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Controlled Substances: Federal Policies and Enforcement
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Subcommittee on Crime, Terrorism, and Homeland Security

Members of the Committee:

Thank you for the opportunity to submit testimony regarding federal policies for controlled substances. On behalf of the drug policy program at Rice University's Baker Institute for Public Policy, this statement is submitted for the record for the hearing on "Controlled Substances: Federal Policies and Enforcement" on March 11, 2021. The following section provides a brief overview of current trends in drug use and drug policy. This is followed by a discussion of two specific policies, the class-wide fentanyl ban and mandatory minimum sentences. This testimony concludes with policy recommendations for Congress.

Introduction

The 40-year War on Drugs is a policy failure. It is unable to stop the steady flow of drugs into communities across the U.S.; it ignores the complex causes of drug use and fails to provide effective treatment for addiction; it contributes to mass incarceration and violence on our Southern border; it is exceedingly expensive; and it inflicts immeasurable harm on people who use drugs and on minority communities writ large.[1] The overdose crisis, which has occurred alongside the drug war for the last two decades, is the clearest indictment so far of the failure of prohibition to curb drug use. COVID-19 has worsened the overdose epidemic, and 2020 was another record-breaking year for drug-related deaths.[2]

The War on Drugs is first and foremost a war on people. More people are arrested for drug possession than for any other offense in the U.S. Of more than 1.5 million drug arrests in 2019, about 90% were for possession. Roughly 450,000 people are incarcerated for nonviolent drug offenses on any given day. Nearly half (46%) of the federal prison population consists of people convicted of drug offenses. National survey data consistently show that Black people account for about 12% of people who use drugs, proportionate to their population size, but they make up 29% of drug arrests. Forty-three percent of people in federal prison for drug offenses are Black and approximately 60% of people in state prisons for drug offenses are people of color.[3] The federal government has undeniably led the charge in the War on Drugs; harsh policies at the federal level have contributed to punitive, ineffective, and unequal drug policy at all levels of government. [4]

Arrest and incarceration statistics show only one facet of the harms the War on Drugs has caused. It has infiltrated nearly every aspect of the lives it entangles. Involvement in the criminal justice system increases the likelihood of future law enforcement encounters and negatively impacts multiple areas of one's life, including education and employment prospects, parental rights, immigration status, and access to housing and health care. Children whose parents have been arrested and incarcerated for drug offenses incur greater risk for these same negative outcomes in their adolescence and adulthood. Increasingly, public health experts are recognizing the micro- and macro-level adverse physical and mental health effects caused by encounters with the justice system.[5]

Drug use can also cause harm, and since 2013, the presence of fentanyl in the illicit drug supply has exacerbated the overdose epidemic. The number of overdoses involving

synthetic opioids other than methadone, a category dominated by fentanyl, doubled from 2015 to 2016.[6] It is overly simplistic, however, to assume that opioids alone explain the current overdose crisis. Analysis of overdose fatalities over time suggests that such deaths have been increasing exponentially as far back as 1979.[7] Overdoses involving cocaine and methamphetamine have been increasing since 2010, and the majority of overdose deaths involve two or more drugs.[8] Taken together, these trends suggest that the recent sharp increases in overdoses may be a particularly intense manifestation of a more persistent substance use problem, one that U.S. drug policy has done little to address.[9]

Despite this grim overview, there is hope that we are moving toward a more evidence-based approach. The tragedies of the overdose epidemic have forced a reckoning with tough-on-drugs thinking, albeit one made possible only because the epidemic's early victims were predominantly White.[10] Still, any departure from the drug-war mentality is a welcome development. We now find ourselves at an inflection point, where demands for reforms centered on racial justice and harm reduction are up against entrenched prohibitionist policies.

Recent reforms such as the First Step Act and federal funding for expanded access to medication-assisted treatment for opioid use disorder are important steps toward developing more evidence-based drug policy. Other trends, however, are concerning. Drug bans, such as those for fentanyl analogues, continue to play a central role in U.S. drug policy, demonstrating a failure to internalize the lessons of past drug war battles and a misunderstanding of the roots of the current overdose epidemic. Furthermore, while the First Step Act reduced mandatory minimum sentences for people convicted of certain drug offenses, this problematic sentencing structure continues. The next sections address each of these policies.

Limitations of Drug-Specific Measures

Given the overdose-related risks of fentanyl and its analogues, the urge to ban these substances and harshly punish anyone who sells them is understandable, but it is also misguided.

DEA argues that its emergency class-wide ban on all fentanyl-related substances, authorized by Congress in 2018 and set to expire on May 6, 2021, is critical to aiding prosecution of people selling fentanyl who try to skirt federal prohibition by making small tweaks to the drug's chemical structure. But it is not clear that this ban and the additional authority it grants to DEA are actually necessary. An analysis by the U.S. Sentencing Commission found that in fiscal year (FY) 2019 only two cases regarding fentanyl analogues involved substances not already listed in the Controlled Substances Act, and in neither case did the courts appear to rely on DEA's 2018 emergency scheduling order to issue rulings.[11]

Law enforcement agencies often point to the number of drug seizures and prosecutions as indicators of prohibition's importance and effectiveness. By this logic, prosecution of

fentanyl trafficking is working when more cases of fentanyl trafficking are being prosecuted. This rationale is used to justify ever-increasing resources and authority to law enforcement for drug-related interventions, without providing evidence of the efficacy of such policies for reducing drug supply or demand. A 2018 GAO report found that federal law enforcement agencies lacked metrics for assessing the effectiveness of their efforts, concluding that "without specific outcome-oriented performance measures, federal agencies will not be able to truly assess whether their respective investments and efforts are helping them to limit the availability of and better respond to the synthetic opioid threat."[12] If we evaluate fentanyl-related law enforcement efforts using fentanyl-related overdoses as a metric, they are hardly a success; these overdoses continue to increase even as overdoses involving prescription opioids and heroin have leveled off or slightly declined.[13] Recent empirical research has also found that law enforcement seizures of fentanyl are associated with an increase in overdose deaths.[14]

The ease and diversity of distribution for fentanyl and its analogues make any efforts to diminish its supply an uphill battle. In the unlikely event that federal authorities do make significant dents in fentanyl access and supply, people involved in manufacturing and trafficking will adapt by finding a drug alternative that is just as lethal, if not more so. To confirm the high likelihood of this scenario, we need look no further than our current predicament. The spike in overdose deaths, first from heroin in 2010 and then from fentanyl in 2013, are a direct consequence of prohibition generally and can be tied specifically to government efforts to reduce the supply of prescription opioids in the early 2000s.[15]

Extending DEA authority to issue class-wide fentanyl bans, then, is not benign. Not only might such bans have the unintended consequence of further increasing the risks related to illicit opioid use, but this practice also increases the authority of an agency whose mission is the pursuit of drug arrests without regard for the evidence of the harms and ineffectiveness of this approach. Zealous pursuit of drug offenses, along with policies that incentivize this behavior such as civil asset forfeiture laws, widens the net of people who encounter the justice system and are subsequently arrested, convicted, sentenced, and continuously monitored by it.

There is also abundant evidence that aggressive law enforcement tactics are used disproportionately against minorities. One particularly egregious example is DEA's reverse sting operations, in which the agency invents nonexistent drug stash houses, purported to have drugs and money, in order to tempt individuals to rob them. DEA then arrests these individuals for crimes related to the attempted robbery. Between 2009 and 2019, all but two of 179 people arrested in DEA reverse sting operations in New York City were Black or Latino. Analysis of data from anti-drug operations using fake stash houses in other major cities show that stark racial disparities are a common feature of this practice.[16]

The Futility and Harms of Mandatory Minimums

Like other federal drug policies, mandatory minimum sentences have not been accountable to performance measures. Steady trends in drug availability and use, and increases in overdoses, indicate they have not curbed drug supply or demand. They have, however, been remarkably successful at imposing long prison sentences. In FY 2016 individuals convicted of drug offenses carrying mandatory minimum penalties received an average sentence of 94 months.[17] These laws have been especially efficient at incarcerating Black people. Nearly 65% of Black people convicted of offenses carrying mandatory minimums received the mandatory minimum sentence compared to 51% of White people convicted of such offenses in FY 2016, a disparity that is actually an improvement since FY 2010, when the gap in mandatory minimum sentences across racial groups was significantly higher.[18]

A general rule of thumb for effective deterrence is that the swiftness and certainty of punishment are more important than severity.[19] Mandatory minimum sentences do the reverse, levying severe punishments that are highly uncertain and unevenly enforced. Furthermore, while mandatory minimums may be meant to focus on "drug traffickers" rather than "drug users," these distinctions often are not possible. Many people who use drugs also sell them and an analysis using data from the National Survey on Drug Use and Health found that 43% of people who said they sold drugs in the previous year also met criteria for a substance use disorder.[20]

The amounts of drugs that trigger mandatory minimum penalties are also a poor indicator of a person's role in a drug selling operation.[21] The arbitrariness of mandatory minimum trigger amounts and the wide discretion law enforcement has over how to determine that a person is selling drugs, increase the ease of prosecuting people for drug sales and the likelihood that individuals who have substance use disorders or who are members of minority communities already subject to government surveillance will become ensnared in this process.[22] The mandatory minimum sentence of five years for anyone convicted of possession of the relatively low amount of five grams of crack cocaine, established by the Anti-Drug Abuse Act of 1986 and enhanced by legislation of the same name two years later, is a prime example of uninformed policymaking with disastrous consequences that disproportionately affect Black communities.[23]

Despite ample evidence that mandatory minimum penalties are unrelated to drug supply, demand, and overdose deaths, support for them lingers, and they are routinely imposed, despite increased deviation in recent years. In FY 2019, more than 50% of people convicted of fentanyl and fentanyl analogue offenses received mandatory minimums and 66% of people convicted of other drug offenses received such penalties. Forty-five percent of people convicted of drug offenses that year (excluding fentanyl and analogues) had little to no prior criminal history, calling into question the narrative that the people convicted under these laws are long-term "career criminals."[24]

The data also contradict law enforcement claims that long sentences are essential to keeping "violent traffickers" off the street. Sixty-seven percent of people charged with offenses relating to drug trafficking for fentanyl and its analogues in FY 2019 were at the

level of a street dealer or below.[25] Any vacancies in these positions in an organized drug selling operation will be quickly filled. And while harsh penalties and zealous enforcement are unable to eradicate drugs or people who sell them, they may disrupt street-level supply just enough to increase the risks associated with drug use, since removal of a trusted source of drugs will force people who use drugs to turn to unfamiliar sources for their supply.[26]

Policy Recommendations

I. Enact reforms that reduce law enforcement interventions and other punitive measures towards people who use drugs.

National drug law reform is essential for reducing the federal prison population and for providing states with a blueprint for effective policy change. The most comprehensive measure Congress could take would be to decriminalize possession of all drugs for personal use. This would effectively remove penalties for drug use and possession and free up resources to devote to more productive initiatives that reduce drug-related harms. Given the political hurdles that may delay this proposal, Congress can take several more immediate steps to reduce harmful and ineffective drug policies:

1. Repeal or significantly reduce mandatory minimum sentences for drug offenses and repeal the crack/powder cocaine sentencing disparity. Restore judicial discretion in sentencing decisions and consider making factors other than drug quantity the primary metrics in sentencing decisions.[27]
2. Restructure grants to law enforcement agencies so that funds are not based on arrest volume, but instead incentivize development of arrest alternatives, such as pre-arrest diversion programs like LEAD and crisis intervention response teams.[28]
3. Bar discrimination and denial of benefits in areas including but not limited to employment, healthcare, housing, immigration, and education based on prior convictions for low-level drug possession. Amend the Drug-Free Workplace Act so that it applies only to people whose work involves hazards to physical safety.
4. Amend or repeal provisions of the Child Abuse Prevention Treatment Act and the Adoption and Safe Families Act that require and incentivize states to remove children from their homes and terminate parental rights on the basis of substance use alone. Redirect funds to community-based treatment and family services.[29]
5. Improve nationwide data collection on race and ethnicity of people involved in stops, arrests, and use of force incidents related to drug use and possession.

II. Facilitate expansion of harm reduction and evidence-based treatment services.

National survey data consistently show that not all drug use is abuse, and that most people who get into trouble with any substance recover from it, many on their own without treatment.[30] The recent preference for treatment over incarceration for people who use drugs is encouraging, but not all people arrested for drug offenses need treatment; assuming they do or mandating participation wastes scarce resources and threatens to widen the net of people under government surveillance for using drugs.

For people who do have substance use disorders, resources must be available to reduce use-related harms. The federal government can take several measures to facilitate evidence-based practices:

1. Remove the federal funding ban on syringe service programs and authorize localities to establish safe consumption sites.[31]
2. Encourage states and localities to provide comprehensive harm reduction services that include supportive housing, safe consumption sites, and syringe and drug testing services by providing grants for these purposes.[32]
3. Rather than focus reduction efforts exclusively on opioids, authorize funding to treat substance use more broadly, including harm reduction services for people who use alcohol and stimulants.[33]
4. Make permanent the lower barriers to medication-assisted treatment (MAT) access that are in place temporarily due to the COVID-19 pandemic.[34]
5. Provide funding for MAT to state prisons and local jails to include all three FDA-approved medications.[35]
6. Authorize pilot programs for heroin-assisted treatment.[36]
7. Enforce parity laws requiring insurers to provide equal coverage for mental health and substance use disorder treatment.

III. Remove cannabis from Schedule I of the Controlled Substance Act and implement measures to alleviate the damages of cannabis prohibition.

Even though the majority of Americans now live in a state where cannabis is legal for some purposes, it remains a Schedule I substance in the Controlled Substances Act, and DEA continues to insist that it has "a high potential for abuse" and "no currently accepted medical use in treatment in the United States." The first assertion is exaggerated; the second is simply false. Removing cannabis from Schedule I is necessary both to facilitate sorely needed medical research and to decriminalize cannabis possession.

The federal government has allowed state experimentation with cannabis policy reform, and many states have now decriminalized possession or legalized sales. But these efforts often do not consider racial equity. Nationally, Black people are still 3.64 times more likely to be arrested for possession, a disparity that has remained constant since 2010 despite several states' loosening restrictions since then. [37] There were over 500,000 arrests for cannabis in 2019, mostly for possession, indicating that the war on marijuana continues.

Burgeoning state cannabis industries are dominated by White men, excluding minorities from the benefits of legalization.[38]

Cannabis reform ultimately requires national leadership. The federal government is the only entity that can remove cannabis from the list of Schedule I controlled substances, allow more scientific research, and give banks legal cover to provide cannabis-related business loans. Measures such as those contained in the MORE Act, including establishing a process for expungement of past cannabis convictions, prohibiting the denial of public benefits and immigration protections on the basis of cannabis-related activity, establishing grant programs to fund services and assistance in communities impacted by the drug war, and improving data collection on the cannabis industry and enforcement of current cannabis laws, are all critical to improving racial and social equity.[39] Congressional action on these issues is important for federal policy reform, and it will also have a powerful impact on state-level policy decisions.

Concluding Comments

One of the many collateral consequences of the War on Drugs is that a large segment of the American public distrusts the intent of U.S. drug policy and the information on drug use that the government provides. In this way the government's drug war has likely impeded its own efforts to reduce demand for drugs through education and prevention programs. Substantive policy reforms like those discussed above thus are crucial to restoring public faith in government and to developing long-term strategies to reduce drug demand.

Policies intended to reduce problematic patterns of drug use must address systemic issues underlying these problems, such as the loss of jobs that provide a livable income, the lack of adequate health care coverage for all ailments and for mental health in particular, and the increasing sense of isolation from community and civic life felt by so many people. [40]

The COVID-19 pandemic adds another layer of complexity to drug-related problems and societal ills by reducing access to drug treatment and intensifying the conditions which contribute to drug addiction—increased unemployment, strained health-delivery systems, limited support services, intensified distrust of government, and frayed social connections. The negative effects of these problems, felt most acutely at society's margins, significantly impacts public health and quality of life for all Americans.

Government policies cannot solve all of the problems that may drive a person's desire to escape an unpleasant reality through drug use, but they can improve current conditions. Doing so will require increasing social and economic opportunities that make heavy drug use less appealing. This involves a significant investment, but one that is necessary to reduce drug-related deaths and addiction in the future.

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[1] See William Martin and Katharine Neill Harris, 2021, Drug policy priority issues for the Biden administration, Issue Brief, Rice University's Baker Institute for Public Policy, https://www.bakerinstitute.org/research/drug-policy-priority-issues-biden-administration/

[2]Joan Stephenson, 2021, CDC warns of surge in drug overdose deaths during COVID-19, *JAMA Network*, January 5, https://jamanetwork.com/channels/health-forum/fullarticle/2774898
[3] E. Ann Carson, 2020, *Prisoners in 2019*, U.S. Department of Justice, Bureau of Justice Statistics, https://www.bjs.gov/content/pub/pdf/p19.pdf
[4] For example, when Congress passed the Anti-Drug Abuse Acts of 1986 and 1988, ratcheting up penalties for crack cocaine, states followed suit. After Congress passed the Fair Sentencing Act in 2010, raising the amount of crack that triggers the mandatory sentences and thereby reducing the sentencing disparity for crack and cocaine from a ratio of 100 to 1 to 18 to 1, many states did the same.
[5] For a more detailed discussion of the health impacts of carceral systems, see the January 2020 special issue of American Journal of Public Health, https://ajph.aphapublications.org/toc/ajph/110/S1
[6] National Center for Health Statistics, Data Brief 294, Drug overdose deaths in the United States, 1999-2016.
[7] Hawre Jalal et al., 2018, Changing dynamics of the drug overdose epidemic in the United States from 1979 through 2016, *Science,* September 21, https://science.sciencemag.org/content/361/6408/eaau1184
[8] Holly Hedegaard et al., 2018, Drugs most frequently involved in drug overdose deaths: United States, 2011-2016, *National Vital Statistics Report,* 67 (9), December 12.
[9] Katharine Neill Harris, 2018, The drug overdose epidemic: not just about opioids, Issue Brief, Rice University's Baker Institute for Public Policy, https://www.bakerinstitute.org/research/overdose-epidemic/
[10] William Martin and Katharine Neill Harris, 2016, Drugs by the Numbers, Issue Brief, Rice University's Baker Institute for Public Policy, https://www.bakerinstitute.org/research/drugs-by-numbers/
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[12] Government Accountability Office, 2018, *While greater attention given to combating synthetic opioids, agencies need to better assess their efforts*, https://www.gao.gov/assets/gao-18-205.pdf
[13] Centers for Disease Control and Prevention, 2021, Opioid data analysis and resources, https://www.cdc.gov/drugoverdose/data/analysis.html
[14] Jon E. Zibbell, et al., 2019, Association of law enforcement seizures of heroin, fentanyl, and carfentanil with opioid overdose deaths in Ohio, 2014-2017, *JAMA Network*, November 8, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2754249
[15] Neill Harris, The drug overdose epidemic, note 9
[16] Shayna Jacobs, 2019, 10 years. 179 arrests. No white defendants. DEA tactics face scrutiny in New York. The Washington Post, December 14, https://wapo.st/3t2BYX1
[17] U.S. Sentencing Commission, 2018, *Federal drug mandatory minimum penalties,* Report-at-a-glance, p.1, https://www.ussc.gov/sites/default/files/pdf/research-and-publications/backgrounders/RG-drug-mm.pdf
[18] Id. In FY 2010, 59.5% of Black people eligible for mandatory minimum drug sentences received them, compared to 39.3% of White people.
[19] National Institute of Justice, 2016, *Five things about deterrence*, U.S. Department of Justice https://www.ojp.gov/pdffiles1/nij/247350.pdf
[20] Evan Stanforth, et al., 2016, Correlates of engaging in drug distribution in a national sample, *Psychol. Addict. Behav., 30*(1), https://pubmed.ncbi.nlm.nih.gov/26502336/
[21] Lindsey Lawson Battaglia, 2015, Will the U.S. Senate finally reform harsh mandatory minimum sentences for drugs? Drug Policy Alliance, March 15, https://bit.ly/3t1fvts
[22] Drug Policy Alliance, 2019, *Rethinking the 'drug dealer',* https://bit.ly/3bvQPna
[23] The mandatory minimum trigger amount for powder cocaine, more commonly associated with White drug users, remained unchanged, at 500 grams. For fuller discussion of race and the drug war see Doris Marie Provine, 2011, Race and inequality in the War on Drugs, *Ann. Rev. Law Soc. Sci., 7*, 41-60.
[24] U.S. Sentencing Commission, see note 11.
[25] Id.
[26] Blythe Rhodes, et al., 2019, Urban, individuals of color are impacted by fentanyl-contaminated heroin, *International Journal of Drug Policy, 73,* https://www.sciencedirect.com/science/article/abs/pii/S0955395919301860; Jennifer J. Carroll, et al., 2020, The protective effect of trusted dealers against opioid overdose in the U.S., International Journal of Drug Policy, https://pubmed.ncbi.nlm.nih.gov/32143185/ ; Also see DPA, note 22.
[27] Ram Subramanian et al., 2020, A federal agenda for criminal justice reform, The Brennan Center for Justice, December 9, https://bit.ly/2OgeAXl ; Criminal Justice Policy Foundation, Mandatory minimums and sentencing reform, https://www.cjpf.org/mandatory-minimums .

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[31] For more information on syringe service programs, see William Martin, 2017, *Syringe Exchange: Sound Science, Proven Policy*, Baker Institute for Public Policy, Issue Brief 03.09.17, https://www.bakerinstitute.org/media/files/files/3f4e6675/BI-Brief-030917-DRUG_SyringeExch.pdf

[32] Housing is a key component of curbing harmful drug use; in November 2020 Oregon voters approved a measure that will use tax dollars from legal cannabis sales to fund comprehensive treatment and harm reduction services, including supportive housing, see Oregon Measure 110, Estimate of Financial Impact, https://bit.ly/2WcUSvP. British Columbia, which opened the first safe consumption site in North American, has started to offer residents safer alternatives to street drugs to help reduce overdoses, see https://www.theguardian.com/world/2020/sep/16/british-columbia-opioids-safer-supply-drugs-canada . For information on efficacy of safe consumption sites, see Jennifer Ng et al., 2017, "Does evidence support supervised injection sites?" *Can Fam Physician*, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5685449/. For information on efficacy of drug testing services, see Nicholas Peiper, "Fentanyl test strips as overdose prevention strategy," *International Journal of Drug Policy*, https://www.sciencedirect.com/science/article/pii/S0955395918302135 .

[33] Substance Abuse and Mental Health Services Administration, 2016, *State targeted response to the opioid crisis grants*, December 14, https://www.samhsa.gov/grants/grant-announcements/ti-17-014; Puja Seth et al., 2018, Overdose deaths involving opioids, cocaine, and psychostimulants—United States, 2015-2016, *Morbidity and Mortality Weekly Report* 67(12), 349-359, https://www.cdc.gov/mmwr/volumes/67/wr/mm6712a1.htm.

[34] DEA and SAMHSA relaxed rules regulating prescribing methadone and buprenorphine in response to the COVID-19 pandemic; these changes have the added benefit of increasing treatment access for people who live in rural locations or are without transportation. See https://www.samhsa.gov/sites/default/files/faqs-for-oud-prescribing-and-dispensing.pdf

[35] The Department of Justice funds MAT for prisons, but there is a strong preference for the opioid antagonist Vivitrol over methadone and buprenorphine, the other two FDA-approved medications to treat OUD. Best practices recommend that all three be made available to fit patients' individualized needs. Rhode Island was the first state to offer all three MATs in its correctional system; for an evaluation of that program see Traci Green et al., 2018, "Postincarceration fatal overdoses after implementing medications for addiction treatment in a statewide correctional system," *JAMA Psychiatry*, https://pubmed.ncbi.nlm.nih.gov/29450443/ .

[36] Several high-quality studies have shown that heroin-assisted treatment for chronic opioid uses who do not respond well to other forms of MAT can result in higher rates of treatment retention, reduced spread of blood borne viruses, reduced criminal activity, and lower risk of incarceration. See M. Ferri et al., 2011, Heroin maintenance for chronic heroin-dependent individuals, *Cochrane Database of Systematic Reviews*, https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD003410.pub4/full and Jens Reimer et al., 2011, Physical and mental health in severe opioid-dependent patients within a randomized controlled maintenance treatment trial, *Addiction*, https://pubmed.ncbi.nlm.nih.gov/21489005/ .

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[39] https://www.congress.gov/bill/116th-congress/house-bill/3884

[40] Michael J. Zoorob and Jason L. Salemi, 2017, "Bowling alone, dying together: The role of social capital in mitigating the drug overdose epidemic in the United States," *Drug and Alcohol Dependence* 173, (1), 1-9, https://www.ncbi.nlm.nih.gov/pubmed/28182980.