

Sam Quinones' Testimony
U.S. Senate Committee on Health, Education, Labor and Pensions
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WRITTEN TESTIMONY

As politicians, the natural response to a crisis like this is to look about for things you can do quickly, to show constituents you're taking action.

I would caution, however, against acting too quickly, and especially in believing only in short-term responses to this problem.

Everything I've learned about this issue has taught me the importance of long-term, community responses to this problem.

CARA and the CURES Act make up a good start, but they are only a start.

I think we, as your constituents, ought to be humble, remain aware that this has festered for more than two decades, though most of the country awoke to it in the last two years. We need, as your constituents, to be patient, and not demand perfection or quick fixes. That's what got us into all this in the first place – demanding quick fixes for the complicated problem of what to do about the mysteries of human pain.

I believe, too, we run into trouble when we attack one drug problem in isolation – and then are surprised and unprepared when the next one emerges.

Thus several of the ideas I've included here - that I've seen, or been told about as a reporter on this topic -- are those that I suspect might have utility for years to come, regardless of the kind of drug we encounter today, tomorrow, or in a decade.

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As I said in my oral testimony, I believe we have in American history two templates for addressing this problem: the Marshall Plan and the space program.

Each involved government and the private sector, acting in concert over many years – bringing money, brains, energy, and focus to bear. Each achieved an unalloyed good for our country.

A Marshall Plan for American Recovery would fund new drug treatment capacity, vastly increase research into addiction and pain treatment, expand law enforcement efforts, especially on the Internet, give incentives to counties transforming jails into recovery units, expand the use of medically assisted treatment, and provide money for coroners in small counties.

It would also focus just as much on reviving those regions that have been caught in dependence on dope and ravaged by economic devastation. It might include a large and sustained federal investment in infrastructure. These are Rust Belt areas, Appalachia. But also of parts of Maine and Vermont. Of the Central Valley of California, and the Rio Grande Valley of Texas. They are parts of Mississippi and Alabama, the inner cities of Baltimore and Chicago, but also rural areas of New Mexico, Kansas, and Oklahoma.

I suspect, by the way, that increased investment in addiction and pain research has the chance to transform some of these areas and be a detonator of economic development over many years.

One such area is the Ohio River Valley, including the states of Ohio, Kentucky and West Virginia.

They possess a constellation of great university medical centers at Ohio State, Cincinnati, Kentucky, Louisville, and West Virginia. At Shawnee State (Portsmouth), Northern Kentucky (Covington), Marshall (Huntington) universities, enrollments are swelling with recovering addicts studying social work and addiction counseling. These students could provide eager workers in these studies. In some areas, abundant cheap real estate could house these studies over many years. They also have thousands upon thousands of addicts – active and recovering – who could be the subjects of these studies.

This region could be a world center for the study of addiction - one of humankind's most persistent torments. Boston is the center of study of cancer and blood – to the great benefit of that area, and the world. Addiction, in all its forms, afflicts far more people than does cancer.

Regional cooperation is key. One state alone, one sub-region alone, one school alone, probably couldn't achieve the synergies and the political pull needed. State and local government would have to work together toward this future. Folks at those medical centers would have to get know each other, cooperate on studies and leverage their research abilities.

Again, a community approach to achieving this idea -- leveraging brainpower of like-minded people and regions. Six senators and a dozen or so congressmen could form an Addiction Research & Solutions Caucus to expand federal research grants. Add to that three governors, several college presidents and many researchers. That's an impressive lobby, seems to me.

This area as a center for addiction study would invite not just dollars but educated people to a region that has seen a lot of both depart over recent decades. Yet the benefit goes deeper. A recovering addict is more than a person who no longer does dope. A recovering addict discovers new energy for the possibilities of the future, with gratitude for a second chance. Harnessing that, I believe, is crucial to defeating not only this epidemic but also the fatalism and inertia on which dope feeds. The more research funding that's out there, the more those recovering addicts could be employed in those studies, channeling their new-found energy.

So I'd urge you as federal elected officials to be aware of the development potential in such multi-year research grants. I'd also suggest you contact Sue Ott Rowlands, who is the provost at Northern Kentucky University and has organized the Ohio River Valley Addiction Research Consortium, and events around this idea.

SUPPLY

Prevention should be an important focus.

But in this case, that means reducing supply.

Supply has ignited all this. We did not have this demand, this widespread addiction, until we unleashed on the public a large supply of new, powerful, legal narcotic painkillers, indiscriminately prescribed in large quantities over more than two decades.

Education is so important, but we should recognize that it doesn't have much effect on an addict once she's enslaved to the morphine molecule.

If you want to reduce demand, you need to reduce supply.

Less access means fewer new addicts starting down that path. There's a reason alcohol is the country's most abused drugs – it's also the cheapest and most prevalent. I think we hide our heads in the sand when we don't realize the effect in all this of massive supply – first pills, now also heroin and fentanyl.

Very importantly, there's no way to really increase the chance of success of an addict coming out of treatment without reducing the supply on the street, that now batters him with massive and plentiful amounts of opiates in various forms as soon as he gets back to his hometown.

We may not be able “to arrest our way out of this,” but it's not clear to me that we can treat our way out of this, especially if the supply of highly potent and now cheap opiates in various forms remains so prevalent.

Much of what's been done up to now in certain parts of the country seem to me like good ideas: Reducing the amounts of drugs prescribed for acute post-surgical pain, or by emergency rooms.

I'm a layman but no one has yet explained to me a satisfactory medical reason for prescribing 30-60 days worth of pain pills for the acute pain from routine surgery that should last only 2-4 days. Often, though, that's done because doctors don't want to see a patient again, and won't get reimbursed for another visit by that patient. So they prescribe large amounts of these pills right from the start. Many patients only use a few of them. But what happens to the pills that remain is the big question. But often, from my research, they end up in the black market, or misused in some way.

Some states have used statutes to do curtail excessive prescribing for post-surgical acute pain.

But I think this problem could be further -- and perhaps better -- addressed by pushing insurance companies to reimburse for these (relatively few) second visits, and certainly to reimburse for a far broader array of pain strategies that do not involve opioids. Then doctors might feel more comfortable in prescribing far fewer of these pills after routine surgery.

As a country, it seems to me, we still, even now, prescribe far too many of these pills far too often and in far too great a quantity at a time. By the end of 2016, prescribing was dropping nationwide. Even so, more than 214 million opioid prescriptions were written that year. That's only just below the number for 2006 and remains far above – nearing triple – the prescribing levels for the mid- and late-1990s. Moreover, it remains very high in many specific regions and counties.

It appears that these pills remain the pain strategy of choice for doctors in so many areas, largely I'd bet because these physicians don't have much training in anything else and/or can't get insurance reimbursement for much else. Dentists still seem to prescribe far too many of these pills after wisdom-teeth extractions.

It doesn't surprise me, therefore, that those states that expanded Medicaid also see an increase in overdoses. Too often, my hunch is, new access to health care still means too much access to opioid painkillers – again too much supply.

It's still just too easy for doctors to dispense a pill; too many patients demand it, too few reimbursed alternatives exist.

That means that too many pain patients have not been given ample access to competing, non-opioid pain alternatives. One chronic-pain advocate told me that when it comes to these pills they face all-or-nothing scenarios. “There are multiple options out there besides opioids,” he told me. “[But] not prescribing is as bad as

overprescribing. Sometimes we need those pills to even be able to get out of bed to go swimming or go to acupuncture. We don't want all or nothing. We want that balance.”

Indeed, balance is the key, seems to me, a holistic approach – again, think of it as a community approach – to one individual's pain. That is precisely what we've not seen from doctors, nor from what insurance companies reimburse for, for many years.

As I travel, I encounter, however, good news on this front.

Veterans Administration hospitals led the country into this epidemic and are now leading it out of it. The V.A. has installed new pain clinics around the country where patients can now get yoga, acupuncture, cognitive behavioral therapy, and much more.

Another two places I'd point you to are Community Care of West Virginia in Bridgeport, WV, and Kaiser Permanente in Southern California. Both are returning to multi-disciplinary approaches to pain – involving many therapies and, importantly, patient accountability and participation in their own care – to treat chronic pain.

Changes in medical-school curricula are crucial here. Young docs need more education in pain and addiction treatment. You, as senators, might want to ask medical schools in your states how they're coming in adjusting curricula, and if they haven't done so, why not. I don't think you should underestimate your own public profile as a lobbying tool.

I'd suggest reviewing whether patient evaluations of doctors (in Medicaid/Medicare) serve a purpose, or whether what they really serve to do is push doctors to prescribe more of these pills, which is my distinct understanding, in talking with physicians. These evaluations don't seem to add much knowledge or data.

Let me add this: This does not mean just cutting off people on high doses of these drugs, and leaving them to fend for themselves. That is cruel and pushes them into the black market. I think we might do well to consider that there may be people out there for whom some dosage of these pills will have to be lifelong companions. That these pills are the only solution they've found in a lifetime of searching. That getting them off will do more damage than good.

That's a doctor's call – not mine. We'd be better off, though, if that call were to come in an atmosphere of widely available, reimbursed non-opioid alternatives to pain, as well as increased education of doctors on how and when they might use these alternatives.

In that regard, I'd mention that I wrote a blog post recently about a federal bust of a heroin delivery service in the San Fernando Valley of Los Angeles. It was known as Manny's Delivery Service. One reader had this to say:

“I was a customer of Manny's and I am sad to see him go. After an accident, I was prescribed painkillers and was fine until I was cut off. I lost my job and then switched to heroin. Everything was fine for almost 15 years, I had a better paying job and no problems. Then Manny was busted. I was too sick to work, and am now on the edge of being fired again.”

One of the achievements of Community Care of West Virginia and Kaiser Southern California is that they don't cut people off. They work with them, as individuals, sometimes over years, to adjust their pain treatment. When they do, opioid painkillers are often part of the mix, albeit in reduced quantities.

My point is this: If all we do is lower pain-pill prescribing without expanding the numbers of pain strategies available for people, and in which doctors are trained, then we'll have created another problem for ourselves.

Law Enforcement

Given what I said above, I believe evidence shows that there is a strong and important role for law enforcement in all this.

In part that's because I believe in a true community of solutions, and most certainly law enforcement is part of the mix – particularly when it comes to attacking mid-level and wholesale level street dealers. They're the ones who'll help in reducing that supply that is now so dangerous to recovering addicts leaving treatment and is such an instigator of addiction.

I would say this, too: I find that it's in law enforcement where we're finding folks most willing to innovate, to change long-held practices and pivot based on new facts. Remarkably so. While it's common to believe that most cops want to arrest people as the solution to everything, I've found that many officers have a vastly different perspective today, one I suspect that has formed in response to what they're seeing in this epidemic.

Courts

One judge in a juvenile court I spoke with noted the wide-ranging problems emanating from this epidemic that jurists now face.

She called for: More resources for targeted law enforcement. More services to support recovering addicts reintegration into the community. More services for families to avoid children being removed. A nationwide prevention campaign, similar to those undertaken to combat smoking, drunken driving, heart disease and lung cancer; the increased use of diversion and Drug Courts of all kinds, support for the frontline folks in law enforcement, emergency rooms, paramedics.

This judge felt strongly about the reauthorization of the Children Health Insurance Program.

As this epidemic has created a crisis in child protective services and foster care, she felt more dollars were needed to help those agencies in counties across the country – something I'll talk more about later.

“Unfunded mandates do not assist anyone,” she wrote, in ending. “Communities across the country are doing their best without dollars. Research can be overwhelmingly helpful for now and in the future.”

Mexico and Another Wall

I lived in Mexico for 10 years, where I wrote my first two books.

More recently, I've spent a lot of time in Tijuana, interviewing old coyotes who ran immigrants across the border from the 1970s to 1994, when the first wall went up between the two countries. That wall, they all agree, put an end to the illegal-immigrant traffic from Tijuana into Southern California, pushing it east to Arizona.

So walls have been a factor – one of several – in slowing the arrival of illegal immigrants in recent years.

As a reporter I remain open to new evidence. But so far, the evidence shows that they have done little to slow the arrival of illegal drugs.

How to do that is a question of paramount importance, as virtually all our illegal drugs come from, or through, Mexico, and, as I've said above, supply is crucial, particularly when it comes to an enslaving class of drugs like opiates.

Speaking here entirely about answers to our flow of illegal drugs, I just don't see how a 2000-mile wall will have much effect. We already have 700 miles of walls in the most vulnerable geographic areas. Two walls, for a span, stand between Tijuana and San Diego. These need maintenance and improvement perhaps.

In the 1990s, American medicine began to claim that opiate painkillers could be prescribed virtually indiscriminately, with little risk of addiction, to all manner of patients. The result over the next two decades was a huge increase in our national supply of painkillers and thus in the number of opiate addicts.

That happened without anyone realizing that our heroin market had also shifted during the 1980s. By the early 1990s, most of our heroin no longer came from the Far East (Turkey, Burma, Afghanistan) but from Latin America – from Colombia and, today especially, from Mexico. From so close by, this heroin got here cheaper and more potent than the Far East stuff. In other words, the Latin American heroin outcompeted the heroin from the Far East.

Truth is, though, most Mexican traffickers for years didn't care much for trafficking heroin, which they viewed as decidedly scuzzy and back-alley and serving a relatively small market of tapped-out users in the United States. So they pushed cocaine and meth, and pot, of course.

Then we began creating legions of new opiate addicts with this expansion of indiscriminate prescribing of narcotic painkillers.

As years passed, that, in turn, unleashed the powerful and ingeniously creative forces of the Mexican drug-trafficking culture, then largely dormant when it came to heroin. By the way, that's not to say, necessarily, *cartels*. Just a widespread culture of drug trafficking, particularly in certain regions of Mexico.

These drugs are coming in through areas with walls. I think it's delusional to spend time and money on yet another wall along the U.S.-Mexico border hoping that this will staunch the flow of heroin and fentanyl.

Heroin hasn't much medicinal benefit that other drugs don't provide with far less risk of addiction. Heroin really exists because it's a great drug to traffic: easy to make, very condensable, easy to cut. The important point to understand is that it is profitable to traffic even in small quantities. Plus, it creates customers who must buy your product every day, usually several times a day.

All this means that small-scale heroin trafficking is a big part of the story of how it gets here from Mexico. To be sure, it comes in 50-kilo, 100-kilo loads, too. But a lot of it comes in small loads – *a la hormiga*, in Spanish (ant-like) – of a few kilos. Again, most of it comes through areas with walls in place. It comes on people's persons, in cars, in trucks.

It's easy to do that with heroin, and individuals can make good money on relatively small quantities.

Fentanyl, which is far more potent and thus easier to traffic in tiny quantities, has only intensified the challenges to law enforcement, and the futility of another wall. It now comes from all over the world, I presume, and through the mail, given its frequent sale on the Dark Net.

I believe a wall will corrode the only thing that will truly help stop these drugs from flowing into our country: a deep, respectful, but also forthright and honest, relationship with Mexico that will lead to it finally become the kind of neighbor and partner we can work with effectively.

I understand your frustration, the frustration of the American people, in this. Mexico has long been unreliable.

It's worth noting too that we've hardly been the best neighbor ourselves. (A few days ago, I spoke with a former member of the Arellano Felix Cartel, which ran the Tijuana drug trade for many years, and was the most notoriously brutal in the days when cartels preferred to be discreet. He assured me that all the guns they used – from pistols to R15s and AK47s, as well as “grenades, bulletproof vests, and more ammunition than you can imagine” -- came down from the United States. So to the extent that there is a force as toxic as ISIS on our border, it has grown powerful and been enabled in good part to our own gun laws.)

But from where I stand, it seems to me that we've done little of the work needed to cultivate that relationship, though we share 2000 miles of border. Yet there is so much promise in doing so, if we'll take the time.

Another wall, seems to me, is just like heroin: feels good for a moment, but will leave us in a worse place in the long run. Again, a Silver-Bullet answer to a complicated adult problem.

As I said above, I do believe in a robust role for law enforcement in this issue. Law enforcement is one of the weapons we have in controlling supply.

But U.S. law enforcement will only succeed to the degree that it partners with its international colleagues.

I visited Dayton, Ohio over the summer. The city had been hammered by fentanyl-related deaths. Yet when I was there, suddenly the deaths stopped. I wondered why. Then I read that some three weeks before, an international coalition of law enforcement – the FBI, DEA, but also Europol, Thai police, and others – working together shut down two of the biggest marketplaces on the Dark Web, where fentanyl was offered, from screenshots I was provided, for \$200 a gram up to \$12,500 for a kilo – all in Bitcoin.

Was that why deaths stopped in Dayton? I have no idea. I do suspect, though, that there's more than a coincidence.

But the point is that that kind of shutdown is possible only when we work deeply and consistently and over years with law enforcement in other countries. Heroin and now fentanyl show that we have no choice but to do that with Mexico.

And I fear that yet another wall will stifle that.

Treatment

I suspect you have heard a lot about the need for dramatically expanding access to drug treatment across the country. This is something we should have done years, decades ago. Now would be a good time to do so.

I'd add that expanding medically assisted treatment (MAT) seems like something we urgently need to do.

I understand the skepticism of some folks who believe this seems to be substituting one drug for another. I felt that too when I began this book. But a couple things changed my mind.

One is that our supply of dope on the streets is so vast that it is tantamount to a death sentence to send a recovering addict from rehab – clean - back to the neighborhood where she first got addicted without some sort of shield. Part of addiction recovery is relapse. I relapsed on cigarettes nine times before I quit smoking for good

on January 19, 1996 in Mexico City. Never did I die. But relapse on this class of drugs often means death. Hence the need for medically assisted treatment, a shield in a sense for addicts leaving treatment.

These drugs allow addicts a chance to repair their lives, restore broken relationships, find work and stay with jobs they find. Above all, though, it keeps them alive. This option, though, is often sparse in rural areas.

Debbie Allen, chief planner for the Adams County Criminal Justice Coordinating Council (a group that works with two other counties to muster responses to this epidemic), writes:

“Rural areas tend to have higher risk occupations that are physically demanding and prone to injury, for which opioids may be prescribed for treatment. Rural primary care providers are less likely to have received waivers to prescribe buprenorphine in rural communities. MAT reduces overdoses, keeps people in treatment and cuts the number of relapses. [But} Medicare doesn’t cover medication-assisted treatment and there is shortage of trained providers in locations such as Veterans Affairs and Indian Health Service facilities. ... Many counties, particularly, rural counties, have fewer providers, more people who are uninsured, and inadequate capacity to connect individuals and families to the resources they need.”

The key thing, seems to me, is that MAT be done with a community focus. It is medically assisted treatment, after all. That means these drugs are tools to be used with other strategies: mentors, group therapy, assisting recovering addicts in finding work, housing, etc.

Part of any Marshall Plan for Recovery might well be investment in vastly expanding our now saturated treatment capacity.

A lot has been said about this. I agree with it.

So let me talk about a place where we can do that, an idea I think is promising and important, but that doesn’t get much attention.

Jail

We know that as the country has awakened to that epidemic, a new mantra has emerged: “We can’t arrest our way out of this.” It is usually accompanied by calls for more drug-addiction treatment.

Yet this plague of addiction has swamped our treatment-center infrastructure. Only one in ten addicts gets the treatment he needs, according to a national government survey. New centers are costly to build, politically difficult to site, and beyond the means of most uninsured street addicts, anyway.

So where can we quickly find cheap new capacity for drug treatment accessible to the street addict? One place, I believe, is jail.

Jail, which houses inmates awaiting trial or those serving up to a year for a misdemeanor crime, has always been accepted as an unavoidable fixed cost. It’s a place to park inmates, most of whom are drug addicts. They vegetate for months, trading crime stories amid an atmosphere of boredom and brutality. “Treatment” is usually limited to a weekly visit by a pastor or AA volunteer. When inmates release, it’s often with no help, wearing the clothes they came in with, regardless of the weather at the time.

Our opiate-addiction epidemic, however, is one of the great forces for change in America. One new idea is rethinking jail. It is jail not as a cost, but as an investment in recovery. Jail as full-time rehab centers – from lights

on to lights out – and with help for inmates when they release. The good part is, the buildings are already up and ready to be used in this way.

This is happening and you can encourage it further.

One state moving ahead on this is Kentucky, where some two-dozen jails have now formed rehab pods. The one I've visited is in Kenton County.

There are others. I'd suggest contacting the jail in Chesterfield County, Virginia, run by Sheriff Karl Leonard. Or the jail in Lucas County, Ohio, run by Sheriff John Tharp.

Jailing addicts is anathema to treatment advocates. But, as any parent of an addict can tell you, opiates are mind-controlling beasts. A kid who complained about the least little household chore while sober will, as an addict, walk through five miles of snow, endure any hardship or humiliation, to get his dope. Waiting for an addict to reach rock bottom and make a rational choice to seek treatment sounds nice in theory. But it ignores the nature of the drugs in question, while also assuming that a private treatment bed is miraculously available at the moment the street addict is willing to occupy it.

The reality is that, unlike other substances, with opiates rock bottom is often death.

Jail can be a necessary, maybe the only, lever with which to encourage or force an addict to seek treatment before it's too late. "People don't go to treatment because they see the light. They go to treatment because they feel the heat," said Kevin Pangburn, director of Substance Abuse Services for the Kentucky Department of Corrections (DOC).

In fact, jail may actually be one of the *best* places to initiate addict recovery. It's in jail where addicts first interface with the criminal-justice system, long before they commit crimes that warrant a prison sentence. Once detoxed of the dope that has controlled their decisions, it's in jail where addicts more clearly behold the wreckage of their lives.

The problem is that at that moment of clarity and contrition we plunge them into a jail world of extortion, violence, and tedium.

"Imagine your most stressful day at work, multiply that by two or three, then imagine that every day," said one inmate told me. "Having to be on your guard. Always tense. Then you're released from that; the first thing you're going to take up is heroin" again.

Interestingly, rethinking jail is cheaper. These rehab pods have fewer fights, fewer health costs, fewer lawsuits. Usually pods run in this way are cleaner and free of contraband.

Pods like this do require political will, changing our long-held ideas regarding addiction, and, above all, rethinking what jail can be. They require elected officials like you to get out front, champion these ideas, urge others to adopt them.

With state DOC funds, Kenton County, has expanded its counseling staff to seven, of whom five are recovering addicts – folks whose backgrounds, it's safe to say, would have kept them from finding work in any other jail.

I don't believe that these pods are some magical cure-all to our national affliction. There is no *one* solution to what our country faces. But they seem to be a smarter bet of public money than the counterproductive way so many jails across the country function today, while offering some hope to a population that has lost it.

What's more, a pod run that way today is more likely to be an asset, not a liability, in the next drug problem we face.

As federal officials, you might give some thought to grants that give incentives to counties to rethink jail in this way.

Again, I'd suggest that you make a big deal of those jails that are doing it. Why not visit these jails and see how they work? Talk them up. Mention them when you travel, in private meetings with local officials, or when you speak to large groups. Get a buzz going.

Your public profile could go a long way to spreading news about some of these ideas and this is one of them.

Counties

No level of government is more affected by this problem than the county, which funds local public health departments, coroners offices, jail and courts, law enforcement, county hospitals and drug counseling, libraries, etc.

Thus it's not surprising that counties are forming coalitions and task forces to attack this problem. This is where Americans are battling heroically, to find community solutions in county after county. Sometimes they're feeling their way, half-blind. Is it messy? Of course! Why would we expect it not be? This is new to most of them. Sometimes they fail. We should applaud them, urge them on, and go to them for their ideas on how to do it better.

They are performing what I believe to be the essential endeavor: that is, leveraging talents and expertise and budgets, bringing together folks who didn't know each other before this, building a community effort to combat the effects of a drug problem that grew from our isolation.

It's here, too, that I think some of the essential work of combating the stigma of addiction is taking place, as well you might imagine it would. It's at the local level, in these kinds of groups and in public forums and churches, where people know each other and the stories they have to tell ring true to their neighbors, that the horrifying stigma that has done so much to push this epidemic nationwide is, I believe, slowly fading. Can't happen soon enough. You might consider grants that move it along.

From my reporting, this epidemic is calling us to this kind of community effort.

In Lycoming County, PA, home to the town of Williamsport, Project Bald Eagle has been operating for several years, focused on bringing together folks from across the area to address this problem.

They just voted to become a regional project, combining several counties. Seems like the right approach to me. In doing so, they hope to be more attractive to funders.

"Our coalition is expanding and we have had no problem getting program funding. But no one funds infrastructure or basic operations," said Davie Gilmour, president of Pennsylvania College of Technology and chair of this project.

When the group moved to seek grants for their work, she told me, it found grants that "could only fund programs -- naloxone training, school education." That looks and feels good. But it takes staff to write, manage and spread the word. It takes office space. That's not sexy but it is essential.

“Finally,” she told me, “we are beginning to work with our local chamber of commerce and workforce development boards on ‘reemployment’ of folks in recovery or recently out of prison. They are successful in programs but they now need to return to society. Funds for employer incentives to reemploy these folks would go a long way to assist.”

I’ve seen examples of things that are working and might be continued and expanded.

The Office of National Drug Control Policy provided grants that have allowed three rural counties in another part of Pennsylvania – Armstrong, Clarion and Indiana counties – to form community coalitions aimed at educating youths about substance abuse.

Once organized, these coalitions applied for grants from the Health Resource Service Administration.

One HRSA grant allowed the counties to form an Addiction Recovery Mobile Outreach Team (ARMOT), training hospital staff to screen patients for drug problems, and then find treatment programs for those they treated.

“Educational programs on drug and alcohol abuse and treatment such as the Science of Addiction were standing room only for many of the sessions for nurses and medical doctors,” said Kami Anderson, director of the tri-county coalition. “The ARMOT members were given offices in the hospital, participated in the hospital’s orientation programs, and were given hospital identification badges, and were treated similarly to their employees. Stigma towards our patients started to subside. At the end of Year 2, the ARMOT team had 427 referrals. Of those 427 referrals, 207 agreed to participate in a level of care assessment. Of the 207 patients assessed, 143 were admitted to drug and alcohol treatment, a 69% success rate if the patient agreed to the level of care assessment. Our overall access rate to treatment is 33.25%, compared to 11% nationally.”

I bring these up not because I’m intimately familiar with their details. Rather, as I travel and talk to folks, they seem to me to be geared toward bringing together people who hadn’t worked together before, who are finding their energy and power in working and learning together.

It’s at these newly formed county task forces where I believe your support, moral and especially financial, would have great impact, for these groups are already hard at work on this. They just need that nod of encouragement, that extra budget to try some new things, or expand what they’re trying.

So don’t be shy about getting to know them, learning their work. In my travels, the formations of these groups over really only the last two years for the most part is one of the great and invigorating aspects to an otherwise pretty bleak panorama.

Seems to me that what they’re doing is essential in combatting addiction to a class of drugs that thrives on our isolation and creates more of it.

Coroners/Medical Examiners

I believe one reason this epidemic spread is that it started in states with too many counties:

Ohio: 88 counties (pop. 11 million)

Kentucky: 120 counties, (pop. 4 million)

West Virginia: 55 counties (pop. 1.8 million)

Indiana: 92 counties, (pop: 6.6 million)
Tennessee: 95 counties, (pop. 6.5 million)
Virginia: 95 counties, (pop. 8 million)

Years ago, the worst of the crack epidemic was seen publicly: drive-by shootings, car jackings, gang graffiti and lines of street dealers. Public mayhem sparked public outrage, and media reports about crack remained constant for more than a decade.

Addiction to opiate painkillers, however, has spawned little of that. Crime plunged as overdose deaths rose, in fact. Most of the victims were white and that further concealed the scourge. It spread through Appalachia, and if there's one part of the country that we're used to ignoring, it's Appalachia. Then it spread to the rest of white America – middle- and upper-middle class suburbs, rural towns. These families were aghast and ashamed. Their loved ones were now stealing, shooting up in library bathrooms, and dying with needles in their arms. So these families kept silent, hid it from public view.

Thus, in the end, deaths -- bodies -- were this plague's only clear warning signs.

Coroners' offices should have been where this problem was most clearly viewed. But these offices are funded by counties. In small counties, with depleted populations and withered tax bases, these offices were barely hanging on. These counties also had relatively few doctors who could do the job. Even in larger, wealthier counties, properly funding the Coroner is hardly a top priority.

In some states, moreover, each county coroner is autonomous, answering to no state medical-examiner authority. In these states, especially, the quality of those investigations depends on a coroner's budget, time, fatigue, interest, and level of experience – all of which have been tested by the rising body count.

The CDC estimates an undercounting of something like 20 to 25 percent, due to problems with our death-investigation system, and largely because coroners offices are funded, or not, in such a disparate way, depending often on county tax base.

This epidemic, seems to me, is calling us to find new, dependable funding for coroners offices. Americans need to clamor for it, to make it politically palatable.

One idea that professionals have suggested is a HIDTA-like (High Intensity Drug Trafficking Area) model of federal support for coroners and medical examiners, similar to what is available to law enforcement agencies in highly impacted drug areas. Medical examiners and coroners would get access to federal funds in a block-grant style, the way law enforcement gets grants through the regional HIDTAs. This model would let the medical examiners in the most impacted areas determine, through an executive board, which initiatives would be most beneficial (funding for complete toxicology studies, funding for up-to-date data collection/sharing programs, etc.) in combating the opioid problem.

Experts also tell me that federal government funding for the centralization of data management and analysis within the Coroner/ME system would be helpful. This would allow for sharing of data across county, even state lines, and thus identify early trends, emerging threats.

Federal funding, they say, might allow smaller offices to afford the expensive machines that are now necessary in some autopsies, including new chemistry instrumentation for forensic toxicology.

We face a serious lack of trained forensic pathologists. We have only some 500 nationwide, roughly half of what was believed necessary *before* this epidemic hammered the profession. New estimates are that we'll need 5700 nationwide by 2030.

This year, the National Association of Medical Examiners believes, some 250 full-time Medical Examiners will be required to do handle nothing but the country's opioid-related deaths – estimated at about 63,000 for 2017.

Incentives to increase the forensic pathologist workforce could include student-loan forgiveness, J1 waivers for forensic pathologists, increased National Institute of Justice funding of forensic pathology fellowships, and the funding of fellowships by Health and Human Services. Federal funding might also help train paraprofessionals, physicians assistants and the like, who can easily do more routine autopsies, thus expanding capacity.

“Short of that,” one told me, “the feds need to fund the professionals, forensic pathologists, such that our salaries are competitive with private practice and help with capital investments such that the work environments are modern and not in the basement of some old building.”

Speaking with forensic pathologists, they urge that the CDC be reorganized to create a new Office of Forensic Medicine. “The DOJ should be reorganized to carve out the current Office of Investigative and Forensic Science from the National Institute of Justice (NIJ) and elevate a new Office of Forensic Science,” said one pathologist. “These two new offices (the CDC OFM and the DOJ OFS) should work together. Formula grant support of medico-legal death investigation operations should be funded. CDC needs to expand efforts to mine the data in near real time of forensic toxicology testing.”

The National Institute of Drug Abuse (NIDA), they suggest, might establish a multicenter network for studying novel drugs and their effects in humans needed to support permanent scheduling of these drugs, as well as to support interpretation of the drug levels and support prosecutions. These centers could also help train forensic toxicology doctoral students.

OBAMACARE

I think we need to stop the attempts to dismantle Obamacare, and focus instead on improving it.

I'm no expert in the functioning of Obamacare.

But I can say that we need some non-employer, nationwide form of healthcare, as that part of our economy that involves freelancers -- the so-called “gig economy” – expands dramatically with the tech innovations that allow it. As a freelancer, I can say I feel this need acutely in my own life. Not to do so would risk blunting the huge increase in productivity that can be unleashed when these folks go independent, which they can do when working on their own, but only with some kind of independent health care.

These attempts to dismantle Obamacare have only served to show how out of touch a lot of Congress is with this problem of opiate addiction. Obamacare allowed states to expand Medicaid, which allowed people to get coverage for drug treatment. Why would you dismantle the only thing standing between your most vulnerable constituents and the drug treatment they need and couldn't otherwise afford?

From what I saw, nothing you proposed would have replaced what you were planning to dismantle.

So I've been perplexed to watch these attempts over the last year.

* *

These are a few ideas that I believe evidence from this epidemic shows are necessary.

I would say again that they all require qualities in short supply: Patience and commitment for the long term.

It's hard to suggest patience when so many people are dying.

But this scourge is about issues far deeper than drug addiction.

It's about isolation, hollowing out of small-town America and the middle class, of the silo-ization of our society, and it's about a culture that acts as if buying stuff is the path to happiness.

This epidemic shows us no matter how high the stock market rises, how rich some Americans have grown, that neither we, nor they, can isolate ourselves from the world. Problems will find them, and us. Again, a holistic, community view is the only way -- and the approach that will be prepare us for the next drug crisis.

I believe therefore that the antidote to heroin is not naloxone. It is community.

Community is the response to a scourge rooted in our own isolation.

So I'm urging you to see this not only as the catastrophe that it is, but also as the gift that it can be.

Just as chronic pain is best addressed with a holistic approach. Just as addiction recovery requires a community and not just a tab of Suboxone, and just as chronic pain is best treated with an array of techniques and strategies -- so this problem overall, I believe, requires a community response.

I hope you will think of what you can do to foment community in an era that discourages it. I suspect that it will require a lot more money and a focus that lasts a long time. It will also require sacrifice -- from the American people above all.

But it offers something even greater.

It offers an opportunity to reinvest in areas that need it most. To include those Americans who have been left out, or left behind.

To you, as public officials, above all, it offers a chance to inspire us, as Americans, to something great again.

Thank you very much.

Sam Quinones

ADDENDUM:

I'm taking the liberty to provide you links to stories/op-ed pieces/blogposts that I've written that are related to what I've mentioned above:

Manny's Delivery Service: <http://samquinones.com/reporters-blog/2017/12/27/mannys-delivery-service-2/>
(A well-put comment to this post is also worth reading.)

Another Border Wall and Heroin: <https://www.nytimes.com/2017/02/16/opinion/sunday/why-trumps-wall-wont-keep-out-heroin.html>

Rethinking Jail: <https://www.nytimes.com/2017/06/16/opinion/sunday/opioid-epidemic-kentucky-jails.html>

Kaiser Permanente Reduces Opioid Prescribing:
<https://www.theatlantic.com/health/archive/2017/03/california-doctors-opioids/518931/>

Addiction Research and Economic Opportunity in the Ohio River region:
<http://www.kentucky.com/opinion/op-ed/article70835552.html>

Immigration: <http://beta.latimes.com/opinion/op-ed/la-oe-quinones-immigration-and-consumer-culture-20170129-story.html>

Marijuana Legalization and Hyper-Potent Pot: <http://www.sacbee.com/opinion/california-forum/article96718922.html>

Donald Trump and Opiates in America: <http://samquinones.com/reporters-blog/2016/11/21/donald-trump-opiates-america/>