Opinion

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EDITORIAL

Disarming the campaign war chests

If he decides to run for governor in 2022, former Boston mayor Marty Walsh will have a $5.1 million head start, thanks to the campaign war chest he amassed from donors who may have naively imagined they were supporting his mayoral reelection. If she runs for the corner office, Attorney General Maura Healey will have $3.3 million to draw from. And if Charlie Baker, who announced Tuesday he would not seek a third term, ever decides to seek another office, he'll have about $700,000 in leftover campaign dough to knead. What's more, since the three politicians raised much of that money in previous election cycles, they'd be free to hit up the same donors again for another check, allowing some of their supporters to effectively get around rules that are supposed to limit to $1,000 what any one person can give a state candidate in a single election cycle.

Nothing against Walsh, Healey, or Baker, but the way that Massachusetts candidates can build campaign accounts for one election, then carry them over to another, gives incumbents and those who have held public office previously a financial edge that just isn't good for democracy. And it's a bit of a scam on donors, too; some of Walsh's supporters might not have given if they'd known the money would be used to run in a gubernatorial Democratic primary against Healey, and vice versa. None of the prospective candidates have done anything illegal or even unusual, but they have highlighted a long-standing weakness in the state's incumbent-friendly campaign finance rules.

Indeed, although statewide candidates tend to raise the most money and attract the most attention, the problem created by carried-over campaign accounts is even more pernicious at the local level. A mayor or state representative can raise thousands of dollars every cycle, which scares off would-be opponents, allowing the incumbent to run unopposed — and then, in a vicious cycle, to raise and sock away even more money. State Senate President Karen Spilka, for instance, raised about $200,000 last year for an election campaign in which she ran unopposed. In 2020, 30 of the 40 state Senate races featured only one candidate.

Allowing candidates to carry over campaign accounts is just one more way the playing field is tilted against challengers and nontraditional candidates in Massachusetts.

In much of the state, incumbents are listed first on ballots. They get to be identified as "candidates for reelection," putting their political resume on the ballot. A large number of incumbents — including a third of Spilka's fellow state senators — came into office in the first place in low-turnout special elections called on short notice that maximize the advantage of elected officials who already have campaign accounts with a balance (both of the main candidates in the state Senate special election in East Boston, for instance).

But at least when it comes to carried-over accounts, this structural advantage for incumbents could be changed. In Alaska, candidates can only carry forward a small portion of their campaign account from one election to the next, limited to $50,000 for gubernatorial candidates and less for lower offices; they have to spend the rest down by the Feb. 1 after the election. Although the law was challenged by the Alaska ACLU as a free speech infringement, it was upheld by the state's highest court. The court there noted that when a candidate who is unopposed raises money and squirrels it away for a future election, they are effectively circumventing donation limits for that future election. In Washington state, candidates can keep leftover money, but only to run for the same office; they have to seek written permission from donors to use funds to seek a different office.

Since it's the Legislature that would have to eliminate incumbent lawmakers' own perk, we won't hold our breath. But if Massachusetts were somehow to force candidates to use campaign funds in the race and cycle in which they were raised, the positive impact on the state's political culture could be immediate and far-reaching. Candidates could still raise as much as they want, and donors could still give as much as they want. But candidates would have to start from scratch every cycle. Incumbents would lose the automatic fund-raising head start they have now over newcomers, and part of their unfair edge in special elections. Donors would know that the money that they give is used in the election cycle that they wanted to give it in. Of course, politicians like Walsh and Healey would still be formidable candidates. But who knows how many other good candidates, for offices from governor down to city councilor, Massachusetts loses because of laws that stack the deck against newcomers?

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Jamel Davis in front of his tent in the Tenderloin, a neighborhood in San Francisco on April 17. He said his girlfriend died from a fentanyl overdose.

Why isn't the US treating the overdose epidemic like the public health emergency it is?

By **John E. Rosenthal**

For the past 20 months, the drug overdose epidemic has been overshadowed by the COVID-19 pandemic, which has also fueled it.

An estimated 100,306 Americans died of drug overdoses in the 12-month period ending April 2021, according to figures released recently by the Centers for Disease Control and Prevention. This was an increase of 28.5 percent from the year before, making it the highest drug death toll ever, and surpassing the toll of gun deaths and car crashes combined. The vast majority of these cases involved polysubstance use, including alcohol.

Many of these people did not need to die. Law enforcement and public health officials know how to prevent drug overdose deaths and create better access to treatment. They just need to do it.

The Police Assisted Addiction and Recovery Initiative was founded in 2015, when fatal overdoses peaked at 52,404. Recognizing that we cannot arrest our way out of a public health crisis, PAARI has created a model for lifesaving public health and public safety partnerships. Since PAARI's founding, more than 700 law enforcement agencies in 40 states have prevented overdoses by creating non-arrest pathways to treatment and recovery. Our evidence-based programs are saving lives and opening doors to recovery, and our experience has taught us valuable lessons.

Yet, given the continued increase in overdose deaths, America's response to the drug overdose epidemic is clearly flawed and lacks the urgency necessary to save lives. Are we meeting people where they are at, only to then leave them there to die?

Five years ago, overdoses occurred more frequently in those who became addicted through often fraudulently marketed and over-prescribed pain medications or from heroin than from other substances. But with Fentanyl, the synthetic opioid now found in most illicit drugs, overdose deaths are rising sharply among users of cocaine, methamphetamine, and other drugs and spreading death to new parts of the country and new populations. People of color now make up a rapidly rising percentage of all overdose deaths. What is needed is extensive outreach and education efforts, including with health care providers, to address stigma and increase demand for access to treatments.

There have been and continue to be effective treatments, such as methadone, buprenorphine, and extended-release naltrexone Vivitrol for some substance use disorders. However, our systems of care have failed to take urgent steps to employ them, and hospital emergency departments continue to lack the capacity, or the desire, to treat patients with substance use disorders.

While there are effective medication treatments for opioid and alcohol dependence, as exist for other chronic diseases, there remains an urgent need to put overdose blocking naloxone, commonly known as Narcan, in the hands of every first responder and family with a loved one suffering with opioid addiction — while we also develop therapies for stimulant dependence. Our law enforcement partners tell us that for every overdose death there are 9 to 10 overdose reversals with naloxone. There would have been about 1 million deaths instead of the more than 100,000 overdose deaths last year without naloxone.

America's response, albeit delayed, to the HIV/AIDS epidemic resulted in the HIV Cascade of Care Continuum, which has had extraordinary outcomes at reducing stigma and driving down infection and death. More recently, the response to COVID-19 has been similarly extraordinary. In relatively short order, vaccinations were developed, and our systems of care adapted. Health care providers, from primary care to neurosurgery, quickly trained in the fundamentals of the disease.

Clinics, hospitals, and drug treatment programs must be incentivized and required to provide medication-assisted treatment for substance use disorder.

Our health care system can react similarly to substance use disorder but has chosen not to. The health care and health insurance systems are a significant barrier to access to treatment and medications. Almost 4 in 5 Americans with the disorder receive no treatment, and even fewer receive medications for treating it.

Shockingly, those with substance use disorder are increasingly more likely to access treatment and receive medications while they are incarcerated than while in the community. That is unacceptable. Access to medication-assisted treatments in the community must be expanded, because we know that those receiving medications have a significantly reduced risk of fatal overdose.

Clinics, hospitals, and drug treatment programs must be incentivized and required to provide medication-assisted treatment for substance use disorder. In fact, existing and unenforced federal law already requires such level of care. Hospitals and other medical providers must stop shirking their responsibility to help people in need. Restrictions on Medicaid for people who are incarcerated should be waived so there's no gap in coverage when they return to the community. Research has shown that people with SUD who are released without treatment are 50 times more likely to overdose and die.

In 2017, PAARI was invited to the White House when a public health emergency was declared. Since then, despite overdose deaths breaking records and fentanyl-laced methamphetamine deaths rapidly rising, we are still waiting for the urgency and resources required to fully address this crisis.

The United States must declare methamphetamine an emerging threat, swiftly research treatment therapies, and urgently renew the public health emergency declaration of 2017. The institutions of public health and public safety have adapted; our health care systems and the highest levels of government must do the same.

While new funds to treat substance use disorder have been appropriated in the American Rescue Plan, PAARI law enforcement partners and public health professionals across the country fear that they will be expended by states on the same old flawed systems of care, and overdoses will continue to rise.

What we do, or fail to do, now, will have real life and death consequences.

John E. Rosenthal is cofounder and board chair of the Police Assisted Addiction and Recovery Initiative.