Defining the Opioid Crisis and the Limited Role of the Criminal Justice System Resolving It

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I. INTRODUCTION

The opioid epidemic has ruthlessly permeated American society.[1] Its ruin touches every human demographic. The Centers for Disease Control and Prevention ("CDC") report that every day in

1. This issue is personal to me, since nowhere has the crisis been more tragic than in my beloved home state of West Virginia, where the death rate attributed to opioid overdose is the highest in the nation. *Drug Overdose Death Data*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/drugoverdose/data/statedeaths.html (last updated Dec. 19, 2017). The devastation has reportedly caused the state's Indigent Burial Program to run out of funds. Heather Ziegler, *Overdoses in W.Va. Drain Fund For Burials*, THE INTELLIGENCER (Mar. 5, 2017), http://www.theintelligencer.net/news/top-headlines/2017/03/overdoses-in-w-va-drain-fund-for-burials/. The West Virginia Funeral Directors Association attributes this depletion to the ever-increasing number of deaths by overdose. *Id.* My hometown of Huntington, West Virginia, is at the epicenter of the crisis, with dozens of overdoses having occurred within hours. Joel Massey et. al., *Opioid Overdose Outbreak—West Virginia, August 2016*, CTRS. FOR DISEASE CONTROL & PREVENTION (Sept. 22, 2017), https://www.cdc.gov/mmwr/volumes/66/wr/mm6637a3.htm; *see also* Wayne Drash & Max Blau, *In America's Drug Death Capital: How Heroin Is Scarring the Next Generation*, CNN (Sept. 16, 2016), http://www.cnn.com/2016/09/16/health/huntington-heroin/.

America 115 people die from opioid overdose.[2] Over 560,000 people died from drug overdoses in America between 1999 and 2015.[3] In 2016 alone, over 50,000 people died of opioid overdose, compared to just over 10,000 who died from cocaine overdose.[4] In addition to the significant human toll, the opioid epidemic's economic impact, in terms of health care, criminal justice, and lost productivity costs, amounts to $78.5 billion per year.[5]

How do we curb the demand that is fueling the opioid crisis? Do we double down on our reliance upon law enforcement and incarceration, or should we focus on epidemiological solutions, like increased restrictions on opioid prescriptions while expanding access to treatment? Huntington, West Virginia, Mayor Steve Williams said it best: "If you define the problem, you can own the problem . . . [i]f you own the problem, you can defeat it."[6] This Article endeavors to define the role of the criminal justice system, albeit limited but necessary and secondary to the public health response, in combating the opioid crisis.

At its core, opiate addiction is a public health crisis, one that the healthcare industry has largely generated. A cultural recalibration of society's overall view of drug addiction, particularly opioid addiction, will lead to an understanding that addiction is ultimately a disease to be treated and addressed through public health interventions. Although the real answers lie in measures that restrict unnecessary

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2. *Opioid Overdose: Understanding the Epidemic*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/drugoverdose/epidemic/index.html (last updated Aug. 30, 2017) [hereinafter CDC, *Understanding the Epidemic*].

3. THE PRESIDENT'S COMM'N ON COMBATING DRUG ADDICTION AND THE OPIOID CRISIS, FINAL REPORT 115 (2017) [hereinafter PRESIDENT'S COMM'N FINAL REPORT], https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf.

4. *Overdose Death Rates*, NAT'L INST. ON DRUG ABUSE, https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates (last updated Aug. 2018).

5. Curtis S. Florence et. al., *The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the United States, 2013*, 54 MED. CARE 901, 904 (2016), https://www.ncbi.nlm.nih.gov/pubmed/27623005; *accord* U.S. DEP'T OF HEALTH & HUMAN SERVS., THE OPIOID EPIDEMIC IN THE U.S. (2017), https://www.hhs.gov/sites/default/files/2017-opioids-infographic.pdf.

6. Drash & Blau, *supra* note 1.

prescribing practices and expand access to medically assisted treatment ("MAT"), far too often people view addiction as a criminal behavior to be deterred, and society has favored incarceration as the designated treatment of choice to date. This misdiagnosis amounts to a declaration of war on the drug addict and diverts limited law enforcement resources and attention away from the prosecution of drug traffickers. The penal system incarcerates convicted drug addicts alongside drug traffickers; there is no attempt to remedy the very addiction that fuels the demand. Thus, while the opioid crisis has triggered a renewed commitment to the war on drugs, this war will have been in vain unless a reformed understanding of drug addiction and the most effective forms of treatment accompany and motivate it.

While lawmakers, regulators, healthcare providers, and law enforcement struggle for solutions to the opioid crisis, there does not appear to be a consensus in terms of understanding the true nature of addiction. The catastrophic nature of the opioid crisis, however, causes many to re-evaluate the nature of drug addiction, particularly to opioids, as primarily a public health issue. Thus, this Article begins with a discussion that sets out to define the opioid crisis as a public health event.

Beginning with a primer on how opioids function and the addictive nature of opioids, this Article will proceed to explore the scope of opioid use in the context of a health epidemic and examine the human toll of opioid addiction, particularly in Tennessee. This Article will further examine the statutory and regulatory limits on the prescription and dispensation of opioids to prevent further drug abuse, as well as federal and state policies that expand access to treatment services for those currently suffering from the disease of addiction. This conversation includes observations on areas where there is room for further epidemiological reforms.

The Article then delves into the consequences that result from using the criminal justice system to fix the opioid crisis. It argues that the criminal justice system was simply not designed to control the demand for drugs, and that incarceration does not function as an adequate deterrent, nor as a substitute treatment method, for opioid addiction. This Article, however, is not an indictment of the criminal justice system, nor does it suggest that the criminal justice system has no role in curtailing the demand for drugs in this country. Thus, the Article poses, then answers, a salient question: what is the role of the

criminal justice system in the opioid epidemic? In answering this question, one must always concede, when addressing criminal behavior, that criminal behavior is often a symptom of drug addiction. The key to solving the opioid epidemic will be the use of effective policies, rather than reflexively employing solely punitive measures.[7]

II. DEFINING THE OPIOID CRISIS

If we are to successfully eradicate the opioid crisis, we must first recognize the public health nature of the crisis.[8] On March 29, 2017, President Trump signed an executive order creating the President's Commission on Combating Drug Addiction and the Opioid Crisis ("the President's Commission").[9] In the order, the President recognized the opioid epidemic as a "public health crisis" that "has caused families and communities across America to endure significant pain, suffering, and financial harm."[10] On October 26, 2017, the President declared a Nationwide Public Health Emergency in response

7. The criminal justice system must identify offenders with substance abuse disorder and design a sanction that balances rehabilitation with personal responsibility. What is more, especially with nonviolent offenders, the law should presume that an evidence-based supervision program equipped to provide treatment would be superior to incarceration. While certainly not exhaustive, this Article highlights several effective and innovative programs in various jurisdictions to ensure that offenders receive necessary treatment and oversight.

8. The United States Department of Health and Human Services has acknowledged that opioid abuse is a serious public health issue and that drug overdose deaths are one of the leading causes of injury-related deaths in the United States. *What Is the U.S. Opioid Epidemic?*, U.S. DEP'T OF HEALTH & HUMAN SERVS., https://www.hhs.gov/opioids/about-the-epidemic/index.html (last visited Oct. 14, 2018). The CDC Guideline for Prescribing Opioids for Chronic Pain states that more than 600,000 people died from drug overdoses between 2000 and 2016, with 66% resulting from opioid use. CDC, *Understanding the Epidemic*, *supra* note 2. A *New England Journal of Medicine* article dubbed "[t]he nonmedical use of prescription opioids" as "a major public health issue in the United States," due to the "overall high prevalence and because of marked increases in associated morbidity and mortality." Wilson M. Compton et al., *Relationship Between Nonmedical Prescription-Opioid Use and Heroin Use*, 374 N. ENGL. J. MED. 154, 154 (Jan. 14, 2016), https://www.nejm.org/doi/pdf/10.1056/NEJMra1508490.

9. Exec. Order No. 13,784, 82 Fed. Reg. 16,283 (2017).

10. *Id.*

to the opioid crisis, which will expand and expedite treatment services.[11]

As with any public health epidemic, we should control the opioid use disorder fueling this crisis epidemiologically. Lawmakers and the health care industry cannot rely upon the criminal justice system to fix a disease. Instead, the law should embrace policies that restrain the prescription of opioids for pain management if we are to prevent further abuse. Likewise, lawmakers need to take appropriate steps to ensure that those suffering from opioid addiction have access to treatment in the event of an overdose, as well as for long-term sobriety.

A. What Are Opioids, and How Are They Harmful?

To fully appreciate the nature of opioid abuse and its impact on the human body, one must first understand what opioids are and how the different categories of opioids function.[12] The four primary categories of opioids are (1) natural and semisynthetic opioids that are common in prescription painkillers, (2) synthetic opioid analgesics like fentanyl and tramadol, (3) methadone, and (4) heroin.[13] The first category, prescription painkillers,[14] or opioid analgesics, breaks down

11. Press Release, The White House, President Donald J. Trump Is Taking Action on Drug Addiction and the Opioid Crisis (Oct. 26, 2017), https://www.whitehouse.gov/the-press-office/2017/10/26/president-donald-j-trump-taking-action-drug-addiction-and-opioid-crisis.

12. The National Institute on Drug Abuse describes opioids as "a class of drugs that . . . are chemically related and interact with opioid receptors on nerve cells in the body and brain." Nat'l Institutes on Health, *Opioids: Brief Description*, NAT'L INST. ON DRUG ABUSE, https://www.drugabuse.gov/drugs-abuse/opioids (last visited Oct. 14, 2018).

13. *Opioid Overdose: Opioid Data Analysis and Resources*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/drugoverdose/data/analysis.html (last updated Feb. 9, 2017) [hereinafter CDC, *Opioid Data Analysis*].

14. The CDC reports a "dramatic increase in the acceptance and use of prescription opioids for the treatment of chronic, non-cancer pain, such as back pain or osteoarthritis, despite serious risks and the lack of evidence about their long-term effectiveness." *Opioid Overdose: Prescription Opioids*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/drugoverdose/opioids/prescribed.html (last updated Aug. 29, 2017). It warns that "taking too many prescription opioids can stop a person's

into subcategories, natural and semisynthetic.[15] Natural opioid analgesics include codeine and morphine.[16] Semisynthetic opioid analgesics include hydrocodone, oxycodone, hydromorphone, and oxymorphone.[17] The synthetic opioid analgesics fentanyl and tramadol make up the second category of opioids.[18] Fentanyl in particular, while "approved for treating severe pain, typically advanced cancer pain," is "50 to 100 times more potent than morphine" and has been "diverted for misuse and abuse in the United States."[19] Third is methadone, a synthetic opioid that can help treat chronic pain.[20] The final category is the illicit drug heroin, which "is pharmacologically similar to prescription opioids."[21] Heroin is a "highly addictive opioid

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breathing—leading to death." *Id.* Risk of opioid overdose increases when taken in conjunction with benzodiazepines, such as Xanax, which are described as "central nervous system depressants used to sedate, induce sleep, prevent seizures, and relieve anxiety." *Id.*

15. CDC, *Opioid Data Analysis*, *supra* note 13.

16. *Id.*

17. *Id.*

18. *Id.*

19. *Opioid Overdose: Fentanyl*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/drugoverdose/opioids/fentanyl.html (last updated Aug. 29, 2017). Many fentanyl-related overdoses result from "illegally made" or "non-pharmaceutical" fentanyl. *Id.* Users obtain this product "through illegal drug markets for its heroin-like effect," and "often [mix it] with heroin and/or cocaine as a combination product—with or without the user's knowledge—to increase its euphoric effects." *Id.* In 2015, the CDC issued a health advisory in response to an increase in non-pharmaceutical fentanyl-related overdose deaths. *Increases in Fentanyl Drug Confiscations and Fentanyl-Related Overdose Fatalities*, CTRS. FOR DISEASE CONTROL & PREVENTION (Oct. 26, 2015, 8:15 AM), https://emergency.cdc.gov/han/han00384.asp.

20. *Vital Signs: Prescription Painkiller Overdoses*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/vitalsigns/methadoneoverdoses/index.html (last updated July 3, 2012). However, taking methadone for pain management is dangerous, as "the difference between appropriate prescribed doses and dangerous doses of methadone is small" and "taking it more than 3 times a day can cause the drug to build up in a person's body, leading to dangerously slowed breathing," and "disrupt the heart's rhythm." *Id.*

21. Compton et al., *supra* note 8, at 155.

drug," that is "typically injected" and can "cause slow and shallow breathing, coma, and death."[22]

B. The Evolution the Opioid Epidemic

Drug abuse, particularly heroin abuse, has been an ongoing problem since the 1960s. In fact, some scholars trace opioid addiction to doctors prescribing iatrogenic morphine for chronic pain as far back as the 19th century.[23] The President's Commission, however, has affirmed the fact that the genesis of the opioid crisis as we understand it today "began in our nation's health care system."[24] More specifically, it began in the late 1990s when doctors increasingly prescribed painkillers upon pharmaceutical companies assurances' that there was only a small degree of addiction risk.[25] The introduction of prescription opioids has been "a driving factor in the 16-year increase in opioid overdose deaths."[26] The CDC has recognized studies that show that "the amount of prescription opioids sold to pharmacies, hospitals, and doctors' offices nearly quadrupled from 1999 to 2010," even though the reports of pain during this time period did not increase.[27]

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22. *Opioid Overdose: Heroin*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/drugoverdose/opioids/heroin.html (last updated Aug. 29, 2017).

23. Andrew Kolodny et al., *The Prescription Opioid and Heroin Crisis: A Public Health Approach to an Epidemic of Addiction*, 36 ANNU. REV. PUB. HEALTH 559, 561 (2015).

24. THE PRESIDENT'S COMM'N ON COMBATING DRUG ADDICTION AND THE OPIOID CRISIS, DRAFT INTERIM REPORT 3 (2017), https://www.whitehouse.gov/sites/whitehouse.gov/files/ondcp/commission-interim-report.pdf.

25. Nat'l Institutes on Health, *Opioid Crisis*, NAT'L INST. ON DRUG ABUSE, https://www.drugabuse.gov/drugs-abuse/opioids/opioid-crisis (last updated Mar. 2018).

26. *Cf.* Dale Bowman, *Putting a Face on the Opioid Epidemic: Fishing and the Life of Andrew Narro*, CHI. SUN-TIMES (Feb. 18, 2018, 5:49 AM), https://chicago.suntimes.com/sports/putting-a-face-to-the-opioid-epidemic-fishing-and-the-life-of-andrew-narro/.

27. *Cf. Middle Tennessee School of Anesthesia Is Helping to Combat the National Opioid Epidemic*, MIDDLE TENN. SCH. OF ANESTHESIA, http://mtsa.edu/opioids/ (last visited Oct. 14, 2018).

The prevalence of opioids has made them more readily available for use as nonmedical prescription pain relievers ("NMPR"), either through prescription, friends, or dealers. Accordingly, "91.8 million (34.1%) or more than one-third of U.S. civilian, noninstitutionalized adults used prescription opioids; 11.5 million (4.3%) misused them."[28] As of 2015, 1.6 million people suffered from opioid use disorder.[29] There has been a "steady increase" in the number of opioid prescriptions from 2006 to 2012, when it peaked at 255 million prescriptions.[30] And in 2016, while the total prescriptions fell to 214 million, "[i]n 16% of U.S. counties, enough opioid prescriptions were dispensed for every person to have one."[31]

There is also cause to believe that NMPR use may lead to heroin use.[32] The President's Commission reports that "approximately 80% of heroin users are estimated to have transitioned from misuse of prescription opioids in recent years."[33] In fact, studies have shown that "the rate of heroin initiation among prior NMPR users was approximately 19 times greater than those who did not have NMPR use."[34] Moreover, 75% of those undergoing treatment for opioid addition, and whose "opioid abuse initiation" occurred in the 2000's, as opposed to the 1960s, began by using prescription opioids.[35] It

28. PRESIDENT'S COMM'N FINAL REPORT, *supra* note 3, at 23.

29. *Id.*

30. *Opioid Overdose: U.S. Prescribing Rate Maps*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html (last updated Oct. 3, 2018). This is a "prescribing rate of 81.3 prescriptions per 100 persons." *Id.*

31. *Id.*

32. Pradip K. Muhuri et al., *Associations of Nonmedical Pain Reliever Use and Initiation of Heroin Use in the United States*, CTR. FOR BEHAVIORAL HEALTH STATISTICS & QUALITY, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (Aug. 2013), https://www.samhsa.gov/data/sites/default/files/DR006/DR006/nonmedical-pain-reliever-use-2013.htm.

33. PRESIDENT'S COMM'N FINAL REPORT, *supra* note 3, at 28.

34. Muhuri et al., *supra* note 32.

35. *See generally* Theodore J. Cicero et al., *The Changing Face of Heroin Use in the United States: A Retrospective Analysis of the Past 50 Years*, 71 J. AM. MED. ASS'N PSYCHIATRY 821 (2014), http://jamanetwork.com/journals/jamapsychiatry/fullarticle/1874575. A review of these studies in the *New England Journal of Medicine* suggests that the association of

appears, however, that only a small percentage of NMPR users—3.6% or 4.2% depending on the study—transition into heroin use, but the number is still high when considering the volume of NMPR users.[36]

C. The Scope of the Opioid Crisis in Tennessee

The opioid epidemic has devastated Tennessee in particular. According to the Tennessee Department of Health ("TDOH"), "[t]he misuse and abuse of prescription drugs, along with the associated morbidity and mortality, has been identified as one of the most serious and costly issues facing Tennesseans today."[37] TDOH reports that "[o]pioid use is disproportionately high in the northeastern (Appalachian) region of the state, while heroin use in highest in the southwestern (Memphis) area, reflecting disparities for both geographic and racial/ethnic segments of the population."[38]

Tennessee experienced a 91% increase in the mortality rate for synthetic opioid abuse between 2014 and 2015 and a 44% increase in the same for heroin.[39] With the exception of methadone overdoses,

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NMPR and heroin use is "highly suggestive and plausible, given the common pharmacologic principles described above." Compton et al., *supra* note 8, at 156. It concluded that "[t]rajectory analysis of patterns of nonmedical use of prescription opioids suggests that persons most often start with oral nonmedical use of opioids." *Id.*

36. Compton et al., *supra* note 8, at 158. Once addiction to NMPR use takes hold, opioid users must find "more efficient routes of administration, such as insufflation, smoking, or injection, as tolerance to opioids develops and it becomes more costly to maintain their abuse patterns." *Id.* at 156. To that end, heroin is more "reliably available, more potent, easier to manipulate for nonoral routes, and more cost-effective than prescription opioids." *Id.* According to one study, 94% of the participants surveyed "indicated that they used heroin because prescription opioids were far more expensive and harder to obtain." Cicero et al., *supra* note 35.

37. *Naloxone Training Information*, TENN. DEP'T OF HEALTH, https://www.tn.gov/health/health-program-areas/health-professional-boards/csmd-board/csmd-board/naloxone-training-information.html (last updated Jan. 2018).

38. *Prescription Drug Overdose (PDO)*, TENN. DEP'T OF HEALTH, https://homebuilding.tn.gov/health/health-program-areas/pdo.html (last visited Oct. 14, 2018).

39. K. EDWARDS, TENN. DEP'T OF MENTAL HEALTH AND SUBSTANCE ABUSE, TRENDS IN DRUG OVERDOSE DEATHS INVOLVING OPIOIDS: TENNESSEE AND THE UNITED STATES 2014 AND 2015, at 4 (2017),

this increase from 2014 to 2015 in the opioid death rate is significantly higher than the national average.[40] Opioid users received treatment for an additional 22,944 nonfatal overdoses in either an inpatient or outpatient facility in 2016.[41] A reported 190,000 adults in Tennessee, or 3.9% of the population, used nonmedical pain relievers from 2013 to 2014.[42]

Opioid Death Rate[43]	Tennessee Death Rate Increase from 2014 to 2015	Average National Death Rate Increase from 2014 to 2015
Natural/Semisynthetic: • Morphine (natural) • Codeine (natural) • Oxycodone (semi) • Hydrocodone (semi) • Hydromorphone (semi) • Oxymorphone (semi)	13%	3%
Synthetic: • Tramadol • Fentanyl	91%	72%

https://www.tn.gov/content/dam/tn/mentalhealth/documents/Drug_Overdose_Deaths_CDC_2.14.2017_.pdf.

40. *Id.*

41. *Data Dashboard*, TENN. DEP'T OF HEALTH, https://tn.gov/health/topic/pdo-data-dashboard (last visited Oct. 14, 2018).

42. K. EDWARDS & R. JONES, TENN. DEP'T OF MENTAL HEALTH AND SUBSTANCE ABUSE, FAST FACTS 5 (2017), https://www.tn.gov/content/dam/tn/mentalhealth/documents/DPRF_Fast_Facts_4.7.2017_ke.pdf.

43. EDWARDS, *supra* note 39 (using rounded figures).

Heroin	44%	21%

Despite the morbidity and fatalities resulting from opioid addiction, the volume of opioid prescriptions in Tennessee remains exorbitant. In 2018, Governor Bill Haslam's administration acknowledged that "[e]ach year, more opioid prescriptions are written than there are people living in Tennessee, with more than 1 million prescriptions left over."[44] Notably, Tennessee ranks second behind Alabama for the highest number of opioid prescriptions per capita in the country.[45] Rather than placing the onus on the justice system to address prescription drug abuse, the healthcare community in Tennessee should embrace policy initiatives aimed at reining in the current practice of prescribing opioids for chronic pain management.

III. EPIDEMIOLOGICAL SOLUTIONS TO THE OPIOID CRISIS

Society cannot contain opioid use disorder unless lawmakers take steps to prevent the spread of the disease.[46] It is also vital that

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44. TENN. DEP'T OF HEALTH, TN TOGETHER: ENDING THE OPIOID CRISIS (2018), https://www.tn.gov/content/dam/tn/opioids/documents/OpioidGraphicSummary.pdf; *accord* Hon. William E. Haslam, *Tennessee Together: Governor's Welcome*, 48 U. MEM. L. REV. 1025 (2018).

45. *See* IMS INST. FOR HEALTHCARE INFORMATICS, USE OF OPIOID RECOVERY MEDICATIONS: RECENT EVIDENCE ON STATE LEVEL BUPRENORPHINE USE AND PAYMENT TYPES 13–14 (2016), https://www.iqvia.com/-/media/iqvia/pdfs/institute-reports/use-of-opioid-recovery-medications.pdf. Keeping these statistics in mind, a 2016 Tennessee Attorney General opinion concluded that neither "doctors [n]or pharmacists [are] held harmless if a patient is addicted or becomes addicted to medication prescribed by a doctor or dispensed by a pharmacist." Liability of Doctors and Pharmacists for Negligently Prescribing to, or Filling Prescriptions for, Patients Who Become Addicted, Op. Tenn. Att'y Gen. No. 16-32 (2016), http://bit.ly/2J1Rfln. Moreover, depending on the facts presented, doctors and pharmacists can be "found negligent for enabling a person's addiction by prescribing or dispensing an opioid." *Id.*

46. The CDC defines "opioid use disorder" as "[a] problematic pattern of opioid use that causes clinically significant impairment or distress." *Opioid Overdose: Commonly Used Terms*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/drugoverdose/opioids/terms.html (last updated Aug. 28, 2017). One is diagnosed based on a "specific criteria such as unsuccessful efforts to cut down

policies expand access to treatment. To contain and prevent further opioid addiction, prescribers must prescribe opioids more responsibly. Echoing this sentiment, the CDC maintains that "[r]educing exposure to prescription opioids, for situations where the risks of opioids outweigh the benefits, is a crucial part of prevention."[47] The CDC published the Guidelines for Prescribing Opioids for Chronic Pain with instructions concerning "when to initiate or continue opioids for chronic pain[,] . . . opioid selection, dosage, duration, follow-up, and discontinuation[,] . . . and . . . assessing risk and addressing harms of opioid use."[48] A fundamental principle buttressing these guidelines is that "[n]onopioid therapy is preferred for chronic pain outside of active cancer, palliative, and end-of-life care."[49] When opioids are necessary, "the lowest possible effective dosage should be prescribed," and the patient should be closely monitored.[50]

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or control use, or use resulting in social problems and a failure to fulfill obligations at work, school, or home." *Id.* An article in the *New England Journal of Medicine* explains that "prescription opioids and heroin both have the potential to use similar pharmacologic mechanisms to induce euphoria (or analgesia)," but "different opioid molecules have different euphorigenic properties and withdrawal-syndrome patterns." Compton et al., *supra* note 8, at 155.

47. *Opioid Overdose: Improve Opioid Prescribing*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/drugoverdose/prevention/prescribing.html (last updated Aug. 30, 2017).

48. *CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm (last updated Mar. 18, 2016).

49. Press Release, Ctrs. for Disease Control & Prevention, CDC Releases Guideline for Prescribing Opioids for Chronic Pain (Mar. 15, 2016), https://www.cdc.gov/media/releases/2016/p0315-prescribing-opioids-guidelines.html.

50. *Id.* In the *New England Journal of Medicine* piece, the authors also appear to adopt the view that reduction of opioid prescriptions is central to the prevention of opioid addiction. They explain that "a key underlying characteristic of the epidemic is the association between the increasing rate of opioid prescribing and increasing opioid-related morbidity and mortality," and that, "[t]aken together, these trends suggest the need for balanced prevention responses that aim to reduce the rates of nonmedical use and overdose while maintaining access to prescription opioids when indicated." Compton et al., *supra* note 8. They further note the importance of "interventions for persons who have clinically significant complications from opioid

To that end, many states have adopted policies to encourage responsible opioid-prescription practices.[51] Additionally, the private healthcare industry has taken some initiative to reduce the over-prescribing of opioids.[52] But while policies in place to prevent the further opioid addiction are useful, it is also imperative that those suffering from opioid addiction gain access to treatment to both reverse the onset of an overdose and facilitate long term sobriety.[53]

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use, and improved treatment for those with opioid-use disorders," to reversing the opioid epidemic. *Id.* at 161.

51. Some states place limits on the supply of controlled substances that caregivers can dispense, based on the schedule designation of the controlled substance. For example, South Carolina limits the prescription of Schedule II controlled substances to a 31-day supply and prohibits dispensation ninety days after issue, while limiting Schedule III through V controlled substances to a 90-day supply with some limits placed on the timeframe for refill. S.C. CODE ANN. REGS. 61-4.1102, 61-4.1203 (2018). Tennessee imposes a similar 30-day supply limit on the prescription of all opioids or benzodiazepines. TENN. CODE ANN. § 53-11-308(e) (2018). A law recently went into effect in Kentucky that limits the amount of a Schedule II controlled substance that caregivers can prescribe for acute pain to a three-day supply. KY. REV. STAT. ANN. § 218A.205(3)(b) (2017).

52. For example, Kaiser Permanente of Southern California created the Safe and Appropriate Opioid Prescribing ("SAOP") program, a "clinically-driven initiative led by physicians from primary care, pain management, and addiction medicine departments, and pharmacy operations." Jan L. Losby et al., *Safer and More Appropriate Opioid Prescribing: A Large Healthcare System's Comprehensive Approach*, 23 J. EVALUATION IN CLINICAL PRAC. 1173, 1174 (2017), http://onlinelibrary.wiley.com/doi/10.1111/jep.12756/full. The SAOP program involves "prescribing and dispensing policies, follow-up and monitoring processes, organizational and clinical coordination, and information technology integration to reduce inappropriate opioid prescribing." *Id.* at 1173. A SAOP study found a reduction in opioid prescriptions dispensed to health plan members by healthcare providers included in its medical group. *Id.* While the study limited its sample to an insured population located in Southern California, it proffers that perhaps "the interventions could be effective with different patient populations and in other states." *Id.* at 1178.

53. The President's Commission reports that "only 10 percent of the nearly 21 million citizens with a substance use disorder (SUD) receive any type of specialty treatment." PRESIDENT'S COMM'N FINAL REPORT, *supra* note 3, at 115.

A. Common Methods of Opioid Addiction and Overdose Prevention and Treatment

Opioid antagonists play an important role in the occasion of an overdose by "displac[ing] opiates from receptor sites in the brain and revers[ing] respiratory depression that is usually the cause of overdose deaths."[54] A commonly used opioid antagonist is naloxone. Administered when an individual is symptomatic of an opioid overdose, naloxone "blocks opioid receptor sites, reversing the toxic effects of the overdose."[55] The CDC has called for "[e]xpand[ed] access to and use of naloxone," because it is "a non-addictive, life-saving drug that can reverse the effects of an opioid overdose when administered in time."[56]

Buprenorphine, an "opioid partial agonist" is similar to opioids in that "it produces effects such as euphoria or respiratory depression," but "these effects are weaker than those of full drugs such as heroin and methadone."[57] It functions to "[l]ower the potential for misuse," "[d]iminish the effects of physical dependency to opioids, such as withdrawal symptoms and cravings," and "[i]ncrease safety in cases of overdose."[58] Because the dispensation requirement for buprenorphine does not require the same level of physician supervision as methadone, there is more access to this treatment.[59] Pharmacists often combine

54. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., OPIOID OVERDOSE TOOLKIT: FACTS FOR COMMUNITY MEMBERS 4 (2013) (citing L. Enteen et al., *Overdose Prevention and Naloxone Prescription for Opioid Users in San Francisco*, 87 J. URBAN HEALTH 931 (2010)), https://www.integration.samhsa.gov/Opioid_Toolkit_Community_Members.pdf.

55. *Naloxone*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/medication-assisted-treatment/treatment/naloxone (last updated Mar. 3, 2016).

56. *Reverse Overdose to Prevent Death*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/drugoverdose/prevention/reverse-od.html (last updated Aug. 29, 2017).

57. *Buprenorphine*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine (last updated May 31, 2016).

58. *Id.*

59. *Id.*

naloxone with buprenorphine to "decrease the likelihood of diversion and misuse of the combination drug product."[60]

MAT is also effective for rehabilitation and long term sobriety. MAT utilizes opioids, such as methadone and buprenorphine, to reverse dependency and is both "safe and effective" when used "as part of a comprehensive treatment plan that includes counseling and participation in social support programs."[61] Caregivers have long used methadone as an MAT for opioid addiction. Methadone "works by changing how the brain and nervous system respond to pain."[62] It also "lessens the painful symptoms of opiate withdrawal and blocks the euphoric effects of opiate drugs such as heroin, morphine, and codeine, as well as semi-synthetic opioids like oxycodone and hydrocodone."[63] Because of methadone's highly addictive nature, a physician must administer and supervise methadone treatment, and the law only permits methadone dispensation through a SAMHSA-certified opioid treatment program.[64]

Naltrexone is another MAT that differs from buprenorphine and methadone. It functions as an opioid antagonist because it prevents a user from experiencing the effect of the opioid.[65] It also does not carry the risk of abuse and diversion.[66] Moreover, rather than stimulate receptors, naltrexone blocks opioid receptors to reduce opioid craving.[67] Thus, it prevents someone suffering from opioid use disorder from "getting high."[68] Naltrexone therapy is most effective in "highly motivated and carefully selected patients."[69]

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60. *Id.*

61. *Methadone*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/medication-assisted-treatment/treatment/methadone (last updated Sept. 28, 2015).

62. *Id.*

63. *Id.*

64. *Id.*

65. Kolodny et al., *supra* note 23, at 568.

66. *Naltrexone*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/medication-assisted-treatment/treatment/naltrexone (last updated Sept. 12, 2016).

67. *Id.*

68. *Id.*

69. Kolodny et al., *supra* note 23, at 569.

Federal and state laws have placed a number of limitations on MATs. Under the federal Controlled Substances Act ("CSA"), any physician who dispenses narcotics for the purpose of drug treatment must first register with the U.S. Drug Enforcement Agency ("DEA") and qualify under federal guidelines to treat substance abuse addiction.[70] Congress later amended the CSA to provide waivers for those otherwise-qualified physicians to administer MATs using FDA-approved prescription drugs for the treatment of substance abuse.[71] This waiver specifically allows physicians to treat individuals with opioid use disorder with buprenorphine outside of a clinical setting. Federal Department of Health and Human Services rules limit the total number of patients that a qualified practitioner can treat at a time to 275.[72] For those who require emergency treatment for opioid use disorder, DEA regulations allow practitioners who have neither registered nor obtained a waiver to administer narcotics to relieve a patient's withdrawal symptoms.[73] The rules limited this accommodation in time to 72 hours, and the practitioners it covers may only administer the narcotics while the patient awaits referral to a qualified treatment program.[74] Additionally, this accommodation covers the administration of narcotics only; it does not include providing a prescription.[75]

The CDC endorses MATs as "a comprehensive way to address the needs of individuals that combines the use of medication . . . with counseling and behavioral therapies."[76] SAMHSA reports, however, that there has been a "slow adoption of these evidence-based treatment options for alcohol and opioid dependence."[77] It attributes this

70. 21 U.S.C. § 823(g)(1) (2012).

71. 21 U.S.C. § 823(g)(2) (2012 & Supp. 2016).

72. *See, e.g.*, 42 C.F.R. § 8.610 (2017).

73. 21 C.F.R. § 1306.07(b) (2017).

74. *Id.*

75. *Id.*

76. *Opioid Overdose: Treat Opioid Abuse Disorder*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/drugoverdose/prevention/treatment.html (last updated Aug. 23, 2017).

77. *Medication and Counseling Treatment*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/medication-assisted-treatment/treatment (last updated Sept. 28, 2015).

hesitation, in part, "to misconceptions about substituting one drug for another."[78]

For any treatment program to be effective, individuals with opioid use disorder must follow the prescribed program through its duration. Many programs, however, report high dropout rates.[79] Therefore, because opioid addiction is a disease, one way to treat it preventatively is to restrict the number of unnecessary opioid prescriptions. To treat those who are suffering from the disease, lawmakers must expand access to opioid antagonists and MATs. Society must embrace this strategy if it is going to successfully eradicate the opioid epidemic.

B. Tennessee's Attempts to Prevent NMPR Use

While Tennessee remains the second-highest opioid prescriber in the country, changes to the law have additionally restricted and created oversight for both prescribing physicians and pharmacists. In 2013, Tennessee enacted the Addison Sharp Prescription Regulatory Act ("the Prescription Regulatory Act") to establish guidelines and accountability for opioid prescribers.[80] The Prescription Regulatory Act requires Tennessee's Commissioner of Health to "develop recommended treatment guidelines for prescribing opioids that can be used by prescribers in this state as a guide for caring for patients."[81] The Commissioner must present the guidelines "to each prescribing board that licenses health professionals who can legally prescribe controlled substances and to the board of pharmacy," and "[e]ach board shall be charged with reviewing the treatment guidelines and determining how the treatment guidelines should be used by that

78. *Id.*

79. Lori Whitten, *Low-Cost Incentives Improve Outcomes in Stimulant Abuse Treatment*, NAT'L INST. ON DRUG ABUSE (Oct. 1, 2006), https://www.drugabuse.gov/news-events/nida-notes/2006/10/low-cost-incentives-improve-outcomes-in-stimulant-abuse-treatment. A Clinical Trials Network study by the National Institute for Drug Addiction has found that patients who participated in programs that used incentives, such as prizes, were four times more likely to achieve twelve weeks of sobriety. *Id.*

80. 2013 Tenn. Pub. Acts 430, § 1.

81. TENN. CODE ANN. § 63-1-401(b) (2018).

board's licensees."[82] The guidelines maintain that covered providers must prescribe controlled substances in "adequate doses, and for appropriate lengths of time, which in some cases may be as long as the pain or related symptoms persist."[83] The Prescription Regulatory Act, however, expressly limits the quantity of opioids or benzodiazepines available for dispensation to a thirty-day supply and requires the prescriber to submit information relating to the prescription to the controlled substances monitoring database.[84] Moreover, physician assistants and nurse practitioners may only prescribe certain Schedule II and III opioids and only for a non-refillable thirty-day supply.[85]

The Prescription Regulatory Act also expanded the definition for "pain management clinics" to include any "privately-owned facility . . . in which any health care provider . . . provides . . . pain treatment to a majority of its patients for ninety (90) days or more in a twelve-month period."[86] Pain management clinics must now ensure that patients have a government-issued identification or insurance card, and the clinics must also "conduct urine drug screening in accordance with a written drug screening compliance plan."[87] The maximum administrative penalty for failure to comply with the protocols set forth in statute or administrative guidelines increased from $1,000 per day to $5,000 per day with passage of the Prescription Regulatory Act.[88] Pain management clinics must also employ "a medical director who is a [licensed] medical doctor or osteopathic physician" who must be a qualified "pain management specialist."[89] Finally, pain management clinics may not dispense controlled substances beyond samples of schedule IV or schedule V controlled substances in quantities sufficient for seventy-two hours.[90]

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82. § 63-1-401(e).

83. TENN. COMP. R. & REGS. 0880-02-.14(6) (2017).

84. TENN. CODE ANN. § 53-11-308(e), (f) (2018).

85. TENN. CODE ANN. § 63-19-107(2)(B)(iii) (2018); TENN. CODE ANN. § 63-7-123(b)(2)(C) (2018).

86. TENN. CODE ANN. § 63-1-301(7)(A) (2018).

87. TENN. CODE ANN. § 63-1-303(c)(1)(B) (2018).

88. *Compare* TENN. CODE ANN. § 63-1-311(b) (2018), *with* 2011 Tenn. Pub. Acts 340, § 1.

89. TENN. CODE ANN. § 63-1-306(a)(1)–(2) (2018).

90. TENN. CODE ANN. § 63-1-313(a) (2018).

In 2014, on the heels of the Prescription Regulatory Act, Tennessee lawmakers enacted an additional opioid-prescription reform that requires anyone with permission to dispense a Schedule II–IV controlled substance to first demand that the individual "taking possession" of the prescription first present a valid government identification or insurance card.[91] Broad exemptions in this mandate, however, may leave the door open for abuse.[92] For instance, a person whom an authorized dispenser knows personally does not need to present identification.[93] Also, the law does not require that the individual taking possession of the prescription be the same individual to whom the caregiver prescribed the substance.[94]

In 2016, Tennessee also expanded the Prescription Safety Act of 2012. These reforms included the establishment of the controlled substance monitoring database ("CSMD") within the TDOH.[95] The expressed purpose of the database is to "equip[] healthcare practitioners with accurate, timely information that the practitioners can use to determine when patients acquiring controlled substances may require counseling or intervention for substance abuse."[96] The database is an electronic collection of information "regarding all controlled substances in Schedules II, III, and IV dispensed in this state," and those Schedule V substances identified as having a "potential for abuse."[97] It is also "to be used to assist in research, statistical analysis, criminal investigations, enforcement of standards of health professional practice, and state or federal laws involving

91. TENN. CODE ANN. § 53-11-310(a) (2018).

92. *See* § 53-11-310(c) (2018) (providing carve-outs from the mandates set out in § 53-11-310(a)).

93. § 53-11-310(a).

94. § 53-11-310(c)(1).

95. Pursuant to the Controlled Substance Monitoring Act of 2002, the legislature originally charged the Tennessee Board of Pharmacy with oversight of the database to police the dispensation of Schedules II, III, IV & V controlled substances. *See generally* 2002 Tenn. Pub. Acts 840 (codified as amended at TENN. CODE ANN. §§ 53-10-301 to -312 (2018)); *see also* TENN. CODE ANN. § 53-10-304(a) (2018); *cf.* 2012 Tenn. Pub. Acts 880.

96. § 53-10-304(c).

97. *Id.*

controlled substances."[98] The database must function to specifically identify:

> Individuals, facilities, or entities that receive prescriptions for controlled substances from healthcare practitioners, and who subsequently obtain dispensed controlled substances from a healthcare practitioner in quantities or with a frequency inconsistent with generally recognized standards of dosage for that controlled substance, or by means of forged or otherwise false or altered prescriptions.[99]

All Tennessee practitioners prescribing or dispensing controlled substances who practice more than 15 days per year, and who must register with the DEA, must also register in the database.[100] Failure to comply can result in the loss of the practitioner's license and other sanctions, including civil penalties.[101] Law enforcement (or other preapproved law enforcement personnel) may also access information from the CSMD as part of an "investigation and

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98. *Id.* TDOH was tasked with designing the electronic database so that "practices and patterns of prescribing and dispensing controlled substances" can be identified. TENN. CODE ANN. § 53-10-305(e)(1) (2018).

99. § 53-10-305(e)(2).

100. § 53-10-305(a). Moreover, practitioners who prescribe controlled substances must submit the following information to the database for each controlled substance prescribed:

> (A) Prescriber identifier;
> (B) Dispensing date of controlled substance;
> (C) Patient identifier;
> (D) Controlled substance dispensed identifier;
> (E) Quantity of controlled substance dispensed;
> (F) Strength of controlled substance dispensed;
> (G) Estimated days' supply;
> (H) Dispenser identifier;
> (I) Date the prescriber issued the prescription;
> (J) Whether the prescription was new or a refill;
> (K) Source of payment; and
> (L) Other relevant information as required by rule.

2016 Tenn. Pub. Acts 1002, § 5 (codified as amended at TENN. CODE ANN. § 53-10-305(b)(1)(A)–(L) (2018)).

101. TENN. CODE ANN. § 53-10-307(a) (2018).

enforcement of state or federal laws involving controlled substances or violations under this part."[102] Drug court judges can also access the CSMD.[103]

The Prescription Safety Act also increased accountability and oversight for wholesalers and manufacturers of controlled substances. These entities must submit information to the CSMD, including identification information, the types and quantity of drugs sold, and the date of the sale.[104] A wholesaler must "design and operate a system to disclose to the wholesaler suspicious orders of controlled substances," and notify "the board of pharmacy and the boards whose licensees have prescribing authority of suspicious orders when discovered."[105] Wholesalers also have the duty to report to law enforcement and the committee overseeing the database any time there is a "theft or significant loss of controlled substances."[106]

At least once a year, TDOH must "[i]dentify the top fifty (50) prescribers who have unique DEA numbers of controlled substances . . . in the previous calendar year . . . from the data available in the controlled substances database . . . ."[107] The agency must notify each of the fifty prescribers, and if appropriate, "the collaborating physician" in writing that it has identified them as such.[108] This letter must also set forth the type of controlled substance prescribed, the number of patients for whom these prescriptions were written, and "the total milligrams in morphine equivalents of controlled substances prescribed during the relevant period of time."[109] TDOH has discretion to require that these prescribers submit a written "explanation justifying the amounts of controlled substances prescribed in the relevant period of time by the prescriber demonstrating that these amounts were medically necessary for the patients treated."[110] If the prescribers are "advanced practice registered nurses and physician

102. TENN. CODE ANN. § 53-10-306(a)(9)(A) (2018).

103. § 53-10-306(a)(10).

104. TENN. CODE ANN. § 53-10-312(a) (2018).

105. § 53-10-312(c). "Suspicious orders include orders of unusual size, orders deviating substantially from a normal pattern, and orders of unusual frequency." *Id.*

106. § 53-10-312(d).

107. TENN. CODE ANN. § 68-1-128(a)(1) (2018).

108. § 68-1-128(a)(2).

109. § 68-1-128(a)(2)(C).

110. § 68-1-128(b)(1)(A).

assistants," then they must show that "the collaborating physician had reviewed and approved the prescribing amounts."[111] When determining whether the prescriber's response justifies the prescription, TDOH must consider the prescriber's specialty and the age of the patient.[112] The statute affords prescribers an opportunity to address TDOH's concerns with their response.[113] If the prescriber does not satisfy TDOH's concerns, however, TDOH has the discretion to alert "the member of the controlled substance database committee who represents the board which has licensed the [prescriber]" of the unsatisfactory response.[114] If the member agrees with TDOH's assessment, that member "may" then submit the concerns to the "entity responsible for licensure of that prescriber" for an investigation.[115]

As of 2017, the TDOH must also identify "high-risk prescribers based on clinical outcomes, including patient overdoses" on an annual basis.[116] The law authorizes TDOH to establish the criteria for identifying high-risk prescribers, and those prescribers who are so identified "shall be subject to selected chart review and investigation by the department."[117] Moreover, TDOH must notify the high-risk prescriber's licensing board "for appropriate action."[118] For its part, the licensing board must notify those who have been determined "high-risk" and impose certain requirements for a period of one year.[119]

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111. *Id.*

112. *Id.*

113. § 68-1-128(b)(2).

114. § 68-1-128(b)(3).

115. *Id.*

116. § 68-1-128(c)(1).

117. *Id.*

118. § 68-1-128(c)(2).

119. § 68-1-128(c)(3)–(4). First, the high-risk provider must "[p]articipate in continuing education that is designed to inform providers about the risks, complications, and consequences of opioid addiction." § 68-1-128(c)(3)(A). The licensing board has discretion over the courses and the hours the prescriber must complete. *Id.* High-risk prescribers must also ensure that "educational literature that warns persons of risks, complications, and consequences of opioid addiction" are made available and within the view of their patients. § 68-1-128(c)(3)(B). Finally, high-risk prescribers must first get the written consent from "any patient who will receive opioid therapy for more than three (3) weeks with daily dosages of sixty (60) morphine milligram equivalents (MME) or higher." § 68-1-128(c)(3)(C). The consent form must "explain[] the risks of, complications of, medical and physical

While it is evident that Tennessee has taken significant steps to ensure responsible opioid-prescribing practices in pain-management contexts, it remains the second-highest opioid prescriber in the country, a ranking that correlates with an increasing death rate from opioid overdose. The requirement that TDOH identify high-risk prescribers took effect on July 1, 2017, so it remains to be seen what its criteria for identifying these prescribers will be and what degree of subjectivity it will allow.[120] There may also be some overlap between the high-risk providers and the top fifty prescribers identified.

A degree of disparity, however, appears to exist between the accountability and scrutiny imposed on these two categories of prescribers. Where the law automatically imposes special requirements on a provider whom TDOH designates as "high-risk," and even authorizes disciplinary action for failure to satisfactorily justify its conduct, not everyone in the top fifty prescribers may receive the same treatment. TDOH has unfettered discretion over whether to demand that the top fifty prescribers submit a written justification for the volume of prescriptions they have written over the designated period. TDOH may also choose whether to notify the licensing authority of their unsatisfactory attempt to justify the volume of prescriptions they have written. Likewise, licensing authorities have no duty to investigate, even if they agree with a TDOH assessment that a given provider's response was unsatisfactory. Thus, even if the prescriber fails to satisfy concerns related to their prescription practice, TDOH and the licensing board have the discretion to forego initiating any action at all. Perhaps Tennessee should address the disparity by eliminating the discretion that current law affords both TDOH and licensing authorities to act against prescribers who abuse their own authority.

Amendments to current law could also remove any discretion or subjectivity and expand the statute's reach to apply to any prescriber who exceeds a designated threshold of high-risk daily dose

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alternatives to, and consequences of opioid therapy and addiction," and the consent form must be renewed every four weeks if that patient continues to receive opioid therapy. § 68-1-128(c)(3)(C)–(D). The prescriber's failure to comply with these requirements "shall be treated as an act constituting unprofessional conduct for which disciplinary action may be instituted under the authority of the board that issued the prescriber's license." § 68-1-128(c)(4).

120. *See* 2017 Tenn. Pub. Acts 334, § 15.

prescriptions, a specified volume, or a specified volume over a certain period of time. For instance, TDOH reports that eighty-one morphine equivalent daily dose may increase the risk of overdose "tenfold."[121] The policy could also include practitioners and outside pain-management clinics that exceed a specified volume of prescriptions per patient treated and for prescriptions that exceed a specified duration. Expanding this accountability would create additional incentives for prescribers to conform with TDOH guidance that "[r]easonable non-opioid treatments should be tried before opioids are initiated" and initiated at the "lowest effective dose" for "no greater quantity than needed for the expected duration of pain severe enough to require opioids."[122]

Further, there is room for Tennessee to expand its continuing education requirement. Perhaps lawmakers may wish to consider mandating that practitioners receive training specific to the risks associated with prescribing opioids for pain management as a part of their continuing education requirements. Currently, DEA-licensed controlled-substance prescribers must undergo two hours of "continuing education related to controlled substance prescribing" every two years.[123] By law, the instruction must cover the TDOH treatment guidelines related to opioids,[124] but the law should require more education that focuses specifically on addiction and how to mitigate against the risk thereof.

Deficiencies in continuing education, however, are not limited to Tennessee. SAMHSA reports that "[m]ost opioid analgesics in the United States are prescribed by primary care physicians and internists; most have little training in pain management or addiction."[125] The

121. TENN. DEP'T OF HEALTH, TENNESSEE CHRONIC PAIN GUIDELINES: CLINICAL PRACTICE GUIDELINES FOR OUTPATIENT MANAGEMENT OF CHRONIC NON-MALIGNANT PAIN 3 (2d ed. 2017), https://www.tn.gov/content/dam/tn/health/healthprofboards/ChronicPainGuidelines.pdf.

122. *Id*. at 1, 3.

123. TENN. CODE ANN. § 63-1-402(a) (2018).

124. *See* TENN. CODE ANN. § 63-1-401(b) (2018).

125. *SAMHSA's Efforts to Fight Prescription Drug Misuse and Abuse*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/prescription-drug-misuse-abuse/samhsas-efforts (last updated Mar. 21, 2016).

CDC guidelines state that "[p]rimary care clinicians report having concerns about opioid pain medication misuse . . . and report insufficient training in prescribing opioids."[126] Lawmakers and public health officials should consider targeting primary care physicians, as well as their nurse practitioners and physician assistants, for additional education and training.

C. Tennessee Reforms to Increase Access to Opioid Addiction Treatment

Tennessee has also taken steps to ensure that those suffering from opioid use disorder to have access to treatment at the onset of overdose, as well as for long-term sobriety, by adopting policies that make opioid antagonists more readily available to ensure that immediate assistance is accessible in an emergency overdose event.[127] To ensure that opioid antagonists are on hand during an overdose, Tennessee enacted "the Good Samaritan Law," which affords civil immunity to a "licensed healthcare practitioner," who, upon a good faith and a reasonable belief that an individual is at risk of overdose, prescribes an opioid antagonist an at-risk individual.[128] To establish good faith, the law encourages practitioners to explain in writing to an individual the basis for the provider's reasonable conclusion that a risk of overdose exists.[129] Upon a showing of reasonableness, the practitioner who prescribes the opioid antagonist receives immunity from civil liability.[130] An individual administering the opioid antagonist also receives protection from civil liability, so long as they

126. Deborah Dowell et al., *CDC Guideline for Prescribing Opioids for Chronic Pain–United States 2016*, CTR. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm (last updated Mar. 18, 2016).

127. Tennessee law defines "opioid antagonist" as "a drug that binds to opioid receptors and blocks or inhibits the effect of opioids acting on those receptors, including, but not limited to, naloxone hydrochloride or any other similarly acting and equally safe drug approved by the United States food and drug administration for the treatment of drug overdose." TENN. CODE ANN. § 63-1-157(a)(2) (2018).

128. TENN. CODE ANN. § 63-1-152(b) (2018).

129. § 63-1-152(c).

130. § 63-1-152(g)(1).

exercise reasonable care in administering the drug to someone they believed in good faith to be overdosing.[131]

Tennessee's Addiction Treatment Act of 2015 was a significant step toward expanding access to treatment. This legislation expanded the Good Samaritan policy to extend criminal immunity to individuals who, in good faith, request medical assistance for either themselves or anyone believed to be suffering an overdose.[132] This immunity includes shields from "[p]enalties for a violation of a permanent or temporary protective order or restraining order," as well as "[s]anctions for a violation of a condition of pretrial release, condition of probation, or condition of parole based on a drug violation."[133] However, there are some limits. The individual experiencing the overdose will only benefit from the immunity one time, and the immunity only covers a "drug violation if the evidence for the arrest, charge, or prosecution of the drug violation resulted from seeking such medical assistance."[134] Individuals who do not qualify for immunity may rely on a recipient's request for medical assistance as a mitigating factor against a resulting criminal charge.[135]

The Addiction Treatment Act also provides for the use of buprenorphine as a MAT.[136] It also, however, expressly limits the authority to prescribe buprenorphine for MAT to "a physician licensed [by the Board of Medical Examiners or the Board of Osteopathy]."[137]

As for those prescribing opioid antagonists, Tennessee's chief medical officer gained statutory authority in 2016 "to implement a statewide collaborative pharmacy practice agreement specific to opioid antagonist therapy with any pharmacist licensed in, and practicing in, this state."[138] The agreement allows participating pharmacists to dispense opioid antagonists to anyone "at risk of experiencing an opiate-related overdose," or to that individual's family

131. § 63-1-152(g)(2).

132. 2015 Tenn. Pub. Acts 396, § 2 (codified as amended at TENN. CODE ANN. § 63-1-156(b) (2018)).

133. § 63-1-156(b)(1)–(2).

134. § 63-1-156(b).

135. § 63-1-156(c)(1).

136. *See generally* TENN. CODE ANN. § 53-11-311 (2018).

137. § 53-11-311(c)(1).

138. 2016 Tenn. Pub Acts 596, § 1 (codified as amended at TENN. CODE ANN. § 63-1-157(b)(1) (2018)).

or friends.[139] To participate in the agreement, pharmacists must complete a training program that must "include, but not be limited to, proper administration techniques, use, documentation, and quality assurance."[140]

In 2017, the legislature responded to concerns related to students who overdose in schools and enacted a law to assist "schools, both public and nonpublic, [to] be prepared to treat drug overdoses in the event other appropriate healthcare responses are not available."[141] Now, "[t]he state board of education, in consultation with the department of health, shall develop guidelines for the management of students presenting with a drug overdose for which administration of an opioid antagonist may be appropriate."[142] Local education agencies must develop a plan in accordance with the guidelines in the event a student were to overdose,[143] and schools are authorized to maintain opioid antagonists, to be used by trained school personnel, in the event a student suffers an overdose while on school property.[144]

Tennessee has also increased the number of prescription-drug-disposal drop-box locations throughout the state from thirty-six locations in 2012 to 222 locations in 2017.[145] Further, the Tennessee Department of Mental Health and Substance Abuse Services ("DMHSAS") created a program called Screening, Brief Intervention, and Referral to Treatment ("SBIRT"), which it describes as "an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs."[146] From the program's inception in October 2011 to February 2017, it has performed a reported 43,060 screenings.[147] Currently,

139. § 63-1-157(b)(3)(A)–(B).

140. § 63-1-157(a)(3).

141. 2017 Tenn. Pub. Acts 256, § 1 (codified as amended at TENN. CODE ANN. § 49-50-1604(c)(1) (2018)).

142. § 49-50-1604(a).

143. § 49-50-1604(b).

144. § 49-50-1604(c)(2).

145. E. OMOHUNDRO, TENN. DEP'T OF MENTAL HEALTH & SUBSTANCE ABUSE SERVS., PRESCRIPTIONS FOR SUCCESS: DATA INDICATORS 5 (2017), https://www.tn.gov/content/dam/tn/mentalhealth/documents/Rx_for_Success_Indicators_4.26.2017.pdf.

146. *Id.* at 6.

147. *Id.*

eighteen medical facilities across Tennessee participate in the SBIRT program,[148] and DMHSAS oversees thirteen opioid treatment clinics in Tennessee.[149] Looking forward, Governor Bill Haslam has called on the legislature to "invest[] more than $25 million for treatment and recovery services for individuals with opioid use disorder," which will "include an increase in peer recovery specialists in targeted, high-need emergency departments to connect patients to treatment immediately."[150]

D. The Effects of Tennessee's Reforms

Creation of the CSMD was one of Tennessee's most important reforms. According to TDOH Commissioner John Dreyzehner, the CSMD "has proved to be remarkably helpful in our state's efforts to address our opioid challenges that the nation has now clearly recognized as a national epidemic."[151] In August 2016, TDOH

148. *See Substance Abuse Screenings in Tennessee (SBIRT-TN)*, TENN. DEP'T OF MENTAL HEALTH & SUBSTANCE ABUSE SERVS., https://www.tn.gov/behavioral-health/substance-abuse-services/treatment---recovery/treatment---recovery/substance-abuse-screenings-in-tennessee--sbirt-tn-.html (last visited Mar. 6, 2018) (including facilities in Bristol, Del Rio, Jackson, Jelico, Johnson City, Kingsport, Knoxville, Madison, Memphis, Milan, Murfreesboro, Nashville, Ripley, and Smyrna).

149. *See* TENN. DEP'T OF MENTAL HEALTH & SUBSTANCE ABUSE SERVS., TENNESSEE OPIOID TREATMENT CLINICS (2018), http://bit.ly/2NV97Pm (including clinics in Bernard, Chattanooga, Columbia, Dyersburg, Jackson, Johnson City, Knoxville, Memphis, Paris, and Savannah); *accord Opioid Treatment Programs*, TENN. DEP'T OF MENTAL HEALTH & SUBSTANCE ABUSE SERVS., https://www.tn.gov/behavioral-health/substance-abuse-services/treatment---recovery/treatment---recovery/state-opioid-treatment-authority/opioid-treatment-programs.html (last visited Mar. 6, 2018) (de-published web content).

150. Press Release, Tenn. Office of the Governor, Haslam Announces Aggressive, Comprehensive Plan to End Tennessee's Opioid Epidemic: TN Together Fights Opioid Addiction Through Prevention, Treatment and Law Enforcement (Jan. 22, 2018) [hereinafter TN Together Release], https://www.tn.gov/governor/news/2018/1/22/haslam-announces-aggressive--comprehensive-plan-to-end-tennessee-s-opioid-epidemicemic.html; *accord supra* note 44 and accompanying text.

151. Press Release, Tenn. Dep't of Health, CSMD Impacts Prescription Opioid Challenges in Tennessee (Aug. 24, 2016),

reported that "[o]ne third of the state's clinicians report they are now more likely to refer a patient for substance abuse treatment after checking the CSMD."[152] Also, "the number of 'doctor shoppers—those who go to multiple healthcare providers seeking a prescription for certain narcotics—has decreased more than 50 percent."[153] Further, the "average amount of opioid pain relievers prescribed to those receiving them has decreased by 28 percent."[154] There was also a reported "reduction of more than two billion morphine milligram equivalents prescribed across the state," with "every county in the state . . . record[ing] a decrease from the 2013 prescribed amounts."[155]

Moreover, pursuant to the Prescription Safety Act, TDOH must publish an annual report to outline "the outcome of the [CSMD] program with respect to its effect on distribution and abuse of controlled substances, including recommendations for improving control and prevention of diversion of controlled substances in this state."[156] According to the 2017 Annual Report, there are 46,576 registrants that must report to the CSMD.[157] In 2016, there were less than three prescriptions reported per CSMD patient request, down from fourteen prescriptions per request prior to the Prescription Safety Act.[158] There has been further "decline in Morphine Milligram Equivalents (MMEs) prescribed in 2016 for long acting and short acting opioids."[159] From 2012 to 2015, there was a 40% decrease in "the number of people receiving more than an average daily dose of 120 MME."[160] The decline is sharpest amongst individuals 20 to 30

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https://www.tn.gov/health/news/2016/8/24/csmd-impacts-prescription-opioid-challenges-in-tennessee.html.

152. *Id.*

153. *Id.*

154. *Id.*

155. *Id.*

156. TENN. CODE ANN. § 53-10-309 (2018).

157. CONTROLLED SUBSTANCE MONITORING DATABASE COMM., TENN. DEP'T OF HEALTH, CONTROLLED SUBSTANCE MONITORING DATABASE 2017 REPORT TO THE 110TH TENNESSEE GENERAL ASSEMBLY 5 (Mar. 1, 2017), https://www.tn.gov/content/dam/tn/health/healthprofboards/csmd/2017_Concise_CSMD_Annual_Report.pdf.

158. *Id.*

159. *Id.* at 2.

160. *Id.*

years of age, a trend that TDOH hopes is "an indicator that [its] efforts are preventing a new generation from being overexposed to opioids by the healthcare system."[161] The trend, however, also shows an increase in MMEs for those ages 60 years and older, which could increase addiction risks for this demographic.[162]

The 2017 Annual Report also noted a "decline in potential doctor/pharmacy shoppers and a significant decline in the total MMEs of top 50 prescribers in the state," as well as a 44% decrease from 2014 to 2016 in the number of pain clinics operating in Tennessee.[163] A 2016 survey showed that approximately 69% of dispensers check the CSMD and consult the prescriber before dispensing a controlled substance or when they suspect abuse disorder.[164] Just over 70% report discussing the CSMD with their patients, while 87% "report the CSMD is useful for decreasing doctor shopping."[165] Also, 70% of prescribers report that they changed their treatment plan upon reviewing patient information on the CSMD, while 84% of dispensers report that they are less likely to fill a prescription.[166] Only 28% of prescribers, however, report that they are "more likely to refer a patient to substance abuse treatment" after reviewing patients information on the CSMD.[167]

TDOH reports that it is in the process of coordinating with eleven healthcare facilities to design a data system that collects "near real-time data on nonfatal drug overdoses."[168] Once implemented statewide, the "data will be used in developing risk indicators to provide clinicians with the important information that their patients may be headed for serious risk of negative outcomes, including fatal overdose."[169]

While Tennessee has made positive gains, TDOH has acknowledged that it remains "concerned that overdose deaths for

161. *Id.* at 5.
162. *Id.* at 6.
163. *Id.* at 2, 4.
164. *Id.* at 8.
165. *Id.*
166. *Id.* at 8–9.
167. *Id.* at 8.
168. *Id.* at 3.
169. *Id.*

2015 were up despite progress observed from the data."[170] The agency characterized the revelation "that approximately one third of drug overdose deaths include a combination of opioids and benzodiazepines, an interaction that is known to have high risk for respiratory suppression, the main cause of overdose death" as a "special concern."[171] A reported "[56%] of people who died of overdose had controlled substances dispensed in the 60 days prior to death, suggesting that other factors played a significant role in overdose deaths, including illicit fentanyl, heroin, and diverted prescription opioids."[172] Moreover, "[74%] of those who died had filled a prescription for a controlled substance within the past year."[173] TDOH opines that "these are likely signs that the epidemic is evolving and that changes are needed in how we identify and intervene prior to fatal overdose."[174]

The TDOH has recognized the specific impact of Tennessee's opioid dispensation reforms, noting that "after the implementation of a comprehensive mandate and delivery of letters to the top 50 prescribers of controlled substances, opioid prescriptions decreased by about 7 percent, from some 9.5 million in 2013 to around 8.8 million in 2014."[175] Overall, "[o]pioids dispensing in Tennessee decreased by 5 percent . . . falling from 9.8 billion to 9.35 billion MME during the same period, despite an increase in the state's population."[176] Moreover, "the number of patients filling five or more prescriptions from different prescribers at five or more dispensers within 90 days decreased approximately 31 percent, from around 8,750 to 6,000."[177]

While Tennessee's CSMD has effectively curbed prescribing practices, it could have even greater potential. The Pew Charitable

170. *Id.* at 2.

171. *Id.* at 3.

172. *Id.* at 2.

173. *Id.* at 2–3.

174. *Id.* at 3.

175. THE PEW CHARITABLE TRS., PRESCRIPTION DRUG MONITORING PROGRAMS: EVIDENCE-BASED PRACTICES TO OPTIMIZE PRESCRIBER USE 9 (2016) [hereinafter PEW, PDMPS], http://www.pewtrusts.org/~/media/assets/2016/12/prescription_drug_monitoring_programs.pdf.

176. *Id.*

177. *Id.*

Trusts, in collaboration with the Prescription Drug Monitoring Center of Excellence at Brandeis University and Institute for Behavioral Health, has studied strategies for optimizing "Prescription Drug Monitoring Programs."[178] Their study indicates that state controlled-substance databases "are not achieving their full potential, in part because they can be difficult or inconvenient to use."[179] The study provides a number of solutions to these problems.[180] Tennessee's CSMD policy incorporates many of the suggestions set forth in the report, such as allowing prescribers to delegate their reporting requirements to designees to ensure an efficient flow of information,[181] and requiring prescribers to check the CSMD prior to prescribing controlled substances.[182] One policy suggestion that Tennessee has yet to adopt, however, relates to unsolicited reports that the database sends to prescribers, alerting them to high-risk patients.[183] Studies have shown that this feature can be particularly helpful in notifying prescribers of patients who may be doctor-shopping or seeking the same controlled substance from different health care providers.[184] It can also issue an alert whenever a patient has been prescribed a daily dose of MMEs that triggers an increased risk of opioid overdose.[185] There is also the added benefit that unsolicited reports will foster coordination between prescribers and prompt substance abuse screenings.[186] As of August 24, 2017, thirty-two states have designed their state database program to send unsolicited notifications to

178. *See generally* PEW, PDMPS, *supra* note 175.

179. THE PEW CHARITABLE TRS., INFOGRAPHIC: STRATEGIES TO OPTIMIZE PRESCRIBER USE OF PRESCRIPTION DRUG MONITORING PROGRAMS (2016) [hereinafter PEW, STRATEGIES], http://www.pewtrusts.org/~/media/assets/2016/07/pdmpinfographic.pdf.

180. *See generally* PEW, PDMPS, *supra* note 175, at 8–55.

181. *Compare* TENN. CODE ANN. § 53-10-304 (2018), *with id.*

182. *Compare* TENN. CODE ANN. § 53-10-310(e)(1) (2018), *with* PEW, PDMPS, *supra* note 175, at 8–55.

183. *See, e.g.*, PEW, STRATEGIES, *supra* note 179.

184. Cindy Parks Thomas et al., *Prescriber Response to Unsolicited Prescription Drug Monitoring Program Reports in Massachusetts*, 23 PHARMACOEPIDEMIOLOGY & DRUG SAFETY 950, 950–51 (2014).

185. PEW, PDMPS, *supra* note 175, at 23.

186. *Id.*

prescribers.[187] In the southeast, Florida, Alabama, North Carolina, Louisiana, and Virginia have implemented unsolicited notification features.[188]

There is also room for Tennessee to expand access to MATs. Tennessee should consider allowing qualified nurse practitioners and physician assistants to prescribe buprenorphine, which would be consistent with federal law.[189] Ironically, Tennessee law does permit nurse practitioners and physician assistants to prescribe all other Schedule II opioids for the purpose of pain management.[190]

In 2017, the Tennessee House of Representatives assembled a member task force to study the impact of the opioid crisis, and on September 26, 2017, the task force presented a list of twenty-four reforms directed at combatting the opioid crisis.[191] The recommendations included public awareness campaigns, as well as requiring continue education to focus on alternative pain management as a condition for license renewal for those authorized to prescribe opioids.[192] The task force also recommended that veterinarians, who can currently prescribe opioids with little oversight, should register with the CSMD and adhere to its reporting requirements.[193] The recommendations also called for further limiting the prescribed dosage allowable to ten days at the lowest effective dose unless a patient satisfies additional insurance preauthorization requirements.[194] The task force also recognized the need to expand access to drug treatment

187. *See id.*

188. PRESCRIPTION DRUG MONITORING PROGRAM TRAINING AND TECH. ASSISTANCE CTR., STATES ENGAGED IN SENDING SOLICITED AND UNSOLICITED REPORTS TO PRESCRIBERS (2017), http://www.pdmpassist.org/pdf/Prescribers_Sol_Unsol_Reports_20170824.pdf.

189. *See* 21 U.S.C. § 823(g)(2)(G)(iii) (2012) (defining "qualifying practitioner").

190. TENN. CODE ANN. § 63-19-107 (2018) (physician assistants); TENN. CODE ANN. § 63-7-123 (2018) (nurse practitioners).

191. *See generally* TENN. H.R. TASK FORCE ON OPIOID & PRESCRIPTION ABUSE, TASK FORCE RECOMMENDATIONS (2017) [hereinafter TN HOUSE TASK FORCE RECOMMENDATIONS].

192. *Id.* at 3.

193. *Id.* at 4.

194. *Id.*

and to ensure specific treatment drugs, such as naloxone and naltrexone, are more readily available.[195]

An enhanced understanding of the epidemiological nature of the opiate addiction, as well as the continued development of MATs and policies that ensure expeditious treatment for an overdose, has proven effective in combating opioid abuse. If we are to contain the epidemic, however, lawmakers must continue to rein in the medical community's practice of prescribing opioids for chronic pain. The law must also expand access to substance-abuse treatment programs with incentives for successful completion.

As subsequent Sections demonstrate, attempts to incarcerate our way out of the drug crisis has proven to be an exercise in futility. In fact, with prison having been designated the treatment of choice, we have seen incarceration rates steadily rising across the country alongside the rates of addiction and overdose. Thus, as lawmakers impose more responsibility on the medical community, we must also reevaluate the role of the criminal justice system in treating drug-addicted offenders.

IV. THE ROLE OF THE CRIMINAL JUSTICE SYSTEM SHOULD BE LIMITED

In the war on drugs, the primary duty of the criminal justice system is to shut down the supply of drugs. Too often, however, the law also tasks the justice system with containing the demand for drugs because "[t]he criminal justice model views drug addiction as one of many antisocial behaviors manifested by criminals."[196] This view has proven faulty in both the treatment of the disease and the promotion of public safety. As this Article explains, as the incarceration rate for drug offenses, including possession, has increased, so too has the spread of the disease of addiction.

Former President Richard Nixon receives widespread credit for originating the "war on drugs" concept and articulating this view in a 1971 letter to Congress, wherein he requested that it direct additional

195. *Id.* at 3.

196. NAT'L INST. OF JUSTICE, U.S. DEP'T OF JUSTICE, DRUG COURTS: THE SECOND DECADE 1 (2006) [hereinafter NIJ, DRUG COURTS], https://www.ncjrs.gov/pdffiles1/nij/211081.pdf.

funds toward "programs to control drug abuse in America."[197] President Nixon's vision of a "war on drugs" involved a law enforcement "strike" on drug suppliers, while decreasing the demand through the rehabilitation of drug users.[198] Drug users were not the intended enemy, as demonstrated by the President's request for "additional funds to meet the cost of rehabilitating drug users, and . . . additional funds to increase our enforcement efforts to further tighten the noose around the necks of drug peddlers, and thereby loosen the noose around the necks of drug users."[199]

Unfortunately, the war on drugs has evolved such that drug users and drug traffickers are often viewed as a distinction without a difference in the eyes of the law. Indeed, one cannot ignore the fact that crime is often a symptom of drug addiction, and many drug addicts engage the criminal justice system due to crimes they commit in order to stave off the symptoms of withdrawal.[200] Especially with the onslaught of the opioid epidemic, jails and prisons across the United States are full of drug addicts who are incarcerated alongside traffickers and violent criminals, and they have limited access to effective treatment and rehabilitation services.[201]

That being said, how should the criminal justice system respond, particularly in light of the opioid crisis? The National Center on Addiction and Substance Abuse at Columbia University ("NCASA") stated it best: "It starts with acknowledging the fact that addiction is a disease for which evidence-based prevention and treatment programs exist and that these programs can be administered effectively through the criminal justice system."[202] This means that

197. President Richard M. Nixon, *Special Message to the Congress on Drug Abuse Prevention and Control*, THE AM. PRESIDENCY PROJECT (June 17, 1971), http://www.presidency.ucsb.edu/ws/?pid=3048.

198. *Id.*

199. *Id.*

200. *Alcohol, Drugs and Crime*, NAT'L COUNCIL ON ALCOHOLISM & DRUG DEPENDENCE, INC., https://www.ncadd.org/about-addiction/alcohol-drugs-and-crime (last updated June 27, 2015) [hereinafter NCADD, *Alcohol, Drugs and Crime*].

201. Joseph A. Califano, Jr., *Foreword and Accompanying Statement* to NAT'L CTR. ON ADDICTION AND SUBSTANCE ABUSE, COLUMBIA UNIV., BEHIND BARS II: SUBSTANCE ABUSE AND AMERICA'S PRISON POPULATION ii (2010), https://www.centeronaddiction.org/download/file/fid/487.

202. *Id.*

the criminal justice system must appreciate the balance of sanction and rehabilitation. It must identify and effectively treat offenders with substance abuse disorder in way that reduces the risk of re-offense. This means the system must implement diversion programs for nonviolent offenders as an alternative to incarceration, while more serious offenders can also receive effective treatment services while in prison and upon release.[203] Reforms are necessary, and have popular support,[204] because the traditional presumption in favor of punishment and incarceration has proven to be an exercise in futility in terms of addressing the demand for drugs.

A. The Criminal Justice System Model for Dealing with the Opioid Crisis Has Proven Futile

The criminal justice system was not designed to preside over public health events. Yet, for decades, lawmakers have universally applied the "tough on crime" approach that presumes that incarceration

203. This reformed view has received widespread, bipartisan, public support. In its letter to the President's Commission, The Pew Charitable Trusts asserts that "U.S. voters spanning demographic groups and political parties strongly support a range of major changes in how the states and the federal government punish those who have committed drug offenses." Letter from Adam Gelb, Director, Pub. Safety Performance Project, The Pew Charitable Trs., to Governor Chris Christie & The President's Comm'n on Combating Drug Addiction & the Opioid Crisis 11 (June 19, 2017), http://www.pewtrusts.org/~/media/assets/2017/06/the-lack-of-a-relationship-between-drug-imprisonment-and-drug-problems.pdf [hereinafter The Pew Charitable Trusts Letter]. Concerning federal corrections, "8 in 10 favored permitting federal prisoners to cut their time behind bars by up to 30 percent by participating in drug treatment and job training programs that are shown to decrease recidivism." *Id.* Moreover, coalitions of organizations from across the philosophical and subject-matter spectrums have joined forces in support of these reforms. For instance, in Tennessee the Coalition for Sensible Justice was formed in September of 2016 by the Beacon Center of Tennessee, a conservative think tank, the ACLU of Tennessee, Goodwill Industries, the Nashville Chamber of Commerce, and the Tennessee County Services Association. *Who We Are*, TENN. COALITION FOR SENSIBLE JUSTICE, http://tnsensiblejustice.com/who-we-are/ (last visited Oct. 21, 2018).

204. *NEW POLL: Voter Support Sky High for Bipartisan Justice Reforms Especially Among Women Voters*, JUSTICE ACTION NETWORK, http://www.justiceactionnetwork.org/new-poll-voter-support-sky-high-bipartisan-justice-reforms-especially-among-women-voters/ (last visited Oct. 21, 2018).

is a concept of justice to the drug trafficker and the drug user alike.[205] So the law sentences someone whose substance abuse disorder drives a criminal act to incarceration to punish their behavior. This regime pays insufficient attention to the disease that drove the behavior. Such an individual will serve time in prison and will still suffer from the disease of addiction at the time of release. Despite perhaps severe punishment for their behavior, an individual may reoffend or die of a drug overdose—what end did the punishment serve? Society derived this draconian concept from a theory that incarceration would be an effective deterrent to drug use, and more generally, that keeping drug users incarcerated for as long as possible kept the public safe.[206] The practical effect of this theory has seen the widespread expansion of drug abuse, particularly opioids, and a burgeoning prison population coupled with a profoundly negative impact on recidivism rates.[207]

The result of favoring incarceration over treatment for "substance-involved" offenders is multifaceted. Again, it results in failure to contain the human toll caused by the opioid epidemic. But there is also the matter of public safety triggered by the recidivism rates among "substance-involved" offenders. NCASA has observed the correlation between the country's burgeoning prison population and the increase in substance abuse, concentrating specifically on the failure to offer effective treatment for offenders with substance abuse disorder.[208] It highlighted the 33% increase in the inmate population

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205. Governor Matt Bevin, *Justice Reform Is Real and Conservative Governors Are Leading the Way*, FOX NEWS (Nov. 15, 2017), http://www.foxnews.com/opinion/2017/11/15/kentucky-gov-matt-bevin-justice-reform-is-real-and-conservative-governors-are-leading-way.html.

206. The Pew Charitable Trusts Letter, *supra* note 203, at 13.

207. In practice, this theory imposes significant costs to the tax-payer with no public safety benefits in return. In fact, reports indicate that "[o]ver half (52.2 percent) of substance-involved inmates have one or more previous incarcerations compared with 31.2 percent of inmates who are not substance involved," and at an average cost of $25,144 per inmate. *See* NAT'L CTR. ON ADDICTION AND SUBSTANCE ABUSE, COLUMBIA UNIV., BEHIND BARS II: SUBSTANCE ABUSE AND AMERICA'S PRISON POPULATION 5 (2010) [hereinafter NCASA, BEHIND BARS], https://www.centeronaddiction.org/download/file/fid/487. Hence, the fatal flaw in the theory: a fundamental misunderstanding that drug addiction is primarily a criminal behavior to be punished, and not a disease to be treated.

208. *See id.*

from 1996 to 2006, coupled with the population of inmates who were "substance involved" having increased 43%.[209]

Many leaders in the criminal justice community have called for reforms where nonviolent drug offenders are concerned, opting instead for diversion into effective drug treatment programs. In a memorandum to all prosecutors under the jurisdiction of the Department of Justice, for example, then-Attorney General Eric Holder acknowledged that "[l]ong sentences for low-level, non-violent drug offenses do not promote public safety, deterrence, and rehabilitation."[210] The "Holder memo" rescinded the previous policy requiring federal prosecutors to pursue the most serious charge possible under the law. Attorney General Jeff Sessions, however, later reinstated the policy in 2017.[211]

The National Institute for Justice ("NIJ") acknowledges that incarceration "by itself, has not been effective in breaking the cycle of drugs and crime."[212] Echoing this sentiment, the Commission on the Future of the Tennessee Judicial System, a commission that the Tennessee Supreme Court created to examine the future of the judicial system, explicitly longed for a future where treatment trumped the justice system where addiction was concerned.[213] The Commission "imagine[d]. . . what great good might come of advances in treatment for substance abuse," and recognized that "[e]ffective pharmacology could bring drastic reductions in drug and alcohol use, a change that would have more effect on crime than almost anything the judicial system might do."[214]

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209. Califano, *supra* note 201, at i.

210. Memorandum of Att'y Gen. Eric Holder, U.S. Dep't of Justice, Department Policy on Charging Mandatory Minimum Sentences and Recidivist Enhancements in Certain Drug Cases 1 (Aug. 12, 2013), https://www.justice.gov/sites/default/files/ag/legacy/2014/04/11/ag-memo-drug-guidance.pdf.

211. Memorandum of Att'y Gen. Jeff Sessions, Department Charging and Sentencing Policy (May 10, 2017), https://www.justice.gov/opa/press-release/file/965896/download.

212. NIJ, DRUG COURTS, *supra* note 196.

213. TENN. ADMIN. OFFICE OF THE COURTS, REPORT FROM THE COMMISSION ON THE FUTURE OF THE TENNESSEE JUDICIAL SYSTEM 6 (1996), http://www.tncourts.gov/sites/default/files/docs/report_of_future_of_tn_judicial_system.pdf.

214. *Id.*

The President's Commission report reminds of President Nixon's call to Congress.[215] The President's Commission compiled the substance of the report in consultation with numerous stakeholders, including governors, treatment specialists, healthcare providers, and data analysts; it published an interim report that contained a number of preliminary recommendations to curb opioid addiction.[216] Many of its recommendations focused on the expansion of access to treatment and increased education for prescribers, while a few called for increased coordination among law enforcement to reduce the supply of illicit opioids.[217] The President's Commission's report, however, does not embrace the concept of incarceration as an effective response to drug use, but rather seeks the expanse of drug courts across the country.[218] It also warns against the adoption sentencing enhancements for fentanyl traffickers that courts may construe to apply to simple possession.[219] This is important where any considerations for "harsher penalties for smaller quantities" is concerned, in which case the law should consider "whether users, who buy fentanyl unknowingly, could be unnecessarily punished for distribution."[220] The President's Commission clearly seeks to avoid subjecting those with opioid abuse disorder to unfair criminal sanctions.

1. Incarceration Does Not Deter Drug Use

The rapid increase in the incarceration rate for drug crime, coupled with the continued widespread demand for illicit controlled substances, reflects the overall ineffectiveness of incarceration as a deterrent to illicit drug use. In fact, incarceration generally fails to deter future criminal conduct.[221] Yet, in many criminal justice systems, incarceration remains the default response to nearly all

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215. *See generally* PRESIDENT'S COMM'N FINAL REPORT, *supra* note 3.

216. *See generally id.* at 115–24.

217. *Id.* at 12, 16, 77.

218. *Id.* at 10.

219. *Id.* at 61.

220. *Id.*

221. Daniel S. Nagin, *Deterrence*, *in* 4 REFORMING CRIMINAL JUSTICE: PUNISHMENT, INCARCERATION, AND RELEASE 19, 20 (Erika Luna ed., 2017), http://academyforjustice.org/wp-content/uploads/2017/10/Reforming-Criminal-Justice_Vol_4.pdf.

criminal conduct, including possession, and other conduct driven by substance abuse disorder. The assumption that invoking a fear of being locked up for an extended period of time will prevent those with drug addiction from further drug use animates this policy choice.[222]

The flawed reasoning of this assumption is not simply a matter of opinion, but we can actually quantify the magnitude of error with available data. According to the Bureau of Justice Statistics, for example, there were under 25,000 offenders in federal and state facilities in 1980 whose primary offense was a drug offense.[223] This population now stands at nearly 300,000.[224] The United States Sentencing Commission attributes the overall increase in the federal inmate population to the imposition of mandatory-minimum sentences, which became favored in the 1980s.[225] For example, an opioid addict who misrepresents information to their doctor, or otherwise obtains opioids through "misrepresentation, fraud, forgery, deception, or subterfuge," will be subject to a four-year mandatory minimum sentence in prison without parole.[226] Thus, drug addiction has continued to spread and reach epidemic levels, even though the incarceration rate of drug users skyrocketed, and sentences, especially where jurisdictions impose mandatory minimums, have become more severe. For its part, the U.S. Department of Justice ("DOJ") committed to release some of these inmates from the custody of the Bureau of Prisons in 2015 in an effort "to reduce the number of nonviolent drug offenders."[227]

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222. *See generally* The Pew Charitable Trusts Letter, *supra* note 203, at 4–6.

223. TRACY L. SNELL, U.S. DEP'T OF JUSTICE, CORRECTIONAL POPULATIONS IN THE UNITED STATES, 1993 at 11 (1995) (19,000 in state correctional facilities in 1980), https://www.bjs.gov/content/pub/pdf/cpop93bk.pdf; UNIV. OF ALBANY, SOURCEBOOK OF CRIMINAL JUSTICE STATISTICS 2003 at 519 (2004) (4,749 in federal correctional facilities in 1980), https://www.albany.edu/sourcebook/pdf/t657.pdf.

224. The Pew Charitable Trusts Letter, *supra* note 203, at 1.

225. U.S. SENTENCING COMM'N, AN OVERVIEW OF MANDATORY MINIMUM SENTENCES IN THE FEDERAL CRIMINAL JUSTICE SYSTEM 48 (2017), https://www.ussc.gov/sites/default/files/pdf/research-and-publications/research-publications/2017/20170711_Mand-Min.pdf.

226. 21 U.S.C. §§ 843(a)(3), (d)(1) (2012).

227. E. ANN CARSON & ELIZABETH ANDERSON, U.S. DEP'T OF JUSTICE, PRISONERS IN 2015, at 3 (2016), https://www.bjs.gov/content/pub/pdf/p15.pdf.

Drug offenders fare no better in the state systems. By the end of 2015, there were 206,300 inmates whose primary offense was a drug crime living in state corrections facilities.[228] Of these inmates, 46,000 were convicted of drug possession as a primary offense.[229] Drug offenders are also serving longer prison sentences. From 1990 to 2009, time served for drug offenses increased 36% at the state level.[230] Federal sentences increased 153% from 1988 to 2012.[231] To top it off, NCASA found that "65 percent—1.5 million—[of the inmate population at the time of the report] meet the DSM-IV medical criteria for alcohol or other drug abuse and addiction."[232]

Studies that focus specifically on the effect of criminal sanctions on substance abuse, particularly opioid abuse, have also directly undermined the notion that incarceration functions as a deterrent. The Pew Charitable Trusts Public Safety Performance Project ("Pew Project") recently "compared publicly available data from law enforcement, corrections, and health agencies" to examine "whether and to what degree high rates of drug imprisonment affect the nature and extent of the nation's drug problems," particularly the opioid crisis.[233]

See Appendix A at the end of this Article for a table[234] that compares by state the drug imprisonment rates to "the three measures of state drug problems: rates of illicit drug use, drug overdose deaths, and drug arrests." According to the Pew Project's analysis, there is no statistically significant relationship between a state's drug imprisonment rate and its drug problem.[235] Likewise, there is no

228. *Id.* at 14, 30.

229. *Id.* at 30.

230. The Pew Charitable Trusts Letter, *supra* note 203, at 1.

231. *Id.*

232. Califano, *supra* note 201, at i.

233. The Pew Charitable Trust Letter, *supra* note 203, at 1.

234. *Id.* at 1, 5–6.

235. *Id.* at 4. For instance, Louisiana and Oklahoma have the first- and second-highest drug imprisonment rates, respectively, but they also respectively rank thirteenth and tenth in illicit drug use, respectively, and twenty-third and tenth, respectively, in drug overdose deaths. *Id.* at 5. Thus, neither state has achieved success in curbing their drug epidemic through incarceration. Another observation is that "Tennessee imprisons drug offenders at a rate more than three times greater than New Jersey, but the illicit drug use rate in the two states is virtually the same," while,

significant correlation between state drug imprisonment rates and illicit drug use or overdose.[236]

Perhaps alluding to the logic of President Nixon, the Pew Project presented its view of "[t]he most effective response to the growth in opioid misuse."[237] It recommended "a combination of law enforcement to curtail trafficking and halt the emergence of new markets; alternative sentencing to divert nonviolent drug offenders from costly imprisonment; treatment to reduce dependency and recidivism; and prevention efforts that can identify individuals at high risk for developing substance use disorders."[238] Subsequent Sections in this Article discuss a number of alternative sentencing and drug treatment programs in greater detail.

2. The Allocation of Limited Law Enforcement Resources to Punish Nonviolent Drug Addicts Undermines Public Safety

Not only is the "tough on crime" approach to drug addiction ineffective in deterring the demand, but it effectively undermines public safety. As Tennessee Governor Bill Haslam has aptly noted, "spending time in jail or prison can increase the risk of future offending, rather than decrease it."[239] This is particularly true for a nonviolent offender suffering from substance abuse disorder and incarcerated without access to effective treatment.

The NCASA reported an especially high rate of recidivism among substance-involved inmates, compared to the remainder of the population, due to the failure to provide effective treatment.[240] The increased recidivism rates of substance-involved inmates suggests that reliance upon incarceration alone actually compromises public safety,

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on the other hand, "Indiana and Iowa have nearly identical rates of drug imprisonment, but Indiana ranks 27th among states in its rate of illicit drug use and 18th in drug overdose deaths while Iowa ranks 44th and 47th respectively." *Id.*

236. *Id.* at 7.

237. *Id.* at 8.

238. *Id.*

239. *Public Safety Act of 2016*, OFFICE OF TENN. GOV., https://web.archive.org/web/20170112232317/https://www.tn.gov/governor/article/2016-legislation-public-safety-act (last visited Oct. 24, 2018).

240. NCASA, BEHIND BARS, *supra* note 207, at 37–38.

as the failure to focus on the factor driving the criminal conduct—drug addiction—leads to more criminal conduct.

Allocating limited law enforcement resources to nonviolent drug addicts also creates a public safety risk because diverting funds for this purpose takes resources from the investigation and prosecution of violent crime. Laura Nodolf, the District Attorney for Midland, Texas, for example, has publicly professed that, in her experience, the diversion of limited resources away from the prosecution of violent crime, particularly crimes against children, has actually undermined public safety.[241] She explained that "people who are addicted to narcotics enter the criminal justice system due to possession of controlled substances or because they have committed a non-violent crime, like shoplifting, so they can purchase controlled substances."[242] District Attorney Nodolf rebuked the idea that "the answer to that type of criminal behavior was to incarcerate them."[243] She contended further that "warehousing non-violent offenders is costly . . . , does not contribute positively to public safety, and does not lead the perpetrator to take responsibility for their actions."[244] She proposed to "[u]tiliz[e] the resources available through specialty courts," which would "provide[] prosecutors the time to focus necessary attention on crimes against children and dangerous offenders and still have sufficient resources remaining to properly assist victims of crime."[245]

The Pew Project also affirms this notion. In pointing to the lack of benefit incarceration has yielded in deterring drug use, it contends that "[w]ith limited public safety budgets, this can amount to a zero sum proposition: dollars spent in one area are unavailable for others."[246] In other words, "[m]ore imprisonment for drug offenders means more funds siphoned away from programs, practices, and

241. *See generally* Laura Nodolf, *Criminal Justice Reform Is a Win-Win for Prosecutors, Community*, THE MIDLAND REPORTER-TELEGRAM (Sept. 9, 2017, 9:52 PM), http://www.mrt.com/opinion/article/Criminal-justice-reform-is-win-win-for-12184030.php.

242. *Id.*

243. *Id.*

244. *Id.*

245. *Id.*

246. The Pew Charitable Trusts Letter, *supra* note 203, at 13.

policies that have been proven to reduce drug use and crime. And that is a net loss for public safety."[247]

3. Incarcerating Drug Addiction in Tennessee

In Tennessee, even without showing intent to traffic, prosecutors can easily convict an individual who suffers from opioid use disorder of a felony for possession.[248] An individual who is otherwise legally permitted to possess a firearm, but possesses that firearm while also in possession of illegal opioids, also commits a felony.[249] Additionally, anyone who obtains or attempts to obtain any controlled substance "by misrepresentation, fraud, forgery, deception or subterfuge," is guilty of a felony.[250] Increasingly, then, convictions for drug charges have led to significant periods of incarceration.

Data from the Tennessee Administrative Office of Courts, for example, reveal a steady flow of drug cases filed and adjudicated since 2008, with only a small percentage of total criminal cases afforded

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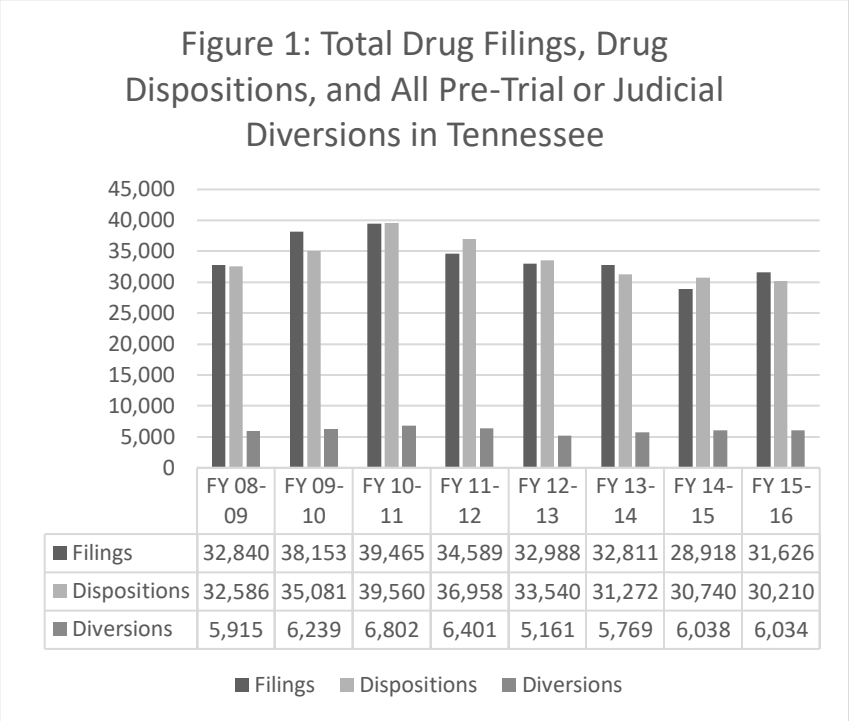
247. *Id.*

248. For example, if an individual has two or more prior convictions for simple possession, a subsequent conviction for simple possession of heroin will be enhanced to a Class E felony. TENN. CODE ANN. §§ 39-17-418(a), (e) (2018).

249. Specifically, if the prosecution shows that the firearm could have been employed in order to protect or obtain the controlled substance, such a person commits a Class C felony. *See* TENN. CODE ANN. §§ 39-17-1324(a), (b), (h)(2), (i)(1)(L) (2018). A conviction for the employment of a firearm to protect or obtain a controlled substance carries a mandatory minimum six-year sentence or, if the defendant has a prior felony conviction, a mandatory minimum sentence of 10 years. § 39-17-1324(h)(1)–(2).

250. TENN. CODE ANN. §§ 53-11-402(a)(3), (b)(1) (2018) (making a violation of this section a Class D felony). This level of felony carries a sentence of 2–12 years. TENN. CODE ANN. § 40-35-111(b)(4) (2018). If it is an individual's first conviction for obtaining drugs by fraud, the statute allows for diversion into drug treatment. TENN. CODE ANN. § 53-11-402(a)(3) (2018). However, individuals convicted for this offense served an average of about 31 months in prison during Tennessee's 2015–2016 fiscal year. TENN. ADMIN. OFFICE OF THE Courts, SENTENCING PRACTICES IN TENNESSEE 21 (2016), http://www.tncourts.gov/sites/default/files/docs/statistics_report_-_november_2016.pdf.

pretrial or judicial diversions.[251] In 2016, for example, only 3.7% of all criminal cases resulted in pretrial or judicial diversion.[252] Data from the Tennessee Bureau of Investigations ("TBI") reveal a significant increase in heroin related arrests and a relatively constant volume of arrests related to "Other Narcotics":[253]

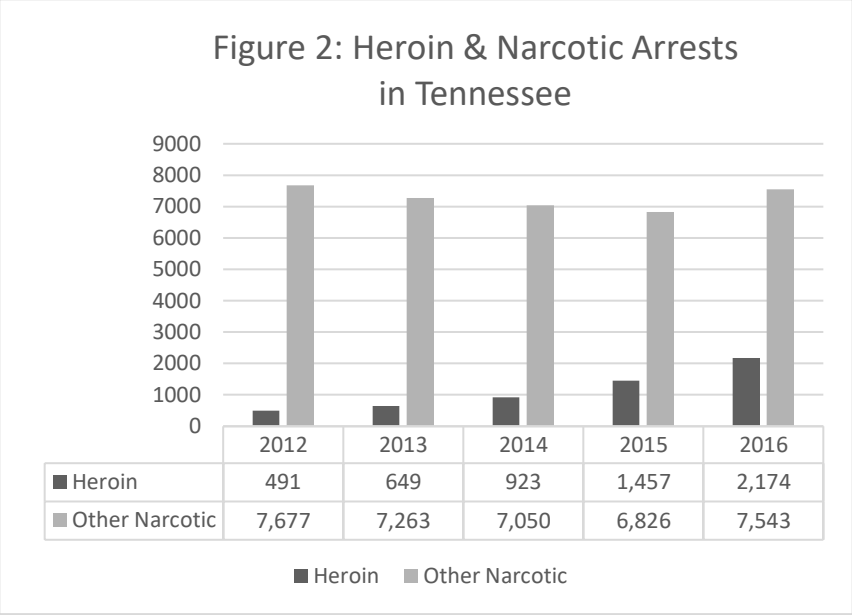


	FY 08-09	FY 09-10	FY 10-11	FY 11-12	FY 12-13	FY 13-14	FY 14-15	FY 15-16
Filings	32,840	38,153	39,465	34,589	32,988	32,811	28,918	31,626
Dispositions	32,586	35,081	39,560	36,958	33,540	31,272	30,740	30,210
Diversions	5,915	6,239	6,802	6,401	5,161	5,769	6,038	6,034

251. See Figure 1, which is based on data drawn from individual annual reports available at *Annual Statistical Reports*, TENN. STATE COURTS, https://www.tncourts.gov/media/statistical-reports (last visited Oct. 24, 2018).

252. *See* TENN. ADMIN OF COURTS, ANNUAL REPORT OF THE TENNESSEE JUDICIARY FISCAL YEAR 2015-2016 20 (2016) (6,034 diversions out of 163,487 total dispositions), http://www.tncourts.gov/sites/default/files/docs/annual_report_fy2016.pdf.

253. See Figure 2, which is based on data drawn from the TBI's data dashboard. Tenn. Bureau of Investigation, *Drug Arrests by Drug Type*, TENN. CRIME ONLINE, https://crimeinsight.tbi.tn.gov/public/View/dispview.aspx?ReportId=70 (last visited Oct. 28, 2018).



TBI also reports that there has been an overall increase in drug and narcotic offenses, rising from 48,380 in 2014 to 54,445 in 2016.[254] The 2016 data indicate that prosecutors characterized 45,965 of the drug crimes as possessing/concealing, 9,289 as using/consuming, and only 8,670 as distributing/selling.[255] Moreover, in 2016, there were 53,343 arrest incidents in which police suspected the offender of having used *some* form of drug or narcotic.[256]

Tennessee's overall corrections budget and inmate population have both also increased over the years. The Governor's Task Force on Sentencing and Recidivism reports that Tennessee's imprisonment

254. Tenn. Bureau of Investigation, *Crimes—Three Year Trends*, TENN. CRIME ONLINE, https://crimeinsight.tbi.tn.gov/public/View/dispview.aspx?ReportId=69 (last visited Oct. 28, 2018).

255. Tenn. Bureau of Investigation, *Drug Related Offenses*, TENN. CRIME ONLINE, https://crimeinsight.tbi.tn.gov/public/View/dispview.aspx?ReportId=23 (last visited Oct. 28, 2018).

256. Tenn. Bureau of Investigation, *Offender Suspected of Using*, TENN. CRIME ONLINE, https://crimeinsight.tbi.tn.gov/public/View/dispview.aspx?ReportId=56 (last visited Oct. 28, 2018).

rate has increased 256% since 1981.[257] In Fiscal Year 2016–2017, Tennessee appropriated $975,506,000 to the Tennessee Department of Corrections ("TDOC"),[258] more than a 5% increase from the previous fiscal year.[259] An increase in the inmate population from 29,362 in 2016 to 30,161 in 2017 accompanied this increased appropriation.[260] Projections expect the inmate population to reach 30,215 by 2020, accompanied by an "unmet bed demand" of 7,109.[261] Interestingly, the total number of inmates convicted primarily of drug offenses has remained relatively level despite an annual 2-month increase in their average sentence term:[262]

257. TENN. STATE GOV'T, FINAL REPORT OF THE GOVERNOR'S TASK FORCE ON SENTENCING AND RECIDIVISM: RECOMMENDATIONS FOR CRIMINAL JUSTICE REFORM IN TENNESSEE 6 (2015) (citations omitted) [hereinafter GOVERNOR'S TASK FORCE RECOMMENDATIONS], http://bit.ly/2COwjwW.

258. RESEARCH & PLANNING DIV., TENN. DEP'T OF CORRECTION, STATISTICAL ABSTRACT FISCAL YEAR 2017, at 11 (2017) [hereinafter STATISTICAL ABSTRACT FY 2017], https://www.tn.gov/content/dam/tn/correction/documents/StatisticalAbstract2017.pdf.

259. *Compare id.*, *with* RESEARCH & PLANNING DIV., TENN. DEP'T OF CORRECTION, STATISTICAL ABSTRACT FISCAL YEAR 2016, at 17 (2016) [hereinafter STATISTICAL ABSTRACT FY 2016] (budget outlay of $926,444,440), https://www.tn.gov/content/dam/tn/correction/documents/StatisticalAbstract2016.pdf.

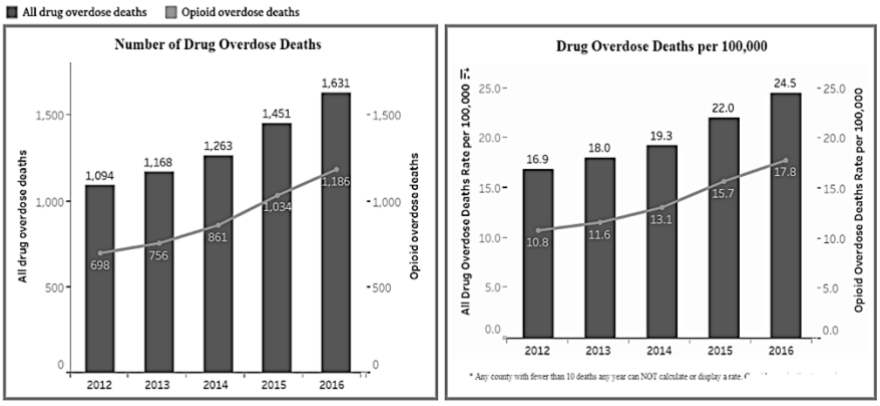
260. *Compare* STATISTICAL ABSTRACT FY 2016, *supra* note 259, at 23, *with* STATISTICAL ABSTRACT FY 2017, *supra* note 258, at 17.

261. STATISTICAL ABSTRACT FY 2017, *supra* note 258, at 16.

262. *Compare* TENN. DEP'T OF CORRECTION, FY 2013 ANNUAL REPORT 6 (2013), https://www.tn.gov/content/dam/tn/correction/documents/AnnualReport2013.pdf, *with* TENN. DEP'T OF CORRECTION, FY 2014 ANNUAL REPORT 6 (2014), https://www.tn.gov/content/dam/tn/correction/documents/AnnualReport2014.pdf, TENN. DEP'T OF CORRECTION, FY 2015 ANNUAL REPORT 6 (2015), https://www.tn.gov/content/dam/tn/correction/documents/AnnualReport2015.pdf, TENN. DEP'T OF CORRECTION, FY 2016 ANNUAL REPORT 6 (2016), https://www.tn.gov/content/dam/tn/correction/documents/AnnualReport02October2016.pdf, *and* TENN. DEP'T OF CORRECTION, FY 2017 ANNUAL REPORT 8 (2017), https://www.tn.gov/content/dam/tn/correction/documents/AnnualReport2017.pdf.

Fiscal Year	Inmates Convicted for Drug Offense	Average Sentence Length (Years)
2013	6,169	9.7
2014	6,226	9.9
2015	6,059	10.0
2016	5,984	10.2
2017	6,257	10.4

Despite the significant law enforcement response to drug crime across the state, and the increase in the average sentence for drug offenses, the rate of overdose and overdose related deaths continues to climb:[263]



Moreover, there does not appear to have been a noticeable public safety benefit. The FBI's 2016 Uniform Crime Rate indicates that Tennessee's violent crime rate is at 632.9 per 100,000 persons, up from 618.9 the previous year.[264] For context, the national average is

263. *Data Dashboard*, TENN. DEP'T OF HEALTH, https://www.tn.gov/health/health-program-areas/pdo/pdo/data-dashboard.html (last visited Oct. 29, 2018).

264. U.S. Dep't of Justice, *2016 Crime in the United States: Table 2*, FED. BUREAU OF INVESTIGATION, https://ucr.fbi.gov/crime-in-the-u.s/2016/crime-in-the-u.s.-2016/topic-pages/tables/table-2 (last visited Nov. 4, 2018) [hereinafter Dep't of Justice, *Table 2*].

386.3,[265] while the average crime rate of Tennessee's neighbors being 387.9, with the highest rate being Arkansas at 550.9, and the lowest being Virginia at 217.6.[266] The Governor's Task Force reported that, "from 2010, 46 percent of people released from prison or jail in Tennessee were reincarcerated within three years."[267]

In response, Tennessee Governor Bill Haslam created the Public Safety Subcabinet, which he "tasked with developing a plan that included action steps that identified and addressed the challenges to public safety in Tennessee."[268] As an extension of the Public Safety Subcabinet, Governor Haslam convened his Task Force on Sentencing and Recidivism ("Task Force").[269] The legislature embraced many of the Task Force's recommendations in the Public Safety Act of 2016 ("PSA"), which went into effect on July 1, 2016, with full implementation expected by January 2017.[270] This Article examines the validated risk- and needs assessments and graduated sanctions for supervision violations portions of the PSA in later Sections.

The Tennessee House of Representatives' member task force recommended expanding access to treatment, including expanding participation in recovery courts, and expanding the naltrexone grant program to include county jail inmates.[271] These reforms, if implemented, are certainly welcome and reinforce the criminal justice system's limited role in reducing the demand for illicit drugs. To crack down on illicit supply of opioids trafficked in the state, the House task force also recommended that the Tennessee Bureau of Investigations receive appropriations for 25 additional investigators.[272] The

265. U.S. Dep't of Justice, *2016 Crime in the United States: Violent Crime*, FED. BUREAU OF INVESTIGATION, https://ucr.fbi.gov/crime-in-the-u.s/2016/crime-in-the-u.s.-2016/topic-pages/violent-crime (last visited Nov. 4, 2018).

266. U.S. Dep't of Justice, *Table 2*, *supra* note 264 (considering the averages of Tennessee's neighbors: Kentucky, Virginia, North Carolina, Georgia, Alabama, Mississippi, Arkansas, and Missouri).

267. GOVERNOR'S TASK FORCE RECOMMENDATIONS, *supra* note 257. This rate remained relatively flat for those released in years 2001 to 2005. *Id.*

268. TENN. DEP'T OF CORRECTION, FY 2017 ANNUAL REPORT, *supra* note 262, at 2.

269. GOVERNOR'S TASK FORCE RECOMMENDATIONS, *supra* note 257, at 3.

270. 2016 Tenn. Pub. Acts 906.

271. TN HOUSE TASK FORCE RECOMMENDATIONS, *supra* note 191, at 3.

272. *Id.* at 4.

recommendations, however, also called for "enhance[d] penalties for and enforcement efforts against offenses involving opioids, including fentanyl."[273] While this recommendation is broad in scope, any lawmaker considering such a reform must ensure that any proposed statutory language is narrowly tailored in scope to capture only drug traffickers. The President's Commission attached a similar caution to its recommendation for sentencing enhancements for those convicted of trafficking fentanyl or its analogues.[274] The enhancements should be subject to the court's consideration of "other factors beyond quantity" that often trigger enhancements to ensure that an addicted individual in possession of fentanyl for personal use is not charged and convicted as though they were trafficking fentanyl.[275]

B. Criminal Justice System's Supporting Role in Resolving the Opioid Crisis

The criminal justice system still plays a pivotal role in the resolution of the opioid epidemic because drug addiction can drive criminal activity. To obtain drugs in the first place, it is not uncommon for addicts to perpetrate prescription fraud, or steal property and money, to stave off withdrawal symptoms.[276] Some even revert to drug trafficking.[277] "Among substance-involved inmates, those who have committed a crime to get money to buy drugs have the highest average number of past arrests (6.6) . . . ."[278]

While it serves neither the interests of the rule of law nor public safety to discount or entirely excuse criminal acts that are symptoms of a disease, justice must include rehabilitation. For nonviolent drug offenders, the ideal sanction is diversion into an evidence-based treatment program with increased monitoring and participation as a condition of their supervision. It is also important that the law not simply warehouse offenders suffering from addiction for whom incarceration is necessary, like violent, high-risk offenders. To avoid

273. *Id.* at 5.

274. PRESIDENT'S COMM'N FINAL REPORT, *supra* note 3, at 61.

275. *Id.*

276. *See, e.g.*, NCASA, BEHIND BARS, *supra* note 207, at 2–3, 10–13.

277. *See, e.g.*, *id.* at 17, 19.

278. *Id.* at 3.

reoffending, and because 95% of all inmates will eventually be released,[279] these offenders must also be afforded an evidence-based treatment program.

With this in mind, on September 22, 2017, DOJ announced an award of $59 million in grants toward different programs targeting the opioid epidemic.[280] The Office of Justice Programs' Bureau of Justice Assistance's Comprehensive Opioid Abuse Program and the Harold Rogers Prescription Drug Monitoring Program will award $24 million in grants to "50 cities, counties and public health departments . . . to create comprehensive diversion and alternatives to incarceration programs for those impacted by the opioid epidemic."[281] NIJ will award $3.1 million "for research and evaluation on drugs and crime," with an emphasis on "heroin and other opioids and synthetic drugs."[282] The grants also include a $22.2 million DOJ award to "53 jurisdictions to support the implementation and enhancement of adult drug courts and Veterans Treatment Courts," and $9.5 million to the Juvenile Drug Treatment Court Grant Program and the Family Drug Court Statewide System Reform Implementation Program.[283]

There are numerous effective strategies and programs that rehabilitate offenders with substance abuse disorders while also reducing recidivism. Jurisdictions across the country have implemented a few of these strategies and programs in some form or fashion, such as risk- and needs assessments and drug courts. Individual cities or states have created other programs that are in developmental stages but carry the potential for replication in other jurisdictions. Many of these strategies focus on the diversion of nonviolent drug offenders into treatment programs.

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279. Timothy Hughes & Doris James Wilson, *Reentry Trends in the U.S.*, BUREAU OF JUSTICE STATISTICS, https://www.bjs.gov/content/reentry/reentry.cfm (last visited Nov. 4, 2018).

280. Press Release, U.S. Dep't of Justice, Department of Justice Awards Nearly $59 Million to Combat Opioid Epidemic, Fund Drug Courts (Sept. 22, 2017), https://www.justice.gov/opa/pr/department-justice-awards-nearly-59-million-combat-opioid-epidemic-fund-drug-courts.

281. *Id.*

282. *Id.*

283. *Id.*

1. Risk- and Needs Assessments

To encourage recovery and prevent re-offense, the law should provide tailored treatment strategies to anyone who finds themselves engaged with the criminal justice system as a consequence to their drug addiction. This holds true regardless of where an addict may be within the criminal justice system.[284] To that end, risk- and needs assessments ("RNAs") are critical tools that help guide the determination of a proper strategy for each offender. More specifically, RNAs "inform sentencing, determine the need for and nature of rehabilitation programs, inform decisions concerning conditional release, and allow community supervision officers to tailor conditions to a person's specific strengths, skill deficits, and reintegration challenges."[285]

One critical function of an RNA is the identification of the needs of offenders with substance abuse disorders, especially considering that approximately 80% of inmates are in prison due to some degree of substance involvement, whether they were charged with a drug crime, were under the influence when arrested, committed a crime to support a drug habit, or have a significant history of substance abuse.[286] Indeed, studies have shown that nearly 65% of the total U.S. inmate population meet "the DSM-IV medical criteria for alcohol or other drug abuse and addiction."[287] If an offender never receives effective treatment for substance abuse issues when they engage the criminal justice system, then there is an increased risk that they will reoffend.

Many RNAs use an objective actuarial formula, the benefit to which is the lack of human bias. The Council for State Government echoes this sentiment, noting that "[o]bjective risk and needs assessments have been shown to be more reliable than a professional's

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284. *Cf.* NAT'L INST. ON DRUG ABUSE, PRINCIPLES OF DRUG ABUSE TREATMENT FOR CRIMINAL JUSTICE POPULATIONS 3–4 (2014) (discussing the need to plan treatment for an individual across phases of the criminal justice process), https://www.drugabuse.gov/sites/default/files/txcriminaljustice_0.pdf.

285. R. KARL HANSON ET AL., A FIVE-LEVEL RISK AND NEEDS SYSTEM: MAXIMIZING ASSESSMENT RESULTS IN CORRECTIONS THROUGH THE DEVELOPMENT OF A COMMON LANGUAGE 3 (2017), https://csgjusticecenter.org/wp-content/uploads/2017/01/A-Five-Level-Risk-and-Needs-System_Report.pdf.

286. *See* NCADD, *Alcohol, Drugs and Crime*, *supra* note 200.

287. Califano, *supra* note 201, at i.

individual judgment."[288] Regardless of methodology, RNAs, while not designed to function as "the sole factor in making . . . decisions," and which should be "routinely validated to ensure their accuracy," remain "the best available method for ensuring that research-based data helps inform the decision-making process."[289] To this point, a 2017 National Reentry Resource Center report on RNAs, with assistance from the Bureau of Justice Assistance, explains that "correctional intervention . . . requires taking into account a person's risk of reoffending and the needs that must be met to change that person's behavior."[290] The report emphasized that the purpose of the RNA is to "inform case management, not just predict risk."[291] Specifically, RNAs should "identify [a] person's needs and strengths to enable appropriate evidence-based correctional responses, and provide statistical data about the expected success of various appropriate risk-reduction strategies."[292]

Many jurisdictions require RNAs at the pre-sentence level, partly to find eligible candidates for diversion rather than incarceration, but to also ensure that the process accommodates the defendant's treatment needs throughout their engagement with the system. Tennessee, for example, requires that probation departments include these assessments in the presentence reports that they submit to the courts, and that courts take them under consideration when imposing a sentence.[293] In fact, Tennessee's PSA mandates performance of RNAs, or "validated risk and needs assessment[s]," on each offender and at each stage in their procession through the criminal

288. Justice Ctr., *In Brief: Understanding Risk and Needs Assessment*, COUNCIL FOR STATE GOV'TS, https://csgjusticecenter.org/jr/in-brief-understanding-risk-and-needs-assessment/ (last visited Nov. 4, 2018).

289. *Id.*

290. HANSON ET AL., *supra* note 285, at 12.

291. *Id.*

292. *Id.*

293. *Cf.* TENN. CODE ANN. § 40-35-207 (2018) (setting forth the required content of pre-sentencing reports); TENN. CODE ANN. § 40-35-209(d)(1) (2018) (providing that courts base sentences on presentence reports that the court can subsequently modify with additional factual findings at the sentencing hearing).

justice system.[294] Tennessee designed its RNA policy to "determin[e] a person's risk to reoffend and the needs that, when addressed, reduce the risk to reoffend through the use of an actuarial assessment tool designated by the department that assesses the dynamic and static factors that drive criminal behavior."[295] Tennessee law also requires that these assessments occur annually for each individual incarcerated or under supervision and that authorities use them to determine to which programs they assign criminal defendants.[296]

There is still room to expand use of RNAs for the purpose of informing decisions concerning pretrial detention. Tennessee, as is the case in many states, does not use any pretrial risk assessment tool. Across the country, many low-risk, pretrial detainees are detained pending trial simply because they could not afford to pay their cost of bail.[297] In fact, the most recent statistics from 2009 indicate that 90% of all felony defendants who were detained pending trial were actually assessed bail, and therefore, could have been released.[298]

Jurisdictions across the country could greatly reduce expensive jail populations if more courts would utilize pretrial RNAs to determine conditions for pretrial release, rather than simply detaining or assessing a secured bail that many cannot afford. The jail population has increased twenty percent between 2000 and 2012, with a "rising share" attributed to the pretrial population.[299] In fact, jail costs have

294. *See generally, e.g.*, TENN. CODE ANN. §§ 40-35-207, 41-1-126 (2018) (providing for validated risk and needs assessments, respectively, prior to sentencing and as an offender enters the corrections system).

295. *See, e.g.*, § 40-35-207(d).

296. § 41-1-126(b).

297. *See* Megan Stevenson & Sandra G. Mayson, *Pretrial Detention and Bail*, 3 ACAD. FOR JUST. 21, 22–23 (2017), http://academyforjustice.org/wp-content/uploads/2017/10/2_Reforming-Criminal-Justice_Vol_3_Pretrial-Detention-and-Bail.pdf.

298. *Id.*; *see also* BRIAN A. REAVES, U.S. DEP'T OF JUSTICE, FELONY DEFENDANTS IN LARGE URBAN COUNTIES, 2009—STATISTICAL TABLES 15 (2013) (finding that only one in ten defendants were denied bail), https://www.bjs.gov/content/pub/pdf/fdluc09.pdf.

299. NATALIE R. ORTIZ, NAT'L ASSOC. OF CTYS., COUNTY JAILS AT A CROSSROADS: AN EXAMINATION OF THE JAIL POPULATION AND PRETRIAL RELEASE EXECUTIVE SUMMARY 2 (2015), http://www.naco.org/sites/default/files/documents/Final%20Executive%20Summary_0_0.pdf.

also increased 74% over the same period.[300] Accordingly, almost 75% of all jails surveyed cited "reducing the jail population" as the top priority.[301] Despite this priority, "[o]nly 28 percent of the detainees released by respondent jails in 2014 were pretrial" detainees.[302]

A jail's risk-assessment score may help inform the court's decision regarding release and treatment of pretrial detainees.[303] A 2015 National Association of Counties ("NACo") survey supports this contention. For context, 87% of America's jails are county-owned and account for 700,000 prisoners in custody.[304] Of the county jails surveyed, 40% "use a validated risk assessment at booking."[305] Further, NACo found that "[m]ost often, these jails identify a majority of their confined jail population as low risk."[306] To wit, "sixty-nine percent . . . of the jails reported that more than half of their detainees are classified as low risk, as assessed at booking."[307] County jails participating in the survey reported that two-thirds of the population were pretrial detainees.[308] Thus, the majority of pretrial detainees are low-risk, and thus candidates for supervision and, if needed, substance abuse treatment programs.[309] Some states, such as Hawaii and West Virginia, have made it a policy to include RNAs as a factor in determining pretrial release.[310]

The President's Commission also recognizes that the "population of pre-trial detainees is several times larger than the

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300. *Id.*

301. *See id.*

302. *Id.* at 3.

303. *See id.* at 2.

304. *Id.* at 1.

305. *Id.*

306. *Id.*

307. NATALIE R. ORTIZ, NAT'L ASSOC. OF CTYS, COUNTY JAILS AT A CROSSROADS: AN EXAMINATION OF THE JAIL POPULATION AND PRETRIAL RELEASE 6 (2015), http://www.naco.org/sites/default/files/documents/Final%20paper_County%20Jails%20at%20a%20Crossroads_8.10.15.pdf.

308. *Id.* at iii.

309. *Id.*

310. S.B. 371, 81st Leg., 2013 Reg. Sess. (W. Va. 2013); S.B. 2776, 26th Leg., 2012 Sess. (Haw. 2012).

population of individuals sentenced to jail."[311] Of "special concern" is the fact that "these individuals may be less likely to receive treatment and other services due to the fact that they may be released or transferred in a relatively short period of time."[312] The President's Commission characterizes the need to "[i]ncreas[e] access to treatment, and especially MAT" for pretrial detainees as "critically important."[313] It notes that "doing so can save lives and reduce future public safety and public health costs associated with unchecked opioid addiction among these individuals."[314]

2. Graduated Sanctions for Technical Supervision Violations

Probation and parole are supervisory functions of the criminal justice system, whereby officials monitor an offender's adherence to the conditions of their supervision.[315] Failure to attend a meeting with the supervising official, failure to attend a treatment program, or missing curfew could result in a technical violation of these conditions.[316] Other violations include a positive drug test or the commission of a new crime.[317] Generally, if a supervisor catches an individual violating the conditions of their probation or parole, the supervision official must then inform the court of the violation, and the court then decides whether to revoke the probation or parole.[318]

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311. PRESIDENT'S COMM'N FINAL REPORT, *supra* note 3, at 72–73.

312. *Id.* at 73.

313. *Id.*

314. *Id.*

315. *FAQ Detail: What Is the Difference Between Probation and Parole?*, BUREAU OF JUSTICE STATISTICS, https://www.bjs.gov/index.cfm?ty=qa&iid=324 (last visited Nov. 4, 2018).

316. *Id.*; *see also* Michael Tonry, *Community Punishments*, 4 ACAD. FOR JUST. 187, 195–96 (2017), http://academyforjustice.org/wp-content/uploads/2017/10/10_Criminal_Justice_Reform_Vol_4_Community-Punishments.pdf.

317. Tonry, *supra* note 316, at 196.

318. Closely monitoring individuals on probation and parole is a difficult task, considering the significant caseloads burdening most supervising officials. For example, Tennessee's community supervision population totals 78,136, compared to the 895 fulltime TDOC employees assigned to community supervision. STATISTICAL ABSTRACT FY 2017, *supra* note 258, at 4, 31. Also, far too many supervised individuals end up incarcerated due to the revocation of their supervision, even though

Where the opioid epidemic is concerned, we understand that many who suffer from opiate abuse disorder may have episodes of relapse during their rehabilitation process.[319] Since it is clearly not an effective policy to revoke supervision and incarcerate an individual for a relapse event, what are the alternatives? Many jurisdictions have adopted a policy of graduated sanctions that supervising officials can impose immediately, rather than awaiting court action. Graduated sanctions primarily target technical violations or failed drug tests and often include increased monitoring, which may include an electronic monitoring device, a weekend in jail, or an extended term of supervision.[320]

The effectiveness of these alternative sanctions lies in the "swift, sure, and commensurate" fashion in which they are imposed.[321] The Pew Project reports that graduated sanctions "have demonstrated a reduction in both recidivism and costs," and it notes that "Texas, Georgia, North Carolina, and South Carolina have saved hundreds of millions of taxpayer dollars by taking this approach."[322] Acknowledging the ineffectiveness of incarceration where substance use disorder is concerned, the President's Commission has expressly argued that those who violate the terms of their supervision by drug relapse "should be diverted into drug court, rather than prison."[323]

Tennessee recently adopted graduated sanctions for its community supervision population. Pursuant to the PSA, the TDOC has developed a "single system of graduated sanctions for supervision violations," which "set forth a menu of presumptive sanctions for the

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their violation may not have called for such a severe sanction. In Fiscal Year 2015–2016, 40% of the new admissions to the TDOC were folks whose supervision was revoked due to a technical violation. TENN. DEP'T OF CORRECTION, FY 2016 ANNUAL REPORT, *supra* note 262, at 12.

319. *See generally* Harsh Chalana et al., *Predictors of Relapse after Inpatient Opioid Detoxification During 1-Year Follow-Up*, J. ADDICTION, Sept. 2016, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5046044/pdf/JAD2016-7620860.pdf.

320. MARC LEVIN, THE TEXAS MODEL, ADULT CORRECTIONS REFORM: LOWER CRIME, LOWER COSTS 1 (2011), http://rightoncrime.com/wp-content/uploads/2011/09/Texas-Model-Adult.pdf.

321. *Id.*

322. The Pew Charitable Trusts Letter, *supra* note 203, at 10.

323. PRESIDENT'S COMM'N FINAL REPORT, *supra* note 3, at 74.

most common types of supervision violations."[324] Among the "common" violations the PSA identified is "failure to refrain from the use of alcohol or controlled substances."[325] The PSA defines "graduated sanctions" as:

> any of a wide range of non-prison offender accountability measures and programs, including, but not limited to, electronic supervision tools; drug and alcohol testing or monitoring; day or evening reporting centers; rehabilitative interventions such as substance abuse or mental health treatment; reporting requirements to probation and parole officers; community service or work crews; and residential treatment facilities.[326]

The precise graduated sanction imposed may depend on "the severity of the current violation, . . . previous criminal record, the number and severity of any previous supervision violations, . . . assessed risk level, and the extent to which graduated sanctions were imposed for previous violations."[327] A TDOC-designed administrative process must approve the sanctions; due process commands that this agency approval process include a mechanism by which a supervised individual may challenge the imposed sanction.[328] The chief supervision officer must approve any graduated sanctions that involves confinement, and in that event, the confinement cannot exceed thirty days, and the system must attempt to accommodate that supervised individual's employment.[329]

The graduated sanction system should also include "positive reinforcements that supervised individuals will receive for compliance with conditions of supervision."[330] If a supervised individual successfully satisfies the graduated sanction imposed, then the courts will not revoke their supervision.[331] Incarceration upon the revocation

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324. TENN. CODE ANN. § 40-28-303(a) (2018).
325. *Id.*
326. TENN. CODE ANN. § 40-28-301(4) (2018).
327. § 40-28-303(a).
328. § 40-28-303(c).
329. *See* TENN. CODE ANN. §§ 40-28-302, -306 (2018).
330. § 40-28-303(a).
331. TENN. CODE ANN. § 40-28-305(e) (2018).

of supervision will result only from violations that "constitute[] a significant risk to prior victims of the supervised individual or the community at large and cannot be appropriately managed in the community."[332]

Graduated sanctions are important to diversion and community supervision programs because they allow individuals to avoid incarceration for violations that do not involve the commission of a new crime. The benefits to this approach are numerous: the individual remains employed, they remain with their families and in their communities, and, where applicable, they can remain in their treatment programs.

3. Early Diversion

Early diversion, or pre-booking diversion, is where law enforcement will assist in the placement of individuals who suffer with from either a mental health or substance-abuse disorder into a treatment program without the accused ever having to first engage the criminal justice system.[333] Randy Peterson, a former police officer and academy instructor and current policy analyst for Right on Crime, explains why "pre-booking" diversion is an important tool for law enforcement, particularly for those offenders suffering from mental health and addiction issues.[334] He contends that "[m]odern police officers are community caretakers looking after the welfare of society."[335] He explains that "[m]oving away from an enforcement model favoring sanctions, which has become prevalent in policing, toward a servant/guardian model, may do more than just mend strained relations with the community," but also "might give police officers the

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332. § 40-28-302(1).

333. *See, e.g.*, *Law Enforcement and Behavioral Health Partnerships for Early Diversion: Initial Announcement*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/grants/grant-announcements/sm-18-005 (last updated Feb. 20, 2018).

334. RANDY PETERSON, RIGHT ON CRIME, PRE-ARREST AND PRE-BOOKING DIVERSION AND MENTAL HEALTH IN POLICING (2017), http://rightoncrime.com/2017/04/pre-arrest-and-pre-booking-diversion-and-mental-health-in-policing/.

335. *Id.* at 3.

tools to better fulfill their mission by helping those who need them most."[336]

The following are examples of innovative, early-diversion programs developed in Knoxville, Tennessee, and Seattle, Washington.

i. The Knoxville Early Diversion Program

The Knoxville Early Diversion Program ("KEDP") is "a collaboration between the Helen Ross McNabb Center (HRMC), Knoxville Law Enforcement, and the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) . . . [to] provide screening, assessment, referral, and treatment to individuals at risk of entering the criminal justice system."[337] KEDP functions through "diversion liaisons" whom the program designates to work alongside law enforcement.[338] The liaisons "intervene and effectively divert" people when they are confronted by police.[339] The liaisons then identify possible treatment options without imposing criminal charges.[340] These individuals then receive a case manager "to ensure that treatment options are reviewed, referrals are made, appointments are set, and all barriers to the individual engaging in or receiving treatment are identified and addressed."[341]

The program has the specific goal of "[d]ivert[ing] 1,250 individuals from entering jail through early diversion liaison outreach during the three-year grant cycle," and "[p]rovide extensive case management services to 175 individuals during the full grant cycle."[342] It also aims to "[l]ink individuals to community resources" while "[a]ddress[ing] current gaps in services in the Knoxville

336. *Id.*

337. *Law Enforcement and Behavioral Health Partnerships for Early Diversion*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/gains-center/grants-grantees/early-diversion (last updated Aug. 20, 2015).

338. *Id.*

339. *Id.*

340. *See id.* (noting that diversion into treatment programs will decrease the number of arrests).

341. *Id.*

342. *Id.*

community."[343] The program anticipates that "[e]arly diversion will decrease the number of arrests and ultimately provide services to individuals who can be better served within the community through behavioral health treatment instead of through incarceration."[344] KEDP received a three-year Behavioral Health Partnerships for Early Diversion grant award from SAMHSA.[345] Knoxville Police Chief Gary Holliday, a proponent of the KEDP, notes that "it's good to keep folks out of jail," and he reportedly boasted $110,000 in savings from unnecessary law enforcement and incarceration expenditures in the three-year period.[346]

ii. The LEAD Program: Seattle, Washington

Similar to KEDP, officials in Seattle, Washington created the Law Enforcement Assisted Diversion ("LEAD") program, a "pre-booking, community-based diversion program designed to divert those suspected of low-level drug and prostitution offenses away from jail and prosecution" and into treatment programs.[347] Participants forego booking and criminal charges; the system instead diverts them into the supervision of a LEAD case manager who assesses their "substance-use frequency and treatment, time spent in housing, quality of life, psychological symptoms, interpersonal relationships, and health status."[348] Case managers also assist participants by connecting them to "existing resources in the community such as legal advocacy, job training or placement, housing assistance, and counseling."[349]

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343. *Id.*

344. *Id.*

345. *Id.*

346. Thomas Fraser, *State Health-Care Task Force Meets in Knoxville for a Lot of Talk*, KNOX MERCURY (May 25, 2016), http://www.knoxmercury.com/2016/05/25/state-health-care-task-force-meets-in-knoxville-for-a-lot-of-talk/.

347. *Program Profile: Law Enforcement Assisted Diversion (LEAD) Program (Seattle, Washington)*, NAT'L INST. OF JUSTICE (July 11, 2016), https://www.crimesolutions.gov/ProgramDetails.aspx?ID=477 [hereinafter *LEAD Program Profile*].

348. *Id.* (click "Program Description").

349. *Id.*

The Seattle Police Department screens drug offenders for participation in LEAD based on the quantity of drugs involved, as well as whether the offender trafficked drugs, is "amenable to diversion," involved a juvenile in the offense, "promoted prostitution," or otherwise has a "disqualifying criminal history."[350] Officers who are designated to conduct this screening are trained "to apply the inclusion/exclusion criteria to identify possible program participants."[351] LEAD is a collaborative program involving "Defender Association's Racial Disparity Project, the Seattle Police Department, the American Civil Liberties Union (ACLU) of Washington, the King County Prosecuting Attorney's Office, the Seattle City Attorney's Office, the King County Sherriff's Office, the King County Executive, and the Washington State Department of Corrections," which together make up LEAD's Policy Coordinating Group.[352]

The NIJ has rated this program as "promising" based on a study that found "statistically significant recidivism improvement for the LEAD group compared to the control group ["system-as-usual" control participants] on some shorter- and longer-term outcomes."[353] Using various calculation methods, the study found that LEAD participants were 57% to 60% less likely to be arrested after they entered the program.[354] Moreover, a study of the long term impact of the program revealed that participants were still 56% to 58% less likely to be arrested.[355]

350. *Id.*

351. *Id.* (click "Implementation Information").

352. *Id.*; *About LEAD*, LAW ENF'T ASSISTED DIVERSION, http://leadkingcounty.org/about/ (last visited Nov. 11, 2018).

353. *LEAD Program Profile*, *supra* note 347; *see also* SUSAN E. COLLINS ET AL., UNIV. OF WASH. LEAD EVALUATION TEAM, LEAD PROGRAM EVALUATION: RECIDIVISM REPORT 2 (2015), http://static1.1.sqspcdn.com/static/f/1185392/26121870/1428513375150/LEAD_EVALUATION_4-7-15.pdf.

354. COLLINS ET AL., *supra* note 353, at 15.

355. *Id.* at 16.

4. Pre-Trial Diversion

Pretrial diversion allows a court to divert an offender into a supervised program as an alternative to prosecution or incarceration.[356] If an offender satisfies the conditions of the supervised program, the court may dismiss the charges, and perhaps allow an individual to maintain a clear record. For nonviolent drug offenders, particularly those with substance abuse disorder, pretrial diversion programs have proven to be a more effective strategy than incarceration for ensuring treatment of drug addiction and reducing the risks of recidivism.

i. Drug Courts

The NIJ has acknowledged that incarceration, "by itself, has not been effective in breaking the cycle of drugs and crime," and it has taken the position that "[d]rug courts offer an alternative to incarceration."[357] Indeed, drug courts have emerged as a highly effective tool in addressing substance abuse issues among nonviolent offenders, with more than 3,000 in operation throughout the country.[358] These courts are described as "specialized court docket programs that target criminal defendants and offenders, juvenile offenders, and parents with pending child welfare cases who have alcohol and other drug dependency problems."[359] These courts "offer[] drug offenders the chance to avoid prosecution, recovery from addiction, and change their lives in a positive direction."[360] Created in 1989 by the Eleventh Judicial Circuit of Florida, the Miami-Dade County Felony Drug Court was the nation's first drug court; since its inception, "[t]housands of people have taken this chance in Miami-Dade County's Drug Court

356. *See, e.g.*, U.S. DEP'T OF JUSTICE, OFFICE OF THE U.S. ATT'YS, JUSTICE MANUAL § 9-22.000 (2018), https://www.justice.gov/usam/usam-9-22000-pretrial-diversion-program.

357. NIJ, DRUG COURTS, *supra* note 196, at 1.

358. *Drug Courts*, NAT'L INST. OF JUSTICE, https://www.nij.gov/topics/courts/drug-courts/Pages/welcome.aspx (last modified Aug. 23, 2018) [hereinafter NIJ, *Drug Courts*].

359. U.S. DEP'T OF JUSTICE, OFFICE OF JUSTICE PROGRAMS, DRUG COURTS 1 (2018) [hereinafter OJP, DRUG COURTS], https://www.ncjrs.gov/pdffiles1/nij/238527.pdf.

360. MIAMI-DADE CTY. DRUG COURT WORKS, http://www.miamidrugcourt.com/ (last visited Nov. 11, 2018).

and have succeeded."[361] In touting the effectiveness of drug courts, the DOJ has acknowledged that "[t]reating the underlying issue of addiction can keep these offenders from recycling through the judicial system."[362]

Drug courts are alternatives to incarceration, and they often provide dismissal of criminal charges, vacation or reduction in sentences, or removal from supervision as incentives for successful completion of the program.[363] Teams of judges, drug treatment specialists, corrections, social workers, prosecutors, and members of the criminal defense bar administer the programs.[364] Most drug courts adhere to a common model that includes the following:

- offender screening and assessment of risks, needs, and responsiveness;
- judicial interaction;
- monitoring (drug testing) and supervision;
- graduated sanctions and incentives; and
- treatment and rehabilitation services.[365]

Similarly, jurisdictions have developed juvenile and veteran drug courts using a similar model, but these focus on specific juvenile and veteran needs with regard to substance abuse issues.[366]

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361. *Id.*

362. Alan R. Hanson, *OJP Funds Opiate Intervention Court*, OJP BLOG (Sept. 22, 2017), https://ojp.gov/ojpblog/blog-substanceabuse.htm (de-published web content).

363. *See* DOUGLAS B. MARLOWE ET AL., NAT'L DRUG COURT INST., PAINTING THE CURRENT PICTURE: A NATIONAL REPORT ON DRUG COURTS AND OTHER PROBLEM SOLVING COURTS IN THE UNITED STATES 11–12 (2016), http://www.ndci.org/wp-content/uploads/2016/05/Painting-the-Current-Picture-2016.pdf.

364. NIJ, *Drug Courts*, *supra* note 358.

365. *Id.*

366. *Compare, e.g.*, *Juvenile Drug Courts Help Youth Dealing with Trauma*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/juvenile-drug-courts-help-youth (last updated Oct. 12, 2018), *with What Is a Veterans Treatment Court?*, JUSTICE FOR VETS, https://justiceforvets.org/what-is-a-veterans-treatment-court/ (last visited Nov. 11, 2018).

NIJ has sponsored studies to quantify the effectiveness of drug courts across the country that have found that drug court participants were less likely to recidivate, compared to "comparable offenders."[367] In fact, impact evaluations discovered "that adult drug courts significantly reduce participants' drug use and criminal offending during and after program participation."[368] Moreover, both the duration of participation and the completion rates are higher among drug court participants than in other drug treatment programs.[369]

In a joint resolution, the Conference of Chief Justices and the Conference of State Court Administrators endorsed problem-solving courts, such as drug courts.[370] The resolution recognized that these courts "have demonstrated great success in addressing certain complex social problems, such as recidivism, that are not effectively addressed by the traditional legal process."[371] The resolution vowed to "[e]ncourage each state to develop and implement an individual state plan to expand the use of the principles and methods of problem-solving courts into their courts" and "[a]dvocate for necessary financial resources for treatment and services that are integral to a successful problem-solving court."[372]

The President's Commission also recognized the effectiveness of drug courts, which it prefers to incarceration when nonviolent offenders with substance abuse disorder are concerned.[373] Its report found that "[d]rug courts have traditionally been a more effective response for non-violent, low-level offenders with [substance use

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367. OJP, DRUG COURTS, *supra* note 359, at 1.

368. John Roman, *Cost-Benefit Analysis of Criminal Justice Reforms*, NAT'L INST. OF JUST., https://www.nij.gov/journals/272/Pages/cost-benefit.aspx (last visited Nov. 11, 2018).

369. Studies show that "80 and 90 percent of conventional drug treatment clients drop out before 12 months," but two-thirds of those who participate in a drug court program complete the treatment program, which can exceed 1 year. NIJ, DRUG COURTS, *supra* note 196, at 1.

370. CONF. OF CHIEF JUSTICES & CONFERENCE OF STATE COURT ADMINS., RESOLUTION 22: IN SUPPORT OF PROBLEM-SOLVING COURT PRINCIPLES AND METHODS 1 (2004), http://ccj.ncsc.org/~/media/Microsites/Files/CCJ/Resolutions/07292004-In-Support-of-Problem-Solving-Court-Principles-and-Methods.ashx.

371. *Id.*

372. *Id.* at 2–3.

373. *See* PRESIDENT'S COMM'N FINAL REPORT, *supra* note 3, at 16.

disorders], rather than lengthy prison sentences."[374] Individualized care, it seems, is an effective way to treat serious addictions.[375] However, "44% of U.S. counties in 2014 did not have a drug court for adults," due to "insufficient funding, treatment, and supervision resources, [but] not a lack of judicial interest."[376] Accordingly, the Commission recommends that the drug court program expand to each federal judicial district, and that "DOJ . . . urge states to establish state drug courts in every county."[377]

In addition to reducing recidivism and providing effective drug treatment, drug courts are also cost-effective. NIJ-sponsored studies show that "drug courts reduced recidivism among program participants in contrast to comparable probationers" with "significantly lower costs."[378] These studies specifically found that, "compared to traditional criminal justice system processing, treatment and other investment costs averaged $1,392 lower per drug court participant."[379] Moreover, the cost savings per participant associated with long-term outcomes, such as decreased in recidivism rates, total $6,744, or $12,218, including victimization costs.[380] "Drug courts that target offenders with high criminogenic risk and high substance abuse treatment needs yield the most effective interventions and maximize return on investment."[381]

According to NIJ studies, however, the degree of effectiveness of a drug court program will depend on a number of factors. For example, "a court's impact may depend upon how consistently court resources match the needs of the offenders in the drug court program."[382] To effectively treat drug addiction, "treatment services should (1) be based on formal theories of drug dependence and abuse, (2) use the best therapeutic tools, and (3) give participants

374. *Id.* at 73.

375. *Id.*

376. *Id.*

377. *Id.* at 10.

378. *Do Drug Courts Work? Findings From Drug Court Research*, NAT'L INST. OF JUSTICE, https://www.nij.gov/topics/courts/drug-courts/Pages/work.aspx (last modified May 1, 2018).

379. *Id.*

380. *Id.*

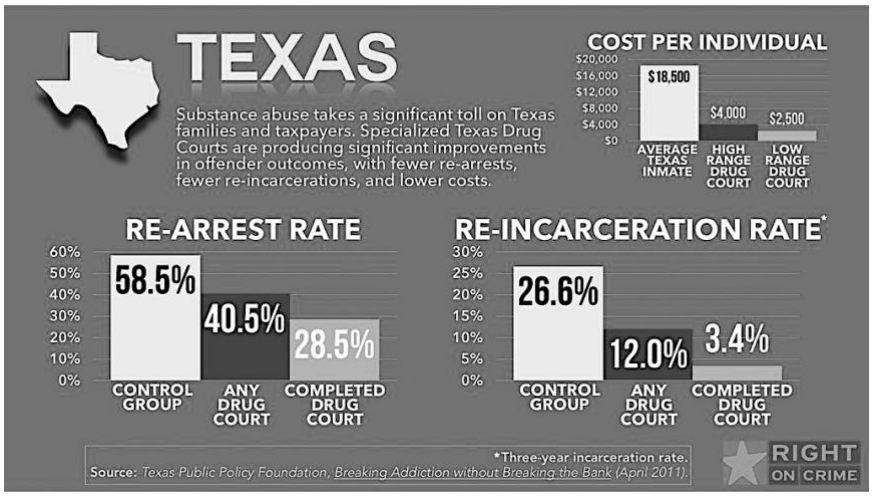
381. OJP, DRUG COURTS, *supra* note 359, at 2.

382. NIJ, DRUG COURTS, *supra* note 196, at iii.

opportunities to build cognitive skills."[383] Every member of a drug court team should be "educated in addiction and substance abuse theory, treatment approaches, and relapse prevention"—not just those providing the drug treatment.[384] Moreover, the interaction between the drug court judge and the offender plays an important role in the offender's success in the program, and preferably the same judge will proceed over an offender's case for the duration of the program.[385]

As Figure 3 below indicates, Texas has arguably one of the most effective statewide drug court programs:

Figure 3[386]



Immediately upon its statewide implementation in 2007, the re-incarceration rate for those who participated in program was 12%, but only 3.4% for those who completed the program.[387] Despite a nationwide incarceration rate increase of 0.8% between 2007 and 2008, numerous reforms to the drug court program allowed Texas to tie with Massachusetts for the most significant decline in incarceration

383. *Id.*

384. *See id.*

385. *Id.*

386. *Texas*, RIGHT ON CRIME, http://rightoncrime.com/category/state-initiatives/texas/ (last visited Nov. 11, 2018) (click "Read More").

387. *Id.*

rate during that period.[388] Texas also experienced a 27.4% decline in parole revocations.[389]

In Tennessee, the Drug Court Treatment Act of 2003 created "a program to facilitate the implementation of new and the continuation of existing drug court treatment programs."[390] This Act recognized that "a critical need exists in this state for criminal justice system programs to reduce the incidence of drug use, drug addiction and crimes committed as a result of drug use and drug addiction."[391] The Tennessee Code defines the goals for Tennessee's drug court program:

> (1) To reduce the use of jail and prison beds and other correctional services by nonviolent chemically dependent offenders by diverting them into rehabilitative programs;
> (2) To reduce incidences of drug use and drug addiction among offenders;
> (3) To reduce crimes committed as a result of drug use and addiction;
> (4) To promote public safety through these reductions;
> (5) To increase the personal, familial and societal accountability of offenders; and
> (6) To promote effective interaction and the use of resources among local criminal justice agencies and community agencies.[392]

In Tennessee, there are currently forty-five drug courts that serve seventy-eight of Tennessee's ninety-five counties.[393] In Fiscal

388. WILLIAM J. SABOL ET AL., BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, PRISONERS IN 2008, at 7, 16 (2010), https://www.bjs.gov/content/pub/pdf/p08.pdf.

389. *Texas*, *supra* note 386.

390. 2003 Tenn. Pub. Acts 335, § 1 (codified at TENN. CODE ANN. § 16-22-102(a) (2018)).

391. *Id.*

392. TENN. CODE ANN. § 16-22-102(b) (2018). Participation in the drug court programs is voluntary, but to qualify, participants cannot be a violent offender, and they must be alcohol- or substance dependent. TENN. CODE ANN. § 16-22-113 (2009).

393. TENN. DEP'T OF MENTAL HEALTH & SUBSTANCE ABUSE SERVS., TENNESSEE ADULT RECOVERY COURTS 1 (n.d.) [hereinafter TENN., ADULT RECOVERY COURTS] (on file with *The University of Memphis Law Review*).

Years 2013 to 2016, 36% of defendants admitted into the drug court program were addicted primarily to opiates (or synthetics) or heroin.[394] Between Fiscal Years 2014 to 2016, however, there were 1,491 drug court participants in Tennessee, with a graduation of 50.8%.[395] The number of drug court participants have increased each fiscal year since 2013.[396] Moreover, 1,204 of the participants gained full-time employment, and 1,054 went from being dependent on some degree of living assistance to being independent.[397] To that end, the number of nonviolent felony and misdemeanor offenders whom law enforcement diverted to recovery court increased 248% from January 2013 to December 2016.[398]

E. Douglas Varney, the former Commissioner of the Tennessee Department of Mental Health and Substance Abuse Services (the agency tasked with funding the drug court program), boasts that drug courts are the "most effective strategies for diverting people from incarceration and reducing recidivism among people with substance abuse addictions who are nonviolent offenders."[399] Further echoing the position of the NIJ and other drug court proponents, he notes that "[b]y treating those who are struggling with substance abuse, we can save taxpayer money, promote public safety and reduce drug abuse in communities."[400] As "a proven budget solution," former Commissioner Varney has called for the expansion of the program in Tennessee.[401]

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394. *See* TENN. DEP'T OF MENTAL HEALTH & SUBSTANCE ABUSE SERVS., RECOVERY COURT MULTI-YEAR ANALYSIS 4–5 (n.d.) [TENN., RECOVERY COURT ANALYSIS] (on file with *The University of Memphis Law Review*) (1,204 addicted to opiates or synthetics; 459 addicted to heroin; 4,672 admitted in total from 2013 to 2016).

395. TENN., ADULT RECOVERY COURTS, *supra* note 393.

396. TENN., RECOVERY COURT ANALYSIS, *supra* note 394, at 6.

397. TENN., ADULT RECOVERY COURTS, *supra* note 393, at 2.

398. OMOHUNDRO, *supra* note 145, at 6.

399. Press Release, Tenn. Dep't of Mental Health & Substance Abuse Servs., Recovery Drug Courts in Tennessee Reducing Crime and Saving Lives (May 4, 2015), https://www.tn.gov/behavioral-health/news/2015/5/4/recovery-drug-courts-in-tennessee-reducing-crime-and-saving-lives.html.

400. *Id.*

401. *Id.*

In Erie County, New York, officials took the drug court program one step further by launching an opioid intervention court in Buffalo on May 1, 2017.[402] DOJ's Office of Justice Programs ("OJP"), which recently announced grant funding for the pilot program, explained that, under this program, law enforcement will test every individual arrested in Buffalo for opioids.[403] The program assigns all offenders who receive a diagnosis of opiate addiction to an inpatient or outpatient treatment program.[404]

OJP notes that the "distinctive element" that separates the opiate court program from drug courts is the Rapid Integration Teams that immediately link the offender to a treatment program based on their individual needs.[405] Where a drug court may take 30- to 90 days to get someone placed in the proper treatment service, Buffalo's opiate court aims to place an individual within hours, or the next morning at the latest.[406] "[A] licensed and credentialed substance abuse counselor" who will monitor each participant and "conduct[] clinical assessments and manage[] the addiction behaviorally and medically" is a key component of the program.[407] In the fewer-than-five months since its inception, law enforcement has placed 113 offenders in the opiate intervention court.[408] Depending on the criminal charges, participants who complete the program may still face criminal sanction, but the system will count their success in the program in their favor.[409] The President's Commission recognized this pilot program as "relatively new, but the initial results are promising and other jurisdictions should consider adopting a similar strategy."[410]

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402. Hanson, *supra* note 362.

403. *Id.*

404. *Id.*

405. *Id.*

406. *Id.*; *accord* Eric Westervelt, *To Save Opioid Addicts, This Experimental Court Is Ditching the Delays*, NAT'L PUB. RADIO (Oct. 5, 2017, 5:02 AM), http://www.npr.org/sections/health-shots/2017/10/05/553830794/to-save-opioid-addicts-this-experimental-court-is-ditching-the-delays.

407. Hanson, *supra* note 362.

408. *Id.*

409. *Id.*

410. PRESIDENT'S COMM'N FINAL REPORT, *supra* note 3, at 74.

ii. Hawaii: HOPE Program

In 2004, the Hawaii court system created Hawaii's Opportunity Probation with Enforcement ("HOPE") pilot program to "reduce probation violations by drug offenders and others at high risk of recidivism."[411] Judge Stephen Alm of the First Circuit in Hawaii designed the program.[412] Described as a "high-intensity supervision program," offenders in the HOPE program who violate the terms of their probation will "receive swift, predictable, and immediate sanctions—typically resulting in several days in jail—for each detected violation, such as detected drug use or missed appointments with a probation officer."[413]

Probationers assigned to the HOPE program must appear before the court for a "warning hearing," during which the court informs them that they risk immediate arrest and incarceration upon failing a drug test or missing an appointment.[414] HOPE program participants do not receive advanced notification of a scheduled drug test.[415] Instead, each participant receives a "color code" that is used to select probationers for testing.[416] The probationer must call a hotline to learn whether the program has chosen their color code for drug testing that day; if so, the participant must appear at a designated location for a drug test by 2 p.m. that same day.[417] Within 72 hours of violating the conditions of the program, the probationer will appear before the court and duly receive a short jail sentence.[418]

411. *HOPE Probation*, HAWAI'I ST. JUDICIARY, http://www.courts.state.hi.us/special_projects/hope/about_hope_probation (last visited Nov. 12, 2018).

412. *Id.*

413. *Id.*

414. *"Swift and Certain" Sanctions in Probation Are Highly Effective: Evaluation of the HOPE Program*, NAT'L INST. OF JUSTICE, https://www.nij.gov/topics/corrections/community/drug-offenders/pages/hawaii-hope.aspx (last modified Feb. 3, 2012) [hereinafter NIJ, *Swift and Certain*].

415. *See id.* (probationers must call a hotline each day to determine if they must submit to a drug test later that day).

416. *Id.*

417. *Id.*

418. *Id.*

The NIJ has rated the HOPE program as "promising."[419] Further, in studying the effectiveness of the HOPE program, NIJ has noted the characteristics that differentiated it from other diversion treatment programs, such as:

- Focusing on reducing drug use and missed appointments rather than on drug treatment and imposing drug treatment on every participant.[420]
- Mandating drug treatment for probationers only if they continue to test positive for drug use, or if they request a treatment referral. A HOPE probationer who has a third or fourth missed or "dirty" drug test may be mandated into residential treatment as an alternative to probation revocation.[421]
- Requiring probationers to appear before a judge only when a violation is detected — in this respect, HOPE requires less treatment and court resources than drug courts. [422]
- Having probationers who are employed serve any jail time, at least initially, on a weekend so they do not jeopardize their employment.[423]

NIJ extols the HOPE program's emphasis on "swift and certain" sanctions for probation violations, rather than severity.[424] This approach "sends a consistent message to probationers about personal responsibility and accountability," which "improves the perception that the sanction is fair and that the immediacy is a vital tool in shaping behavior."[425]

As far as effective drug treatment is concerned, the NIJ further points to the fact that not all HOPE participants must undergo

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419. *Program Profile: Hawaii Opportunity Probation with Enforcement (HOPE)*, NAT'L INST. OF JUSTICE (May 31, 2011), https://www.crimesolutions.gov/ProgramDetails.aspx?ID=49.

420. NIJ, *Swift and Certain*, *supra* note 414.

421. *Id.*

422. *Id.*

423. *Id.*

424. *Id.*

425. *Id.*

substance abuse treatment.[426] Instead, the program utilizes a "behavioral triage" approach that targets those in need of "intensive long-term residential treatment, rather than relying primarily on outpatient drug-free counseling."[427] NIJ identifies specific advantages "behavioral triage" has over the "assess-and-treat" model:

- It is more cost-efficient because it covers a large number of clients while delivering intensive treatment to those who prove to need it.
- It puts a smaller strain on treatment capacity by avoiding the situation in which clients for whom treatment is mandated crowd out clients who voluntarily seek treatment.
- Because the treatment mandate follows repeated failures, it helps break through denial; an offender who has spent three brief spells in jail for dirty drug tests may find it hard to keep telling himself that he is in control of his drug-use.[428]

To avoid short jail sanctions, it is not enough to participate in treatment; rather, participants must completely abstain from illicit drug use, which NIJ researchers conclude "positions the treatment provider as the probationer's ally in the effort to stay in out of jail."[429] HOPE participants have shown a "striking improvement in their drug-testing outcomes [in the first 3 months], with their rate of positive drug tests falling by 83 percent."[430]

The HOPE program has made a considerable impact on probation violations, especially in comparison to other "controlled" programs. The NIJ study found that HOPE program participants were:

- 53% less likely to be arrested for a new crime;
- 72% less likely to use drugs;

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426. *Id.*

427. *Id.*

428. *Id.*

429. *Id.*

430. ANGELA HAWKEN & MARK KLEIMAN, MANAGING DRUG INVOLVED PROBATIONERS WITH SWIFT AND CERTAIN SANCTIONS: EVALUATING HAWAII'S HOPE 18 (2009), https://www.ncjrs.gov/pdffiles1/nij/grants/229023.pdf.

- 61% less likely to skip appointments with their supervisory officer; and
- 53% less likely to have their probation revoked.[431]

Over the years, the HOPE program has undergone some modifications. For example, there may be an "early discharge" for participants who "demonstrate [a] history of compliance," non-aggravated technical violations, with no aggravating circumstances pay otherwise compliant participants may receive a "non-jail sanction."[432] Also, the program has been "integrated into a continuum of supervision," meaning "the supervision-triage structure" entails "conventional probation for low-risk offenders," reserving the HOPE program "for high-risk and for failures from conventional probation," with drug court "reserved for failures from HOPE."[433] The study found that about 7% of the HOPE participants are now "triaged" into drug courts, which are now equipped to include those serious offenders who would have previously been ineligible.[434]

Subsequent DOJ studies indicate continued success of the HOPE program. For example, probationers in HOPE were more successful in avoiding revocation than those who were assigned to "routine supervision."[435] Moreover, HOPE participants had a greater "perception of risk of punishment" for violations, and since "the deterrent value depends on perceived risk rather than actual risk, HOPE appears to benefit from a reputation effect that exceeds the certainty delivered in practice."[436]

Jurisdictions throughout Tennessee that do not have a drug court program, or that may be experiencing a backlog in the in the admissions to drug court or treatment programs, may want to consider the HOPE program. Such a program might alleviate jail overcrowding by reducing revocations through increased monitoring accompanied by swift, certain sanctions as an alternative to probation violation.

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431. *Id.* at 18–26.

432. ANGELA HAWKEN ET AL., HOPE II: A FOLLOW-UP TO HAWAI'I'S HOPE EVALUATION 41, 43 (2016), https://www.ncjrs.gov/pdffiles1/nij/grants/249912.pdf.

433. *Id.* at 10, 44.

434. *Id.* at 44.

435. *Id.* at 3.

436. *Id.*

Moreover, since Tennessee counties without an active drug court, or have programs that are at capacity, remain to which to allocate resources to drug treatment programs for probationers, the HOPE program may also prove beneficial. While each probationer would benefit from a more efficient supervision program, adoption of the HOPE program would help reserve intensive treatment or drug courts for defendants with substance abuse disorders that the system cannot address through increased monitoring.

iii. The Texas Model

Over the past 15 years, Texas has enacted numerous reforms that limit the role of its criminal justice system, instead focusing on prison alternatives for low level, nonviolent offenders, particularly those with substance abuse issues. Beginning in 2003, the Texas Legislature enacted a law that mandated that, rather than imprisonment, any drug offense involving less that one gram of drugs shall result in probation.[437] When the law was passed, the Texas Legislative Budget Board noted that, in Fiscal Year 2002, there were 9,130 offenders in state jail for convictions of a controlled substance of less than a gram, and of this population, 4,040 offenders were not convicted and sentenced with any additional charge.[438]

The most significant reform followed a 2007 budget projection that indicated that the state would need an additional 17,332 new prison beds by 2012.[439] The cost for accommodation would total more than $2 billion, so lawmakers determined to chart a different course.[440] Understanding that substance abuse was a disease that was also a significant driver to its burgeoning incarceration rate, the Texas Legislature commissioned analysis and technical assistance of the

437. H.B. 2668, 78th Leg. Sess., Reg. Sess. (Tex. 2003).

438. H.B. 2668 Fiscal Note, 78th Leg. Reg. Sess., Leg. Budget Bd. (Tex. May 19, 2003), http://www.legis.state.tx.us/tlodocs/78R/fiscalnotes/html/HB02668E.htm.

439. STATE OF TEXAS LEGISLATIVE BUDGET BD., ADULT AND JUVENILE CORRECTIONAL POPULATION PROJECTIONS FISCAL YEARS 2007–2012, at 10 (2007), http://www.lbb.state.tx.us/Documents/Publications/Policy_Report/Adult%20and%20Juvenile%20Correctional%20Populations%20Projections2007-2012.pdf.

440. THE COUNCIL OF STATE GOV'TS, JUSTICE REINVESTMENT IN TEXAS: ASSESSING THE IMPACT OF THE 2007 JUSTICE REINVESTMENT INITIATIVE 3 (2009), https://csgjusticecenter.org/wp-content/uploads/2012/12/Texas_Bulletin.pdf.

Council of State Governments, and ultimately decided to appropriate $241 million for residential and non-residential treatment-oriented programs in the 2008–2009 Biennium Budget.[441] The appropriation allocated funding for treatment programs as follows:[442]

Program Type	**Number of Slots/Beds Funded for the Program**	**Function of the Program**
Probation Outpatient Treatment	3,000	Provide outpatient substance abuse treatment to individuals on probation.
State Jail Treatment	1,200	Provide substance abuse treatment to "low-level property and drug offenders" housed in state run jails.
In-Prison Therapeutic Community	1,000	Provides "intensive substance abuse treatment services to offenders in prison and post release." Participation in the program is a condition of parole.
DWI Prison Treatment	500	"A prison facility dedicated to providing offenders convicted of DWI offenses with a 6-month substance abuse treatment program."

441. *Id.* at 1, 5.

442. *See id.* at 4.

Probation Residential Treatment	800	This is a 3 to 12-month residential substance abuse treatment program.
Substance Abuse Felony Punishment	1,500	This is a residential substance abuse treatment program targeting those who have violated the terms of their probation as a consequence to addiction disorder. The multi-phase program begins with 6 months in a secure facility, then 3 months "secure facility for 6 months, followed by 3 months in a community treatment center, with 3 to 9 months of outpatient counseling.
Transitional Treatment Centers	1,250	Transitional residential treatment facilities that allow that provide up to 6 months of treatment while offenders await treatment into other institutional programs.
Intermediate Sanction Facilities	1,400	Treatment programs located in secure detention facilities

		that serve primarily as alternatives to incarceration for technical violators.

A 2009 Council of State Governments study on the effect of the Texas reinvestment found that the positive impact of the strategy was immediate.[443] The prison population that many expected to rise by 5,141 from 2007 to 2008 instead increased by only 529.[444] From 2006 to 2008, admissions for probation revocations decreased by over 3%, and admissions for parole revocations decreased by nearly 25%, both as a result of expanded access to treatment and "intermediate sanction facilities."[445] Ultimately, the reinvestment "mitigated the state's growth in prison population by about 9,000 and saved the state $443 million between 2008 and 2009."[446] In 2009, Texas invested further by creating sixty-four reentry coordinator positions, each tasked with ensuring that offenders who reenter civil society after prison receive the treatment and support necessary to become productive members of society.[447] As result of these and other reforms, including the expansion of the kinds of drug courts this Article discusses, the incarceration rate dramatically declined.

443. *Id.* at 2.

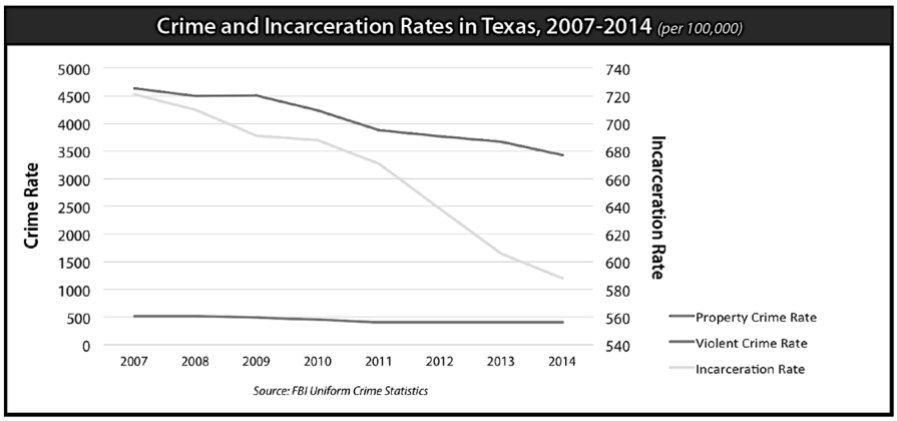
444. *Id.*

445. *Id.* at 8.

446. Council of State Gov'ts, *Texas*, JUSTICE CTR., https://csgjusticecenter.org/jr/tx/ (last visited Nov. 12, 2018).

447. MARC LEVIN, TEXAS CRIMINAL JUSTICE REFORM: LOWER CRIME, LOWER COST, THE TEXAS PUBLIC POLICY FOUNDATION 1 (2010), https://www.texaspolicy.com/library/docLib/2010-01-pp04-justicereinvestment-ml.pdf.

Figure 4[448]



As Figure 4 above indicates, the diversion of nonviolent offenders with substance abuse issues into treatment programs as an alternative to incarceration did not have a negative impact on the state's violent crime rate. To the contrary, the rate has steadily declined. Too often, people with substance abuse issues commit acts of theft or other property crimes in order support their addiction.[449] By targeting the underlying disease and not just the symptom—the criminal behavior—the property crime rate in Texas has significantly decreased.

The innovative reforms that Texas adopted had a direct and immediate impact on the public health needs of offenders with substance abuse issues while also increasing public safety. Mark Levin, Director of the Center for Effective Justice at the Texas Public Policy Foundation and one of the architects in the formulation of the Texas reforms, suggests that one of the "three main reasons" people

448. GREG GLOD, TEX. PUB. POLICY FOUND., TEXAS ADULT CORRECTIONS: A MODEL FOR THE REST OF THE NATION 5 (2015), https://www.texaspolicy.com/library/doclib/PP-Texas-Adult-Corrections-A-Model-for-the-Rest-of-the-Nation.pdf.

449. *See Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition)*, NAT'L INST. ON DRUG ABUSE, https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/drug-addiction-treatment-worth-its-cost (last updated Jan. 2018) (stating that increases in treatment reduce crime).

are imprisoned is that "[t]here are no proven and effective alternatives to prison available."[450] He explained that this "is key to appreciating what Texas—and, subsequently, many other conservative states such as Georgia and South Carolina—achieved in both crime reduction and incarceration."[451]

Indeed, given the success of the "Texas model," these reforms are worthy of consideration by lawmakers throughout the country, including Washington, D.C. In fact, Tennessee is currently entertaining policy initiatives that incorporate some of the concepts behind the Texas model. Governor Haslam's "Tennessee Together" initiative proposes to "[e]xpand[] residential treatment and services for opioid dependence within the criminal justice system and create[] incentives for offenders to complete intensive substance use treatment programs while incarcerated."[452] The initiative specifically requests "$25 million (state and federal funds) for treatment and recovery services for individuals with opioid use disorder."[453] Governor Haslam's proposed Fiscal Year 2018–2019 budget calls for an appropriation of $750,000 "to expand a pilot program that supplies recovery courts with injectable pharmaceuticals that effectively treat opioid dependence" and an additional $300,000 to fund a "pilot program in county jails to provide those local facilities with the same pharmaceuticals."[454] This is all part of a $14.6 million investment in treatment and law enforcement initiatives.[455] Moreover, Governor Haslam has endorsed a measure that would give an inmate 60 days' earned credit for "successful[] complet[ion] [of] an evidence-based,

450. Jerry Madden & Marc Levin, *How Texas Reduced Both Crime & Incarceration*, REAL CLEAR POLICY (Sept. 8, 2016), https://www.texaspolicy.com/blog/detail/how-texas-reduced-both-crime-incarceration (along with the belief that prison is the most just and effective sentence and mandatory minimum sentences).

451. *Id.*

452. TN Together Release, *supra* note 150.

453. *TN Together: Ending the Opioid Crisis*, TENN. OFFICE OF THE GOVERNOR, https://www.tn.gov/governor/2018-legislative-priorities/tn-together.html (last visited Nov. 12, 2018).

454. HON. WILLIAM E. HASLAM, STATE OF TENN., THE BUDGET: FISCAL YEAR 2018–2019 xxii (2018), https://www.tn.gov/content/dam/tn/finance/budget/documents/2019BudgetDocumentVol1.pdf.

455. *Id.*

intensive residential substance use disorder treatment therapeutic community program of at least nine (9) months."[456]

5. Inmate Treatment and Reentry

Ensuring that inmates with substance abuse disorders, whether opioid-related or not, have access to evidence-based treatment while incarcerated is necessary for public safety. Individuals suffering from substance abuse disorder who commit serious, perhaps violent, felonies necessitate a sanction of incarceration. Sixty-five percent of the total U.S. inmate population satisfy the clinical criteria for substance abuse disorder.[457] That said, at least 95% of all inmates in state penitentiaries will eventually reenter society, and approximately 80% will enter a supervision program upon release from incarceration.[458] Because incarceration alone is not a treatment for substance abuse, many inmates with addiction issues will reenter society with the same issues and are a risk to offend.[459]

The President's Commission recognized that "[s]tudies [that] have shown that MAT recipients remain engaged in treatment at higher rates, have fewer positive tests for illicit drugs, and reoffend at lower rates than individuals with [opioid use disorder] not receiving MAT."[460] Thus, to avoid a "revolving door," both state and federal corrections must ensure that each inmate undergoes assessment for substance abuse disorders and, if necessary, begins an evidence-based treatment program. Further, upon their release from prison, it remains imperative that inmates with substance abuse disorders receive a continuum of care coupled with increased supervision and monitoring. Those with opiate addiction particularly must have access to MAT. The American Psychological Association cites research that echoes

456. H.B. 1832, S.B. 2258, 110th Gen. Assemb., 2nd Reg. Sess. (Tenn. 2018), https://legiscan.com/TN/text/HB1832/2017.

457. Christine Vestal, *Helping Drug-Addicted Inmates Break the Cycle*, THE PEW CHARITABLE TRS. (Jan. 13, 2016), http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/01/13/helping-drug-addicted-inmates-break-the-cycle.

458. Timothy Hughes & Doris James Wilson, *Reentry Trends in the United States*, BUREAU OF JUSTICE STATISTICS, https://www.bjs.gov/content/reentry/reentry.cfm (last visited Mar. 8, 2018).

459. Vestal, *supra* note 457.

460. THE PRESIDENT'S COMM'N, FINAL REPORT, *supra* note 3, at 73.

this sentiment: "it is substance abuse treatment both in prison and after release that really works."[461]

Many inmates, however, do not receive the treatment they need. An NCASA study found that "[o]nly 11 percent of inmates with substance use disorders receive any type of treatment during incarceration; few of those receive evidence-based care," even though "[w]ithout treatment, the odds are that substance-involved offenders will end up back in prison."[462] Moreover, the study found that "[o]nly 16.6 percent of facilities offer treatment in specialized settings which can produce better outcomes for offenders as measured by drug use and arrests post-release."[463] As argued earlier, the choice to rely upon incarceration to deter drug use rather than actually treating those with the disease, negatively impacts public safety and the public trust—not to mention the individual whose disease remains untreated, as well as their family and community.

An NIJ paper cites to a number of studies targeting federal and state programs that "suggest that prison-based treatment can be effective in reducing recidivism and relapse," particularly "if the treatment provides a continuum of care, uses a [therapeutic community], and is delivered within a cognitive-behavioral framework."[464] The study also noted that the return on the taxpayer's investment into these programs was "relatively strong."[465]

In addition to effective treatment while in prison, reentry programs are key to ensuring that those who suffer from substance abuse issues continue to receive the necessary treatment and supervision to ensure successful reintegration into society. The following are examples of reentry programs that Kentucky and Tennessee have recently adopted.

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461. *Inmate Drug Abuse Treatment Slows Prison's Revolving Door*, AM. PSYCHOLOGICAL ASSOC. (Mar. 23, 2004), http://www.apa.org/research/action/aftercare.aspx.

462. Califano, *supra* note 201, at ii.

463. NCASA, BEHIND BARS, *supra* note 207, at 4.

464. GRANT DUWE, NAT'L INST. OF JUSTICE, THE USE AND IMPACT OF CORRECTIONAL PROGRAMMING FOR INMATES ON PRE- AND POST-RELEASE OUTCOMES 13 (2017), https://www.ncjrs.gov/pdffiles1/nij/250476.pdf.

465. *Id.* at 12.

i. Kentucky's Substance Abuse Pilot Program

In 2016, Kentucky Governor Matt Bevin created the Criminal Justice Policy Assessment Council ("CJPAC"), which he charged with evaluating Kentucky's criminal justice system and developing evidence-based reforms to promote "a smarter, stronger and fairer system of justice."[466] The following year, the CJPAC proffered a number of recommendations, many of which the legislature incorporated in SB 120, an omnibus re-entry reform package that was introduced during the 2017 convening of the Kentucky General Assembly.[467]

Among SB 120's reforms was the creation of a four-year reentry substance abuse pilot program within the Kentucky Department of Corrections ("KYDOC") to "[p]rovide a continuum of substance use disorder treatments and rehabilitative services."[468] The law requires that officials fully implement this program by March 2018.[469] The KYDOC must create a reentry team, led by a KYDOC hearing officer that will ensure due process and serve as the final determination in the event of a disagreement over participant incentives or sanctions, "to administer and oversee" the program.[470] A parole officer, a reentry liaison or facilitator from the Division of Probation and Parole, a social service clinician, a public defender, and a designate form a community health center with authority to treat substance abuse disorders must round out the reentry team.[471]

Under Kentucky's statute, the reentry team has authority to incentivize participation. Some of those incentives can include a reward of "[c]ompliance credit" or "[i]ncreased privileges and responsibilities."[472] The reentry team establishes conditions to participation in the program, and only the reentry team may impose

466. Press Release, Ky. Dep't of Pub. Advocacy, Governor Announces New Council on Criminal Justice Reform (n.d.), https://dpa.ky.gov/News-and-Public-Information/DPAintheNews/Pages/New-Council-on-Criminal-Justice-Reform.aspx.

467. S.B. 120, 2017 Gen. Assemb., Reg. Sess. (Ky. 2017), http://www.lrc.ky.gov/recorddocuments/bill/17RS/SB120/orig_bill.pdf.

468. *Id.* at 34.

469. *Id.*

470. *Id.* at 35–36.

471. *Id.* at 36.

472. *Id.*

sanctions for violations of those conditions.[473] Sanctions can include "[a]dmonishments by the hearing officer[,] [g]raduated sanctions . . .[,] [c]ommunity service[,] [p]hase demotion[,] [i]ncreased pilot program requirements[,] [e]lectronic monitoring[,] [h]ome incarceration[,] [up to 60 days in 1 calendar year] imprisonment in a state or local correctional or detention facility or residential center[,] and [t]ermination from the pilot program."[474] The reentry team is required to entertain alternatives to incarceration.[475]

The program will also incorporate assessments. KYDOC's Division of Substance Abuse Programming must perform substance abuse assessments on certain new admissions whose offense did not qualify as violent or sexual in nature, did not result in death of physical harm of a victim, who entered an *Alford* or nolo contendere plea to a Class E or Class D felony drug offense or offense arising from substance abuse, whose probation or parole was revoked due to a substance abuse disorder or who has history thereof, and who have not previously participated in the reentry drug program.[476] It will then refer inmates to the parole board, which ultimately determines their candidacy for the program.[477]

The program will immediately parole inmates it chooses for participation and place them under the supervision of the reentry team.[478] Program participants "remain on parole until sentence completion unless the reentry team determines to terminate or administratively discharge the participant from the pilot program."[479] The reentry team refers inmates it terminates from the program to the parole board for revocation.[480]

The program itself lasts 1 year and consists of two phases.[481] The first phase focuses on education, as well as an increased monitoring strategy that requires participants to undergo a minimum

473. *Id.*
474. *Id.* at 36–37.
475. *Id.* at 37.
476. *Id.* at 38.
477. *Id.* at 38–40.
478. *Id.* at 40.
479. *Id.*
480. *Id.* at 41.
481. *Id.*

of three drug screens every week.[482] Participants must also attend therapy sessions "as determined necessary by a community mental health center," as well as one weekly drug supervision session.[483] All housing, as well as employment or the enrollment in a training or education program must be approved by the reentry team.[484] Participants must remain drug-free for 90 days before they can move on to the second phase of the program.[485]

The second phase, or "self-motivation" phase,[486] focuses on employment, training programs, and housing, all of which the reentry team must continue approve.[487] Participants must submit to at least two drug tests per week and also "[i]ndicate an appropriate understanding of recovery lifestyle."[488] Participants who complete the program will either transition to regular parole for a duration equivalent to the remainder of their sentence or they earn their release.[489]

To gauge the success of the program, the KYDOC must submit an annual report to the legislature that outlines the success rate of program participants, the number of and reason for participant terminations, the number parole revocations or new offenses committed by participants, and the type of offense committed.[490]

Similarly, "Federal Reentry Courts" exist in some federal judicial districts to make MAT available to individuals participating in "pre- and post-adjudication diversion as well as post-incarceration reentry programs."[491] These reentry courts are "voluntary contractual program[s] lasting a minimum of 12–18 months," and "typically incorporate an early-discharge program to replace the final year of

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482. *Id.*

483. *Id.*

484. *Id.*

485. *Id.*

486. *Id.*

487. *Id.* at 42.

488. *Id.* at 47.

489. *Id.*

490. *Id.* at 39–40. While separate from the reentry program, it is worth noting that S.B. 120 also provides that law enforcement agencies may create programs that allow individuals who voluntarily seek help for addiction to receive criminal immunity and a reference to drug treatment services. *Id.* at 48–49.

491. THE PRESIDENT'S COMM'N, FINAL REPORT, *supra* note 3, at 73.

incarceration with strictly-supervised release into the drug court regimen."[492] Following their graduation, "participants returning to the community from incarceration are transferred to traditional parole supervision," and "may continue to receive case management services voluntarily through the reentry court."[493]

ii. Tennessee's Seamless Supervision Model

In addition to mandating validated RNAs and graduated sanctions for supervision violations, Tennessee's enactment of the PSA has proven "transformational for TDOC Community Supervision."[494] Through the use of the new day-reporting centers, TDOC will implement "a one year, three-phase program designed to assist moderate- to high-risk offenders with a substance use and/or a mental health issue."[495] TDOC aims to operate two centers in each of its three regions.[496]

To qualify for the day-reporting program, a participant must be a convicted felon, subject to TDOC's supervision, with at least a 2-year probationary term, "and/or have a substance use concern."[497] Either courts or supervision officers using validated RNA tools can refer participants to the program.[498] Similar to the Kentucky pilot program, the duration of TDOC's program is 9–12 months, but it consists of three phases.[499] Each phase, as Figure 5 below demonstrates, will primarily focus on "substance use, job skills, family reunification, and behavioral and social programs; all phases emphasize accountability and self-discipline."[500]

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492. *Id.* at 74.

493. *Id.*

494. TENN. DEP'T OF CORRECTION, FY 2017 ANNUAL REPORT, *supra* note 262, at 5.

495. *Id.* at 11.

496. *Id.*

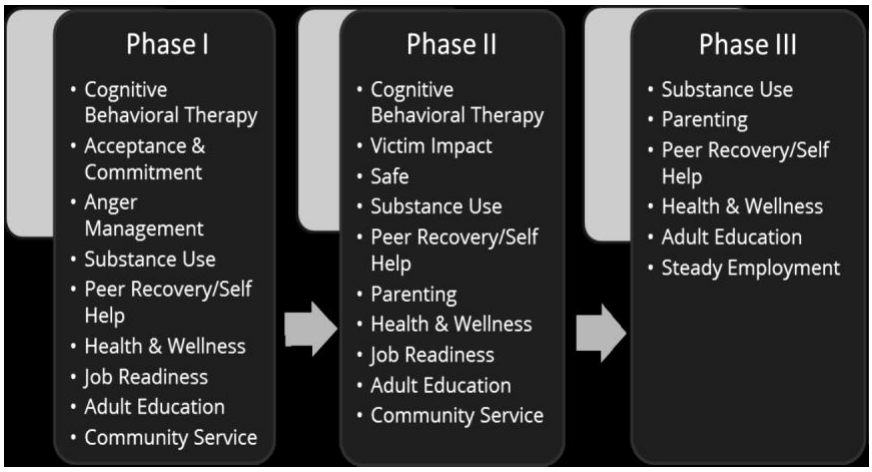
497. *Id.*

498. *Id.*

499. *Id.*

500. *Id.*

Figure 5[501]



Each day-reporting center location will also include a "community resource center" that will be available to everyone under community supervision, regardless of their participation in the program.[502] This service includes access to "employment specialists" assigned to each location to "actively work[] with local businesses, the Tennessee Department of Labor and Workforce Development, American Job Centers, Goodwill, and others to help offenders find meaningful, long-term employment."[503] Moreover, TDOC staff will be available to assist with a number of services, including health and wellness.[504]

Certain counties in Tennessee—Shelby County, for example—have operated day-reporting centers at the county level,[505] but the expansion of the TDOC program will certainly add value. Perhaps Tennessee might further utilize the day-reporting centers to expand its drug court programs, like other states have done. For instance, West

501. *Id.*

502. *Id.*

503. *Id.*

504. *Id.*

505. *Day Reporting Center*, SHELBY CTY. TENN., https://www.shelbycountytn.gov/255/Day-Reporting-Center (last visited Nov. 13, 2018).

Virginia's day-report centers also serve as the "central component of services for the adult drug courts."[506]

C. The Innovative Efforts at Ground Zero

I would be remiss if I failed to conclude this Article without mentioning the trailblazing efforts of my hometown of Huntington, West Virginia, to combat the opioid crisis. Huntington may very well be the epicenter of the opioid crisis. There, first responders receive "at least five overdose calls per day."[507] In August of 2016, they responded to twenty overdose cases over a harrowing 53-hour period.[508]

Huntington Mayor Steve Williams created the Mayor's Office of Drug Control Policy designed to foster partnerships "focused on reducing drug trafficking and related crime while promoting prevention and treatment options" for addicts.[509] The Office has developed a strategic plan that is reminiscent of President Nixon's call to Congress. It states that "[t]he goal and main objectives of law enforcement is to improve law enforcement's ability to target and address drug trafficking and divert people struggling with addiction into treatment and recovery."[510]

The city recently received a $2 million federal grant to assist the Mayor's collaborative effort.[511] A portion of the grant will fund

506. *History of Adult Treatment Courts in West Virginia*, W. VA. JUDICIARY, http://www.courtswv.gov/lower-courts/adult-drug-courts/history.html (last visited Nov. 13, 2018).

507. Story Hinkley, *One West Virginia City's Pioneering Approach to Opioid Crisis*, CHRISTIAN SCI. MONITOR, https://www.csmonitor.com/USA/Society/2017/0522/One-West-Virginia-city-s-pioneering-approach-to-opioid-crisis.

508. Massey et al., *supra* note 1.

509. *Mayor*, CITY OF HUNTINGTON, http://www.cityofhuntington.com/city-government/mayor (last visited Mar. 8, 2018).

510. Taylor Stuck, *Huntington Releases New 2-year Strategic Drug Plan*, HUNTINGTON HERALD-DISPATCH (May 2, 2017), http://www.herald-dispatch.com/news/huntington-releases-new—year-strategic-drug-plan/article_845b363b-8c6a-53aa-b869-ca8acd6ad3fc.html.

511. *City of Huntington Awarded Federal Grants to Combat Opioid Epidemic*, CITY OF HUNTINGTON (Sept. 25, 2017),

the Turn Around pilot program at the Western Regional Jail.[512] Under this program, jail facilitators will "identify and assess individuals convicted of misdemeanors who have co-occurring mental health and substance use disorders."[513] It has been the practice for jail officials to make mental health and substance-abuse services available to misdemeanants housed in West Virginia jails.[514] Misdemeanants, however, were "not systematically screened" to ensure receipt of such treatment, which "mean[s] they are often released with the issues they had when they were initially incarcerated and are more likely to be incarcerated in the future."[515] Program staff will work with the jail to compile and study the data collected from the screening.[516] This information will be used "to develop a pre-release plan consisting of mental health and substance abuse services and a transition plan upon release that is complete with peer support, wrap-around services and connections to community resources."[517]

The grant will also support the Quick Response Teams ("QRTs"), which is a new "multidisciplinary and multifaceted approach to address the opioid epidemic."[518] QRTs consist of health care and treatment service providers, law enforcement, and researchers from Marshall University, and they will develop a response plan tailored for those who have overdosed within 72 hours.[519] The plan includes "assess[ing] an individual's needs, symptoms and strengths to determine an appropriate plan for intervention, which includes improving access and reducing barriers to recovery and treatment services."[520] The plan will also focus on "overdose education, screening, risk-reduction training and naloxone administration training for at-risk individuals, their families and the broader community."[521]

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http://www.cityofhuntington.com/news/view/city-of-huntington-awarded-federal-grants-to-combat-opioid-epidemic.

512. *Id.*
513. *Id.*
514. *Id.*
515. *Id.*
516. *Id.*
517. *Id.*
518. *Id.*
519. *Id.*
520. *Id.*
521. *Id.*

The goal for these programs is to curb the opioid crisis in Huntington. If these data-driven programs prove successful in both the implementation and the quantifiable impact, however, then the expectation is that the same measure of success can be "replicated across the country."[522] Tennessee should pay close attention to the outcomes of these pilot programs. If these programs enjoy a measure of success in Cabell County, West Virginia, then Tennessee may want to implement similar pilot programs in jurisdictions throughout the Volunteer State that currently do not have the resources.

V. CONCLUSION

Opioid addiction is a disease, the containment of which lies in the responsible prescribing of opioids for chronic pain management and the adoption of policies that ensure access to MAT for addicted individuals. For its part, the criminal justice system's role in resolving the opioid crisis is to thwart the supply of illicit opioids by focusing resources towards investigating and prosecuting drug traffickers. The criminal justice system must cease its reliance upon incarceration as the default response to drug use or an addicted individual's nonviolent, criminal behavior. Furthermore, every addicted individual engaged in the criminal justice system must gain access to MAT and counseling services. If our public health communities and criminal justice systems assume their proper roles, and focus their efforts accordingly, then we stand to gain the upper hand over the opioid crisis.

522. *Id.*

APPENDIX A. 2014 DRUG IMPRISONMENT AND DRUG USE INDICATORS BY STATE[523]

	Drug Imprisonment			**Drug Use Indicators**		
State	**Drug Prisoner Count**	**Drug Imprisonment Rate**	**State Drug Imprisonment Rates Ranked**	**Overdose Death Rate (Rank)**	**Drug Arrest Rate (Rank)**	**Adult Illicit Drug Use Rate (Rank)**
Louisiana	10,527	226.4	1	16.7 (23)	380.5 (26)	3,508.4 (13)
Oklahoma	8,286	213.7	2	20.0 (10)	457.0 (17)	3,623.5 (10)
Wyoming	1,050	179.7	3	18.7 (14)	592.1 (7)	2,019.8 (50)
Idaho	2,464	150.8	4	13.0 (35)	453.3 (18)	2,575.0 (45)
Tennessee	9,280	141.7	5	19.4 (11)	633.5 (4)	2,711.3 (40)
Arizona	9,483	140.9	6	18.0 (15)	440.8 (21)	3,933.7 (3)
Missouri	8,229	135.7	7	17.6 (19)	552.4 (11)	2,848.0 (34)
Iowa	4,080	131.3	8	8.5 (47)	293.4 (35)	2,602.9 (44)
Indiana	8,647	131.1	9	17.8 (18)	245.1 (41)	3,070.5 (27)
Kentucky	5,514	124.9	10	24.4 (4)	490.4 (15)	3,118.6 (24)
Texas	33,304	123.5	11	9.6 (45)	503.3 (13)	2,548.8 (46)
Florida	23,804	119.7	12	13.2 (32)	614.2 (6)	3,022.4 (29)
South Carolina	5,721	118.4	13	14.5 (27)	552.9 (10)	2,643.3 (43)
North Dakota	835	112.9	14	5.8 (50)	541.5 (12)	2,800.9 (35)
Virginia	9,380	112.7	15	11.8 (39)	444.2 (20)	2,709.2 (41)
Alabama	5,381	111.0	16	14.9 (25)	205.0 (44)	3,556.1 (12)
South Dakota	944	110.6	17	7.4 (48)	633.6 (3)	2,022.4 (49)
New Mexico	2,101	100.7	18	26.2 (2)	265.1 (38)	3,408.7 (16)

523. The Pew Charitable Trusts Letter, *supra* note 203, at 5–6.

Illinois	12,711	98.7	19	13.2 (33)	228.9 (42)	2,972.3 (31)
Kansas	2,851	98.2	20	11.4 (42)	264.4 (39)	3,209.7 (22)
West Virginia	1,809	97.8	21	33.9 (1)	323.9 (31)	2,929.1 (32)
Alaska	720	97.7	22	16.8 (21)	157.3 (47)	3,454.8 (15)
Nebraska	1,830	97.3	23	6.6 (49)	635.9 (2)	2,190.0 (48)
Mississippi	2,904	97.0	24	11.2 (43)	299.2 (33)	3,668.6 (9)
Arkansas	2,858	96.3	25	12.0 (37)	376.5 (27)	3,583.7 (11)
North Carolina	8,984	90.3	26	13.7 (30)	348.9 (29)	3,253.2 (21)
Montana	890	86.9	27	12.2 (36)	215.4 (43)	2,255.5 (47)
Georgia	8,429	83.5	28	11.9 (38)	422.1 (25)	3,327.2 (20)
Nevada	2,293	80.8	29	19.2 (12)	440.6 (22)	3,033.6 (28)
Ohio	9,193	79.3	30	23.7 (5)	313.4 (32)	3,014.7 (30)
Pennsylvania	9,255	72.4	31	21.4 (7)	448.8 (19)	3,131.5 (23)
Hawaii	998	70.3	32	11.1 (44)	79.0 (50)	2,790.1 (37)
Delaware	657	70.2	33	20.2 (9)	658.7 (1)	3,687.0 (6)
Maryland	3,998	66.9	34	17.9 (16)	632.2 (5)	3,394.1 (17)
Connecticut	2,388	66.4	35	17.3 (20)	276.0 (37)	3,085.2 (26)
Vermont	363	57.9	36	13.2 (31)	105.5 (49)	3,761.3 (5)
Colorado	3,005	56.1	37	16.8 (22)	249.8 (40)	4,137.8 (1)
Rhode Island	540	51.2	38	23.4 (6)	181.3 (45)	3,680.8 (7)
Utah	1,486	50.5	39	20.5 (8)	497.1 (14)	2,892.5 (33)
Wisconsin	2,899	50.4	40	14.8 (26)	431.7 (24)	3,342.4 (19)
New York	9,919	50.2	41	11.6 (41)	297.7 (34)	3,369.7 (18)
Michigan	4,944	49.9	42	17.8 (17)	338.7 (30)	3,108.1 (25)
Maine	643	48.3	43	16.2 (24)	436.2 (23)	2,800.7 (36)
Minnesota	2,542	46.6	44	9.5 (46)	350.9 (28)	2,778.6 (38)
New Jersey	3,864	43.2	45	14.0 (28)	589.8 (9)	2,699.8 (42)

New Hampshire	573	43.2	46	25.2 (3)	469.1 (16)	3,677.3 (8)
California	15,983	41.2	47	11.7 (40)	590.4 (8)	3,996.5 (2)
Oregon	1,470	37.0	48	13.1 (34)	281.2 (36)	3,502.4 (14)
Washington	2,422	34.3	49	13.9 (29)	157.3 (46)	3,808.8 (4)
Massachusetts	2,039	30.2	50	19.1 (13)	155.9 (48)	2,740.8 (39)