

**THE OPIOID CRISIS:  
AN EXAMINATION OF HOW WE GOT HERE  
AND HOW WE MOVE FORWARD**

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**HEARING**  
OF THE  
**COMMITTEE ON HEALTH, EDUCATION,  
LABOR, AND PENSIONS**  
**UNITED STATES SENATE**  
**ONE HUNDRED FIFTEENTH CONGRESS**  
SECOND SESSION  
ON  
EXAMINING THE OPIOID CRISIS, FOCUSING ON HOW TO MOVE  
FORWARD

JANUARY 9, 2018

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Tuesday, January 9, 2018

U.S SENATE,  
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,  
*Washington, DC.*

The Committee met, pursuant to notice, at 10:06 a.m., in room SD-430, Dirksen Senate Office Building, Hon. Lamar Alexander, Chairman of the Committee, presiding.

Present: Senators Alexander [presiding], Paul, Collins, Young, Murkowski, Scott, Murray, Casey, Bennet, Baldwin, Murphy, Warren, Kaine, and Hassan.

OPENING STATEMENT OF SENATOR ALEXANDER

The CHAIRMAN. The Senate Committee on Health, Education, Labor, and Pensions will please come to order.

Today, we turn our attention again to the opioid crisis, the Nation's No. 1 public health challenge. Our witness today is Sam Quinones, the author of *Dreamland: The True Tale of America's Opiate Epidemic*.

Senator Murray and I will each have an opening statement, and then I'll introduce the witness. Then we'll hear from Mr. Quinones, and then Senators will each have 5 minutes of questions. Since he's our only witness, I've suggested to him that if he wants to take a little more than 5 minutes to say whatever he has to say, we would welcome that, but there'll be plenty of conversation back and forth from Members of the Committee.

Mr. Quinones, it is unusual to have a single witness at our hearings, but this is an unusual topic, one you quote Washington State research professor, Gary Franklin, as calling the worst man-made epidemic in history. The challenge this crisis presents has captured the attention of every Member of this Committee. Your research and writing has been acclaimed for their depth and breadth.

So this is what we call a bipartisan hearing—most of ours are—one in which Democrats and Republicans have agreed on the topic, on its importance, and on the witness. It is my hope that we Senators will restrain our habit of lecturing one another about health insurance and focus today on the topic, which is the opioid crisis. This epidemic kills more Americans every day than car accidents. In each of our states, we're reminded of that almost every day.

Yesterday, I dropped by a meeting at the Tennessee Governor's residence in Nashville. The heads of all of our state institutions in-

volved in training doctors were planning how to discourage the overprescribing of opioids. The Governor told me that in our state of 6.6 million people, there were 7.6 million opioid prescriptions written in 2016, and that even though the state has reduced the amounts of opioids prescribed, the number of overdose deaths is up because of the abuse of fentanyl, a synthetic opioid.

Rather than spend more time establishing the crisis, I want to focus today on what we can do about it. Here are two things I'm hoping to learn from you. First, when 100 million Americans live with pain, 25 million of them with chronic or severe pain, why is it not a good idea to continue to find the so-called Holy Grail of Medicine, a non-addictive pain medicine? Second, if stronger communities are the ultimate solution to this crisis, as you often suggest in your book, what can a central government in Washington do that actually helps?

Now, my first question—you have a chapter in your book entitled Searching for the Holy Grail: Finding a Non-addictive Pain Medicine. I've actually read your book. I think there are a number of others here who have and who even brought it with them. This search for the Holy Grail began, you say, 75 years ago in 1928 with the Committee on Problems with Drug Dependence. That was the goal, as you describe it, quote, "Couldn't the best scientists find a way of extracting the pain-killing attributes from the morphine molecule while discarding its miserable addictiveness," unquote.

This effort to find a better way to treat pain, you say, led to a revolution in attitudes toward pain treatment, first using opiates to relieve pain for dying patients; then for patients with chronic pain; and then, abetted by a multitude of helpers from Mexican gangs to pain clinics, overprescribing doctors, and enterprising drug companies, spiraling into the addiction and consequences we find today.

At least twice before this Congress, Dr. Francis Collins, the head of the National Institutes of Health, has predicted that the Holy Grail that was first sought 75 years ago is now within reach. Last month, he said perhaps within 5 years. With our encouragement, Dr. Collins has organized NIH researchers in partnership with private companies to speed up the process, and the Food and Drug Administration Commissioner, Dr. Scott Gottlieb, is on board to fast-track the effort within the bounds of safety and efficacy.

But I read at least some of your book to say that this Holy Grail may never be found. You even quote some scientists who say it should not be found. So I hope you'll tell us what you think about this. Should we not continue to try to find non-addictive pain medicine to relieve suffering without addiction? Is that not the obvious antidote to the opioid epidemic?

The second area I would hope to learn from you about is what we can do from Washington, DC. We have tried in important ways to address the ravages of this crisis which we've all experienced in our states. In 2016, Congress passed the Comprehensive Addiction and Recovery Act, CARA, and the 21st Century Cures Act to give states and communities, those on the front lines, the tools and resources they need to combat this crisis.

For example, in CARA, a provision by Senators Warren and Capito was included that made it clear that pharmacies could only fill

part of certain prescriptions, like oxycodone, an opioid. That way, a mom filling her son's pain medicine prescription after his wisdom teeth surgery could ask only for 3 days worth of pills instead of the 30 days he was prescribed.

In addition to encouraging the development of a non-addictive pain medicine, Cures included more than \$1 billion in state grants. We're considering additional funding for treatment and to discover alternative pain medicines. We've held hearings on wellness, lifestyle changes, which you mention in your book, such as exercising and eating healthier, that help people lead healthier lives and what incentives would help people make those lifestyle changes.

But you and I apparently have at least one thing in common. I am a skeptic of Washington's capacity to solve problems that are essentially problems of communities, families, and lifestyle. You say that the opioid crisis is a problem of society, that when we lose our sense of community, we become easy prey for quick external solutions for complex problems like opioids. In your words, quote, "I believe more strongly than ever that the antidote to heroin is community. Make sure people in your neighborhood do things together. Break down those barriers that keep people isolated," unquote.

In my own experience in public life, including time as Governor, I've been increasingly convinced of the problem solving ability of communities with good jobs, good schools, strong families, where everyone seems to be interested in the well-being of everybody else. Whenever I've tried as Governor or Senator to solve a problem, in the end, it's boiled down to creating an environment in which communities could themselves fix problems, not sending in single-shot solutions from a distance.

For example, after spending years on state reforms in education as Governor, I ended up traveling the state to create 143 better schools community task forces, because I believed that communities who wanted good schools could have them, and those who did not would not. I held the same views as we fixed No Child Left Behind in 2015 when we restored more decisions to classroom teachers, school boards, and states.

So exactly what does Congress do from Washington, DC, about this opioid crisis? This Committee has jurisdiction over a significant amount of what you have written about in Dreamland, but not the spending of money. That belongs in the Appropriations Committee. We're eager to hear your testimony and to hear your solutions.

Senator Murray.

#### OPENING STATEMENT OF SENATOR MURRAY

Senator MURRAY. Well, thank you very much, Mr. Chairman. I'm glad to be continuing our discussion on this really important issue. I know our witness today has been following the opioid crisis and its growth into the full blown epidemic families and communities across the country are facing today.

Mr. Quinones, thank you for joining us. I also want to welcome your wife and daughter, whom I assume are sitting right behind you there. I'm glad they were able to be here with you today.

I look forward to hearing your perspective on how we can better help our communities fight this crisis and support all of those who

have been impacted, and I really appreciate the investigative work that you've done to help shed light on this challenge.

Of course—and I'm sure you'd agree—the rise of this epidemic is broader in scope than any one book can tell. There are people from every background in every corner of the country who have stories about the harm that this has done, and they are parents who have lost children to an overdose, children who have lost parents to an overdose, veterans in chronic pain who are struggling with addiction, doctors who are treating babies born addicted to opioids, and a lot more.

I've heard these heartbreaking stories firsthand traveling around my home State of Washington and meeting with doctors and families and communities fighting this disease. I was visiting a local hospital in Longview, a rural community in my state, and the staff there told me that almost one out of every two babies born there have mothers who struggle with substance abuse. That was astonishing and heartbreaking, but it's, unfortunately, not the only evidence of this epidemic.

Since 2000, nearly 10,000 people in Washington State alone have died of opioid overdose, and this isn't just happening in Longview. It's happening in local hospitals across the Nation. We are losing 91 people every day to opioid overdose. When I say this epidemic affects everyone, I don't just mean the individuals facing opioid addiction. There are other victims as well. This epidemic hurts families. It leaves children struggling to cope with the impact of their parents' addiction. It leaves many of them in foster homes. It leaves parents who are shattered with the heartbreak of their child's illness and leaves many struggling with the financial cost of opioid misuse and treatment and recovery as well.

This epidemic hurts our communities as a whole. It takes up resources of public health, hospitals, and law enforcement. It takes workers out of our local economy. It takes a toll on the morale of small towns and big cities alike with each new tragedy, and we are behind the curve on fighting this epidemic.

One of the stories that stood out to me in your book was about a state employee from the Washington Department of Labor and Industries, a woman named Jaymie Mai. Jaymie was a pharmacist charged with overseeing the cases of workers who were receiving prescription drugs for injuries. After 6 months, she noticed that some of these workers were dying from the same painkillers that they'd been prescribed. The paper she published in 2005 about the uptick in high-strength opioid prescriptions and deaths was one of the first papers in the country to document the impact of the crisis we face today. But she published her paper over a decade ago, which just shows we have been fighting this battle for far too long, and we have to do more.

Now, I'm glad that we have taken some necessary steps. In 2016, Congress passed the 21st Century Cures Act, which included nearly \$1 billion of funding for states to address the opioid crisis through prevention, treatment, and recovery efforts. The Comprehensive Addiction and Recovery Act, which supports specific outreach for veterans and pregnant and postpartum women, expands access to medication-assisted treatments and much more.

But there is a lot more to do. Along with many of my colleagues, I hope that we can move more funding in the upcoming budget or appropriations agreements. First responders, state and local officials, treatment professionals and families have made it clear that continued Federal funding is key to addressing this crisis. Unfortunately, we have heard a lot of talk from the Administration on this, but we have yet to see the President take the kind of serious action this emergency demands and that he promised families on the campaign trail.

The White House's own Council of Economic Advisors released a report estimating the economic cost of the opioid crisis to be over \$500 billion dollars just for 2015. Addressing a problem this big will take an enormous investment of time, energy, focus, and robust funding. The President's third quarter paycheck is not going to cut it. Our communities are crying out for serious solutions, not stunts.

So I am eager to see this Committee continue its bipartisan approach and take substantive action to address this epidemic over the next few months.

Mr. Chairman, I look forward to working with you to have all of our Members bring their ideas forward so we can work on moving policies that help our families and communities. We have to do a lot more to fund prevention efforts and treatment programs and build on the gains we've made. This means immediately providing supplemental funding states need to implement evidence-based tools that can help turn this epidemic around.

We need to ensure that local stakeholders and partners, the people on the ground who know what works best in their communities, have the resources and information they need to respond to this crisis. It also means going beyond prevention, treatment, and recovery. We have to work to support not only the individuals facing addiction, but the families and communities who are suffering as well.

I'm interested to hear your perspective on this today and how we do that, and I'm really grateful for you coming here today to testify before us, because if we're going to beat the scourge of this opioid addiction, we have to fund and enact solutions that are as comprehensive as this challenge.

So thank you again very much for having this hearing. I look forward to working with you and all our Members.

The CHAIRMAN. Thank you, Senator Murray, and thank you for working in this way to have such an important hearing.

I'm pleased to welcome Sam Quinones and his family today. Thank you for taking the time to be here. Mr. Quinones has 30 years of experience as a journalist and author. He's written extensively on the opioid crisis and drug trafficking. He's the author of three acclaimed books. His most recent book, *Dreamland: The True Tale of America's Opiate Epidemic*, won the National Book Critics Circle Award for general nonfiction.

Early in his career, Mr. Quinones was the recipient of the Maria Moors Cabot Prize, the oldest international award in journalism, for his work covering Latin America. He was also the recipient of an Alicia Patterson Fellowship awarded to outstanding print journalists who pursue stories in the public interest.

Welcome again, Mr. Quinones. You'll have 10 minutes to give your testimony, and then Senators are looking forward to having a conversation with you.

**STATEMENT OF SAM QUINONES, JOURNALIST AND AUTHOR,  
LOS ANGELES, CA**

Mr. QUINONES. Chairman Alexander, Senator Murray, and Honorable Members of this Committee, I'd like to thank you for these hearings on our national epidemic of opioid addiction and for allowing me the honor of addressing you. I'm very happy to be here with my wife and daughter, who are part of producing *Dreamland* and without whom the book would never have been finished.

This is the deadliest drug scourge we have known in this country, hitting areas of the country that have never seen this kind of drug problem. It is the first in modern America to be spread not by mafias, not by street dealers, but by doctors overprescribing pain pills, convinced they were doing right by their patients, urged on by the pharmaceutical industry, by the medical establishment, and, indeed, urged on by us, by American health consumers who too often wanted a quick and easy end to pain.

ISIS could not have dreamed of inciting the kind of torment and death that we have visited upon ourselves through this overuse of opiates. These drugs are a symbol for our era. For almost four decades, we have exalted the private sector, the individual, while we ridiculed government as inefficient, incompetent, and wasteful. We admired wealthy business people, regardless of whether the way they made their money produced anything of value for our country and our communities. We wrought, I believe, a second gilded age.

This epidemic of addiction to a class of drugs that thrives on isolation reflects all that. This epidemic's costs have been borne by the public sector. All its profits have been private.

I believe this scourge is about issues far deeper than drug addiction. It's about the effects of this very cultural shift. It's also about isolation in areas rich and poor, about the 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.

I believe we got into this because we believe problems could be attacked in isolation with one magical silver bullet, a pill for all our pain, a jail cell for every addict. We exalted the private and mocked the public and the communal, and in so doing, we rid ourselves of things so essential to us that they have no price. We have been invaded by cheap junk as a result. We dug up *Dreamland Pool* and replaced it with a strip mall—did things like that across America for years now.

Heroin is what you get when you destroy *Dreamland*. I believe isolation is heroin's natural habitat. I believe, too, that this epidemic, therefore, is calling on us to revert these decades of isolation and come together as Americans. I believe more strongly than ever that the antidote to heroin is not naloxone. It is community, people coming together and working in small and local ways toward solutions, no one saving the world alone.

The good news, in fact, in all of this, I believe, is that there is no solution. There are many solutions, each small. Each must be

tinkered with, improved. Some may be discarded. Each must be funded fully and for a long time. But the good news, too, is that none of them is sexy. None will do the trick alone.

I believe that across America today, communities are finding these solutions. The more they band together, the more they leverage all that talent and energy, bringing in PTAs, pastors, artists, and athletes, recovering addicts, and primary care docs, librarians, and the Chamber of Commerce. The more cops and public health nurses go out for a beer—bridge that cultural chasm between them. I do believe, as I said, that this is happening in counties across America.

It's my opinion, as the evidence shows, that supply has ignited all this. We did not have this demand, this widespread addiction, until we unleashed a large supply of powerful, legal narcotics on the public for the last two decades. Thus, I believe it essential that doctors reassess how and to whom and in what quantity they prescribe these drugs.

That does not mean just cutting people off who are on high doses of these drugs and leaving them to fend for themselves. It does mean lobbying insurance companies to reimburse for pain strategies that do not involve narcotics, allowing doctors a wider array of pain strategies than simply pain pills. Young docs, meanwhile, need more education in med school in both pain management and addiction treatment.

I have to say that I think it's delusional to spend time and money on yet another wall along the U.S.-Mexico border, hoping that this will somehow staunch the supply of heroin and fentanyl. These drugs are coming in through areas with walls already. I believe a wall will, in fact, corrode the only thing that will truly help stop these drugs from flowing into our country, and that is a deep, respectful—but also forthright, sometimes blunt, certainly honest—relationship with Mexico that will lead to it finally becoming the kind of neighbor and partner we can work with effectively, and in so doing, become the kind of neighbor that country needs of us.

Another wall, however, seems to me, is just like heroin. It feels good for the moment, but it will leave us in a worse place in the long run, another silver bullet for a complicated adult problem.

Sometimes the solutions are about the mundane mechanics of governing. We should find, for example, new ways of funding coroners' offices around this country and expanding our national force of forensic pathologists, which is dangerously dwindling. This epidemic spread because so many of those offices are so poorly funded.

I believe we must expand treatment options in this country. One place to do this, ironically, crucially, I believe, is jail. Consider how the country will be helped by transforming jail into a place of nurturing recovery instead of a place of predation and tedium. It becomes then an asset instead of a liability, and this is happening, particularly, I would note, in the State of Kentucky.

I'd also like to add that all across America are families who are suffering due to the addiction of a loved one or the loss of that loved one. I believe they are a raw material to be marshaled, harnessed in this fight. Many now want to be involved, need to be involved to help salve the lacerating wounds that will last a lifetime. I believe you as Senators can help this by recruiting them, recog-

nizing them, giving them platforms from which to tell their story. Maybe it's because I'm a reporter, but I believe that through their stories, the awful stigma of addiction will be reduced.

I'm happy to elaborate on any of this. Before I do that, though, I want finally to urge you to view this as an opportunity, view this as an opportunity to revive those regions hammered by globalization and free trade. The roots of our national epidemic of narcotic addiction lie there, while the epidemic itself, in turn, stands in the way of their revival. Many of these regions cannot revive until enough of their people can pass a drug test to fill new jobs. Indeed, this is not only a story of drug addiction. It is a story of economic affliction.

As politicians, I suspect your natural response to a crisis like this is to look about for things you can do quickly to show constituents you're taking action, and I believe that is entirely understandable. I would caution, however, against believing in short-term responses. CARA and the Cures Act make up a great start, and I thank you for them. But they are only a start.

Everything I've learned about this issue has taught me the importance of long-term community responses and commitment. I believe American history offers us two templates for action from which you might take guidance and inspiration. First is the Marshall Plan to rebuild Europe after World War II. Second is our space program. Each involved government and the private sector acting in concert over many years, bringing money, brains, energy, and, of course, long-term focus to bear.

Each achieved an unalloyed good for our country, though they were about doing things that seemed on first blush far beyond our own short-term self-interest. The Marshall Plan was about building up ravaged regions to allow them to function independently while containing the viral spread of Soviet Communism. It allowed reborn countries to prosper and contribute to the world again. A Marshall Plan for American recovery might focus on rebuilding those regions that have been caught in dependence on dope and ravaged by economic devastation to contain the viral spread of addiction.

Through our space program, we were inspired as a people to spend years and dollars, all to achieve something no previous generation ever thought possible. We ended up far beyond the moon. The spillover in economic benefit, increase in knowledge, and in simple human inspiration is beyond calculation. It seems to me that we might profitably apply these examples, the Marshall Plan and the space program, to regions of forgotten Americans where this problem began.

Let's do it perhaps not because it is easy, but, as JFK said, "because it is hard", because that's what Americans do and have always done at their greatest.

Like our space program, I believe such an effort will have to last for years to be effective, focused far beyond the immediate goal of drug addiction and on the more profound problems of community destruction and the hollowing out of stretches of this country. Thus, I'm here today to urge you to see this not only as the catastrophe that it is, but also as the gift that it can be. It offers an opportunity to reinvest in areas that need it most, a chance to inspire us as Americans again to do something great. It's an opportunity

to bridge that political polarization that so gnaws at our country. It is one of the few issues today that can do that. Do not miss this opportunity. It does not come around often.

This calling, I suspect, is the very reason many of you got into public service in the first place, and you are lucky, I think, to be here when it has again. You will be remembered for acting when acting was not easy to do. If you do, I believe your hometowns will thank you. Your counties will thank you, and we, your country's men and women, will thank you long after you're gone.

With that, I'm happy to talk about anything you guys want.

[The prepared statement of Mr. Quinones follows:]

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PREPARED STATEMENT OF SAM QUINONES

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 2 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.

\* \* \*

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-1990's. 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 cutoff. 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 1970's 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 1990's, 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 1980's. By the early 1990's, 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 (anti-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 3 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.

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 too 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 toward 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 percent success rate if the patient agreed to the level of care assessment. Our overall access rate to treatment is 33.25 percent, compared to 11 percent 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 2 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 combating 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 HDTAs. 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.

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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 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.

### 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/>

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[SUMMARY STATEMENT OF SAM QUINONES]

Chairman Alexander, Sen. Murray, and Honorable Members of this Committee: I'd like to thank you for these hearings on our national epidemic of opiate addiction and for allowing me the honor of addressing you.

I'm very happy to be here with my wife and daughter, who were part of producing Dreamland, and without whom the book could never have been finished.

This is the deadliest drug scourge we've known. Hitting areas of the country that had never seen this kind of drug problem.

It is the first in modern America to be spread not by mafias and street dealers, but by doctors overprescribing pain pills, convinced they were doing right by their patients. Urged on by the pharmaceutical industry, by the medical establishment, and, indeed, urged on by us, by American health consumers, who too often wanted a quick and easy end to pain.

ISIS could not have dreamed of inciting the kind of torment and death that we have visited upon ourselves through this overuse of opiates.

These drugs are the symbol for our era.

For almost four decades we have exalted the private sector, the individual, while we ridiculed government as inefficient, incompetent and wasteful. We admired wealthy businesspeople, regardless of whether the way they made their money produced anything of value for our country and our communities. We wrought a second Gilded Age.

This epidemic of addiction—to a class of drugs that thrives on isolation—reflects all that. This epidemic's costs have been borne by the public sector. All its profits are private.

I believe this scourge is about issues far deeper than drug addiction. It's about the effects of this cultural shift. It's also about isolation in areas rich and poor, about the hollowing out of small-town America and the middle class, and of the siloization of our society. It's about a culture that acts as if buying stuff is the path to happiness.

I believe we got into this because we believed problems could be attacked in isolation, with one magical Silver Bullet. A pill for all our pain. A jail cell for every addict.

As we exalted the private and mocked the public and the communal, we rid ourselves of things so essential to us that they have no price. We have been invaded by cheap junk.

We dug up Dreamland pool and replaced it with a strip mall. Did things like that across America for years now.

Heroin is what you get when you destroy Dreamland.

Isolation is heroin's natural habitat. This epidemic is calling on us to revert these decades of isolation and come together.

I believe more strongly than ever that the antidote to heroin is not naloxone. It is community. People coming together and working, in small and local ways, toward solutions. No one saving the world alone.

The good news, in fact, is that there is no solution. There are many solutions, each small, each must be tinkered with, some discarded. Each must be funded, fully and for a long time.

But none of them is sexy; not one will do the trick alone.

I believe that communities are finding those solutions the more they band together, leverage all that talent and energy, bring in PTAs, pastors, artists, athletes, recovering addicts and primary care docs, librarians and Chambers of Commerce. The more cops and public health nurses go out for a beer, and bridge the cultural chasm between them.

This is happening—in counties across America.

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Supply has ignited all this. We did not have this demand, this widespread addiction, until we unleashed a large supply of powerful legal narcotic painkillers on the public for the last two decades.

Thus doctors must reassess how, and to whom, and in what quantity, they prescribe these drugs.

That does not mean just cutting off people on high doses of these drugs, and leaving them to fend for themselves.

It does mean lobbying insurance companies to reimburse for pain strategies that do not involve narcotics. Allowing doctors a wider array of pain strategies than simply pain pills.

Young docs need more education in pain and addiction treatment.

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I have to say 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 supply of heroin and fentanyl. These drugs are coming in through areas with walls.

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.

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. Another Silver Bullet for a complicated adult problem.

Sometimes the solutions are about the mundane mechanics of governing. We should find, for example, new ways of funding coroners offices, and expanding our national force of forensic pathologists, which is dwindling. This epidemic spread because so many of them are poorly funded.

We must expand treatment options. One place to do this is, crucially, jail. Consider how the country will be helped by transforming jail into a place of nurturing recovery, an asset instead of a liability. This is happening.

I'd like to add that all across America are families who are suffering due to the addiction of a loved one, or the loss of that loved one. I believe they are a raw material to be marshaled, harnessed in this fight. Many now want to be involved, need to be involved to help salve the lacerating wounds that will last a lifetime. I believe you as Senators can help this, by recruiting them, recognizing them, giving them platforms from which to tell their stories. Maybe it's because I'm a reporter, but I believe that through their stories the awful stigma of addiction will be reduced.

I'm happy to elaborate on any of this.

Before I do that, though, I want to urge you to view this as an opportunity.

An opportunity to revive those regions hammered by globalization and free trade.

The roots of our national epidemic of narcotic addiction lie there, while the epidemic itself, in turn, stands in the way of their revival. Many cannot revive until enough of their people can pass a drug test to fill new jobs.

As politicians, your 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 believing in short-term responses.

CARA and the CURES Act make up a good start—thank you for them—but they are only a start.

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

American history offers two templates for action from which you might take guidance and inspiration.

The Marshall Plan to rebuild Europe after World War II, and our space program.

Each involved government and the private sector, acting in concert over many years—bringing money, brains, energy, and long-term focus to bear.

Each achieved an unalloyed good for our country—though they were about doing things that seemed, on first blush, far beyond our own short-term interest.

The Marshall Plan was about building up ravaged regions to allow them to function independently, while containing the viral spread of Soviet communism. It allowed reborn countries to prosper and contribute to the world again.

A Marshall Plan for American Recovery might focus on rebuilding those regions that have been caught in dependence on dope and ravaged by economic devastation to contain the viral spread of addiction.

Through our space program, we were inspired to spend years and dollars, bringing together smart people—all to achieve something no previous generation thought possible. We ended up far beyond the moon.

The spillover in economic benefit, increase in knowledge, and in simple human inspiration is beyond calculation.

Seems like we might profitably apply these examples—the Marshall Plan and the space program—to the regions of forgotten Americans where this problem began. Let's do it not because it is easy, but as JFK said, "because it is hard." Because that's what Americans have always done at their greatest.

Like our space program, I believe such an effort will have to last for years to be effective, focus far beyond the immediate goal of drug addiction, and on the more profound problems of community destruction and the hollowing out of stretches of this country.

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

It offers an opportunity to reinvest in areas that need it most. A chance to inspire us as Americans to something great again.

It's an opportunity to bridge the political polarization that so gnaws at our country—one of the few issues that can do that.

Do not miss this opportunity. It does not come around often.

I suspect this is the reason you got into public service. You are lucky to be here when it has.

You will be remembered for acting when acting was not easy to do.

Your hometowns will thank you.

Your counties will thank you.

We, your countrymen and women, will thank you long after you're gone.

The CHAIRMAN. Thank you, Mr. Quinones.

We'll begin now to have 5-minute rounds of questions. I'll say to Senators I'm going to try to stick to the 5-minutes because we have lots of Senators who want to ask questions, and I'll be glad to stay for a second round of questions if any Senators would like to.

Senator Paul.

Senator PAUL. Mr. Quinones, thanks for coming. The book was great, and I think—

Mr. QUINONES. My pleasure.

Senator PAUL —when you write a book, you're not sure how many will read it, but you're also not sure how much public policy effect it will have. But I can see copies around the desk, and I would say half or more of our Committee have read your book probably, at least. It's having some effect on the public policy, and that's why you're here.

As I read the book, I was reminded when I was a kid, I used to visit my grandparents in Pittsburgh, and there's a big pool like Dreamland. It's 100 yards long, built around the same time, probably in the 1930's, and an amazing pool—100 yards long with the slides in the center, and so you can see how the community was surrounding that pool and the activities.

As I read through the book, and we try to think what we can do better or change, the idea that Big Pharma lied and committed fraud is a part of the book and a part of the problem. They were punished, but we need to make sure that people cannot lie and that it is fraud and that it's punished and it is preempted in some way. Some of that can be Federal. Some of that could be state law.

As a physician, I continue to become more and more alarmed that our profession was part of the problem, and we've tried to fix it. In Kentucky, we've done a lot of things. We monitor, and you can type into the computer a patient's name and find out if they're seeking different doctors, or have they gotten opioids somewhere else 2 days before. We have gotten rid of the bad doctors, the doctors you mentioned up south of Portsmouth, you know. They're mostly gone. The pill mills are no longer in Kentucky, and yet we have a county up in the mountains that has 21,000 people last year

that had 2.8 million doses of hydrocodone and oxycodone. This is after all of the stuff.

So all of the stuff—everybody knows it’s a problem. Everybody knows more people are dying than are dying from car accidents, that it is a horrible problem, and it was worse last year in this county. They prescribed more. And, in fact, since Medicaid expansion, it’s an 11 percent increase.

So when we look at what we do, we say, “Well, let’s have a Marshall Plan or let’s spend more money.” We have to think about how we spend it and what we do, because we want more people to have healthcare, so we expanded Medicaid. If you look at the expansion of Medicaid and you put that map overlaying the United States, you have an overlay of the heroin problem and the opioid problem, and it’s related to poverty and the expansion of healthcare.

So in your book, you talk about, well, you can get—for \$3, you can go—you don’t have to pay \$200 to go—now you pay \$3 a month, and you can get it and trade it and all of that that came. So we do have to figure out more rules on this. We have some new rules in Kentucky on acute management, but I think the hard part is the chronic. So if I’m your physician, and you’ve been on it forever for low back pain, how do I get you off of it, and how do I get you to keep coming to me? Or would you just choose another doctor if I take you off of it?

So I guess that’s the problem, and the question is: We all know the knowledge. People have read your book. We know there’s a problem out there and we’ve done some changes, and yet we still have this enormous prescription opioid problem. So what do you think we do beyond that? I agree with you that community—more local than Federal is probably better and it’s a local response. But we still—how do we fix the medical aspect of this? How do we go a step beyond where we are?

Mr. QUINONES. Well, I mean, there’s a lot—that’s a massive question, and I think there are smarter people than I who might also contribute to it. I think one of the reasons that you find that kind of correlation between heroin overdose and Medicaid expansion is because more access to medical care means more access to pills. We still have not changed, really, the basic culture, and one of the reasons of doctors to prescribe pills as a solution.

So it seems to me that crucial in all this is that we get back to what we were doing in the 1970’s, and that is where insurance companies were reimbursing a wide array of strategies for pain. They have cut back significantly in many areas, I think, that for one time I think it was all across the country. Some insurance companies are stepping up a little bit more.

But, to me, it gets back to what the doctor has available to him or her in the appointment, at the point of contact with the patient. To me, that feels like a crucial step. Every place I go to speak on this topic, I run into doctors who tell me that they just don’t have much in the way of other options to provide.

Senator PAUL. I guess the hard part of this is, like, I live in a county where we have 4 percent unemployment, and the employers come to me and say, “We can’t find enough workers who are drug free and have a work ethic.” There’s not enough workers. Then I have counties where 30 percent of the people don’t work, and 30

percent of the people are disabled, whereas in my county, 4 percent of the people are disabled.

So the problem is we all have big hearts, and people say, “Well, let’s help the disabled. Let’s help the unemployed,” and we give them stuff. But perhaps once you become a non-worker, a permanent non-worker, we get you into this cycle where it’s much more difficult to avoid addiction.

Mr. QUINONES. Oh, I agree.

Senator PAUL. So we have to figure out how to do it with both a heart and a brain, where we have work requirements and where you’re only temporarily disabled until you’re back in the workforce. So it might involve money, but we do have to be careful about how we do it, such that they don’t have perverse incentives.

Thank you.

The CHAIRMAN. Thank you, Senator Paul.

Mr. Quinones, you can see the little time clock we have on these Senators, because everybody will be very interested in having long conversations with you. So we’re going to try to wrap each segment up in 5 minutes, and then we’ll keep going as long as we can.

Mr. QUINONES. All right, then.

The CHAIRMAN. Senator Murray.

Senator MURRAY. Thank you, Mr. Chairman.

Thank you very much for your compelling testimony and thoughts. Specifically here, I wanted to talk about the Federal Government. We play a very critical role in preventing and tracking and solving this epidemic and in some areas have truly unmatched capacity and reach to be able to affect broad change.

One example is the Centers for Disease Control and Prevention. They provide funding today to 45 states and Washington, DC. They support prescription drug monitoring programs, are invested in running a much needed public awareness campaign, and manage a critical national surveillance program, which is the only surveillance program to capture non-fatal overdoses as well as fatal overdoses, and it uses some innovative ways to get timelier data.

That public awareness program actually started under the Obama administration back in 2016 to raise awareness of the opioid crisis and is funding states to actually personalize and disseminate this messaging. This administration has repeatedly requested cuts to CDC’s budget.

So I wanted to ask you—you have mentioned in your writing that we need quality data collection in raising awareness in communities. Can you share your thoughts on the necessity for continued robust funding for programs like that in CDC?

Mr. QUINONES. Yes. I would suggest that the evidence shows it is probably a good idea. I would also say that I think we need to greatly expand the amount of money we provide for research about addiction as well as pain management or pain treatment.

All of this is part of all these many solutions, and when I talk about the Federal Government’s role in all this, it is in no way to suggest that it has a dominant role or that—I believe the important stuff is going on very often at the local level, and the role of the Federal Government might well be to just simply facilitate, make easier their lives. I think CDC has a number of proposals and programs that I think are extraordinarily effective.

I would say that when I was doing this book, I found almost nobody who wanted to talk about this except for government workers. This was the first line of defense in this. When nobody really knew about this topic, when nobody really cared, when I thought I'd bitten off an enormous contract to write a book and put my family at jeopardy for a story that no one cared about, the people who really did care, who were working on this from the beginning—cops, coroners, CDC, DEA, prosecutors, public health nurses, all of whom were gaining—earning a government salary, many of whom were at the local level. Of course, CDC is not that.

But I believe that the folks at CDC do remarkable stuff. In fact, I was a crime reporter. I am a crime reporter and did not write a word about healthcare until I wrote this book, and my overall feeling is one of awe for our public health folks. Honestly, they have done amazing work in the face of almost rare thanks. I would put it that way.

Senator MURRAY. I also want to ask you—you've written about the importance of Medicaid expansion to make sure patients get medication-assisted treatment, key to responding to part of this very complex crisis. In fact, Medicaid expansion allowed about 1.6 million previously uninsured people with substance use disorder to get the healthcare and the treatment for mental and health that they need to fix this.

Can you talk a little bit about the importance of Medicaid in making sure individuals with opioid—

Mr. QUINONES. Well, Medicaid expansion provided drug treatment for people who did not have it, hundreds of thousands of people in different states. It's extraordinarily important, I think. I know people in different communities who have been enormously helped by this. I don't want to downplay, though, what Senator Paul was talking about, which is that you do have increases in overdose when that happens, and I think one reason for that—my hunch is that in too many communities, pills are still the only medical treatment that's—

Senator MURRAY. An important part of that is also the mental health support and everything else that Medicaid brings.

Mr. QUINONES. Of course. When you get more access to healthcare, there are other things that come along with it, and I think one thing that does come along with it is a reliance still to this day on these pills. We have dropped our prescribing, but it's still at about 2006 levels and almost triple what it was in the late 1990's. To me, that means that we probably still rely far too much on these.

That said, of course, I do not understand the impulse to strip away Medicaid expansion, particularly in areas where this problem is so intensively felt. To me, it feels like these are regions that desperately need the services that they've been provided through Medicaid expansion, drug treatment being primary among them.

Senator MURRAY. Thank you.

The CHAIRMAN. Thank you, Senator Murray.

Senator COLLINS.

Senator COLLINS. Thank you.

First of all, let me thank you for writing such an important book that offers us possibilities. What has been discouraging to me is de-

spite much greater public awareness and much more money and much greater intentions that the problem does not seem to be getting much better. One possible community-based approach was described in the *Morning Sentinel*, a paper in Waterville, Maine, and it struck a chord with me because law enforcement officials in my state tell me that their jail intake rooms resemble hospital emergency rooms.

So what some police departments in Maine—including in Waterville and Scarborough and other areas—are doing is they are telling addicts that if they come in with their drugs and turn them in that they will place them in treatment facilities. This is a whole different approach for law enforcement to take—rather than locking people up, helping them to get the help that they need. It's also very community-based, as you have suggested in your book.

In your experience, have you seen that type of program work better than the traditional approach?

Mr. QUINONES. A couple of things I'd say. First of all, in reference to your first point, Senator Collins, I think we need to keep in mind that we've been—this problem has been festering for 20-plus years. People come to me all the time—why isn't the—I'm like, "It's been going on for 20 years. We've been at this for a year and a half or 2 years." It seems to me that as a culture we need to learn patience and to not believe in silver bullet answers to mysterious problems like the mysteries of human pain. Those are complicated things.

So if we have not solved this problem in the last year and a half to 2 years, I would say, well, yes, of course not. We just need to keep working at it. It's not—these things exist because it took a long time for these things to exist.

Now, with regard to law enforcement, I'd say, in general, some of the most innovative folks and innovative things I've seen come from law enforcement. You'd think not. You'd think that law enforcement would be holding onto the old ways of locking people—no. I've been amazed to see the remarkably innovative ideas that are coming out of law enforcement. The one you mentioned is one of them.

The one that I mentioned in my written testimony is about the transformation of jail. I believe if we come out of this with a new kind of jail, a new way that jail is run, as you see, actually, in the State of Kentucky—two dozen jails doing this—that would be an enormous advance. And, what's more, jail would then be an asset, again, and not a liability. Today, jail is a liability. It's a place where you take people who, once they've detoxed, want to see clearly the records of their own lives and want to change, and then we put them in a place that is tedious, predatory, ganged up, sexual stuff going on, all that kind of baloney.

The pods that I've seen in certain jails—and one, in particular, in Kentucky—are a remarkable change, one of nurturing, one of coming together. It's where you're working on your recovery from the moment you get up at 8 o'clock in the morning and make your bed military style until 11 o'clock or whenever lights go out. That kind of change in jail would be enormous. As I said in my testimony, I tried to highlight things that I thought would not just be

beneficial to this problem, but for the next drug problem as well, so we're not playing whack-a-mole with this stuff.

So I believe jail, in fact, is one of the great places of effervescence, you might say, when it comes to this epidemic, and the way new ideas are being tried is in jail. I've never been to Maine, but it sounds like what you're highlighting is one of those. I do believe it's an essential part of this, that if we come out with jail the way we always have used to run jail, then we will not really have advanced. The next problem will hit us, and we'll wonder why we're not making greater advances. My feeling is changing jail is the way it's happening. It's not just a revolutionary idea. This is an—you can find various examples of this around the country, and it's very invigorating to see it.

Senator COLLINS. Thank you.

The CHAIRMAN. Thank you, Senator Collins.

Senator CASEY.

Senator CASEY. Thank you, Mr. Chairman.

Mr. Quinones, thank you for your testimony and for your work on these issues.

Mr. QUINONES. My pleasure.

Senator CASEY. I wanted to start with some of the realities that, at least, I see in a state like Pennsylvania. We've had, last year, the last count in 2016, 4,624 overdose deaths. That's up 37 percent from the prior year, 2015, and in rural areas, higher, almost 10 percentage points higher by way of percentage of an increase. That's overdose deaths overall, obviously a lot of that being driven by the opioid crisis—epidemic, really.

What I see—and I missed some of your testimony going back and forth between hearings. But what I see in Pennsylvania is a tremendous resource gap. When we went across—when I went across Pennsylvania the last year, especially this past summer, we would have meetings with county officials, often in small rural counties, small town counties, where you have kind of a group of people coming together. You have the mayor of a small town and the police chief and the coroner and the medical professionals, the treatment professionals, all around the table, meeting all the time, every week, because the dead bodies keep coming in.

One county, a very small county, said to us—maybe the most graphic metric was they didn't have enough places to put bodies. That's how bad it was.

So it's everywhere, but what I keep hearing from folks at the local level is, "We need more resources. We're getting our arms around this. We're dealing with it as a local community, but we need more resources." They certainly need it for community health workers, social workers—law enforcement, obviously, is bearing a lot of the burden—pathologists and otherwise.

So I guess the first question I'd ask you is what recommendations do you have for closing that resource gap, which I think is a—even though the Federal Government has made some strides, as you note, with Cures and with CARA, what's your sense of the ways the Federal Government can provide more resources?

Mr. QUINONES. Well, in speaking with people in the county—this is one of the great places in America where this is taking place. Counties are the level of government most affected, right? It's coro-

ners, jails, libraries, public health, sheriff, et cetera, courts. So I've been struck, particularly in the last year, year and a half, to watch these very organic task forces or committees or what have you—whatever you call them—sprout up in county after county.

In fact, in Pennsylvania, I know I was in Lycoming County, which is—it's the home of Williamsport where they hold the Little League World Series. I spoke with those folks at some length. Yes, these folks are coming together in very healthy ways, it seems to me. They are leveraging a lot—there's a whole bunch of people on that committee in Lycoming. There's recovering addicts, primary care docs, I mean, a lot of different folks.

Speaking with the president there recently, she said, "You know, one of the problems is we cannot find—we can find money for programming, for naloxone, for whatever. We can't find money for the nuts and bolts that make it work, like office space and telephones," that kind of stuff that is as essential if not as sexy as the other stuff.

To me, I think that's where the Federal Government needs to step up, and I would say again, as I said in my testimony, that CARA and the Cures Act—that's wonderful. Thank you. But do not think that that—we've been doing this for 20 years, overprescribing, creating addiction unintentionally for 20 years. One year, \$1 billion—it's a lot of money in some sense, but in comparison to what the country needs—it's in every state in America. There's an unprecedented problem, because it's in every state in America, coast to coast.

So this is—what I'm suggesting is that the evidence shows that there's a need for sustained—I'm talking years worth—sustained investment in, I think—thinking in terms of, for example, this more mundane idea of how to let their job be easier. Well, fund the office space, fund the telephones, that kind of thing. And, again, we could talk later if you like about the issue of coroners. But, to me, that's a crucial part of this as well.

So I think—I know it feels like a lot of money—a billion dollars. It is a lot of money, but not compared to the breadth and depth and length of time of this problem. It seems to me that this needs to go for some time now.

Senator CASEY. Well, thank you for that, and I know we're out of time. I actually introduced a bill to commit \$45 billion over 10 years, so roughly \$4.5 billion a year. I borrowed the idea from, of all places, the Republican version of the repeal of ACA, where they were setting up a separate fund. So I just took what I thought was a good idea and made it into a different bill. We're hoping that we can get support that will be bipartisan. But we appreciate your testimony and your commitment to these issues.

Mr. QUINONES. My pleasure. Thank you for having me.

The CHAIRMAN. Thank you, Senator Casey.

Senator Young.

Senator YOUNG. Mr. Quinones, thanks for being here today. Thank you so much for writing this important book, and I appreciate your visit to Zionsville, Indiana, to visit with us last week.

I'd like to discuss our children. Thousands of children across my state and really around the country are having their lives turned upside down on account of this epidemic, not because they are ad-

dicts, per se, but because they're being removed from the home. Their parents have become addicted. They're entering an already overwhelmed foster care system.

You've identified in your book a need for more services for families. Can you elaborate on what, specifically—what sort of either programmatic needs there are for families or resources in your experience that might help mitigate this crisis?

Mr. QUINONES. Well, I think—honestly, as a reporter, I would like to say that probably you'd be best off talking to people who work in that field. I do think one of the areas that's just been devastating is foster care, though. I mean, my goodness, there's so much need now. If it weren't for grandparents in America today, it would be just mind boggling to think of what the need would be. I mean, seriously, so many kids are living with their grandparents now because their mom and dad are gone or they're in prison or what have you.

So my feeling, just on a very blunt basic kind of macro level, is that we need to look at how to fund more foster care. How to do foster care better is most likely another great question, but it's not one I feel I can answer.

Senator YOUNG. Well, I think your larger point about the solution, if you will, to this broader epidemic is hundreds, thousands of individual solutions, and, collectively, many of them fall under the banner of community.

Mr. QUINONES. Absolutely.

Senator YOUNG. If we can persuade individuals that a fellow human being's plight, a fellow child's hard luck, is actually their own plight, then we can entice more people to be foster parents, to care for these children, to lobby on their behalf and so forth. So I think that's a good overall message that I've taken away from your book.

We've already discussed jails, and in your book you highlight some jails that offer rehabilitation services, and, peculiarly, in those areas, you have people putting themselves into the criminal justice system just so they can get assistance, or you have the relatives or friends doing so. I'd like to sort of discuss a different sort of setting.

I've visited with jails. I used to represent in the House of Representatives, Austin, Indiana.

Mr. QUINONES. I've been there.

Senator YOUNG. You know that name, because we have a huge HIV outbreak there on account of the intravenous use of an opioid by the name of Opana. Many local sheriffs in communities like that around Indiana have a strong suspicion, because I've spoken with them, that their inmates have either HIV or Hep-C or something else that they might typically test for.

But they have a moral dilemma. They're on the horns of a dilemma because if they test these individuals, they are legally on the hook to provide medical services to them, and in a place like, say, Scott County, Indiana, that would deplete their entire law enforcement budget for a year if many of them tested positive.

Now, look, I'm not asking you be a magician here. But, No. 1, have you encountered this dilemma, and if yes, do you have any thoughts about how we—

Mr. QUINONES. I honestly, Senator, have not. I don't doubt it exists. I mean, nothing surprises me anymore about this topic, I have to say, but I don't doubt it exists. You know, all I can say is that this seems to be the nature of this problem, that we are asking, well, in one case, foster care, but in another case that you just mentioned, jailors to be, again, the magicians, to figure out this deep social problem that I don't think they have an answer for—they do not have an answer for, nor do they have the funding for.

What they go about doing—sometimes I'm a reporter. Sometimes I just have to say, I mean, I don't know. Honestly, sometimes it gets to that point where I'm just kind of overwhelmed by all the ways that this problem manifests itself. I do believe locally is the place where we find the solutions, but that you all have an absolute role in facilitating, making sure that they have the resources they need, because on the ground, I have to say the counties, the people in those counties that I've been to, are working hard and working very imaginatively.

So you going to them and finding out what they need, to me, seems to be the way we proceed on this. I don't believe that—I do not believe most of these solutions are many from Washington, DC. I do believe, absolutely, Federal Government has a profound role in helping those solutions and facilitating those solutions.

Senator YOUNG. I agree. Thank you.

The CHAIRMAN. Thank you, Senator Young.

Senator Bennet.

Senator BENNET. Thank you, Mr. Chairman. I very much appreciate you having this hearing.

Sam, it's nice to see you again. Thank you.

Mr. QUINONES. You too, Senator.

Senator BENNET. Your book is one of the most compelling pieces of nonfiction I've read in a long, long time, and it's very, very depressing. The story you tell about something we haven't really talked about, which is the heroin epidemic that rode on the back of the prescription drug—I mean, you just tell it brilliantly, and my reaction when reading it was this was all happening in plain sight, but somehow we missed it.

Today, 42,000 people a year are dying from this. The White House estimated that this is costing the United States economy \$504 billion a year. So a billion dollars is a lot of money, but it's .2 percent, what it's costing our economy. And the rural counties in my state—now, this isn't just about rural counties anymore, but the rural counties in my state, where you go and the sheriff tells you that 92 percent of the people he's admitting into his jail are testing positive for heroin, or the jailor who opens up his jail and takes you to the back and opens the window and says, "Look, look," and you say, "Well, what are you showing me?" "There are women in my jail. I've never had women in my jail," and they have two jail cells full, and we're spending .2 percent on treatment, targeted treatment.

So I'm all—as a former local person—all about people in the local community. But they can't do it without resources, and in the rural counties that I go to, if anything, they have less access today to addiction treatment than they did 10 years ago. So it strikes me that

we're moving in the wrong direction. I wonder whether you'd want to comment on that.

Mr. QUINONES. Well, there's a lot to comment on. One of the problems is that with our opiate—with our overprescribing of these pills, we, in time, created legions of addicts, and that, in turn, awakened the vast logistics potential of the Mexican drug trafficking culture, which I lived in Mexico 10 years and know fairly well.

Most traffickers never really cared to traffic heroin. It's viewed as a pretty disgusting drug, and people are far more enamored with meth and coke and stuff. So they didn't really traffic heroin, or they didn't really want to get involved in it too much until we began to—and now, of course, their profit motivation is that that radar is at a very high level, and they want to get involved in that, and it's exploded the numbers of people who are trafficking it, I think, from Mexico and elsewhere. So that's one thing.

As I said before, I believe that the community solutions—community is where it seems to me that I have seen people working hard and coming up with solutions appropriate to their counties and their regions. I do not believe that they can continue long-term without a whole lot more help and sustained, as I said, long-term focus from the Federal Government. I believe that a lot of folks are looking to the Federal Government, Republican and Democrat, right wing and left wing, in this fight for sustained help, not one off kind of idea.

Senator BENNET. Could you also say a word about—you mentioned it very briefly earlier—about the ways in which health insurance reimbursement create challenges for the work at the local level that people are trying to do? What are you writing about the inability of people to get low-cost social work, for example, reimbursed as opposed to pills, which—

Mr. QUINONES. Right. Initially, in pain management—for many years, pain management was to take one individual and design over a period of time in close connection, the patient and the doctor together—design a menu of strategies that would help this one individual. So one individual, many, many, many strategies—marital counseling, diet, acupuncture, on and on like that—physical therapy, et cetera, social—job therapy.

As we began to believe that one pill—one kind of pill or drug would be the solution to all pain, insurance companies dropped a lot of that, and you couldn't really design the full panoply of strategies—a doctor could not—because you were no longer getting reimbursed for a lot of that. To me, I think that's fundamental in this whole problem.

Doctors need to be more educated, but when they get educated, they also need to have the tools. And doctors were told, "There's a pain epidemic in this country," and, increasingly, through the 1990's and the 2000's, they were left with one tool, and that's a big reason why we got into this.

So my belief, strongly—and this comes from talking with lots of doctors about their dilemmas—is that they need more solutions in that moment when they're meeting with the—and some places are doing it. By the way, the VA—hats off to them, I think. They started us—they were a leader into all this, and now they've done a U-

turn, and I think you can get yoga, acupuncture, et cetera, as well as some dose of opioid pain killers, not to say that these drugs have no use. They are absolutely useful in certain windows. So I think we are seeing these kinds of changes.

It seems to me that the reimbursement for different kinds of pain strategies is just like a fundamental part of this.

Senator BENNET. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Bennet.

Senator Murkowski.

Senator MURKOWSKI. Thank you, Mr. Chairman.

Mr. Quinones, welcome, and thank you for your leadership on this issue and really raising that level of awareness. As you point out, this has been out there for a while. But I think my colleague just mentioned it's been growing in plain sight here, and thank you for acknowledging that there is no one silver bullet. I think you said it's a complicated—no silver bullet for a complicated adult problem.

Yet we all know, as has been mentioned, it's not just an adult problem. Our children are dying of overdoses. Our children are suffering because the parents are checked out.

I went to a senior center. I was sitting with a group of primarily senior ladies, and I said, "Well, if I weren't here having lunch with you today, what would you be talking about?" And they looked around, and they said, "Where we would find services for our grandkids, because all of us, all of us, are taking care of our grandkids because our kids are either in jail, have given up the kids, or whatever." So this is truly a problem that consumes all ages, all spectrums, all classes.

I'm interested in your suggestion that we need to look at this from a very, very broad perspective and really strive high—a Marshall Plan, follow the same lines of the space program.

Mr. QUINONES. Yes.

Senator MURKOWSKI. The problem that I see with that is we are still suffocated, strangled, by the stigma that is attached. It seems like it's just been recently that you will see in the obituaries that there is an acknowledgment that this young person or this individual died from an overdose.

But we have buried it because there's a sense of, "Well, I failed as a parent if my kid died from a drug overdose." So until you can get beyond that stigma—I think are still so many that it's like, "Well, those are the ones who just couldn't make it. Those are failures, losers," which is a horrible thing to say, and I even hate to say it in front of a microphone. But there is that stigma that is out there.

So how do we get people galvanized to help and to be inspired to do something as big as—I agree with you. This needs to be in order to make that difference. Are we making headway in reducing the stigma?

Mr. QUINONES. Yes. A great question, Senator. Thanks for asking. I think, definitely, we are. I can tell you in 2013, I was writing this book, and I had a conversation with my wife. I said, "You know, we're going to write this book. We're going to put it out and fulfill the contract. But the truth is it's going to die when it comes

out, because nobody in this country cares about this problem." I could not find anybody to want to talk about it, except for a public health nurse, an occasional narcotics officer, or a judge.

But everybody else—and the reason was—one of the main reasons was that parents or families were mortified, embarrassed. This is a different kind of problem than has existed in the past. People were mortified at what had happened to their children, and you never, ever saw an obituary that told the truth. It's like the AIDS thing early on, the AIDS issue. People were like, "Well, he died of cancer." Well, in this case, it was, "Well, he died at home of a heart attack at age 25."

Now, I believe that what is helping to change that—I think similar to say the gay marriage issue, which is a radical transformation in public attitudes in the last 10 years—is getting to know people who are actually affected by it. That's where I believe—I know you've heard a lot about how you need to provide more funding, but I do believe you have a public profile role as Senators. If you go to communities, find those parents, talk to them, point out the programs, meet with those county groups that are sprouting up all over the country—it's amazing to see this—and lend your own high public profile to them.

Meet with parents and say, "Thank you, tell us your story." Recruit them. I think, frequently, there's a lot of folks who would go along—would do that if they were asked, if they were pled with—please do this. And as I said in my testimony—maybe it's because I'm a reporter—but I believe in the enduring power of story to change people's minds. We have, as human beings, from the pre-historic times until today, always needed stories to help us understand. The only people—and the reason this was not very well publicized years ago and hidden was because the people who could best tell the story didn't want to talk.

Now, increasingly, they want to talk, and it's so important to embrace them, to bring them out of the shadows. They want to, many of them—some of them not yet, but maybe someday soon. And with that, my feeling is there's a horrible stigma, exactly as you say, and that one of the main ways we defeat that is through stories. I believe, as public officials, you all could have a magnificent role.

Whenever you go home, whenever you go to some public event that may deal with this, find those parents, bring them out, have them talk a little bit about their lives, recruit them, give them a phone call saying, "Hey, I heard this happened. We would love for you to tell your story. If you can't right now, fine." But just let them know we're here together. So many of them felt alone. They made horrible, bad mistakes because they thought there was nobody else nearby to—that they were all alone in this. I think defeating that isolation, again, is part of the many, many solutions, the things that have to be tried.

Senator MURKOWSKI. That's a great reminder to us that it's not just all resources, but that we can have that role, too.

Mr. QUINONES. Yes.

Senator MURKOWSKI. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Murkowski.

We have several Senators remaining who want to ask questions. So I'm going to try to stick to that 5-minute—

Mr. QUINONES. Okay, my bad; I'm sorry.

The CHAIRMAN —if I may, just so we have time for everybody to be involved.

Senator Murphy is next.

Senator MURPHY. Thank you very much, Mr. Chairman.

You know, if one of us were to go down to the Senate floor and give a speech on loneliness, we would worry that we would come off sort of feeling or looking silly. And yet if you look at the map of the suicide epidemic in this country, the crisis is the worst where social isolation is the greatest. If you read Pete Earley's great book about the mental health crisis in this country, he comes to the conclusion that in the end, the only really effective treatment programs are the ones that build connectivity between people.

You didn't title your book *The Great American Heroin Epidemic*. You titled it *Dreamland*, and you made your case in your opening comments, that this is really about connectiveness. But the story of *Dreamland*, that pool, is a complicated one. It was a private, low-cost, community pool that closed in part because of factors that were outside of government's control. People just had a lot more going on in their house. They had their own pools. They had more TV channels, and kids had lots of reasons to stay inside.

Yet you are sort of—you hint at being critical about the decision by the government to let that pool close, because, theoretically, there were other options. They could have spent some taxpayer money in order to keep it open. They probably would have been criticized for throwing away money in a money-losing effort. But the result might have been that a community asset stayed open.

I guess—let me sort of take you from where you left off in your testimony. You focus your book on this question of building community, and we're really awkward when we try to address the ways in which government can build community and attack loneliness, because it sounds like something we're not supposed to do. Yet, at the heart, this is a critique that we should be thinking about those things.

Just share with us your thoughts on how we can change maybe the way that we spend money, the way that we do public policy, to try to build communities rather than tear them down.

Mr. QUINONES. I think it's to—the best idea that I can come up with is to consult those people who are already working on that, and I think all across the country, that's happening. That's another thing that's changed, in an answer to Senator Murkowski, that we have now on the ground lots and lots of people working on this in a variety of ways.

My feeling as a reporter is always to go there and ask them, but also understand that government has, it seems to me, an essential convening role by providing the infrastructure that does bring people together. That includes stop signs and good roads, by the way. I mean, that kind of thing, but also funding to provide the community centers and this kind of thing.

I think you guys might talk more about that on the Senate floor, honestly. I think it's not a conversation that we have enough in this country, and you all might be the ones to perhaps lead it, honestly. I think we'd all be inspired if you did, seriously—my feeling, anyway, would be.

How do you do that? I mean, I'm a reporter. I'm not sure I know all the ways. My impulse as a journalist is to go to those areas, talk to as many people as you can, and also highlight them. As, again, I was saying to Senator Murkowski, just find the people who are working hard. Find those community coalitions, those task forces, and your presence at one of their meetings would be huge, huge. Try that. Try doing that. It's a great idea. I mean, try to be there with these folks and understand and see.

Will it be a PR event? Probably. Who cares? You want to highlight—these are the folks working—and from that kind of—that's how innovation works, right? You've got—on the factory floor, you've got the factory worker, the supervisor, the computer software guy, the accountant. They're all putting their brains together and they're finding little incremental ways to make that product better, and that's—I think cities and towns work the same way. No magic bullet, no silver magic wand. Just slow incremental work.

Senator MURPHY. I just raised the question because if we're going to spend an awful lot of money on this epidemic, I think it's worth challenging us to think about the ways in which we can—

Mr. QUINONES. Oh, most definitely, and I'm not saying I have all the answers, either.

Senator MURPHY —be in the community as well as paying for treatment, right?

Mr. QUINONES. Absolutely. No, I do believe in the overall—if somebody asks me, "Well, what are some of the details?" I don't have a clue. I'm not—I'm just a guy, a reporter out there trying to understand this enormous country we have, and sometimes it's hard.

Senator MURPHY. Thanks, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Murphy.

That's a pretty good description of the way we feel.

Mr. QUINONES. Yes, I bet you do. I don't blame you.

The CHAIRMAN. I want to ask you about the Holy Grail, your chapter, "Searching for the Holy Grail." What do you think about that? You don't pretend to be a medical expert, but why is it not a good idea to try to find non-addictive pain medicine?

Mr. QUINONES. You know, it's a strange thing. My friends from college would look askance when they hear me say this, but as I got into this story, I, for the first time in my life, began reading philosophy about how we create happiness as human beings, how we achieve—what is happiness? How do we—because it seems like all these people all across the country are looking to this substance in one form or another of opiates to be happy, at least for a few hours.

It seems to me that—a few ways that I think the philosophers that I read talked about—working hard toward something that you are fulfilled by, that you are excited by, that you love to do, and along the way comes a fulfillment that we call—

The CHAIRMAN. But if I may interrupt, in your book, you go through how, first, opiates were used to help people dying who were in horrible pain. Then it appeared that, erroneously, they might not be addictive, and so this whole revolutionary, as you describe it, way of making pain a vital sign came about. Then they turned out to be addictive. But just because opiates turned out to

be addictive, is that a reason not to try to find other medicines that are non-addictive—

Mr. QUINONES. I would never stand in the way of—

The CHAIRMAN —for people who are in severe pain today, and the hundred million who have some pain?

Mr. QUINONES. Exactly, and I would never stand in the way of science. But I feel that in the long run, we are humans, and humans have never done well when they have it all, when they have all the pain treatment and none of the consequence. To me—this is a hunch. I'm not saying I know, and if 10 years from now, science has come up with a pill that reduces all pain to negligible amounts and does not addict anybody, I'd be thrilled and happy for those people who benefit, and I'd probably be one of the—

The CHAIRMAN. Well, it sounds like with your general approach, you—and I don't want to put words in your mouth, but it sounds like you would suggest if that could be possible, that would be good if it were, but it might only be one strategy for dealing with a complicated—

Mr. QUINONES. I believe other strategies—given the fact that we are humans and need friction and tension in our lives to actually be productive and be happy, in fact, I believe that there are other things that need to happen in American culture. I believe as individuals—when I was writing this book, I stopped drinking sodas. I believe—I wanted to be the change that I wanted to see in the country, so I stopped eating food that I saw advertised on TV. I felt that it was important to do things that would reduce the chance that I would have of pain.

I have no problem with research trying to find a pill that would be completely pain killing without any addiction. I just have a skepticism that in the long run it would be—that we would, as humans, be able to handle it, that some problem would—we behave very poorly. Kings, dictators, Hollywood producers apparently these days behave very poorly when they have no other friction in their lives, nobody to—no accountability.

The CHAIRMAN. I mentioned earlier that yesterday, I dropped by the Governor's residence, and he had a meeting of all the people in the state and the universities who were in charge of training physicians with the goal of changing their attitudes toward prescribing of opiates. One of the health officials there said to me when I told them that I would be hearing from you today—said, "Ask him about fentanyl and where it fits. So in 50 seconds, can you tell us about that?"

Mr. QUINONES. Fentanyl has transformed the heroin market completely. It has democratized it. Used to be when heroin was in our country, we knew it came from four or five Mexican states. Now, it could come from Hungary, it could come from Nebraska, from Canada. It has made heroin dealers far more willing to kill people.

Used to be for many years, you got—one way you got customers was by overdosing your clients. When someone overdosed, that was not a warning. That was an advertisement on the street. A lot of addicts ran to find that dope that just ODed that person or killed them.

But that was very expensive to do. In heroin trafficking, what you want to do is cut. You want to reduce—because it gets you more volume. So you get a kilo, you cut it into two or three, and you sell that. But it's weaker—less chance of ODing people.

So what fentanyl has done—has made it far, far cheaper to OD people and therefore create buzz around your product. It's a diabolical thing to describe. But that is the nature, it seems to me, of this world. Also, it has allowed many, many, many more people to get involved in this, and by the Dark Web—it's coming from Mexico, but it's also being sold on the Dark Web very prevalently, and that has allowed a lot of people now to get involved in selling it that probably never would have before.

The CHAIRMAN. Thank you.

Senator HASSAN.

Senator HASSAN. Thank you, Mr. Chair and Ranking Member Murray, for holding this hearing.

Thank you, Mr. Quinones, for being here and for your work. Just at the outset, I would say that some of the themes you've touched on today about community are also themes that the author and sociologist, Robert Putnam, has touched on in his book, *Our Kids*—

Mr. QUINONES. Absolutely, yes.

Senator HASSAN —and I think your book and his together are really important.

I want to just start by laying a little bit of groundwork. I was Governor of New Hampshire starting in January 2013. I'm also a Governor who worked with my Republican legislature to implement Medicaid expansion which was implemented in the middle of 2014 in August, I think. In 2013, we had 192 overdose deaths in New Hampshire, and in 2014, 326. We were on an upward trajectory, even before Medicaid expansion.

In fact, one of the reasons we all came together to implement Medicaid expansion is because we had a crisis in our behavioral health and drug overdose deaths in our state, and we knew that Medicaid expansion would get more treatment to people. And my own anecdotal sense that Medicaid expansion did not, in fact, cause an increase in opioid deaths is reinforced by a recent article in *Health Affairs*. So I just want folks to have a sense of that. I think there may be a correlation here. But to suggest that there is a causation is very troubling to me and I also think speaks to some of the stigma issues that you've talked about.

I do also want to thank you for your insistence that this is a problem that was decades in the making. It is going to be decades in the fixing, and it requires subtle approaches and approaches that can evolve with the way this epidemic is evolving. To the Chairman's point, fentanyl in our state has changed a lot in the way law enforcement and the treatment community addresses this. So I thank you for your advocacy for that.

I want to spend a little bit of time on one of the issues that I don't think we've touched on as much right now as it deserves. In your book, you chronicle the so-called Porter and Jick letter—

Mr. QUINONES. Yes.

Senator HASSAN —which was a 1980 letter to the editor of the *New England Journal of Medicine* that was completely misinterpreted and used by prescription opioid makers to claim that their

products are, quote, “virtually non-addictive.” Doctors also wrongly relied on the letter as scientific evidence that addiction is rare when using opioids. It’s astounding that one paragraph jotted down in 1980 helped fuel the horrible epidemic that we are seeing today.

Your book outlines how drug companies have played a big role here and how some of them have misled patients, providers, and public officials about the addictive nature of their products.

Can you give us a brief overview of the role of the pharmaceutical industry in creating the misconceptions about the Porter and Jick letter?

Mr. QUINONES. Brief?

Senator HASSAN. You’ve got a minute and 45 seconds.

Mr. QUINONES. I’ve got a minute and 45 seconds. Well, I think the evidence shows it was pivotal in all this. This starts really with pain specialists believing that we were poorly treating pain, and we were. This was not—this is a story of a lot of people doing what they thought was the right thing, but doing too much of it, maybe, or—it turned out badly.

I don’t believe that they would have had the megaphone that they came to have were it not for a lot of the money and the funding and use of their—the selective use of their information by pharmaceutical companies. I think their money and influence was what really changed the tide, and then, of course, they were joined by certain institutions, like the VA and JCAHO, the hospital accreditation organization, the fifth vital sign, and all that kind of stuff.

But I think they saw early on—and Perdue was one of these that saw—that they had tried a time-released opioid, right, MS Contin, only for cancer patients, and it was a magnificent drug. Had they just kind of stuck right there, we’d have been applauding them.

Senator HASSAN. Right.

Mr. QUINONES. Instead, what they saw was that the dying cancer patient market was pretty small, and there was a much, much larger one called chronic pain or just normal pain of Americans, basically, and they got on board. This was also, by the way—an important part of all this is that these years were—involved a—the industry went through a sales force arms race, where every company was hiring more and more and more sales reps, and these were not the older sales reps who were really more grounded.

In fact, it’s my impression in talking with doctors who knew these older fellows—mostly guys—that these guys knew what they were doing, and they were not such a hard sell. They were more informational. And then you hire a bunch of young folks, a lot of very good-looking young folks, to inundate, and so our pharmaceutical reps went from something like 35,000 to over 100,000 in about a 5-year period. All of that also is part of this story.

I have to say this, though. This is a complicated tale, and I wanted to not blink at the complications. I believe also that we as Americans play a huge role in all this—our desire to have quick end to pain, to not be accountable for our own wellness.

Senator HASSAN. I think that is fair. I am over time, and I see that. I thank you for this. I also just won’t have time for a second round of questions. But I will say that in my state, the need for funding to support the grassroots efforts like our safe station programs and some of the things our law enforcement is doing in

treatment is critical, and I would look forward to talking with you more about that.

Thank you, Mr. Chair.

The CHAIRMAN. Thank you, Senator Hassan.

Senator Kaine.

Senator KAINE. Thank you, Mr. Chair.

Thank you, Mr. Quinones. I think *Dreamland* and *The Factory Man* are the two best works of reporting that I've read in the last 25 years.

Mr. QUINONES. Well, thank you so much.

Senator KAINE. I think it's tremendous work. I want to ask two questions, if I can get to two. The first one is we've had witnesses here, Mr. Quinones, and I've asked them the question—Francis Collins, Scott Gottlieb—could we set a goal of addiction free by 2030. I'm mindful of your point that there's no silver bullet. But I'm also mindful if you don't have a target to organize around—we will be on the moon by the end of the decade.

Mr. QUINONES. Well, that's probably true.

Senator KAINE. We will rebuild these economies and enable them to protect themselves from the spread of Soviet Communism. If you don't set the target, then you don't marshal your resources around meeting the target. So if you were to advise us about what the target would be—again, I posed the question to these folks, could we set the target of addiction free by 2030, and Francis Collins and Scott Gottlieb said yes, that's doable, if you define it the right way, and it's doable within the current scientific knowledge and technological—likely, near-term future.

But if you were to give us a target, what would you tell us?

Mr. QUINONES. If I were to give you a target, we'd all be in trouble. I would say that a target is good, and it's my hunch as an American that that is something to strive toward. It's always good to have a deadline, always good to have a goal. What that year should be and whether or not humans can ever be addiction free is a debatable point in my opinion. I'm not sure that's possible.

However—and as I said in some of my testimony, written and oral—to me, this is a supply story. I lived in Mexico 10 years, and when I was in Mexico, I grew—not having thought about it very deeply, I just adopted the idea that all our American drug problem was demand driven.

Senator KAINE. There's a lot of evidence for that. When you arrest a street corner dealer, another one pops up right there.

Mr. QUINONES. Of course.

Senator KAINE. You go after it on the supply side, but the demand is going to keep producing street corner dealers.

Mr. QUINONES. Yes, but what really—I agree. But what really—the primer and all that, the thing that starts it, I believe, is supply. I came to believe that after living in Mexico, where I believed the demand—because Mexicans like to believe that because it absolves them of the responsibility in our drug problem, which is really not our drug problem. It's a binational drug problem and needs to be addressed as such—us and them.

But when I started doing this book, I began to realize—no, that's exactly not what happened, that we had no real problem with this before this overprescribing of opiates. The difference in this story

is that the supply did not come from Colombian dealers and Mexican cartel guys from Sinaloa. It came from doctors buying into—sincere, well-meaning, good, well-trained doctors buying into an idea that they could help their patients by just massively prescribing these pills.

So the goal is a laudable one—the goal, the target, and all that. But to my way of thinking, supply is the issue—and, of course, that means pills, also with heroin and fentanyl—and, therefore, to get there, I believe, requires that—there’s a reason why all those guys from Vietnam came back addicted—so many of them kicked, because, first of all, they were no longer in war-torn Vietnam.

But second of all, they were in rural Tennessee, they were in Alaska—there was no supply. So they found it—the more you separate the addict from the supply, the better chance that addict has of success, and that’s what they’re finding in some parts of Portsmouth, Ohio.

Senator Kaine. Let me ask you a second question. I have a brother-in-law, Dwight Holton, who’s the—

Mr. Quinones. Well, I know him well, and I was going to say thanks to Dwight. He’s a wonderful guy.

Senator Kaine — U.S. Attorney in Portland, who then decided for his next gig he would be the CEO of a substance abuse and suicide prevention organization, Lines for Life. Dwight says this. He’s told me this many times. If there was a social movement for the recovering, it would become the most powerful political movement in the United States, because he’s grappling with this issue of how do you get over the stigma, and then Democrats, Republicans, red state, blue state—this recovering social movement would be massive and would help us meet whatever target we set. I’m curious what you think about that.

Mr. Quinones. Again, I believe, the more stories you tell, the more people who end up—this is what happens to me on airplanes all the time. I’ll start talking about the book I just wrote—or what do you do for a living? I’ll tell them, and they’ll start looking around like this, and they’ll touch my—and under their breath, they go, “Well, my cousin is—he’s doing 5 years in prison,” whatever.

I think the more those stories come out, the more we all know how many people around us have this issue in their lives, the more it becomes a way of—you don’t have to lower your voice anymore. It becomes natural. “Well—you know, recovering from X.” That’s why I think it’s very important for recovering addicts to mention that a lot, just because it normalizes and it makes us all understand that this is actually something that’s going on all around us. It is an amazing thing to have written a book like this and then go on the road and have these encounters in airports and places like that. So I believe in the power of story, as I said.

Senator Kaine. I’m over my time. But I really, really appreciate you being here today. Thank you.

Mr. Quinones. Oh, it’s my pleasure.

The Chairman. Thank you, Senator Kaine.

Senator Warren.

Senator Warren. Thank you, Mr. Chairman.

Thank you, Mr. Quinones, for being here, and thank you for your research on the rise in prescription opioid use. I want to follow-up on your point about supply. In your book, you write about a hospital in Columbus where a doctor in the Adolescent Medicine Department helping heroin addicts get detoxed talks about the kids he was seeing who had started with prescription painkillers. He says it was all of them. That's how all of them had gotten started, was with prescription painkillers.

Mr. QUINONES. Right.

Senator WARREN. A story that is true, I take it, for far too many Americans. According to the CDC, people who are addicted to prescription painkillers are 40 times more likely to be addicted than to heroin, and many people who misuse prescription opioids take the pills that were legally—start out with pills that were legally prescribed, whether it was to them or to a friend or to a relative.

I know you've written about your own personal experience with opioid prescriptions when your appendix was removed.

Mr. QUINONES. Right.

Senator WARREN. Do you mind saying a bit more about that experience, about how many painkillers—you can keep this one short—how many painkillers you were prescribed and how many you think you actually needed?

Mr. QUINONES. Sure, and I don't think my story is very—I think my story is multiplied by millions every year for 20 years. I mean, I had an appendix rupture at work when I was at the L.A. Times. On the night shift one night, I had a—I didn't realize it and went home and went to the hospital later. They said my appendix had ruptured, and I spent 2 days in the hospital. Each of those—it was a perfect example of what to do and what not to do in my case, I think.

Each of the two days I was in the hospital, they gave me two Vicodin—perfectly—very good idea. I had just been cut open—very good idea. And then when I left, they gave me a bottle of 60 Vicodin and said to take as needed. This was—again, I'm a crime reporter. I've done work on gangs and stuff like that. I did not—had never written about healthcare. I did not know—once I'd spent most of my last 10 years in Mexico, not really paying attention to this issue at all, I did not know what Vicodin was. I thought it was a glorified aspirin, because they told me as I left, "Take as needed," and I was like, "Okay. That sounds like aspirin to me." I don't like taking pills, so I took two of them.

Senator WARREN. So two—

Mr. QUINONES. Right, of the 60.

Senator WARREN —is what you think you actually needed, and you got 60. So you had 58 unused pills.

Mr. QUINONES. Fifty-eight remained in my medicine cabinet for 4 years until I got in the middle of this project and said, "I think I've still got that Vicodin." I knew now what Vicodin was and, sure enough, dug through and found it and disposed of it. But, again, a couple of things. That is a perfect example of the supply that we have unleashed on this country. You multiply my case by millions and millions of people every year for 20 years and you get to where we are.

Senator WARREN. So there's actually some data on this. There's a study in the Journal of the American Medical Association that found that between two-thirds and 92 percent of patients who underwent various surgical procedures like you did report that they end up with unused opioids afterwards.

Mr. QUINONES. Sure.

Senator WARREN. Just like you, a lot of these sit around in the medicine cabinet and can then fall into the wrong hands because of the wrong reasons.

Mr. QUINONES. Very easily.

Senator WARREN. As Senator Alexander very generously noted earlier, last Congress, Senator Capito and I had passed a bill to try to tackle this problem by letting patients request only a fraction, only a day or two's worth of their opioid prescription to be filled at the pharmacy, and if they're still in pain a few days later, they can get a few more pills if that's what they want to do. I know it's not—you've talked about how complex this problem is. But I just want to talk about that one little part.

Mr. QUINONES. I think that's exactly the kind of thing I'm talking about, these small solutions, many, many small solutions. One of them is to take that kind of supply out of the medicine cabinets of America, basically, and I think also to get doctors in the habit of questioning—I think it was routine for years in this country to prescribe 60 or 90 of these pills—get doctors out of that.

Think of the windfall, by the way, to a pharmaceutical company when a doctor in a white coat prescribes you 10 times more of the pills than you need, and you dutifully, like I did, say, "Oh, okay"—

Senator WARREN. Or in this case, 30 times more.

Mr. QUINONES. Sometimes, plus there's refills and so on. Again, I get back to the basic dichotomy here. This is a story built on belief in a magic bullet solution. No. I think there's lots and lots of little things, and what you're outlining sounds like to me one of those little things.

Senator WARREN. Good, and I just want to say on this we got the law passed here, but that doesn't make it a reality. So we've sent letters—Senator Capito and I have—to every Governor in the country, to a lot of the different medical organizations, asking them to back us on the implementation of partial fill, and, also, here we are, more than a year after the law has changed, and the Drug Enforcement Administration still has a definition of partial fill that is out of date, not in compliance.

So just a couple of weeks ago, Senator Capito and I along with Senator Grassley and Senator Feinstein sent a letter to the DEA to ask them to update these regulations. So, as you say, big and complex problem. We've done our part. Now, we've got to get the bureaucracy to get in line with this. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Warren.

Senator Baldwin.

Senator BALDWIN. Thank you.

I really appreciate your being here today.

Mr. QUINONES. It's my pleasure, Senator.

Senator BALDWIN. What an opportunity to really have a conversation. You chronicle this epidemic as having its roots two decades ago, at least.

Mr. QUINONES. Yes.

Senator BALDWIN. Yet we find ourselves still scrambling and in some cases not gaining ground but losing ground. I want to share—I represent Wisconsin, and the new front of this battle appears to be fentanyl.

Mr. QUINONES. It does, indeed.

Senator BALDWIN. In a community like Milwaukee County, the largest county in the State of Wisconsin, fentanyl, specifically, was the cause of 170 deaths in 2017. Combined with other opioid overdoses, there were about 420 in that county last year.

Mr. QUINONES. I'm sorry.

Senator BALDWIN. Yes. It's just one example in the State of Wisconsin, and at this point, there's no sense that 2018 is going to be a turnaround here, despite the fact that Milwaukee County has a very committed heroin task force, and leaders from our local law enforcement and health providers have been collaborating to address this.

I wanted to sort of dovetail on your conversation with the Chairman about synthetics like fentanyl sort of changing this epidemic in some ways. Do we need to be prepared for even a next generation of synthetic opioids, and what is the Federal role, again, in assisting communities?

Mr. QUINONES. Well, gosh, that's a huge question, I think, and I'm not sure I have all the answers to it.

Senator BALDWIN. I have a couple of more huge questions for you, too.

Mr. QUINONES. There's just nothing but huge questions on this topic, it seems to me. Yes, fentanyl has been remarkable in its transformative—it's like the third stage—starts with pills, then the heroin, and now we're on to fentanyl and carfentanyl, which is a rhinoceros painkiller. I do believe—it's my belief, strongly, having lived in Mexico, that it is calling on us to understand that the only way we are going to stop any—have any kind of effect on fentanyl is by working with Mexico, not at odds with Mexico.

There's no way you can stop the smuggling of fentanyl—we, alone, can stop the smuggling of fentanyl into the United States because it is so small. A sugar packet worth of fentanyl can kill everybody in this room, and probably on this whole floor.

So my feeling is that one thing we need to—that seems to be extraordinarily counterproductive, in my opinion, having lived in the country for a lone time, is rhetoric that demonizes Mexico. I'm not saying that as a way of putting on rosy—kind of rose colored glasses with regard to Mexico. I lived there. I know the issues. I know the corruption. I know the depth of problems that they have there.

But, nevertheless, I think, in a person-to-person connection, which we never really have achieved as government-to-government, I don't think, from what I can see—that is how you advance. You know, they just shut down—it was a very interesting case in July. They shut down two major Dark Web marketplaces in July of last year, and they did it with Europol, Thai police, Dutch police, FBI,

DEA, and some others, I think. It was a classic example of how you make a huge dent in supply by working with these governments.

A global economy—the only groups, apparently, that don't work together are governments, and that was one example I thought was fascinating of how you move forward. To me, those are the ways that you help local law enforcement. Being in local law enforcement today feels to me like you're standing in the ocean trying to keep back the tide, when you're talking about this topic.

Senator BALDWIN. I want to ask a question. I don't think there's going to be time for an answer, but maybe we can follow-up.

Mr. QUINONES. Sure.

Senator BALDWIN. I've held a lot of roundtables with stakeholders, from recovering addicts, family members who have lost loved ones, law enforcement, health, et cetera, around the state. You talk so much about solving this through ending isolation and having stronger communities. I do find some significant variation between what I hear in urban centers in Wisconsin and what I hear in rural areas, everything from the availability of resources to help people who want to get treatment for their abuse, even to what drugs are being taken and abused.

I would love to hear your thoughts—I'm not going to be able to stay for the second round, but perhaps in follow-up—about how we strengthen communities in all of those different settings as they respond to sometimes unique and sometimes common challenges.

Mr. QUINONES. Okay.

The CHAIRMAN. Thank you, Senator Baldwin.

Senator Collins.

Senator COLLINS. Thank you, Mr. Chairman.

I want to explore further with you the link between economic affliction and drug addiction that you referred to. Many of the communities featured in your book, like Portsmouth, Ohio, have been devastated by mill closures, for example. Also, you've said that heroin is what you get when you destroy Dreamland. You've said that isolation is heroin's natural habitat.

In the State of Maine, the opioid crisis appears to have started decades ago in Washington County, which borders Canada, and is an economically disadvantaged county with very high rates of unemployment and a lot of isolated communities. It then spread everywhere in Maine, including our most prosperous towns and cities.

The Portland Press Herald last summer ran a 10-part series on the opioid epidemic, and it focused one story on the lobster industry, highlighting the high entry rate in that industry and also the logistical challenges of securing treatment in rural communities.

Mr. QUINONES. Great story. I read it.

Senator COLLINS. So you read it. They'll be glad and impressed to know that.

Mr. QUINONES. Oh, yes. Tell them I tip my hat.

Senator COLLINS. In your investigation, did you find that drug dealers tend to target communities that are economically devastated? Are they more fertile grounds for addiction?

Mr. QUINONES. I didn't notice that. I don't think drug dealers are deep sociologists. I think they're following the money, and the first place where this began—again, this began in areas that are economically devastated because pain treatment and resorting to doc-

tors was part of how you navigate economic disaster. You get disability, as we were talking about earlier. I can't remember which Senator asked about this. You know, people who are trying to navigate their—and they go get workers' comp, they get SSI or SSDI, whatever it happens to be. To get that, you need a doctor. Again, this seemed to be also—as time went on, the pills became something to resort to for economic sustenance.

You could get pills, you could get high on them, but you could also sell them, and people figured that out. Some of the first dealers in Appalachia were seniors. They were not young people at all. They were seniors who figured out—"Gee, all these kids will buy this stuff, and I'll sell half of—keep what I need and sell the rest," that kind of thing.

I do believe, as you say, that this starts in areas of deep economic affliction and, again, the areas that are viewed as kind of like the losers in the great free trade globalization gambit we've had over the last about 30 or 40 years perhaps. Now, of course, those are some of the things that I began to realize—what made me change my view of the story that I was writing was that it had now switched to, Charlotte, North Carolina—banking center, very, very wealthy, country clubs and mansions. They had the problem as well, and I think it gets into some larger questions, and also of we, as Americans, how we view pain and whether we—what we want to—how quickly we want to—easily we want to deal with it.

Senator COLLINS. I also want to follow-up on your comment about the heroic role that's played by grandparents. I held a hearing in the Aging Committee to look at this issue of grandparents raising their grandkids due to the opioid crisis. Just as an important statistic, I will tell you that in my state, between 2010 and 2015, the number of grandparents taking care of their grandchildren and being solely responsible for their care soared by 24 percent, and it's because of the opioid epidemic.

Mr. QUINONES. Yes, and I think that's what's happening—I think that story is repeated in almost every—well, in many states in this country.

Senator COLLINS. Thank you for your good work.

Mr. QUINONES. Thank you, Senator.

Senator COLLINS.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Collins.

Senator Murray, do you have additional questions or comments?

Senator MURRAY. Well, I just want to thank our witness for being here today.

Your name has been pronounced a lot of different ways. Can you pronounce it for me?

Mr. QUINONES. Quinones.

Senator MURRAY. Quinones. Thank you.

Mr. QUINONES. It's been pronounced to me numerous different ways through our lives.

Senator MURRAY. Thank you for tolerating us. Thank you for your excellent work and your thoughts.

Mr. Chairman, I look forward to working with you and all of our Committee Members on this.

The CHAIRMAN. Thank you, Senator Murray.

I think Senator Murkowski has a question, and then we'll wrap up the hearing.

Senator MURKOWSKI. Thank you, Mr. Chairman.

Mr. Quinones, thank you, truly, thank you. There are so many statistics that you have cited in your book, but one that just really floored me was the reference to the volume, really, that those in the United States consume when it comes to narcotics. You state that the United States consumes—and at the time of the writing—83 percent of the world's oxycodone and fully 99 percent of the world's hydrocodone. Gram for gram, a group of specialists wrote in the journal, *Pain Physician*, in 2012, people in the United States consume more narcotic medication than any other nation worldwide.

Okay, so people can become addicted, whether you're a U.S. citizen or whether you're some place in South America, Europe. What is it about this country that has us at fully 99 percent of the world's hydrocodone, the opiate, and Vicodin and Lortab? What is it that has happened here?

Mr. QUINONES. You know, that's a terrific question and one that began to hit me as I got into this book and realized that this was not really just a story about drug addiction. It was a story about who we've become as Americans.

Senator MURKOWSKI. The United States as drug addicts.

Mr. QUINONES. Exactly. Two generations ago or so, 11 million people joined the Army, and the whole country participated in defeating the Nazis, and now we can't get our wisdom teeth out without getting massive doses of opiates. I sought the answer to that. Why—what is the common denominator between Portsmouth, Ohio, a Rust Belt town battered by almost every economic force for the last 30 years, and Charlotte, North Carolina, a very wealthy town, Salt Lake City. These towns have done very, very well. What is the overriding common denominator? It's not economics, obviously. You've got two very different economic situations.

In my way of feeling, it's a combination of isolation, and also, frankly, maybe this is an essay on the dangers of prosperity, that too much stuff given too freely, people not expecting to—kids being raised bubble wrapped against any kind of pain, everybody fearing what skinning their knees may do to kids when they're outside, so keeping them indoors, and all across the country, you can see that.

Senator MURKOWSKI. Was it interesting to you that the Nayarit boys, those that were doing the deliveries, did not—they didn't use the stuff?

Mr. QUINONES. No, they were addicted to something else.

Senator MURKOWSKI. They were addicted to—

Mr. QUINONES. Going home a king.

Senator MURKOWSKI —to the resources that came back.

Mr. QUINONES. Giving away pants and what-not.

Senator MURKOWSKI. But, still, you look at that, and you say, "What is it about Americans that has pushed us in this direction, in such an extreme direction? You have other countries that have the same issues that we have. They have economic decline. They have isolationism. They have the same things that we have, and yet we have turned to opioids to numb it all.

Mr. QUINONES. I think, in part, it's also what I was talking about at the beginning, which was there's this focus—we have focused on the individual, exalted the individual, and so great ideals of American kind of experiment, become twisted in our pursuit of convenience and our pursuit of an end to pain. So self-reliance, this wonderful American ideal, becomes isolation. Accountability becomes tantrums whenever any political official or any cop or any doctor doesn't do exactly what we say. It seems to me that these are things that are behind a lot of this, that we maybe have had too much. We've become pampered in some sense.

I don't pretend to know it all. These are questions that I'm fascinated by and I love to talk about them, but I make no claim to know all the answers to these very important questions you're posing here.

Senator MURKOWSKI. So this statement was made back in 2012 in the journal, *Pain Physician*. Would you assume that those numbers have continued to increase even, or—

Mr. QUINONES. Well, they have not dropped significantly.

Senator MURKOWSKI —relative to other countries?

Mr. QUINONES. Yes, yes, and part of it—I have to say this, also. It bears noting. Part of that is because a lot of countries don't use enough of these drugs. People die in horrible agony from cancer when they shouldn't. There is a proper role for these drugs in human medicine. It's just debatable what that role is. It's a very, very important one, and up to now, in the last 20 to 25 years in this country, the proper role appeared to be, a bottle in every medicine cabinet, and that's where we got into trouble, essentially.

Senator MURKOWSKI. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Quinones, if I may just make a couple of quick observations about your testimony and then one about your Space Shot, Marshall Plan idea, listening to this, one thought I had was, with your family here especially, as I mentioned to you before, you should be glad you weren't nominated for something, or some Senator would have chased you under a table and accused you of killing your grandmother in the process.

[Laughter.]

Mr. QUINONES. I'm aware of that.

The CHAIRMAN. But we have thoroughly benefited from your testimony, and it strikes me that with your book and with your testimony, you may be helping to lead a revolution in a different direction than the one you describe in your book—

Mr. QUINONES. Thank you.

The CHAIRMAN —when people, as you say, mostly well-meaning, but a whole variety of participants from—some not so well-meaning—but Mexican drug dealers and enterprising pharmacists and doctors who thought they were doing the right thing all caused an over-prescription and use of opiates, that now there is some relatively simple steps that we can take to move back in the other direction. But it takes being aware of that, and your book is helping us do that.

I think of the meeting I dropped by and that I mentioned, yesterday. If you have all of the heads of the universities and institutes training physicians in Tennessee, one of the leading states for this

problem, working together with the Governor to change the way they teach doctors about what to do about opiates, then you'll have many more prescriptions of 3 days worth instead of 60, as needed. So there's some steps that we can take, and I congratulate you for that.

On your testimony, two aspects. One is you've demonstrated some humility. You don't claim to know everything. We find around here that's a very useful attribute, because we don't know everything, either. It helps to hear from you. And, second, you're a wonderful storyteller. It reminds me of my late friend, Alex Haley, who wrote *Roots*, who was a great storyteller, and he once told me after hearing me make a speech—he said, “May I make a suggestion? If you would—when you begin, you would say ‘May I tell you a story?’ instead of making a speech, someone might actually listen to what you have to say.” So because of your storytelling, people—we're listening to what you have to say.

Finally, on the Marshall Plan and the Space Shot, Senator Murray and I and Senator Murkowski all worked together to fix No Child Left Behind a couple of years ago. One of the things No Child Left Behind did in education was have as a goal that 100 percent of children would be proficient in reading and math by the year 2014. I remember when that was said—I wasn't in the Senate—and I thought, “Well, I guess that's all right.”

We say all people are created equal, and Samuel Huntington, a professor at Harvard, once wrote that most of our politics is about setting high goals for ourselves that we never reach, and then dealing with the consequences of not having reached them. But that's sort of what we do as a country.

Then I was thinking about—but it created a lot of problems for us that we had to—the consequences that were attached to that high goal did.

On the Marshall Plan and the Space Shot, I think this may be more like the Marshall Plan. The Space Shot was a high goal, inspired everybody, but it was done really from Washington. It was a centrally organized single shot effort, and when it succeeded, we'd reached the moon. The Marshall Plan actually was a request of European countries to come up with their own plan.

Mr. QUINONES. Yes. Correct.

The CHAIRMAN. It wasn't General Marshall's plan or President Truman's plan. It was—those countries came up with a plan, and we funded it. But then they implemented it, and some succeeded more than others, which is probably what will happen here. So some sort of high goal, but I think the more important and better example may be the Marshall Plan.

Mr. QUINONES. You may be right.

The CHAIRMAN. Because each of the states are different, and I like the fact that you talk about the parts of the country that are ravaged by globalization and online purchasing and all this business that leaves main streets empty and people without things to do. But then we have the problem that spreads to Charlotte and Nashville, too, and those aren't poor cities.

So it's a complex problem, and you've helped us understand it. Thank you for your leadership, and we appreciate your family coming as well all the way from Los Angeles.

Senator Murray, do you have anything else?

[No verbal response.]

The CHAIRMAN. The hearing record will remain open for 10 days. Members may submit additional information for the record within that time if they would like. Our Committee will meet again on Thursday, January 11th, for an executive session on nominations.

Thank you for being here. The Committee will stand adjourned. [Whereupon, at 12:06 p.m., the hearing was adjourned.]

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