfilling my oath if I wasn't engaging my patients with diabetes every time to encourage them to do what I'm recommending them to do, or same thing with people who smoke or otherwise.

So I think this is an important piece of recognition that engagement, whether it's through harm reduction or through peer recovery network, or peer support network, or otherwise, the engagement is the key here. And engagement will yield the outcomes eventually, the intended outcomes. So it's not an issue of forcing people into treatment on one hand, but at the same time, it's not about meeting people where they are and then leaving them there, because that's not humane nor something that aligns with a lot of the practice of good medicine.

>> SANDRO GALEA: Thank you. I think the shift to engagement is really excellent. Thank you. A question from Dr. Pak commending you on your focus on justice-involved populations and commenting that many law enforcement officials are reluctant to make methadone available. What are policy levers to speed the adoption of these evidence-based practices?

>> RAHUL GUPTA: I have to first say that one of the surprising things that often doesn't get talked about in the public health community is the shift that is happening in law enforcement to also recognize addiction, SUD as a disease. And law enforcement officers, the ones I've met with are tired of incarcerating and putting people behind bars for a disease. I think we have to take advantage of that.

We have to make sure that the law enforcement community becomes a partner, not an adversary in addressing it. So that's the first commentary I wanted to make. It's a huge opportunity for public health communities to be able to make progress here with an area which has been tough and difficult over decades. But I will say, when I look at this criminal justice arc, the arc starts at deflection.

We put a deflection model in state law out. There's a thousand deflection programs across the United States. If someone has a mental condition and they are caught, the best practice is to get them help, whether it's food security, housing, other things rather than incarcerating. So deflection or diversion is such an important piece of justice.

Second is of course, while in custody, to get people treatment. And then, the fourth part is re-entry, making sure they have the help they need. Now, policy-wise what needs to happen is we have about 15 or 16 states that have already applied for the 1115 Medicaid waiver to start Medicaid 90 days before release from jail or prison in the state.

Two of them have been approved already, California and

Washington. It's been both blue states and red states. I would love to see literally all 50 apply. I would love to get everybody to have that ability to get treatment, because that will be a significant game-changer for both not only not spending taxpayer dollars in funding prison systems, but also in people becoming much more productive post-release and not be subject to overdose or re-incarceration.

>> SANDRO GALEA: Thank you. Just a note that just last week, Boston University hosted the annual meeting of the police-assisted recovery initiative. And several people who are on this call have been involved in starting PARI. That group has been doing outstanding work in bringing law enforcement to engage in dealing productively with the opioid epidemic. There are groups like that have been paving the way for a more productive way to engage law enforcement.

We're almost running out of time, so I'll end with my last question. You're dealing with an epidemic of overdose, overdose deaths, as you've said several times. For every death there are more other injuries. And some days I feel like the substance use and substance use disorder crisis feels intractable. You deal with this every day. What gives you hope?

>> RAHUL GUPTA: I just want to mention, first of all, about PARI. PARI is a fascinating organization and I'm glad that you are partnering and there are people here on there, because they are champions on that. When it comes to hope, here's what gives me hope.

I've spent a lot of time treating people. I've also been to a lot of funerals of people who didn't make it. I really believe that behind these numbers are actual people and behind people are families. And now we're coming towards holidays. There are going to be a number of empty chairs around dinner tables which cannot be and will not be filled because a mom would say to me only if I knew that naloxone was there I would have saved my child's life.

It is so painful for her to say that. And it's so painful for me to hear that. And so it gives me hope that if there's one more we can prevent, one person we can save, every one of us today can save one person, that's going to be hundreds of people. And that's the hope of prevailing goodness and making sure that we're taking a point of compassion as opposed to one of judgment and trying to help a fellow person in their time.

I think we can do it. I really believe that we can bring these numbers down significantly. I think we can have an impact. If there's more chairs at the next holidays that are filled, you know, we all like to be a small part of that. This is nothing -- not an issue that only one agency, one person, one institution can do. This is one that is part of President Biden's unity

agenda for a reason. All of us have a role to play.

And only if all of us work on this issue can it be solved.

>> SANDRO GALEA: There's no better way to end this conversation than on a note of compassion and hope. Dr. Gupta, thank you for everything you do every day. I'd like to thank the participants in this conversation who are engaged, many questions in the Q&A, many comments in the chat. I know these conversations draw participants who engage in these issues on a daily basis and I feel strongly that it requires a whole community of experts, people with lived experience, people who are interested in the issue to advance us on the hardest issues we deal with.

Everybody, thank you once again for being a part of this. Thank you for what you do every day. Everybody, take good care. Have a good day.

>> RAHUL GUPTA: Thank you.

(Session concluded at 2:00 p.m. ET)

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