

Hulu/KHN Forum: The Opioid Crisis Beyond the Script

October 18, 2021

Chaseedaw Giles [00:00:00] Hi, I'm Chaseedaw Giles, a digital strategist at Kaiser Health News, and that was a clip from the new Hulu series "Dopesick." I'm sitting here with Danny Strong, executive producer of the series; Beth Macy, author of the bestselling book the show is based on; Aneri Pattani, KHN correspondent who has reported on opioid policy, substance use and mental health; and Nirmita Panchal, KFF's senior policy analyst, whose work focuses on mental health and substance use. So let's jump right in. How did writers work with journalists to put this script together? Like, how did you guys collaborate to get to the final product?

Danny Strong [00:00:49] We had a wonderful collaboration. I mean, Beth is an incredible journalist. She wrote a magnificent book. She's also a really lovely person, and it was, you know, she was in the writers' room full time on the show. And so we had a resident expert in the room. And then I think that what was unique about my collaboration with Beth is that the journalism side of the process never ended. We kept doing interviews. It was as if it was an ongoing investigation all the way till we wrapped production. So we would do interviews together. People would leak documents to us, we would do interviews separately and come back together. So it was this unusual process in which it was ... we were writing a scripted drama and then simultaneously doing, you know, active, active investigative journalism simultaneously.

Beth Macy [00:01:40] New documents were coming out all the time in the legal filings from the Massachusetts and New York case. So we were ... the whole room would like ... we'd take turns. "I'll go through this." "You go through this" ... and then we would all report back to Danny and kind of decide what the best highlights were. And it was just, I mean, we had hope when we first started, we were like, we really hope we could get this one memo, you know, and —

Danny Strong [00:02:02] Which we didn't get —

Beth Macy [00:02:04] Which we did *not* get.

Danny Strong [00:02:04] But we got a Justice Department memo that was the summation of the memo, which was pretty good, you know —

Beth Macy [00:02:10] — and led to a couple of amazing things.

Danny Strong [00:02:13] Amazing, amazing scoops that we got from that Justice Department memo.

Chaseedaw Giles [00:02:17] And how did you build the characters? Because, in the book, the characters aren't exactly as they are in the book. They're kind of like manifestations of a few things. Or you explain it.

Beth Macy [00:02:29] Yeah. So I was kind of surprised. Danny already had the outline for the major characters in the book. A couple of the ones in the last couple of episodes are directly from my book, but the victim profiles, the Michael Keaton character, the Kaitlyn Dever character who is the coal miner. Those were amalgamations that Danny created based on research he had done. And then we put heads together. We ended up bringing in an amazing resource who was a

physician in Tennessee, named Dr. Steve Loyd. And he sat in the writing room with us, and he was somebody that has every element of experience with addiction that you can think of and including he was a past Tennessee drug czar. So, we were able to get all kinds of stuff from him. And, like Danny said, we just kept reporting.

Danny Strong [00:03:22] Yeah, it was important to me when ... there's so much research out there, there's so many books written on the opioid crisis. I think Beth's book is the strongest as far as covering people on the ground and telling the stories of the victims. And there are so many stories. And I thought if we were to just tell this story with one person's life events, it wouldn't be ... it would be, I thought, more interesting if we could do composite characters and get life events from as many people as we want. And in doing that, we were able to get so many more stories in of what people went through. And I thought that could create an almost ... a grander universal truth of the crisis than if you were sort of confined with one person's life events. So, it was a decision I made early on, and I think it was, I think it turned out well. You know, and Beth embraced it immediately when she came on board. She thought that was a great idea and I think it worked quite well.

Chaseedaw Giles [00:04:22] So that brings me to, because I watched all seven episodes, and especially the Richard Sackler character, I was wondering, like, which parts are fictional and which are fact? Did you have someone fact-check the script? I assume, since you were in the writers' room, you did some fact-checking, probably.

Beth Macy [00:04:40] Yeah, I did some. We had Ben Rubin, who was the staff writer. He did a lot of that. It was heavily legal-reviewed, and fact-checked by the lawyers at Disney.

Danny Strong [00:04:52] Fine-tooth comb. And we had Gerald Posner, who wrote "Pharma," was a consultant for us. Andrew Kolodny was a consultant for us. So we had a we had a wide swath of experts on it, you know. As far as the show, it is a dramatization. It's as Aaron Sorkin, who's sort of the king of nonfiction movies, I love this phrase he uses, "It's a ... it's a painting, not a photograph." Right? So did the Sacklers say every word that we portray in the show? No, obviously not. That ... that account doesn't exist. They wouldn't even know, right, who said every word what, where and when. The question is, does it, is the foundation of it truthful? Does it represent the truth? And there's a technique I use in these nonfiction scripted dramas. Which is, I'll create fictional scenes as a conduit to get true facts out. So, so sure that meeting didn't happen. But everything they're saying in it is true information —

Beth Macy [00:05:48] Directly from the document.

Danny Strong [00:05:49] Directly from the documents. Did they say it that way? No. Now, in some cases, I would take emails that either came out in discovery or were leaked to us and create a scene that is verbatim their email exchange. Right. So and those are some of the more damning scenes — are literally just verbatim from their emails to each other.

Chaseedaw Giles [00:06:09] And Beth, did you have any veto power on anything?

Beth Macy [00:06:14] That's a better question for Danny: Did Beth have veto power? There were a few things that I was worried, like, here's a better, I'm going to re- ... I'm going to answer the question I wish you would have asked. No, I'm just kidding. But there were two things I really wanted to happen by the end of the show, and Danny was totally open to them. Once he, you

know, once I brought him up to board with my research, because I was still reporting on a second book by the time the writing room got together, I didn't want us to stereotype Appalachia, and I don't think we do. I think people will be proud of their stories because they are perceived as not just victims, but people who are fighting back from oppression, from a century of oppression. And then the other thing is, we have a really strong storyline about medication-assisted treatment, which at the beginning, I think maybe the first time I mentioned it, you thought, was a little wonky because it is a little in the weeds —

Danny Strong [00:07:12] No, no, no. It was always important to me. There was a certain elements of it that I was like, Well, that might be tricky to dramatize, but the story overall, I absolutely wanted to end the show with that, with those concepts.

Beth Macy [00:07:22] Right. And including this massive division, as you guys know, between abstinence-only, which grows out of the fact that addiction was always the stepchild in health care. And what science says is the gold standard of care for opioid use disorder, which is buprenorphine and methadone. So you see people being stigmatized at 12-step meetings, you see all different kinds of rehab, many of which aren't working, which we know American families are remortgaging their houses to do exactly what science says you shouldn't do. And so I think by the end, like, you can read all that and all the articles and books, but to see it play out in drama, it makes it understandable.

Danny Strong [00:08:06] Yeah, I think it's actually one of the most important things the show does ... it shows these therapies in a positive light. They're controversial and stigmatized and, you know, it's like, it's like having insulin stigmatized, right? They should not be stigmatized. And I think that this show could hopefully move the needle on that even if, say, twice as many people that need these treatments go on them, it'll be such a huge, wonderful victory. But maybe we can move the needle even further on it.

Chaseedaw Giles [00:08:39] And so the opioid crisis was declared a public health emergency in 2017. So why is now the time for a show like this? And that's something all of you could speak to if you'd like to.

Chaseedaw Giles [00:08:51] Yeah, tell us what you're seeing on the ground.

Aneri Pattani [00:08:53] Yeah, sure. So, I think that a lot of the show takes place in the early 2000s and we see this growing. But this is still a very large, very urgent public health crisis right now. Last year, 2020, saw the highest number of overdose deaths on record, with 93,000 people dying. So it's certainly just as much of an issue now as it was then, if not more. And some of that has to do with the pandemic, but some people are saying, you know, public health experts, I've spoken to, that the deaths were going up in early 2020 before covid hit as well. So we can't say, you know, this was a blip. This is something that's continuing to be a problem. And some of the differences from, you know, maybe what we might see in the show in the early stages of the epidemic is that now a lot of the overdose deaths are coming from synthetic opioids like fentanyl as opposed to prescription opioids, that sort of transition. And we're also seeing it affecting all the states and a lot more people. It kind of maybe started it off in these select communities, but it has spread out. And we're seeing racial impacts, too, with Black Americans seeing one of the fastest-growing rates of overdose deaths. So it's just impacting more and more people.

Beth Macy [00:10:05] Yeah, we have an 88% treatment gap right now. At the time of the public health declaration emergency, it was 90. So then, you know, the government puts in these billions, and a lot of it never made it to the ground. A third of it didn't even get spent. So we've got a real infrastructure problem. And I know you're probably a better expert at kind of where the gaps are, but we need to really move that treatment gap, I think.

Nirmita Panchal [00:10:35] Yeah. Yeah, we're definitely seeing a number of gaps and also to touch on what Aneri was saying about what we're seeing in 2020, during the pandemic. We're seeing a number of things that consequences of the pandemic have actually exacerbated the drug epidemic itself. So, for example, we had an economic recession where millions of people lost their jobs, and also many people are reporting poor mental health. So, prior to the pandemic, there were about 1 in 10 people who were experiencing anxiety and depression. Fast-forward to now, that has significantly increased to 1 in 3 people. And when we take all of this into account, the job loss, financial hardship, poor mental health, these are things that can often go hand in hand with substance use. And then another thing we're seeing is a disruption in substance use treatment on top of barriers that already existed. So, for some treatment facilities, that means suspending services, and for others, that may have meant closing entirely during the pandemic. There's also some research showing that the medications used to treat opioid overdose like buprenorphine and the medications to reverse drug overdoses like naloxone are actually being filled at lower levels than prior to the pandemic. And then, as Aneri mentioned, we're continuing to see widespread fentanyl-related deaths. So when we see these numbers of over 90,000 drug overdose deaths in just 2020, these consequences of the pandemic, including job loss, poor mental health, access to care issues and fentanyl being widespread, they really speak to the numbers that we're seeing.

Chaseedaw Giles [00:12:43] And why do you think small, rural towns like the one depicted in the series are so vulnerable to crises like this?

Beth Macy [00:12:51] Well, because Purdue Pharma directly targeted those towns. Because they bought the data set from IMS Health, which we dramatized in the show, telling them which doctors in the nation were already prescribing the most competing opioids. And then they sent their reps out armed with that data, along with psychological profiles. And with this notion that, look, we have this new drug that's better than Percocet, Vicodin, and the FDA allows us to say it's virtually non-addictive. And they pick those areas because they had higher painkiller-prescribing rates already because they were areas where there were a lot of workplace injuries — mining, farming, logging — rural Maine, Appalachia. And the really, just the saddest, most tragic part of this to me, is that it was the same time a lot of the jobs were going away. So, yeah, sure, there were maybe more people there with workplace injuries, but there were also really desperate people and when we're desperate, you know, they were survivors. And so a lot of folks, in addition to taking them and becoming dependent on them, they also saw the prescriptions as a way to, as a side hustle, as a way to make money, to pay their other bills because they had lost their jobs. And then for Richard Sackler to just blame that on them is just unconscionable.

Danny Strong [00:14:24] He addicts them and then he blames them for their addiction. There's also another element that shows how effective Purdue's marketing campaign was, which was that there were five states that had triplicate prescribing systems where a doctor would have to fill out three different forms to prescribe narcotic painkillers. So prescribing in those five states was just way less than the other 45 states. So Purdue didn't target those states from '96 to 2007 or 2008 until most of these states got rid of those triplicate prescribing regulations. And those five states

had way less rise in addiction overdose rates as the other 45 states, which is essentially proof positive that Purdue's marketing techniques had this drastic effect and that even after. Yeah, even now, even after the triplicate regulations went away, those states were still spared those ... their overdose rates and addiction rates haven't significantly gone up post that, which shows how powerful that nine-year period was, in which Purdue was heavily marketing the other 45 states.

Chaseedaw Giles [00:15:42] So the next thing I want to ask, I want to go back to treatment. So, in the show, we kind of see how difficult it can be to treat opioid use disorder and the different kinds of treatment that the characters try. So can we talk a little bit about how easy is it to access treatment if you are a victim of opioid use disorder?

Beth Macy [00:16:07] Sure. I have a new book I just finished last Friday. Well, not finished — turned in last Friday — that's about a lot of these gaps in care. And we know that people who take buprenorphine die at rates far less. We're talking 60 to 80% less likely to overdose and die. And yet only 1 out of 5 people has access to that, and I'm stunned by the fact that there are fewer prescriptions. I'm sure it's because of the economy. Right. And less access. And that's really disturbing. So we really need to work on closing that treatment gap. And the other thing is, so many families that I've met have just moved mountains to send their kids to rehabs. Abstinence-only rehabs, which is still most rehabs in America, are abstinence-only. I mean, there's hardly any regulation about rehabs. ASAM [the American Society of Addiction Medicine] says, only 1 in 5 people with OUD [opioid use disorder] even need rehab. But mostly, they can be treated outpatient with counseling and social support. Social supports, often very lacking. But you see so many people just losing everything because they think if they spend a lot of money to send their kid to some abstinence-only rehab in Arizona or Las Vegas, that it's going to work. And it doesn't. And then they get out of rehab and they are what's called "opioid naive." And then when they use it again, that's when they're most likely to die. And in my book "Dopesick," I tell the story of a young former honor student who gets addicted by prescription and then moves to heroin and is sent out to abstinence-only rehab in Las Vegas. And then when she bombs out of that, which she had done previously, she's then on the streets and doing sex work and working in and out of criminal gangs, and she ... her body, is found in the bottom of a dumpster on Christmas Eve in 2017. Her murder remains unsolved. But the thing I want to tell everybody is that the first time I met her, in 2015, I was just starting "Dopesick" and I said, "What do you ... how did you get addicted?" And she tells me she was overprescribed at an urgent care. And what I wish I would have known is, like, she knew what she needed. She said, "We need urgent care for the addicted. We need places where people like me can go and not be judged, not be turned away because there's all these rigid rules." You know, you have to go to counseling three times a week, nine hours a week, all the stuff to get ... We make them go through too many hoops, and by the time they're homeless, they don't have IDs. They need walk-in clinics where they can just go for treatment. Otherwise, we're going to have ... we already have, skyrocketing hepatitis C, but we're already seeing in places like Charleston, West Virginia, which just outlawed needle exchange, skyrocketing HIV outbreak, and our politics in this country have just gotten so rabid. And, you know, they're still blaming ... they're still following Richard Sackler's playbook, and they're blaming the abusers.

Danny Strong [00:19:26] When you talk about politics and this is, sorry if I'm going to ask them a question, but I just feel like politics is a potential way out of this situation. That it seems to me that there's good politics in a bipartisan way for federal intervention, federal treatment programs, federal dollars into these states that could help supply treatment to the people that need them. And you've got states, red and blue states, that are suffering from this problem. And it's a

devastating problem to many of them. And I just think there could be, you know, a humanitarian win, a way to move the needle on this with federal government intervention. But that it's also a political win as well, because of the situation, of the crisis, you know, it spares no one. So, you know, why isn't there more appetite for federal intervention for at least, you know, trying to cut prices for suboxone treatment or these walk-in clinics? That, to me, I hadn't heard that from you before. Well, that's a great idea, right? Yeah, I can't wait.

Aneri Pattani [00:20:30] I don't think that it's I don't think there's anyone on either side of the aisle who's saying, we don't want to help, right? Everyone is in a ... representing a district that has constituents affected by this. So I haven't talked to a politician who says we don't need to address the opioid epidemic. But I think they all disagree on how. And it gets to some of the divisions you're talking about, right? Who favors medication-assisted treatment? Who favors your traditional rehab and —

Beth Macy [20:56] Or lock them up!

Danny Strong [00:20:57] But I think what Beth talks about is ... that “lock ’em up” and traditional [methods are] not working for opioid use disorder. You know that that's ... that's pretty cut-and-dry at this point. So why not have federal intervention, federal dollars to help on the medical treatment side for those that can want it. And we're just hoping that the show can move the needle on acceptance of it, and that that could potentially snowball.

Aneri Pattani [00:21:22] Yeah, I mean, certainly I know I was previously reporting in Pennsylvania specifically, and there it's still very divided politically, and the traditional rehab providers have strong lobbies too.

Danny Strong [00:21:32] There you go. There's the answer, yeah.

Beth Macy [00:21:35] And the sheriffs, especially in places like you and I report on in rural North Carolina, they've got to get reelected, and a lot of that reelection happens by, “We're tough on crime,” you know, “if we have MAT treatment in our jail or we divert them from jail into treatment.” I mean, it's a real, it's moving that Overton window, that Rosario was talking about last night. It's a real ... we need a real shift to happen for people to understand that, you know, the police don't have to emasculate themselves. It's a way when they start doing it, like Fairfax County Jail is doing bupe counseling, CSB [community services board] workers located inside the jail, picking people up when they get out, taking them to their next spot, helping them with social supports and why every sheriff in America doesn't want to do that. Because once they start doing it, they see, they're not seeing the same people come back all the time. And it's just like with doctors in the EDs who prescribe buprenorphine, which, oh my gosh, nobody wants to. “We don't do that. That's not in our purview.” But once they start doing it and they see results, then they become evangelists. And that's what frustrates me that the law enforcement side hasn't quite gotten there yet.

Danny Strong [00:22:52] But that's also another argument of what you two were talking about for federal dollars instead of state dollars because there's a lot more internal politics for state dollars with these exact issues you're talking about. But it seems to me federal intervention on a national basis could supersede and just bypass the issues of the sheriff and the local rehab.

Beth Macy [00:23:12] Using the power of the purse.

Danny Strong [00:23:13] Yeah, exactly.

Aneri Pattani [00:23:14] I feel like that's the hope for a lot of health care, but our system is so fragmented it becomes difficult to do, right? Federal dollars are trickled down. The way they get implemented on the ground is often through state and then even state funds them to counties to do, you know, "You how to treat the people in your area at best." And there's some merit to that. But a lot of it is —

Danny Strong [00:23:34] In this situation, it's not working —

Aneri Pattani [00:23:36] And it's really to make it, you know, systemized across the whole country. But I think a lot of people have that same hope that you just verbalized.

Chaseedaw Giles [00:23:45] So here I'm going to play another clip... So, in this show, we see how much the Sacklers incentivized misleading information and how much, like you were saying with the marketing, how much marketing they did. And in the present day, we see Purdue taken to court, and then a settlement's reached. So I guess Aneri, if you could answer, what does that settlement money do for people who are already addicted?

Aneri Pattani [00:24:12] So a lot of that is still up in the air and being decided. But there are, as I speak to advocates, families, public health experts, all the people who are trying to influence where that money goes, there's a lot of different buckets. So one bucket is kind of your prevention side. Can we invest in communities that are at risk, in youth, their academic and economic success that kind of helps them stay away from, you know, using this as their only economic means to make money or otherwise. The other one is treatment bucket, right? And there you end up, you know, does the money go towards the rehabs or does it go towards medication? And that's a divide there. Another bucket is diversion from criminal justice. So instead of locking these folks up, can we funnel them towards treatment or things that might be more helpful? And then there are also direct payments to families who have lost loved ones to opioid overdoses or to families who have kids with neonatal abstinence syndrome. So I think it's still being worked out where it's going to go, but there are a lot of places that it could go to hopefully help the people affected by the epidemic.

Beth Macy [00:25:22] Only about half of the states have done legislation to make sure that the money gets spent correctly, so I'm hoping that will increase.

Chaseedaw Giles [00:25:31] Now in this show, Dr. Samuel Finix is just the one doctor for this whole entire rural town. So Nirmita, if I could ask you, how could telehealth help in towns that are set up similar to this?

Nirmita Panchal [00:25:44] Sure. Well, as you said, the show touches on the scarcity of providers in these rural towns. And so it makes for a lot of people with mental health and substance use issues, it's challenging for them to get access to care. And the role that telehealth could play is linking these patients into care that they normally would have to potentially drive so far to. And another thing is that what we see in rural towns is they ... there are disparities between the type of care we're seeing in rural towns versus urban towns, where rural towns are not taking up on medication-assisted treatment in the same way that urban areas are. So if we're able to link patients in rural areas to, you know, providers from urban areas that are more equipped to

administer medication-assisted treatment, that could also make a difference. As we know, during the pandemic, there's been a huge uptick in telehealth and some recent data showing that it is starting to taper off for physical health care. But it's still holding strong for mental health and substance use treatment. So that could be a promising sign of what that means, especially for towns like the one in the show. There's also still some barriers to consider with telemedicine, for example, internet access and patients who prefer to be in person, possibly privacy concerns and of course, cost.

Chaseedaw Giles [00:27:27] And then for the three of you and then I have a follow-up question for you. How does health insurance play into all of that or lack thereof?

Aneri Pattani [00:27:35] Yeah, I'm so glad you asked that. I think in most of my reporting, and I'm curious if you found similarly, Beth, insurance is one of the No. 1 barriers that comes up in terms of why people aren't able or aren't willing to get care. You know, even when we're talking about the rehab stays that, you know, a lot of people are opting for, some don't accept any insurance. The ones that do, then you get into most insurances are going to cover 14 days, maybe 28 days, if you're lucky. And a lot of them also have a cap. You can go to rehab two times. We'll fund it. And that's it. But addiction is a chronic disease, and so a lot of people have to go multiple times before they're going to be in long-term rehab or they have to try medication and rehab or different things. And if your insurance maxes out at a certain point, then it becomes, "How do I even try treatment again even if I want to?" And I think I've done some reporting in North Carolina and South Carolina, which are both states that have not expanded Medicaid yet, and there are a lot of people who are falling into that gap and don't have insurance. It's one story that really sticks with me is there is a family in South Carolina. They went to the ER when the son was in withdrawal from opioid use, and he wanted to get care, and the hospital essentially said, you know, we need to admit you if you want any kind of long-term care. And he said, "I don't have insurance. I can't afford an inpatient hospital stay." And so the family left. They couldn't afford it. They wanted to try medication, but that's really expensive, too. He didn't have insurance to cover that. And a few months later, he ended up passing away of an overdose. So insurance and cost is kind of the No. 1 thing that I come across in talking to families.

Beth Macy [00:29:16] The Medicaid expansion and Obamacare has been the No. 1 tool for turning back the crisis. The little teeny bit that we have has been largely because of that. I think the studies bear that out, and I've been doing a lot of reporting in North Carolina too, and of the biggest barrier is still lack of insurance.

Chaseedaw Giles [00:29:38] And so I wondered, in the show, it doesn't get into health insurance at all. And as you can see, like, it's a very complicated topic. So did that go into your decision not to get into health insurance within the scripts?

Danny Strong [00:29:50] Well, ultimately our goal was to show a path forward, you know, and that that path forward has a lot of complications to it and a lot of different avenues. But because that path forward is so stigmatized right now, I think partly we didn't want to undercut it with some of the complications that go into it. And we just wanted to show that here is a medication that you can get over-the- ... with a prescription that you don't have to go to a clinic every day, although methadone is also very effective as well, that could change your life and get you on a path forward. And so, you know, that was our, that was our primary goal. And then simultaneously, you know, that's why we have a whole rehab episode in which we see two different characters ... one goes into sort of a higher-end rehab facility. One goes more of a religious rehab route, which felt

very authentic to the region. And, you see, in both cases, it just doesn't work. It doesn't work for opioid use disorder. So it was ... that was part of the larger goal of what we were trying to do was to just once again show a path forward.

Chaseedaw Giles [00:30:58] That makes a lot of sense, like health insurance gets, like, really tricky. And it can be very discouraging. And I'm actually down to my last question. So, is the opioid crisis getting a different treatment from Hollywood now? And I ask that question thinking about the crack epidemic. And when we see shows that depict the crack epidemic, it usually focuses on law enforcement, and criminals, and the people that are victims of the crack epidemic are painted as not as victims, but as criminals. Whereas this show is very different in its depiction of this town, these people are all victims and they're very sympathetic characters. So, are we seeing a different treatment by Hollywood of the opioid crisis?

Danny Strong [00:31:43] Well, I don't know what Hollywood's up to, you know, as far as in sort of a macro sense, I just know that when I first came to the subject matter and this story, there was a criminal organization run by a family, and their crimes were unbelievably outrageous, devious, manipulative and far worse than my perception of them before I started researching it. Then simultaneously, there were very, very clear-cut victims. And so, my original goal before Beth came on board was to dramatize all this, was to create a clear record of what Purdue Pharma did. Also, at the time, I saw the show because OxyContin prescribing had started to come down, because it had become so well-known at that point. But they were using their same dishonest techniques all over the world now. So, part of what I wanted to do was to send a warning to the world that Purdue Pharma and the Sacklers are coming to addict you. So that was part of it, but the other part was to show the victims and to hopefully redefine the stereotype of addiction, which is what Beth did so beautifully in her book, which is why I embraced her when it was, you know, when we were asked to team up because that seems to be not just as something that could be so incredible for people that suffer from addiction that may not completely understand that their brain chemistry has been altered, but for loved ones, friends, and that by having a new understanding of what is actually happening on a scientific level, it could A) create much more compassion. You know, and then and then hopefully a much better understanding of how to potentially solve the problem. So those were my goals. And it had nothing to do with what anyone else in Hollywood was up to.

Chaseedaw Giles [00:33:32] Mm-hmm. I think it does a very good job of doing that. Like I really got into the characters. I really was rooting for them. I don't want to give anything away, but it definitely ... I think you achieved what you were trying to do.

Beth Macy [00:33:43] And that's great to hear.

Danny Strong [00:33:43] And you haven't seen the last one yet, which really nails home.

Beth Macy [00:33:47] It's the best.

Danny Strong [00:33:48] Oh yeah. Really nails home everything that I'm talking about here, because that's the end. That's the final episode. So I wanted to really make crystal-clear the themes and ideas that the whole piece was trying to achieve.

Chaseadaw Giles [00:34:00] Did you want to add anything to that question? Do you think the opioid crisis versus the crack epidemic ... it's kind of being, it's a different lens that we're looking at it through?

Beth Macy [00:34:08] It is a different lens, and it's absolutely wrong that the crack epidemic didn't get the kind of coverage that it deserved. And you know, we were looking at, America was looking at the crack epidemic through a war on drugs that was really a war on people, mostly Black and brown people, right? And so now, you know, some people have said because of opioid use disorder affecting, at the beginning, largely white areas, although they are more diverse than just that. Now, all of a sudden, everybody cares about it. But I think where we're going to go forward and you guys might want to chime in on this is, as we begin to see a shift from criminal justice to treating people as patients worthy of medical care ... it's going to involve dismantling the war on drugs, and that's going to be really hard on law enforcement and there's going to be a lot of pushback. And what we're seeing right now is like, it's like the wall coming down and the bricks are falling on our heads, you know? And but ultimately, if we can look at places like Oregon, which decriminalized all drugs and then put the money they were spending into social supports, walk-in clinics, better access to buprenorphine, that's helping all families, Black, brown, white families. And it's going to be just much better. But it's going to be a lot of pain getting there.

Aneri Pattani [00:35:45] I'll just add to that quickly. I think just as Beth said, you know, the treatment of the opioid crisis is more as a public health crisis. And as you said, the crack epidemic is often treated as criminal justice. And I think that has, you know, of course, so much to do with the racial history of our country and even within the opioid epidemic, right, where a lot of it ... there is a push to look at as public health and recognize that the people suffering from this are suffering from a disease and they are victims of a company, and marketing, and all these other issues. But I think we still see racial disparities within that. When you talk about access to even the medications, right? A lot of, there are reports that a lot of Black and brown communities really only have access to methadone, which requires you to go every day to a clinic early in the morning. Highly stigmatizing. It's not as easy to maintain with a job, versus buprenorphine is more easily accessible for white communities, which means you can get a 30-day prescription and take it at your home. You could go get it at your primary care doctor's office. So even within the current epidemic, there are still a lot of racial gaps.

Danny Strong [00:36:52] What you just described. It's profound. The difference between having to go somewhere at 7 in the morning and having a prescription at home that you can just take at any point in the day. I mean, it's ... it's the lifestyle shift of ... of that just how it affects your work, your life. Every element of it is so significant. So hearing this is really disheartening. And I do think that it's just an area that we've got to find inroads.

Nirmita Panchal [00:37:18] Yeah. And I think also adding to the conversation about racial disparities is that we are really starting to see a shift where, you know, around five years ago, communities of color were accounting for about 20% of drug overdose deaths. And last year, in 2020, they now accounted for around 30% of drug overdose deaths. And of course, as we've been discussing, this is happening while we know that Black and brown communities don't have the same access. And even on top of that, Black and brown communities that are making it into treatment, they are often not completing treatment.

Chase Daw Giles [00:38:03] This has been a really great conversation. Are there any kind of last things you want to tell people about the show or about, like, what you were trying to achieve with the show? I think you summed it up really good.

Beth Macy [00:38:17] The nicest thing anybody ever said about the book, and I think it will be said about the show, is that this is a person in recovery that came up to me after a talk I gave and she said, "Until I read your book, I didn't understand that I was part of a bigger story. I thought I was just a really bad person." And so I think if that can be the takeaway, that we can, it's almost cliché to say stigma is the biggest problem, but it really is because all of the systemic issues that we've been talking today come from stigma on a personal level, but also on a government level, or a federal level. It really is the answer to shifting that window.