Decarceration Nation Episode 36: Shelia Vakharia

Hello and welcome to Episode 36 of the decarceration nation podcast, the podcast about radically reimagining America's criminal justice system. I'm Josh Hoe, among other things, I'm formerly incarcerated freelance writer, a criminal justice reform advocate and the author of the book writing your own best story addiction and living hope. And a few minutes I'll get to my interview with Sheila Vakharea about addiction, the drug war and harm reduction. But first the news:

Last week I was present at the new university of michigan partial state projects first symposium which included my co nation outside steering team, committee member and friend Ronald Simpson Bay, who many of you might know better because he's on the leadership team of just leadership USA. There's a very exciting new project, the University of Michigan led by folks like my friend and Pulitzer Prize winning historian Heather and Thompson, Amanda Alexander, who is the director of the Detroit Justice Center, Ashley Lucas, who is the Associate Director of one of my favorite Programs at the University of Michigan, the prison Creative Arts project, and Ruby Tapia, who is a professor of critical prison studies. You can watch the entire event here or Well, in my notes, I'm going to attach the video and you can even hear me ask a question right at the beginning of the q & a, which I think is like an hour in if you really find yourself that interested I will attach the video. Like I said in the notes, I'm supposed to speak at one of the later symposiums and this one was standing remotely, which was very exciting.

The very next night the students at the University of Michigan started a program called the prison reentry project. So I showed up for that too, they had done a ton of work. And we're really trying to bring attention to a lot of things the university could do to try to, for instance, divest from companies that worked with private prisons, they could do stuff like try, they were trying to help, like allow formerly incarcerated people to become admitted easily more easily to the University of Michigan just seemed like a really good project. And a lot of students showed up. So I thought that was really cool too. I was glad to show up for that. And they're partnering with nation outside, which is the main organization I belong to.

I mentioned a speech a couple weeks ago about my personal criminal justice reform goals was during a an event hosted by the Friends of restorative justice Washington County. I even did an episode about that a couple weeks ago, there is a video of that event to which I will attach in the notes. If you actually want to see me give my speech as opposed to just read it or hear me on the radio, you can actually see me which like I've said a million times before I have a face for radio, so that might might not be that

might be more scary than just listening to me. Of course, as usual, I also posted my recap of Orange is the New Black season six Episode 11 on Sunday yesterday, so you should if you're getting into that, or if you've been reading that and trying to keep up, make sure you check out the most recent recap. Okay, let's get to my interview with Sheila

Sheila Vakharia received her master's in social work from Birmingham University and postmaster certificate and addictions from New York University. She worked for several years as a social worker in both traditional abstinence only outpatient settings and at a syringe exchange, where she provided counseling using a harm reduction approach. During that work. The dearth of substance use content and harm reduction information and social work programs led her to pursue her PhD in social welfare at Florida International University School of Social Work. She holds a certificate of human rights and Drug Policy at central unit Central European University in Budapest. She wrote a paper writing report summarizing civil society input for the preparations leading up to the United Nations General Assembly special a session on drugs in 2016. And she now works at the Drug Policy Alliance as a self described in house nerd in their office of academic engagement. Hello, Sheila, how are you?

Hey, I'm good. Thanks so much for having me today.

Those are some pretty impressive credentials, they're doing work for the UN and a bunch of other stuff. What I usually like to do is ask people to flesh out the bio a little bit more, what drew you to this work, and what has made you so passionate about doing research about drugs and harm reduction?

Well, I definitely didn't see myself taking this trajectory by any means. I grew up thinking I wanted to be a therapist, I wanted to help people. And it was through going to Social Work school and being exposed to different populations that I decided to do my second year internship at a traditional abstinence only treatment center. And I discovered that I loved working with people who use drugs, but I had a hard time with the model. And so I I shifted gears entirely and started working at a needle exchange and drop in center. And that's really where I became a harm reductionist, and where I really embraced an alternative approach to working with people who use drugs and who engaged in high risk activities. And I'd say, over the years of doing that clinical work, I started to zoom out a little bit and think about some of the structural and environmental and policy issues that really played into substance use and situations that a lot of my clients were in, which led me to get my PhD, I became a professor, I was teaching students about how to be good social workers, and to be informed by Harvard action and their practice.

And I love doing that. But I started also zooming out a little bit more and thinking about how I could get involved with policy advocacy. And that led me to the UN. And it led me to making some really tremendous connections, and ultimately deciding that academia wasn't for me, either. But I wanted to take that research perspective, along with my interest in policy advocacy into the next position, which brought me here,

Awesome, full disclosure, I, myself, recovering addict with over eight years of sobriety. So this discussion means a lot to me, too, I also tend to head in a harm reduction direction myself, in case people listening, don't know what I meant by harm reduction, or what you meant by harm reduction, could you define what it means to you and talk about some examples of harm reduction programs?

Sure, harm reduction is an umbrella term for a public health approach to substance use, which is informed by an understanding that people engage in high risk behaviors in all sorts of ways. And sometimes the best way to engage people is to teach them strategies and skills to reduce the risks of those behaviors, whether it's substance use sexual activity, or other behaviors. So harm reduction philosophically, is one that is quite centered or individual centered. It is a humanistic approach. It is an individualized approach, and it trusts the people can be taught skills to take care of themselves, because most people are invested in taking care of themselves. And it's just a matter of engaging with them where they're at, and helping them to be safer and healthier.

So you said earlier that you started out kind of doing traditional addiction and recovery work and didn't like the model. Could you talk a little bit about what you felt was wrong with the traditional model or the model that you are being taught in and how things of how that changed? And what changed in your thinking? I guess?

Sure, sure. I mean, I have to say that it was tremendously educational and informative, and I had an incredibly positive experience. And what I learned was that the approach was tremendously helpful for the people that worked for. However, there was a substantial number of clients for whom it didn't work. So my job was interesting in that I was both an intake coordinator and I was also an aftercare group facilitator. And what was fascinating to me was that the vast majority of people upon whom I did intake assessments on rarely ever made it to my aftercare groups. And so to me, part of that indicated that we were holding clients to standards that were really challenging for them to meet. And perhaps some of that was even due to the model that they had trouble kind of embracing and really, you know, seeing through another one of the challenges that I faced in that work was the ways in which I was really, really complicit with the criminal justice system. I had a lot of clients who were mandated through parole and

probation. And I found myself in this very tricky, troubling situation in which I was frequently speaking to parole and probation officers who had no clinical training and about some of the challenges my clients were facing, and treatment. And so many times a positive drug screen was potentially a condition to go back to jail. And I also was working with folks who had their child welfare cases, dependent upon their engagement and treatment and their so called treatment success. And I just really, really struggled in trying to be therapeutic and engage with my clients in a meaningful way, while also knowing that there were these outside contingencies which were quite punitive and coercive that led them to be there. And I found that it often created barriers to treatment and engagement, because why would they trust me? Why should they trust me? Who side was I really on?

And I think some people listening might respond by saying, well, what's wrong with sending someone back? If they fail a drug test? Can you maybe talk about that a little bit?

Sure, sure. I mean, I think it's really important for folks who may not have like a strong background in addiction and problematic substance use to to, to think about, you know, substance use as oftentimes a proactive response by a person who may be struggling or challenge or experiencing challenges to try to cope with how they're feeling through the act of using a substance. And we know that many people are also physiologically dependent on upon upon substances or use them for a variety of other reasons. And it's really important for us to remember that when someone's got an ingrained behavior, a coping strategy or something they've been doing for quite some time, it can be really hard to change that just like flipping a switch. And so when people are, you know, coerced or mandated to treatment, oftentimes the expectation is, well, you've started treatment and you're going to stop using and we expect negative drug screens from here on out. But life is challenging life is complicated people, circumstances often in our are hard, and people may lead back on the coping strategies that they've been using all along. And a single kind of slipped back into an old behavior by some is seen as an indicator of no progress all together. Whereas a lot of us say, you know what, sometimes change is a longer process, and it takes time. And sometimes there's a couple steps forward. And sometimes there's a couple steps backwards, but you kind of stay the course. And unfortunately, not everyone always sees things that way. And so I found it really, really hard to kind of, you know, sit with my clients and learn from every, you know, situation in which they might have used because it seemed like it we couldn't use those as teaching moments, instead, he simply crack down

Okay that kind of brings us to the whole notion of, even if all that were, you know,

whatever way you fall on that, how does incarceration in your opinion work as a solution to addiction,

incarceration as a criminal justice attempt at a solution to a public health and physical health issue. And so it is fundamentally not really structured or designed to, to be compatible. And, you know, the criminal justice system uses the tools that has on hand for punishment and for, you know, what they call rehabilitation, but those those constructs means something very differently different to people in public health and people in treatment, and people who are a little bit more therapeutically minded, it seems like a tough approach to help people who might be ready and willing to change but just having a hard time. So incarceration can cut people off from the resources that they need to get better and to get well, and it can cut them off from the supports that could be supporting them to move forward. And it really can disrupt a person's life trajectory by also subsequently denying them opportunity because of they are criminal justice, you know, their their background checks, and the fact that they have an arrest record.

And I think it also can be a pretty ineffective way to detox people. Is that not correct?

Absolutely, I mean, we know that for folks with opioid use disorders and also for folks with alcohol use disorders, and benzodiazepine use disorders. Physiological dependence is a reality for many whose disorders of the most severe and withdrawal syndromes are characteristics of those kinds of high levels of physiological dependence, and they require medical intervention, whereas an opioid withdrawal period or detox period can often be uncomfortable and mild for some for others. It can come with severe nausea, diarrhea, you know, in changes in heart rate, and blood pressure, and can be to dehydration and often require support. We also know that for alcohol use disorders and benzodiazepine these disorders for the most severely dependent that actually any sort of non medically supervised detox is actually now practice we know that people with severe alcohol or benzodiazepines disorders need medical monitoring, because they actually need to be taper down. Cold turkey withdrawal can induce seizures, which could be lethal. So incarceration can absolutely put people in either of those classes of drugs at risk for pretty harmful, harmful effect.

And we also see that a lot of people respond when someone comes out of prison or jail or comes back from say, rehab surprised that sometimes there are relapses, do you have any feelings about that?

Sure, it can be really hard to adjust to live life back on the outside. And as I said before,

being marked as someone who was formerly incarcerated in and of itself creates so many barriers for people upon re entry. We know that it disqualifies many from any sort of financial supports or food supports from various federal programs, we know that it is a disqualifier for various public housing. We also know that it creates a barrier for employment in various fields. And in certain kinds of forms of practice and licensure. We also know that it can disrupt people's social networks, so that upon immediate release, it can be hard to find someone who's willing to let you crash with them, or who's willing to lend you some money to kind of help you get back on your feet. So there's a lot of stress and turmoil and isolation that can that can be experienced by people upon re entry. And again, as I said before, for a lot of people, substance use is often a coping mechanism or strategy to kind of get through challenging situations. And so in some ways, it's quite understandable that people may react that way. In fact, we're often setting people up

That makes sense. So unfortunately, I mean, I'm always hopeful. But unfortunately, I don't think we're going to get rid of incarceration for drugs anytime soon. And, you know, most of my experience with recovery in prison or programs in prison deal with what I would call shame based models or models based on what was called the Minnesota model. Can you think of ways within our jails and prisons that we might create some better methods?

Sure, absolutely. I mean, I think that first and foremost, we need to become very aware that open up disorder needs to be treated like a health condition. And people while they are inside need to be offered resources and supports to to stay well, and oftentimes, that means medication assisted treatments, specifically methadone and buprenorphine. So that people are not forced to go through uncomfortable and potentially harmful withdrawal while inside and can be maintained at a comfortable level while they're inside. And we know that ensuring that people have access to that can reduce dramatically the risk of an overdose while they're inside in case they do get access to an underground supply of opioids, which we know that prisons are not Drug Free Zones. We know that we know that people can get access inside and you know, the danger of people's tolerance going down so dramatically, while they're in can put them at risk of overdosing on a quantity that might not have led led to an overdose for incarceration. We also know that keeping people medicated and well while they're inside can also reduce the risk of an overdose Upon release, because it again, maintains their tolerance and keeps them connected to care. So that Upon release, hopefully they are transition to another provider to prescribe and are thereby less likely to have any sort of people overdose.

There's a lot of prisons across the country and jails across the country. They're in kind of, well, they would consider it a crisis with Suboxone, Is there a better way that we could basically people smuggle Suboxone in through mail through a bunch of other methods? Is there a better way that prisons can be dealing with this or a better way that treatment within prisons could kind of arrest the need for for instance Suboxone smuggling

Suboxone smuggling is a response to an unmet medical need. I will say that again. Suboxone smuggling and diversion and is a is a response to an unmet medical need. If people had legitimate access to Suboxone, there would be no need to divert it. We know that for people who have tolerance for opioids. Suboxone isn't really that intoxicating. And it really doesn't give that much of a sense of euphoria. What I hear that people are diverting Suboxone, I hear that people are self medicating with Suboxone. And so instead of jails, trying to think of ways to manage so called smuggling of a medication that obviously people have a need for, they should instead think about how can we legitimately prescribed this to people who obviously need medication?

And what would be a correct way to do is that a drug that would need medical supervision? You know, I know within you know, kind of some of the harm reduction techniques on the outside, it's usually in a supervised space.

Sure. So Suboxone is let me let me rewind a little bit for maybe some of your life listeners who aren't familiar. Suboxone is a pharmaceutical that it's a medication that is buprenorphine, which is an opioid combined with Naloxone, which is the actual opioid reversal drug, many of you might have heard of Sherlock zone as Narcan, the nasal spray that is used frequently to reverse an opioid overdose. So the beautiful thing about Suboxone is that it's actually an opioid and the opioid overdose substance in one in one sensitive. And so we know that when you give someone access to Suboxone, you're reducing their likelihood of potential poisoning or overdose, if they were to even use on top of it, because there's no oxygen built in. So it's actually quite a safe medication. And so the way that it's often given on the outside is that Dr. meets with a client or a patient and they negotiate together based on the person history of youth and their tolerance of youth what level of like Suboxone to start them often, and different people may have different needs, different people may require higher doses, different people may require lower doses. And it's really just about finding the best way to keep the person from going into withdrawal. And that's a really case to case situation. And so to be able to provide it in a jail would be to use that same model to have medical providers who are familiar with with it, who are licensed to prescribe it, and who see individual clients on a case to case basis and discuss with them the best way to meet their medical needs,

and then to monitor and to see how they do with the dosages that they're provided. Just the same way that a doctor at a at a jail would meditate someone with diabetes with insulin, just just the same way that they would dispense high blood pressure medications.

Think part of this is also getting rid of the illicit market, you know, which creates a lot of bad incentives and a lot of bad use math methodologies, is that correct? Or, you know, I

I'm not as concerned about I really don't think that diverted Suboxone is that much of a high risk practice, I generally think that it's likely to be quite safe, and I don't necessarily think it's something to be too alarmist about.

Okay, so let's move to kind of more general current events. Questions. I had a couple things I saw in the news, I think would be really interesting to ask you about. But before that, I want to get really deep in the weeds for just a moment. I've been saying for years, perhaps decades that the results are in the war on drugs is a failure. It's never really reduced supply. It's really only resulted in misery, incarceration in depth. I suspect we probably agree at some level, is there anything you'd like to say about the overall war on drugs?

I'd say that it is the war on drugs that has placed us in the situation. Last year, we lost over 72,000 people to unintentional overdoses. And when we think about the ways in which people are, you know, using illicit substances, which have no regulation, which have the high potential of adulteration, a lot of that can be attributed to the war on drugs because we would not have fentanyl in our drug supply had we not crack down on heroin, we would not even have heroin in our drug supply if we have not cracked down on legitimate morphine prescription and use among Americans over 100 years ago. And so what we know is that the iron law of prohibition teaches us that when you crack down on a substance oftentimes the more potent form of it will emerge on the market we can see it with the emergence of key to and spice and other synthetic cannabinoids in light of the fact that people can often get regulated access to marijuana and that marijuana stays in of led to it, you know, it stays in in your body and makes you test positive for it for upwards of a month or longer. And so we know that we've incentivized through the criminalization of substances through these, you know, through expensive drug testing and the moralization of substance use we've just further incentivized the development of novel psychoactive substances and substances that can bypass the systems that we put in place

So just recently, I guess it was just a couple days ago on Wednesday, both the Senate

and the House overwhelmingly passed a fairly large bill purporting to address the opioid crisis, including all kinds of things from expanding Medicaid coverage for treatment to treatment options. What is your opinion on this recent legislation?

I have not read it too closely. Unfortunately, I haven't gotten a chance to what I can say is that Medicaid expansion expansion by and large is a Trump just the positive step forward. We know that in states that have expanded Medicaid to access that we've seen more people be able to walk into the doors of the treatment facility and to be able to access medication assisted treatment nationally. When you look at the statistics, and you look at the number of people who sought out treatment in the past year, oftentimes, it's estimated that only about 10% of people with a substance use disorder have engaged in treatment in the past year. And one of the top reasons that people don't engage in treatment is because they don't they can't afford it, they don't have coverage. So we do know that expanding Medicaid for particularly in low income people had really helped remove yet another barrier to care for folks who really do want to seek help.

In addition, we keep seeing bills and attempts all over states and at the federal level, then I think you talked about this a little bit of second ago to create enhancements and more penalties for fentanyl. Can you talk a bit about fentanyl and these proposed approaches?

Absolutely. I think that the emergence of fentanyl and our drug supply is not an individual level issue. I think harsher penalties on individuals found selling fentanyl is not it is not going to address the larger issue. fentanyl is in our drug supply. Because of supply side interventions that have been trying to restrict the amount of heroin coming into our country. We've incentivized drug smugglers and people bringing drugs into the country to bring fentanyl in, because it's easier to get away with bringing in a smaller package than a larger package. And so that is a larger systemic issue. We know that intervening at the you know, individual level, getting low level dealers and low level suppliers is not going to disrupt the fact that for most of them, the fentanyl was added into their supply way higher up in the chain than it was before it got into their hands. And we know that many realtors don't know what's in their supply either. And so they cannot necessarily be charged for not knowing what's what's in what they're selling them. Because for the large part, a dealer wants to keep their clients and customers alive, what incentive does the dealer have to actually tried to kill off their customer base. And so also painting image of dealers, these big bad dealers who want to kill off their customers is disingenuous. And lastly, what we do know is that, you know, additional fentanyl supplies just simply incentivizes, the use of these new charges that we've been seeing popping up across the country of drug induced homicides were, again, just about

to ask about that. Because we think that by somehow going after the big bad dealers and sending them, you know, a message that we would somehow disrupt the supply. But again, when it comes to the illicit market, you simply are playing a game of whack a mole where one dealer may be picked off the, you know, off the block, just another one is going to emerge. And if anything, what we do know is that what we've heard from people who use drugs is that for them, sometimes the best connection they have is a consistent seller and a consistent dealer and disrupting this. And having people have to engage with different people can often mean that again, they're just putting themselves at risk, because they have no idea what they're getting access to. The other thing that we know from drug induced homicides, is that actually, when we look at the prosecution's, they're not really targeting sellers at all, increasingly, we're seeing evidence that people who've been using with one another friends, co users, people who caught for drugs together are often getting charged for these for these crimes, when oftentimes, they were using the same exact substance that yet they woke up in their friend did not. And what we know is that any sort of additional fear of calling 911 or calling for help, just creates more of a reason for people to die, because we're just creating more barriers to calling 911

It's weird too, because we had the same time have these good samaritan laws. So they encourage people to call and these laws that are enhanced, like a way to enhance penalties I this is very bizarre.

And if you know, and it's just another example of like, the idea that if we show that we're getting tough, that somehow we're sending the right message, and it looks like we're acting and we're doing something and being proactive. And it's just really sad that the criminal justice system is being relied upon to be sending these messages when I'd rather see so many more resources being allocated to public health and harm reduction and treatment facilities instead, because I think the only way to really get at this situation is through actually working with people directly seeing what they need, seeing how to help them stay alive, and stay safe.

So recently, on the subject of needle exchanges, which I think you have a lot of experience with, I've got the right person here for this the internet, there were a bunch of experiments. And then this International Journal of drug policy article came out that seemed to throw in the king to put some fire behind the people who are fighting needle exchanges. And I believe that just got retract, fully retracted. Do you want to talk a little bit about that?

Sure. Sure. And I just wanted to correct you, it's actually a study about see for consumption spaces.

Okay, sorry.

So a needle exchange is a place where I used to work at one, it's a place where people who are currently injecting drugs can come and swap out their use syringes, for sterile syringes. And the motivation for opening Cyril syringe exchanges is so that folks make sure that they're injecting with their own sterile equipment to first of all, reduce the risk of any sort of opportunistic bacterial infection from reusing an old syringe, oftentimes, they can be, you know, warehouses of different kinds of bacteria, because they're in contact with different kinds of, you know, they're in contact with the air a different environmental issues, but also they're in contact with someone's skin. And we know that that kind of can lead to all kinds of problems. So partially to help reduce those kinds of risks, partially to reduce the likelihood that someone might share their own use syringe with someone else who may be in need. And we know that there are really, really high rates of HIV and hepatitis C among injection drug users. For this very reason that there is such a restricted limited supply of syringes, it's often really, really hard to get syringes without a prescription so that people are often forced to share even if they don't want to. So needle exchange is a place where someone can go to get access to sterile syringes, so that every shot is done with a new one. And that we're reducing the risk of people sharing. It's also a great place where people can get other kinds of equipment that they may need to inject, for instance, to use a tourniquet to use a queen cooker, to get clean Cotton's and to also meet a friendly face to have someone who's there to check in on them and see how they're doing. So that's kind of what a needle exchanges on the other hand, a safe for consumption space is actually a sterile safe place where people can actually bring their own drugs to inject in medically supervised environment. So there are booths set up where the surface is clean, all the injecting equipment is there and there are health care staff on hand to look for any abscesses or to check for any sort of signs of infection and to make sure that every shot that is done is done the most safely as possible. And these medical professionals are also on hand to administer in the lock zone in case of any sort of accidental overdose. So that's what is safe for consumption spaces. So recently, the International Journal of drug policy published what is called a meta analysis, a meta analysis is a very detailed kind of comprehensive study in which they look at other pre existing studies on a certain topic, and they basically synthesize all of those findings together and they run all those numbers together in aggregate, to try to make a larger kind of declaration about the efficacy of that approach. And so the International Journal of drug policy just one month ago, ran and published a study that was a meta analysis on safe for consumption spaces. And

what their meta analysis supposedly found was that there was little to no positive health effects of safer consumption spaces. And the reason why this study was ultimately retracted just last week was because it was found that there were quite a few methodological errors and the kinds of analysis that they ran. And so the retraction was indeed a victory. However, the problem is, is that it really for a moment gave a lot of ammunition to people who are pushing back against safe for consumption spaces. And those of us who have long said that there are decades and decades of studies internationally, that that clearly and unequivocally say that these do help improve health outcomes.

Yeah, it would just I think this maybe I should have foregrounded with this a little bit, but it seems to me that we have decades of evidence that, you know, tough on attics approaches don't work. And we have decades of evidence that harm reduction approaches, harm reduction approaches do work. So there seems to be something I don't know if it's fundamental in the psyche of Americans or something else. That's really like, if I talk I talk to legislators all the time. And if I bring up kind of radical changes in drug policy, they all look at me like I'm insane, even though they're clearly the ones on the wrong side of the issue by every measure I can think of. So I don't I'm sure you think about this all the time. But how are we going to change kind of the consciousness and narrative of drug policy in this country? And I know you don't have a magical answer, because if you did, we'd probably change the policy. But I'm sure you have some thoughts.

Well, I mean, I think that we in the United States, and, you know, we're not alone in this. Um, I think that personally long historically, that substance use has just been viewed as a moral issue, it's simply a matter of right and wrong. And it's wrong to use certain classes of drugs, depending on where you live and where you're from. And, and so that idea of morality has never really left the conversation. And so for a lot of people, the idea of harm reduction interventions and, you know, working with people who use drugs, to reduce the risks of their behaviors, and to engage them where they're at is seen as quite controversial. Because when someone's doing something wrong, you know, a lot of people think we shouldn't be holding their hand or supporting them, we should be, you know, hitting the hitting the message hard and sending it hard and tough to say, you know, you shouldn't be doing this all together. And so I think that that is the fundamental challenge that we're dealing with here is that it is so deeply ingrained in the United States and in so many other parts of the world. I mean, we can look at the Philippines as an example that that the the ingrained belief that drug use is a fundamentally moral issue, a criminal issue, an issue about someone's character, and whether someone can be saved, I think, is really what we're fighting against. We're not

fighting against them, accepting the evidence, we're fighting against them seeing it any differently

well, but you said a few minutes while several times that it that it is a public health issue, not a criminal issue. So what is the case for it being a medical public health issue,

I think it's a case as a public health issue clearly with substances, especially for which there people are physiologically dependent, you know, physiologically dependence is a medical condition that needs to be treated, and that needs to be managed with someone who has professional expertise. I also think that given the potential health issues packs of ongoing use on people, it's also worth making the argument that it's a health issue, because if we want to have a healthy, safe society, people who use drugs and people who problematically might use drugs may have very unique healthcare needs for which we need to restrict and reduce the barriers to access as much as possible. Right now, there are so many reasons for people who aren't feeling well who aren't doing well who are using drugs to not access care, because even they know that they're healthcare providers may also hold stigmatizing attitudes, they may not want to get that abscess checked out, because they don't want to be looked at and treated like a junkie, they may not want to get that injury checked out, they may not want to go speak to a healthcare provider about a very real medical condition, because they they are fearful of being shamed and blamed and being dismissed and turned away. So it absolutely is a public health issue with those regards. And then we know that high risk populations are often high risk for the simple fact that certain behaviors that they might engage in may put them at at risk for developing different kinds of health conditions or certain kinds of infections.

Okay, so in a perfect world where we could potentially start convincing people what would an alternative system look like in your mind,

I mean, in my fantasy world, we would be able to regulate all drugs so that everyone knows what they're getting and what they're using, but I'm willing willing to make the compromise and and to settle on decriminalization, I think that

I agree with you.

But I'm just saying that all drug decriminalization opens the doors for a lot of potential First of all, in would send the message that substance use is not a criminal justice issue. If people were to be caught using substances or with substance related paraphernalia, the first stop would not be the police station or the precinct or a jail, the first stop would

potentially be a referral to a case manager who could then help the person to kind of engage in and and truly connect with potential to healthcare service, healthcare services, social care, its social supports, and potential housing and other resources that that we need. And we know that the ripple effect of keeping people out of the criminal justice system can then engage them in more helpful and proactive behaviors rather than, again, marking them with a criminal justice background and disrupting a potential trajectory of health and wellness with the isolation and restriction and punitive nature of being incarcerated.

Well, I think then people would say, well, but then you're going to increase violence and death. I think I know the answer to this, pretty much. I just want to go through a couple of the things that they're probably going to push back on. So?

Sure. So some of the biggest fears that people have with all drug decriminalization is that it would somehow lead to increased use, thereby increased problematic use and potentially increased substance use disorders. And actually decriminalization is different than legalization in the sense that in decriminalization, there's still the potential impact of some sort of civil fine or a penalty. And so in the same way that we know that, you know, public urination and you know, speeding aren't necessarily, you know, things that we may get arrested for, we also don't want to get ticketed for them either. And so oftentimes just even the threat of any sort of civil or contact with, you know, the criminal justice system generally deters most people from doing those things anyway. And so decriminalization is is not outright permissiveness, which is, I think, something people are scared of. But second of all, I'd like to push back and say, even if use potentially increased, we know that drug use disorders remain relatively stable among the people who use substances. Generally speaking, among the people who've used any substance, the vast majority never developed a substance use disorder. So again, use isn't necessarily a problem, right? I mean, we don't talk about the, you know, the fact that it's a problem for someone to crack, crack open a beer every so often, or have a glass of wine every so often. And in the same way, use doesn't necessarily equal abuse, dependence, misuse, whatever you want to call it. And so the fear is that it would somehow lead to some kind of like, escalated, you know, huge problem, everyone would be shooting up or everyone would be smoking these different substances, those are far fetched. And the evidence says that even if there was a slight increase in use, there would not necessarily be an increase in use disorders, which I think is the bigger problem, people becoming dependent people needing treatment as a result, people being addicted.

Well, I think the next thing people will say is kind of a version of the Joe Campbell

problem. They'll say, what about the kids?

And so I think the message that that all drug decriminalization would send to kids is, again, in the same ways that they are deterred from not wanting to do things that would get them in civil trouble. I don't think that they would want to do anything, I don't think it necessarily incentivizes drug use anymore. We know that actually drug use of all kinds among teens is at historic lows. alcohol use among teens is at historic lows and tobacco use is at historic lows among teens. And we know that the more we educate teams about substance use, the more likely they are to be informed when when the time comes for them to face a situation and make a decision and so I'd say that our key are pretty are doing all right, and our kids are more capable of making educated informed decisions than we think

Do you think that would happen in a year or so you're saying you think that would happen in a decriminalized world to?

Absolutely and I mean, the evidence is clear. I mean, we are living in a marijuana legalization environment right now. And all the research is showing that in states that have moved forward with with legalization that the rates of marijuana use among teens has remained stable. And so again, I think it's really important for us to to look at the evidence to look at the research and cannot let our fears get the best device.

Okay, so it says I told you a while ago before we started, you know, I asked some of my friends in the addiction recovery field if they had any questions. Here's mostly from my friend Aaron, who is a treatment counselor here's what the questions I got backwards, how would you suggest that people access the tools for and get support with harm reduction. Um, I

I think that right now, the biggest challenge is that harm reduction is not readily available and accessible to the people who need it most. We still live in a country where not every state has even decriminalized syringe possession or access. And there are still states where there are only underground needle exchange programs because of fears of prosecution. So unfortunately, I wish I had a more positive

Something more positive to say. I'd say that there's tremendous harm reduction resources online for people who live in inaccessible or you know, rural situations or places in which they don't have ready access. I think there's tremendous resources online in terms of education and finding out what is accessible to you and what might be the closest to you. I think there are lots of tools and websites and resources for learning

about what substances you are taking the safest ways to take, take them ways to reduce risk, how to get resources if you need them. And even some of the underground programs have Facebook pages and Twitter accounts and ways people can get connected and, you know, engage with some renegades willing to connect them with resources.

Okay, and another question, what does the continuum of care look like in a harm reduction world?

The continuum of care looks exactly the same as the continuum of care now, except the low threshold and beyond outpatient. So if I envision the continuum of care as prevention, early intervention, and then different levels of inner intervention with, you know, low level low threshold outpatient to intensive outpatient to partial hospitalization to inpatient rehab, long term residential, if I think of that as long continuum, I would put harm reduction somebody between prevention and early intervention. So I'd say that, you know, in a harm reduction, world treatment would still be there, there, you know, the best form of harm reduction is abstinence. And so, I would just say that harm reduction just wants to have a seat at the table. And so fitting in next to early intervention. So that, you know, we, you know, that everyone has access to sterile syringes, whether they're in treatment, or you know, or not making sure that people have safe places to inject your use substances. Because even what we do to about safe consumption spaces, is there a tremendous referral source for detox, inpatient rehab, and outpatient treatment.

When we think of like the landmark you know, the the first North American syringe, not syringe safe consumption space and Vancouver insight, they are on the ground floor of a building the floor above them, is there a detox and a floor above them is their rehab. And we know that people who come into insight all the time or putting their names on the waiting list to go upstairs for detox. And so there is no there is no disconnect between harm reduction in traditional treatment. I'd like to see us as part of the larger continuum, there is no animosity we see us all as being connected. We just want to be part of that conversation,

which leads right into this next question. Is there a point at which you would recommend someone try abstinence based treatment? And what would that look like?

Sure. I mean, and I think that that kind of conversation comes within the context of a therapeutic relationship in which we are open and honest, and where we were talking about exploring options. I think when you sit down to work with a client and you engage with them for the first time, I think one of the first questions you need to ask is, you

know, what's working well for you right now? And the way things are going and what would you like to change? And what do you think one of your goals might be that you should be working towards. And for some people, the goal of moderation the goal of, you know, just making sure that they're using safer equipment, the goal of making sure I have no locks own on hand, maybe the first point that they're willing to engage at, but for other people, I've worked with clients myself in the needle exchange program, who said, You know, I want to give all of this up, I do want to work towards abstinence. And so it's really important to understand that in a harm reduction setting, the only difference between what we do and what someone in a traditional absence elite setting does is that on the on day one, and on the point of contact, we're willing to have a broader conversation and really to explore what that person's goals might be, and to have conversations beyond abstinence, but abstinence is definitely included in those conversations as well. And so I, I frequently worked with people in harm reduction settings, who we referred to detox. So we refer to inpatient or we refer to outpatient programs, and I had plenty of people who, through harm reduction alone decided that they wanted to stop using and didn't even have to go through treatment. But they made that decision and recovered through other social supports and other steps that they took. So I don't see a discrepancy. abstinence is always on the table, but other things are on the table, too. And I think that's what makes us different.

Okay, next question. Medical Marijuana to help wean people from opiates that's coming to invoke in the last few years, have you seen clinical evidence of the efficacy of this approach?

So the challenge with the clinical efficacy research is that we have huge barriers around doing medical marijuana research all together, given the scheduling of marijuana. So there are other kinds of studies that do suggest that there are people who find this helpful. So, you know, observational studies with folks who use medical marijuana through through going to clinics and through going through those who live in states where it's already a medically accessible is, you know, I'd seen dozens of studies with folks who report that when asked, you know what, you know, what, what were you using when you started medical marijuana, and they might say, Well, I was using opioids I was using alcohol I was using all these other substances to and then upon follow up over time hearing people in medical marijuana clinics and programs say that that eventually, after weeks, months, years of medical marijuana use that they noticed they had reduced the use of prescription opioids or street opioids. We've also seen different forms of evidence. For instance, there was just recently released study out of Vancouver that showed that people engaged in low threshold methadone maintenance programs who reported, you know, co occurring in the CO Use of Marijuana upon intake

that actually frequent and heavy use of marijuana was associated with 21%, increased likelihood of engagement and methadone maintenance long term because some of them found that it helped kind of augment the, the benefits of the methadone and keep them engaged longer. So those are the kinds of studies unfortunately, that we can only have access to. But I can say that there are dozens of studies like that, but they give that kind of evidence. I'd love to see more clinically design trials where people are actually, you know, started off at the same point to then monitor over time, but right now, we have a lot of these kinds of observational studies, and I find them quite persuasive.

Okay, next question, buprenorphine. But I always say this up. Yes, that's the one undoubtedly is helps stabilize many lives. What do you see as emerging trends for supporting people and their early in long term recovery using drugs like the one I can't pronounce, for instance, more access and funding for medication assisted transitional housing?

Oh, yeah, absolutely. I mean, I think that there's still a lot we can do when it comes to increasing access to buprenorphine. I mean, I think first and foremost, we really need to have conversations with insurers and, and funders to make sure that there are no co pays or that the CO pays are small. We do here increasingly across the country, that there are a lot of people with different kinds of private insurance, who end up paying a lot of money out of pocket for a medication, they find tremendously helpful. Another thing that we know that we need to do more of is to ensure that more doctors are actually wavered to prescribe buprenorphine and buprenorphine is again, like a shorthand for what I was referring to earlier Suboxone, which is actually buprenorphine plus in a lock. So that's kind of the form of it that's generally prescribed to the US. So what we know is that in the United States right now, while any doctor could freely write a prescription for oxy codeine, without any sort of additional certification, that, unfortunately, to prescribe Suboxone in this country, that a doctor must actually go through specific training regimen in for several hours and be registered and go through certain kinds of kind of credentialing requirements with the federal government even be deemed an approved prescriber. And then even after they go through all of these, like jump through all these hoops, there's still only limited in the number of patients that they can prescribe up north into. So we know that that in and of itself, is a tremendous barrier to access because the doctors can't even become waiver to prescribe. And there are so many barriers to even doing that. And we know that doctors are tremendously busy people, it just dis incentivizes actually increasing access to this

The other seems like more than a disincentive, it seems like a moral hazard like it

seems to incentivize them to overproduce, I mean over prescribe the thing that's easier to prescribe Am I wrong or

Heuer and arguably, some would say, that's kind of why we're in this situation.

So I think that that's a really huge barrier that we need to overcome, because I think, think that a lot of medical providers don't know that they can be prescribers and those who do know, think that the barriers are too high to overcome. And we also know that medical providers, in addition to health care providers, and different kinds of allied health professionals, including social work, don't get any sort of adequate training in substance use or addiction, even before they launch off into their careers. And so, you know, doctors just like the rest of us may hold stigmatizing attitudes towards people who use drugs and say, you know, I don't want to work with that population. I you know, there's still kind of this, this population that people tell me are really difficult and challenging, why would I want them in my waiting room? And so I think we also need to think about ways to increase capacity and a willingness among healthcare providers to to work with people who use drugs. I think that that's like a huge element. And then in terms of, you know, how can treatment become more accessible to people on buprenorphine. I think that you know, in the same way that many treatment programs have you no unders practitioner or psychiatrist or some sort of medical professional on staff, I think it would be really great to make sure that whoever that medical professional is on staff is also buprenorphine wavered, so that they can also be a prescriber in house because again, the more hoops that a patient has to jump through to find someone to prescribe to them, so the less likely they're going to get access. And we also know that, you know, you look at a map, there's all these maps online that actually geographically showed the distribution of Butte providers and they are sparse. You know, there's people who lived in parts of the country where the nearest Butte prescriber might be a few hours drive away. So if every treatment facility had someone on staff or someone who came on a few days a week and was there wavered prescriber, we could really engage people while they're in treatment into buprenorphine as well, so that treatment can support the beauty and the can support the treatment gains.

Yeah. Did you want to say anything about medicated medication assistant, traditional a transitional housing,

I mean, in the same way that we don't need separate housing for people who have diabetes and need to take insulin. I don't see any reason why we don't integrate people on buprenorphine, which is a medication in traditional supportive housing structures. In the same way that people on blood pressure medication don't get separate housing

when they were in recovery. There's no reason for someone on deepened or not to be able to stay in the same recovery housing as anyone else.

So the last thing I'll ask before I kind of go into my final thing is, I hear a lot of times from particular kinds of addiction and recovery folks, that it really is about personal responsibility? I found that not to be always the case, do you want to talk kind of about that notion in recovery? not trying to get you in trouble or anything,..

Everyone takes responsibility for all of their actions I get? I mean, I don't know what I'm refuting.

Well, I mean, we had a, for example, we had a harm reduction conference here a couple years ago. And one of the largest treatment facilities in the area, which has had a lot of success, you know, was very opposed to the idea. And the reason why was because they think at the root of recovery is this notion that people have to take personal responsibility not not to use...

Well, yeah. As a harm reductionist I see people who use drugs take personal responsibility every day, the fact that our syringe exchange was very active, and saw clients every day in and out, showed me that people who use drugs take responsibility for their choices when given options and viable supports. So the fact that they could be out there using reusing sharing syringes, and the fact that they came into see us show that they were taking steps and personal responsibility towards putting setting themselves and the people they loved and cared about. So I, I think that that was a perfect example of personal choice. I think that the people who go to methadone every day are the people who to their methadone programs every day. And the people who, you know, seek out people ordering providers and take their doses every day are people taking personal responsibility for reducing harms? I think that, you know, the x, the advent of fentanyl testing strips and the fact that, you know, the the harm reduction folks on the ground who are distributing these testing strips to people who use drugs so that they can test what is in their heroin, what they think is their heroin shows me again, that people who use drugs want to know what they're taking, they want to stay alive, they want to be healthy, they're just not ready to give it all up yet. But on that path are so many ways in which they're taking care of themselves and each other and showing compassion and really taking care of each other in ways that treatment providers are not ready to do. yet. We think about the way our treatment system is structured. And we tell 90% of people who use drugs were out there and not in prevent, don't come to us until you're ready for what we have to offer. And so I think that all along, our harm reduction movement has been grounded and people taking responsibility for themselves

and the people they cared about long before providers said we were willing to open our doors to them.

Great. Now, I always ask the same last three questions. So bear with me on these first, what is the question or questions I should have asked, but did not Oh, um, in other words, how did I mess up?

Oh, um, no, I mean, I think I think you did a great job. I think questions that I could have also answered would have been around what are some lessons that traditional treatment providers can learn from the ways in which we do harm reduction? And, you know, what are some ways that treatment programs can be more open and low threshold for people who want to seek help but aren't ready for abstinence? I would have loved that question perhaps.

Okay. Well, what is that's the second one water the answers to those questions?

Well, I mean, like, Yeah, you got me there. Um, I think that one of those, one of the answers to that is really for treatment providers to think of ways to stay engaged with people through the early days of treatment, because we know that dropout happens in the earliest days of abstinence, only treatment at alarming rates. And then we just kind of see that number pitter out over the end. And so I really think that ways in which, you know, traditional treatment settings that are more abstinence oriented, can be a little bit more receptive or embracing or just kind of a little bit more flexible, would be to, you know, to really, like start people off at lower levels of care until they start showing up more regularly before like bumping up the requirements. I think that often instead, what treatment facilities do is that as soon as someone is seen as so called failing at a lower level of care, we immediately bump them up. And instead of saying like, what were some of the barriers for them for their initial engagement? And how can we help work through those which could actually lead to tremendous long term gains for most treatment facilities in retention and or there are other ways you think that treatment facilities, more traditional treatment facilities could find ways to for you both to learn from each other? I think that was something else you were. Yeah, I mean, I think, to really rethink the relationships they have with referral sources, particularly those who are coercing or mandating treatment and to think about ways to really negotiate how to maintain a therapeutic alliance, while also staying true to referral sources. And really treating those referral sources in a need to know basis and reevaluating the kinds of information you send to them. Because those ramifications can be huge, and can often lead to even more problems for the person before you even had a chance to kind of engage with them and help support them on a trajectory to change.

Okay, and the final question, do you have any questions for me? The answer can be no,

I know, I don't.

Great. Well, thanks so much for doing this. I really appreciate you taking the time and I learned a ton, so I really appreciate it.

Yes. Thank you for having me. This is great.

Yeah. Okay. So thanks. For by.

Okay, now, my take. So as you probably gathered, I am not a fan of the war on drugs. Aside from my personal history, which includes, you know, addiction and recovery. I'm a recovered addict of over eight years. At this point. There's also just I also wrote a book about addiction and recovery, although nothing at the level that Sheila's done, it's it's just a very personal mission to issue to me. But beyond that, I just, you know, from a policy perspective, thinks it's one of the most misguided and stupid policies we've ever engaged in, in my lifetime, in my opinion, backed up by more than a bit of evidence of decades of time, the American war on drugs is a total failure is never even reduce supply, but it has delivered mass, Misery, mass incarceration, and mass death. Here's how Stanford University put it. Several years ago, the war on drugs has failed by making drugs illegal. This country has one put half a million people in prison at the cost of $10 billion a year that's actually gone up since then, to spend billions annually for expanded law enforcement three fomented violence and death and gang turf wars, overdoses from uncontrolled drug potency and shared needles and AIDS. HIV AIDS for eroded civil rights. Five enrich criminal organizations. Because the street price of a single ounce of pure cocaine is sit several thousands of dollars if the cost to produce the drug is less than $20. So this large markup creates a strong incentive for people to enter into sales and the trafficking of the drugs. The stiff penalties we assessed against drug dealers only makes the price higher and the Cardinals more desperate to escape capture, more determined to protect their market from encroachment. If drugs were legalized, for instance, the price would drop to a tiny fraction of their current street values and the incentive to push drugs advantage as would the problem of violence that's associated with drugs because you don't have to protect what is legal to sell. And it does, and on top of that, it doesn't even work as the cato institute put it recently, the debacle of the war on drugs is obvious to any independent observer. In 1988, the United Nations held a conference title the drug free world, we can, we can do it. Since then, consumption of marijuana and cocaine has increased by 50%. Even the US

government admits its own failure and stopping the flow of drugs. The 2015 National Drug to assess threat assessment by the Drug Enforcement Administration states that while cocaine availability is stabilized in recent years, marijuana, heroin and methamphetamines are increasingly available across the country and here's the thing as much misery is the war on drugs is caused domestically It is also cause just as much misery internationally and the efforts increased crime and stability and foment terrorism as Kato continues developing countries and need suffer from week institutions. But drug prohibition actually exacerbates this institutional problem by inflating the profit margins of organized crime to status. Fear stratospheric levels, thus increasing its corrupting and violent power. So we should have learned our lesson over all these years since 1971. I mean, that's how long this craziness has been going on. But instead, now we are in an opium crisis that kills more people every year than cancer. And instead of doing anything smart, like utilizing harm reduction and emphasizing keeping people are live instead of trying to force them to quit, no matter what the cost, we are losing people in unprecedented amounts. And we've doubled down on all the dumb old methods. And the reason is, because as one of the most recognized experts in this crisis, Professor Leo bielicki puts it, we would rather seem like we are doing something to end this crisis instead of doing something to keep people alive. In other words, we care much more about looking active than we do about being smart, which is kind of a microcosm of mass incarceration. And here's the thing for blocky, I'm going to go through the entire thing because I he puts it so much better than I ever could. And at the end of this, hopefully, you'll understand why this entire thing is totally ridiculous. And before I start, let me just mention, you know, when I talked about this the other day online, someone immediately came by and, you know, wrote back and on Twitter and said, Well, isn't the point to get people to stop using No, it's not the point yes, we would love it. If people stop using that ultimately would be great. But if the cost of trying to force people to stop using is a lot more people die, because the drugs get more deadly and etc, etc, etc, then that's not a good solution. It doesn't do anything for us, it ends up killing 10s of thousands of people every year. It's really bad policies. So let's get to this long, blocky quote. I think it explains pretty much everything you need to know about why we need to move from the current situation we're in to a harm reduction and and and public health strategy. Here we go, simply removing access to to drugs. without replacing this therapy with other pain management modalities, and delivering evidence based opiate substitution. Treatment could lead only to only two outcomes increases and untreated pain on managed withdrawal or substitution with other likely more potent opioids. One need look to the country's most well known experience with massive supply reductions to see this mechanism in action. During the period of national alcohol prohibition between 1920 1933, the production and sale of alcoholic beverages was outlawed, save for industrial or limited medical use, some facts are beyond dispute whoever the

resourcing of alcohol interdiction in law enforcement during Prohibition reached unprecedented levels. The Bureau of prohibition sorts of budget increased fourfold over the 1920s the US Coast Guard guard saw similar scale up and federal investment to deter smuggled alcohol from entering us ports. Does this sound familiar? Yet the effect of this intensive effort to decrease supply including to those who are dependent on alcohol should not be surprising in light of the recent opioid epidemic. Soon after national prohibition came into effect, America saw a massive shift toward black market production, supply and distribution of alcohol. The application of this restrictive regime generated a rapid transition from less potent forms of alcoholic beverages to highly distilled spirits like gin and moonshine. Specifically, American expenditure expenditure on distilled spirits. As a share of total alcohol sales skyrocketed from around 40% pre prohibition almost 90% directly following prohibition described as the iron law of prohibition. And you heard Sheila talk about this, this phenomenon follows fundamental economic logic imposing substantial barriers and cost to the illicit drug supply chain creates direct pressure to minimize volume while maximizing profit. More bulky products become more expensive relative to less bulky ones. incentivizing increases in potency. While the overall volume of alcohol consumption initially decreased, Americans were consuming less far more intoxicating products. The potency of alcohol products during Prohibition is estimated to have risen by more than 150%. At the same time, the ability of black market traffickers to get the biggest bang for the buck is catalyzed by reduced consumer ability to exercise preferences. History repeats itself, Marx wrote first his tragedy and then as far as that continued emphasis on supply side interventions to suppress non medical opioid use is both as this crisis is evolved the actor genetic risk to the health of people who use drugs was not just foreseeable, but in some cases directly for seen by policymakers. One of the most shocking articulation of this came from Pennsylvania's former physician general who remarked recently we know the drug user transition to the black market was going to be an issue that we're going to push attics and direction that was going to be more deadly. But you have to start somewhere. This statement is emblematic of the belief that decisive action is more important than reducing overall social harm. While seemingly widespread this sentiment is inimical. Sorry, inimical to both public health scientific and ethical norms in contrast to the early years of HIV AIDS the drivers opioid use disorder are well understood and efficacious treatment already exists substitution treatment using methadone and blueprint effort pooper nap for blueprint group, I cannot say that word I'm sorry I've been bad on this all day. Today, I really appreciate beauty we're just getting called boop is decisively protective against overdose and proven to reduce many of the health and societal harms associated with opioid use disorders. Now, Naloxone is extremely effective at preventing opioid overdoses from turning fatal yet these medications are often not available to those who need them. Overall little of the energy and resources dedicated

to the crisis as focused on evidence driven policies and programs in healthcare settings. prescription drug monitoring programs have figured out as one of the key answers to the opioid crisis. These programs can potentially help identify individuals with opioid use disorders, untreated pain and known overdose risk factors connecting patients with appropriate treatment resources and other care. Similarly, healthcare provider education on opioid therapy and addiction management are dramatically under utilized and offering compromised by industry bias in place of these and other common sense efforts to improve care and prevention. The modal programmatic and policy response has had an almost singular focus on suppression of opioid access and pursuit of that focus. The criminal justice sector has readily intensified its emphasis on arresting, prosecuting and incarcerating drug dealers and users, these interventions are problematic not only because they are often counterproductive, but also because under the semblance of decisive action, they crowd out evidence driven measures. every dollar spent on enforcement is $1 not spent on treatment, harm reduction or prevention. As we failed to invest in what works. The crisis has mutated into something far more deadly. As Sheila mentioned, the reason we have the vet no problem is because we stopped we put we tried to suppress heroin. The reason we have the heroin problem is because we tried to suppress opium or opioid based pain relievers. The whole thing is so absurd, and it it just boggles the mind that we can't get past this. It's time to move to a different model. The definition of insanity that everyone always uses is repeating the same thing over and over again and expecting different results. Why do we keep expecting different results when people are dying all over this country? Let's stop being tough idiots. Let's start being smart on drugs and smart on crime. It's time to start treating addiction as a public health crisis, not a criminal logical problem.

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