Offering Substance Abuse Education and Basic Needs Referral Information to County Jail Personnel for Dissemination to Individuals Released From the County Lockups

By

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Abstract

Substance abuse is an issue that has been addressed since the late nineteenth century in the United States. Education and treatment modalities have changed over time based on the current state of society’s conscience and the effect that the abuse had on the nation as a whole. In the late 1990s, the nation found itself at the beginning of what by the early 2000s became an epidemic of widespread addiction to prescription pain medication. The country was at a loss as to how to address this epidemic which at the present shows no signs of slowing down. Communities began looking to the state and federal government to help address the problem through funding and establishment programs that consist of treatment and prevention. The federal and state governments began providing the funding but the funding did not trickle down to the areas of most need, with the neediest areas being those rural regions of the country. The hardest-hit extends from Southwest Virginia to Northeast Tennessee. Tennessee is third in the nation for the abuse of prescription medication, primarily opioids or pain medication.\footnote{Tennessee Bureau of Investigations, “Drugs,” accessed June 14, 2019, \url{https://www.tn.gov/tbi/crime-issues/crime-issues/drugs.html}.} Advocates continue to work tirelessly to change that ranking by instituting new policies regarding prescription drug procedures: restricting the number of pain clinics in the state and encouraging the establishment of treatment centers to focus not only on substance abuse treatment but also on the overall human experience by eliminating barriers to treatment.

Across the nation the numbers of incarcerated individuals have been steadily rising over the last twenty years, particularly female offenders and the majority of these incarcerations result from crimes committed to feed substance abuse addictions. Most of the women who occupy the county lockups are there because they cannot afford or were denied bail and are awaiting sentencing or trial. While these inmates are waiting for release or for trial, what are they doing? Are there programs offered to help them to address the issues that have landed them in the space that they currently occupy? If programs exist is there any information given to the inmate that would help him or her to continue the services received while incarcerated and are there referral services that can be disseminated so that the inmate can pursue further education or treatment?

The purpose of this project was to gather information from the local lockups in Northeast Tennessee to see what programming is being offered that addresses substance abuse and basic needs. The process in gathering this information consisted of seeking permission to administer surveys to the jail correctional officers (CO) and the jail administrators (JA) to gage knowledge of what is offered, how often it is offered, and to ascertain the willingness to form a partnership with community resources to fill in the gaps. The results of the survey found that there are a limited number of programs offered. The main classes taught were standard: GED, alcohol and drug education, and parenting. The most interesting aspect of this is that not all the inmates who wanted to participate in the programs were allowed to do so and not all programs could be offered due to limitations within the correctional facility.
Introduction

Just imagine, you are lying in your bunk in the county lockup, the Correctional Officer (CO) comes to your cage and tells you to gather your belongings because you are leaving. You look at him with a surprised look and ask him why knowing that you have another six months on your time. The CO tells you that because you have been on your best behavior, participated in the programs that the jail offered, and because of overcrowding, you have earned early release. You hurriedly gather what few belongings that you have and say your goodbyes to the other inmates who have been your constant companions for the last six months. You walk up to the desk, the attendant hands you a small trash bag and tells you to step into the bathroom to change your clothes. You worry that they may not fit because since incarceration you have gained weight. Once dressed you walk down another corridor, through another gate and then out of the front door of the jail. The correctional officer reminds you that you have twenty-four hours to contact your probation officer. He wishes you good luck and tells you not to come back. As you stand there looking around, it feels good to be free, to feel the sun on your face and not to have to spend your time watching every step that you make for fear that you will get in trouble with the other inmates or with the correctional officers. You feel good about yourself because you have been clean for six months, you have avoided participating in the drug use that runs rampant in the jail, and you have learned how to avoid situations and triggers while in jail that would result in you using. Then it dawns on you; you have nowhere to go, no one to call because you have burned your bridges with family and friends; you have no money and no transportation. You turn around and look back at the jail and wonder if being inside there is better than being out here.
The above-stated scenario plays out every day throughout the country. Former inmates are released back into the community without the adequate tools needed to manage their addiction because they have not had enough time to garner the knowledge that they need to remain sober. Unlike prisons, where substance abuse education and treatment is prevalent, and the education and treatment process can last from one to as many years as the individual is incarcerated, local jail inmates participate in education, not treatment that usually lasts less than a year, according to Amy L. Solomon et al. “Life After Lockup: Improving Reentry from Jail to the Community,” a report compiled with the assistance of the Urban Institute, Bureau of Justice Assistance and John Jay College of Criminal Justice. The report included the following statement:

The challenges associated with reentry from jail are daunting—large in scale and complex in a task. Each year, U.S. jails process an estimated 12 million admissions and releases. That translates into 34,000 people released from jails each day and 230,000 released each week. In three weeks, jails have contact with as many people as prisons do in an entire year, presenting numerous opportunities for interventions. The lives of many who cycle in and out of jail are unstable at best. Substance addiction, job and housing instability, mental illness, and a host of health problems are part of the day-to-day realities for a significant share of this population. Given that more than 80 percent of inmates are incarcerated for less than 1 month—many for only a few hours or days—jails have little time or capacity to address these deep-rooted and often overlapping issues.²

In 2019 the problems addressed in the above 2008 statement continue to exist. The need for re-entry programs is just as critical now as it was in 2008 and even more so since the opioid crisis is now deemed an epidemic. Once re-entry into the community occurs, there is a good chance that the released individual will not follow-up with wraparound services because of lack of knowledge about the resources or where to go to obtain them.

My interest in exploring the availability of the different programs that are offered in the local jails stems from my time as a Family Service Worker with the Tennessee Department of Children’s Services (DCS) from August 2005 through June 2011. I worked cases in Northeast Tennessee. My clients with the Department of Children’s services consisted mostly of children whose parents suffered from co-occurring disorders of drug addiction and mental health. Before my position with DCS, I worked as an In-Home Counselor for foster children from June 2003 to 2005, and before that, I worked as a case manager at an alcohol and drug treatment center from March 2002 to March 2003. I witnessed first-hand how substance abuse affected not only the addict but also the family as a whole. I worked on cases where one or both parents were incarcerated in the county jail, and one or both parents had substance abuse problems. I remember asking one of the fathers if there was access to alcohol and drug treatment. He stated that there was an Alcoholics Anonymous meeting available. I also asked about other programs that were available, and he said, “There is an HIV/Aids program that he had attended one time.” When I asked the same question of one of the mothers on my caseload, she told me about a parenting class that she could attend, and religious service on Sundays, but stated that the female inmates did not have access to any substance abuse program. First, I was very disturbed that the programs offered did not address the individual issues that I knew parents were dealing with and second, that the programs offered were gendered, in that the parenting courses were only offered to the women. The men were offered HIV/AIDS and alcohol courses. In explaining this, I felt that both parents should have been participating in the same programs. If only one parent was incarcerated, then the other should participate in the courses within the community setting. My perception was that the jail followed the societal adage that the mother, considered the nurturer, should be the one to participate in the parenting course and not the father. Offering addiction
education to the father but not to the mother, was absurd and offering parenting classes to the mother and not the father, also was absurd when it was imperative that they both receive exposure because both of them were confirmed addicts and they both had children whom they needed to be able to care for once they were released. The cost of addiction not only has a negative impact on the nuclear and extended family in terms of changing the family dynamic but also on society as a whole. The cost not only came in the form of damage to human life, but also the strain placed on the economy, the medical and mental health professions, of which was tasked with the job to find a way to cure the addiction or to at the least move it more toward a manageable situation that did not exact costs of any medium. How did substance abuse become such an epidemic in America? The history of how this happened was simple. It all started with the need to alleviate pain and suffering.

**Historical Background**

The phrase “War on Drugs” is a concept that did not originate in June 1970 when then-President Richard Nixon declared drug abuse to be “public enemy number one”. The concept has always been a part of the fabric of America but was not brought to the forefront until after the American Civil War when wounded soldiers returned home with an addiction to morphine.

In the United States, substances such as opium, cocaine, and morphine were used not only for recreational purposes but also for medicinal purposes. During the American Civil War (1861-65) opium and morphine were used to relieve the pain or to keep the soldiers alert. At the end of the Civil War, a large number of the soldiers came back home addicts as a result of the use of opium to alleviate their pain from the battle wounds they sustained; it was also at this time

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that with the invention and use of the hypodermic needle America’s love affair with opium and morphine began. During the latter part of the nineteenth century, there were an estimated 200,000 addicts in the United States, with the Civil War being a major source.⁴ Opiates increasingly became lauded as the “wonder drug”. Physicians begin to prescribe morphine and opium for all sorts of ailments. The over-prescribing of these two substances stemmed from the lack of medical knowledge and the lack of treatment options at the time and to the physician’s lack of not fully knowing the effects of the administered drug. Physicians continued to treat the wounded soldier with the addictive substances and seeing the fast alleviation of pain, began to administer the drug to others more freely to combat the simplest of ailments.⁵

Addiction could be seen as a problem that was consigned to the male population. This view is an example of the gendered practice of not recognizing that women were capable of participating in activities that were deemed unladylike by society’s standards. But drug addiction in women is not a new problem; instead, it was a problem that until recently was not to be discussed openly. As early as 1782 in the United States, it was a commonly accepted practice among the upper-class white women to use opium every morning. In his 1782 work Letters from an American Farmer and Sketches of Eighteenth-Century America, Hector St. John de Crévecoeur wrote, “It was common practice for the women of Nantucket Island to take a “dose of opium every morning.”⁶ The drug, commonly referred to by users and physicians as


laudanum, was liquid opium dissolved in alcohol. White women of means were the ones who obtained the drug legally from their physicians. Women who could not afford the physician’s fees purchased easily obtainable patent medicines or obtained the real drug through the collusion of physicians and pharmacists, who were viewed by their peers who were concerned about the negative effects of the drugs, as “overzealous, ignorant, or condescending as they were greedy.”

Physicians prescribed opium for a variety of reasons: to control menstrual cramps, relieve emotional stress, to prevent irregular uterine contractions during childbirth, to ease the pain of cancer and hemorrhoids, and to help with the diagnoses as “neurasthenia” or nervousness, which directly connected to the female gender. This practice of prescribing would continue until the late nineteenth century.

In an editorial, published in 1833 in the *Boston Medical and Surgical Journal*, doctors were becoming concerned about the over-prescribing of the drug. Some physicians had become concerned with the addictive behaviors that they begin to witness in some of their patients. The patients, labeled “opium eaters,” drew concern from their physicians because the patients continued to take the drug far beyond its original purpose. The drug, originally prescribed for a nervous affliction or other medicinal purposes, continued to be used not from necessity, but rather from choice. Some physicians began to realize that these patients took the drug, not to become intoxicated, but to strengthen and balance the nervous system and to enable themselves to attend business and to appear normal when they did not feel that way at all.

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8 Kandall, 64.

physicians showed concern for their patients’ need to use more and more of the addictive drug. In the case of women, physicians often prescribed the medicine to quiet some slight degree of nervous irritation and many showed no concern about individuals who took the pill recreationally; in fact, this category of an addict was “left to their own devices.”

To demonstrate the effects of over-prescribing, the editorial described a woman as “being a useless thing, lolling about in idleness and pain, trouble to herself and an annoyance to all around her” and once she took the pill she became composed in mind and body.” It did not take long for the woman to need to take more and more of the pills to be able to function from day to day. The editorial went on to state that years into the addiction the woman sought help and it became evident that she had hidden the habit not only from her community but also from her husband. The stigma of addiction played heavily on women, many of whom felt compelled to keep their addiction secret. Kandall summed it up best “popular stereotyping notwithstanding, addicted women have come from a variety of racial, geographic, and socioeconomic backgrounds, and these factors have affected individual patterns of drug use. If these women share any common bond, it is that their addiction has not yielded to treatment. Despite their best intentions, guilt and shame, both self-imposed and societal, have pushed them to the margins of society.” This is a summation that continues to resonate in the United States today.

Lauded as something that in the words of Oliver Wendell Holmes, “the Creator himself seems to prescribe,” physicians prescribed opium for conditions that did not warrant using the

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10 “Opium Eating,” 66
11 “Opium Eating,” 66
12 Kandall, 8
13 “Currents and Counter Currents in Medical Science” (May 1860): 38, quoted in Kandall, 3.
drug. Its uses to combat any pain became widely known to the real world. “By the early 1870s, medical texts recommended the use of narcotics such as morphine and laudanum to treat an ever-broadening range of illness and behaviors, from consumption and insomnia to masturbation.”¹⁴ The medical reliance evolved into an overdependence upon narcotics; the phenomena of iatrogenic addiction increase to epidemic proportions.

The United States, in the late 1870s, began to move toward a national drug policy that supported the restriction and repression of drugs. The drawback with this move was that the motivation did not combat drug addiction across all segments of society, but only addressed the issue of race, the driving force behind the first laws criminalizing drug use. During this movement not only were African Americans targeted, but also other marginalized groups such as Asian and Mexican immigrants, as well as most European immigrants, dark-complexed immigrants from southern and eastern Europe, many of whom were Catholic or Jewish and who were considered others by the power elite. Matthew Jacobson’s book *Whiteness of a Different Color* explores how European immigrants were categorized as non-whites and how the definition of race was derived from a political standpoint. Categorizing these peoples as non-white gave way to justification to include them in the propaganda of their being drug-crazed and therefore placing them in the same category as the American black and the Asian immigrant. Jacobson further used Madison Grant’s *The Passing of the Great Race* as an example of how treating European immigrants as non-whites was justified. Grant, a well-known racist and advocate of eugenics, believed that the European immigrants were descendants of the African race through race mixing and argued that “whether we liked to admit it or not, the result of the

mixture of two races, in the long run, gives us a race reverting to the more ancient, generalized and lower type.”15 Jacobson explained that legislators used Grant’s points of view in parts of the Immigration Act of 1924, which limited the numbers of members of certain ethnic groups from coming into the United States and further justified the effort to reduce the number of immigrants of the lower grades of intelligence, and of immigrants who made “excessive contribution to our feeble-minded, insane, criminal, and other socially inadequate classes.”16

This rhetoric gave “permission” for the unjust treatment of the immigrants who were already living in the country. These groups (especially the African-American population in the South, depicted as a menace to white female virtue), became fodder for propaganda geared toward instilling fear in the white population that produced a sense of public menace posed by drugs and drug users. Cocaine, one of the ingredients found in Coca-Cola, hailed by the medical community, as well as by Sigmund Freud, as a medical marvel was marketed to the white middle and upper class. The leaders of the New South turned cocaine and by default Coca-Cola into a catalyst to demonize the African American race, especially black men. The federal government went so far as to publicize that black men using cocaine was a safety hazard to white women, meaning that the men were likely to commit to rape and murder if they were using the highly addictive drug. The government’s propaganda regarding cocaine and race prompted Coca-Cola to explore ways to lessen, if not eliminate, the use of cocaine in its product, with this move the company did not want its product to be the source of fear for its’ targeted market and still maintain the products’ integrity so as to not lose customers.17

17 Michael M. Cohen, 57
Another byproduct of the use of the opium and cocaine prescribed by physicians was the drugging of not only the mothers but also of their children. Mothers’ giving opium and cocaine to infants was to “quiet the infants” when they were teething, to wean infants from breastfeeding, and to calm fussy infants. The opium and cocaine administered to children were in the form of elixirs such as Mrs. Winslow’s Soothing Syrup and Dr. Seth Arnold’s Cough Syrup, both of which contained opiates as the primary ingredient. These elixirs (patent medicines), marketed with labels of kind mothers hugging their children on the front, and also with the advice of the trusted physician, enticed mothers to use the concoction without reservation. The administering of opiates to children resulted in the calming of the child to the point that the child would not eat. Physicians failed to recognize that when the child was calm and did not eat, this was a result of the child suffering from malnutrition. Introduction of this means of “quieting the child” attributed to an increase in the infant and child mortality rates from the later part of the 19th to early 20th century, when the government required that the drugs’ ingredients be placed on the label.\textsuperscript{18} The Pure Food and Drug Act of 1907 required that all food and drug produced in the United States or imported into the company be labeled appropriately of its’ ingredients.\textsuperscript{19} This requirement did help mothers determine whether or not to give their children the patent medicines.

In the late 1890s, physicians began to take note of babies born to opiate-addicted mothers. They found that the child suffered withdrawals and sometimes succumbed to death due to the


body’s failure to get the need drug. The physicians noted that to save the babies they had to administer morphine in small doses so that their withdrawal would be less painful. Dr. Louis Fischer, published in the article “The Opium Habit in Children” his concerns that mothers continued to pass their opiate addiction on to their children through breast milk and then continued to contribute to the child’s addiction by giving them medication such as paregoric, laudanum, morphine or other various alkaloids of gum opium to calm them or to take care of some perceived illness. Although not fully explored, physicians showed concern about the long-term effects of addiction that would cause the children.20

By the end of the nineteenth century, drugs were a presence in everyday life for everyone. Legally prescribed, women were encouraged by their physicians to take opiates to ease the most minor of ailments, which exacerbated the problem of addiction. Documented sources revealed that the primary reasons for addiction in women in the latter part of the nineteenth century were that of the physician treating them for uterine or ovarian complications. The medical profession had very little knowledge of how to treat individuals with the problem of addiction. Dr. Fred Hubbard, over a twelve-year period, provided treatment to addicted individuals on a trial and error basis. He recorded his findings as guidelines to others who wanted to help their patients overcome addiction.21

20 Louis Fischer, “The Opium Habit in Children,” Medical Record, 45, no. 7 (February 17, 1894): 197-198.

With the efforts to educate physicians about the dangers and the failed attempts to find a cure, another strategy began to develop. Legislators took advantage of sensationalist news reporting, and both local and state governments began to impose new legislation intended to curb drug usage and eventually drug trafficking. Under the disguise of alleviating diminishing public health, the first anti-opium legislation passed in San Francisco on November 15, 1875. This legislation aimed at stopping whites, especially white women, from frequenting the Chinese Opium Dens. This legislation was inspired more by racism than public concern.\textsuperscript{22}

The Progressive Era (the 1890s to 1920s) was a period of social and political activism. The primary goal of the Progressive Era was to crack down on illegal activities within the government, but this activism turned into a social one, one that spilled over into a fight to make obtaining opiates illegal unless it was solely for medical purposes. The implementation of curtailing or eliminating other vices went hand in hand with opiate addiction. States passed reforms similar to the federal Mann Act of 1910 (also known as the White Slave Traffic Act), a piece of legislation that made it illegal to transport women across state lines to engage in immoral behaviors. These reforms not only made it illegal to cross state lines to obtain narcotics for non-medical use, but also prohibit alcohol, tobacco, gambling, gangs, risqué entertainment, and new forms of dancing.\textsuperscript{23} Teddy Roosevelt in 1908 appointed Hamilton Wright to be the nation’s first Opium Commissioner. Wright stated in the \textit{New York Times} that “the habit has this nation in its grips to an astonishing extent. Our prisons and our hospitals are full of victims of it, it has robbed ten thousand businessmen of moral sense made them beasts who prey upon their

\textsuperscript{22} Kandall, 67.

fellows unidentified it has become one of the most fertile causes of unhappiness and sin in the United States, if not that cause which can be charged with more of both than any other.”24 In 1909, the federal government passed legislation that prohibited the importation of opium illicit purposes. The action on the part of the federal government increased the prices of the drug to the point where the addict's response was to trade the opium habit for a heroin habit. Heroin, before, it became popular as a recreational drug, was first used for medicinal purposes. In 1890 heroin was sold by the Bayer Company as a substitution for morphine and a cough suppressant. Its’ use for medicinal purposes is credited for the rise in heroin addiction in the United States and Western Europe.25 By 1915, most states had passed laws designed to restrict the use of opium and cocaine to therapeutic purposes mainly by limiting its purchases by prescription only. States such as New York had put so many restrictions on obtaining cocaine because dealers and addicts obtained opiates through illegal means, that it was virtually impossible to get the drug legally.26 These laws did put a damper on the use of these substances in cough syrups and other elixirs but did nothing to stem the flow of the drugs, individuals just went underground to obtain what they needed.

In efforts to monitor the importation and administering of drugs in 1914, the Federal Harrison Act became law and superseded any state legislation. The act stipulated that “Federal

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control seemed necessary, and to be effective the law must permit the drug to be watched from the moment it was imported or manufactured until it consumed by the consumer. This monitoring could only be effective by making the law into a revenue law." The law required that anyone who imported, produced, sold, or dispensed narcotics had to register, pay a tax and keep detailed records. This piece of legislation made it easier to enforce the practice of administering drugs by prescription only. The most significant opposition to the law was the pharmaceutical industry, angered by the interference of the federal government. The passage of laws regulating narcotics affected everyone who manufactured or distributed the drug; whether it be the physician who prescribed or the addict who craved it, or the individual who legitimately needed the drug to cope with real physical ailments. The enacting of anti-drug legislation hindered the efforts of individuals other than physicians in providing treatment for drug addiction, but this did nothing to stop the flow or the use of the drugs among addicts because their addiction was stronger than their will to stop even if it meant jeopardizing their health or freedom.

In 1912, Dr. Charles Terry, a critic of physicians whose liberal prescribing methods resulted in drug addiction for many, opened the first maintenance clinic in Jacksonville, Florida. The clinic was a place where the addict could get free narcotic prescriptions. This clinic was the forerunner of today’s methadone maintenance programs. During the tenure of Dr. Terry’s clinic, he documented the following: “55 percent of his patrons acquired their habit through treatment of their physicians; 20 percent from the advice of family and friends; 20 percent

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through dissipation and only 2 percent came from chronic and incurable diseases that needed to
be treated with narcotics.” 29  Terry also documented that of the 646 chronic users that he
registered, whites outnumbered the blacks by almost two to one (416 to 230) and females
outnumbered the males by a margin of three to two and that the females preferred opiates to
cocaine. The case for this preference could be that the opiates could be gained legally for their
physicians or that the cost of getting the cocaine was expensive.30

Tennessee’s Anti-Narcotic Act of 1913 narcotics law came into effect more than a year
before the Harrison Act.  The legislators took the stance that if “addicts need to register and be
able to get their opiate prescriptions refilled, this would minimize their suffering and keep the
drug traffic from getting into the underground and hidden channels.”31  Tennessee legislators
who believed that “opiate addiction was a disease and not simply a moral failing.”32  The law
enabled physicians to prescribe opiates for the maintenance of persons addicted to their use.  The
stipulation of this maintenance program was that the addict would have to register with the State
Board of Health.  This requirement was a benefit in two ways; it served as a way to gather
information on the addict population; and to regulate the dispensing of the drug to only
registered physicians, dentists or veterinary surgeons, and to registered pharmacists.  The
requirement also helped to monitor the sale or distribution by wholesale druggists, dealers or
jobbers within the state, and to retail dealers.  This act also required that a register be kept of the

29 Musto, 98.
30 Musto, 98.
31 Musto, 101
32 Jeffery Clayton Foster, “The Rocky Road to a “Drug Free Tennessee”: A History of the Early
Regulation of Cocaine and the Opiates, 1897-1913,” Journal of Social History 29, 3 (Spring 1996):554,
accessed October 10, 2019,
sale and dispensary of the narcotic. In the first twelve months 2,370 persons registered with 86 percent of the users being morphine addicts. Only 1.3 percent used heroin, and the females outnumbered the males two to one. At the time, just a fourth of Tennessee’s population was black, and only a tenth of the addicts who registered was black. These numbers further solidified that women made up a significant number of addicts during this time. The position that Tennessee took was not one of finding a cure but of one that would alleviate the suffering of the addict.

More than two-thirds of the country’s opiate addicts were women by the end of the nineteenth century. As stated previously, physicians primarily dispensed opium and morphine to patients, many of them women. The restrictions placed on the physicians prescribing authority put women and other addicts in the position of not having many options for obtaining the drugs needed to sustain themselves, therefore, leading them to resort to other addicts or drug dealers. At the end of the nineteenth century, the medically-induced addict began to be replaced by a new kind of addict, according to Courtwright, the new addict is the addict “who was introduced to drugs by and often became a part of a network of experienced users and dealers.” Mara L. Keire went on to describe the new addicts as “coming from the sporting class which comprised of prostitutes, pimps, thieves, gamblers, gangsters, entertainers, fairies, and johns; or, they were youth who admired the sporting men and women…the new addicts emulated the sporting class’s


34 Musto, 101.

manners and mores—including their drug use. 36 These addicts garnered less sympathy than the ones who became addicts by the physicians prescribing them addictive medications. The characterization of addicts as deviants in anti-drug laws had further solidified the bylaws enacted that criminalized drug use, and because of the criminalization, there was an increase in the cost of drugs, which led to the addict having to resort to selling their belongings or committing criminal acts to obtain the funds to purchase the drugs. Women were increasingly becoming involved in the criminal justice system as a result of their need to get drugs. The increased incarceration of women was politically motivated, “most of these arrests and confinements were not due to an increase in the severity of the crimes women committed but to changes in the legislative response to the “war on drugs” and law enforcement practices.”37 Law enforcement’s answer for addiction treatment for women, especially women of lower economic status and color, was to put them in asylums. The lucky ones got the opportunity to “dry out” in a hospital setting where they would wean off whatever substance they were taking. If they were extremely lucky, they could return home and not go to jail. The unlucky ones ended up in jail and were forced to quit cold turkey.

Middle and upper-class white women received treatment from the family physician, either in the comfort of their homes or in upscale sanatoriums and without the scrutiny of their


37 Kandall, 252.
socioeconomic peers due to the stigma associated with substance abuse. Their treatment would be treated under the guise of physical or psychological ailments.38

To illustrate the racial and socioeconomic disparity in the treatment of addicts, Stephanie Buck recounted a statement by the legendary jazz/blues singer Billie Holiday, a heroin addict who stated, “There was no cure, and they don’t cut you down slow, weaning you off the stuff gradually. They throw you in the hospital by yourself, take you off cold turkey and watch you suffer.” 39 Billie Holiday was at the height of her career and considered one of the most prolific and admired blues/jazz singers in the world. It was evident that her career status did nothing to shield her from the same kind of treatment that individuals from the lower socioeconomic and minority class received when classified as addicts.

During the late nineteenth and early twentieth centuries, the answer to discourage drug use was to criminalize not only the possession of drugs but also their use, which did not seem to make a dent in the problem. Physicians had begun to work with their patients to get them drug-free, but their efforts were not very successful. They did not fully understand the adverse effects of the drugs and the treatment that they offered was more often trial and error without any follow-through, in other words, there was no process to help the addict maintain sobriety. The physicians often treated addiction with other drugs. Opiates would be prescribed for physical and psychological illnesses and cocaine would be prescribed for alcohol and opiate addiction;


therefore, maintaining the high, unlike the agonists that are used in modern-day substance abuse
treatment.40

During the 1930s and 1950s, two significant groups moved to the forefront to offer a
different approach to treatment modalities in helping individuals deal with their addictions,
Alcoholics Anonymous (AA) in 1935 and Narcotics Anonymous (NA) in 1953. Both these
groups based on a 12-step program that requires the addict/alcoholic to follow the steps toward
sobriety with one of the steps, making amends for the harm that their addictions have caused to
others. 41 Alcohol Anonymous and Narcotics Anonymous were and continue to be stand-alone
programs which means, as the websites state they are “not affiliated with other organizations,
including other twelve-step programs, treatment centers, or correctional facilities.”42 AA and NA
were programs started by men who learned to lean on each other for support during the journey
to get sober and as a support to keep dry. These groups consisted solely of men until the
appearance of  Margaret “Marty” Mann, Lillian Roth, and other women who stepped out of the
shadows and identified themselves as alcoholics who were in search of sobriety.  Michelle L.
McClellan, explained in her article, Fame Through Shame: Women Alcoholics, Celebrity, and
Disclosure, described how Mann and Roth and others like First Lady Betty Ford came out and
“put their reputation, career, and family relationships on the line because of the rhetoric that
primed Americans to believe that drinking, at least to excess, was not something that came
naturally to women, and therefore, women who did it were unusual in some way---more sinful,
more deviant, more pathological, just more of whatever explanatory model was in vogue at that
time and place.” Mann was one of the first females first, to achieve long-term sobriety in
Alcoholics Anonymous and second to break the long-standing tradition of “men-only” being
involved with AA. She recognized that there were not any groups available that women could
join, so she encouraged the starting the first Alcoholics Anonymous chapters that catered solely
to the sobriety of women and worked tirelessly to change the perception of how women were
viewed as alcoholics. This became the forefront of gender-specific treatment modalities.

In the late 1960s and early 1970s, women began to join groups that allowed them to discuss
issues that at times were considered taboo, among them topics such as incest, domestic violence,
alcohol, and drug addiction. In 1976, two significant events happened in favor of women’s
treatment needs. The first event to occur was that the US Congress, under pressure from feminist
groups and alcohol and drug groups, funded the first specialized women’s treatment initiative.
The second event occurred when the National Council on Alcoholism, formerly the National
Committee for Education on Alcoholism, founded by Marty Mann, created a particular office to
address women's treatment issues. The NCA initially started out as an organization dedicated to
“provide a proactive national education and advocacy program attacking the stigma and
misunderstanding about alcoholism, treatment and recovery and to operate service centers in
communities across the country staffed by professionals helping individuals/families with

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43 “Fame Through Shame: Women Alcoholics, Celebrity, and Disclosure,” *Journal of Historical
Biography* 13 (Spring, 2013): 93, accessed November 11, 2019,
http://journaldatabase.info/download/pdf/fame_through_shame_women_alcoholics

44 Michelle L. McClellan, “Marty Mann’s Crusade and the Gendering of Alcohol Addiction in
Women,” In, *Health and Nation: Canada and the United States since 1945*, ed. Georgina D. Feldberg,
Molly Ladd-Taylor, Alison Li, and Kathryn McPherson (Canada: McGill-Queen’s University Press,
2003), 86.
alcohol programs,” but evolved into a program that not only addressed alcoholism but also other substance abuse disorders.45 The programs born out of these initiatives demonstrated that women would seek treatment if the programs operated from a holistic stance and addressed a broad range of topics, including sexuality, violence, and life-management skills. There needed to be a component that met the requirement of being humanizing, long-term, and child-friendly; therefore, tailoring these programs toward females and the issues that they face would be more successful than the traditional modalities male-centered of treatment.46

**The Rise of Incarceration of Women**

In 1970, President Richard Nixon signed the Comprehensive Drug Abuse Prevention and Control Act. This piece of legislation, instrumental in drug classification based on the potential for abuse, ear-marked federal funds for substance abuse research, prevention, education, and treatment programs. Out of this legislation came what is known today as the Drug Enforcement Agency (DEA). The DEA, established in 1973, marked the beginning of the nation’s modern-day “war on drugs” stance.47 It was also in this decade that due to changes in sentencing policies and law enforcement, the number of arrests and incarceration for women began to increase.48

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1976, the United States Senate and House of Representatives amended the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 to “make inroads to identify the need for prevention and treatment of alcohol abuse and alcoholism by women and by individuals under the age of eighteen and provide assurance that prevention and treatment programs within the State will be designed to meet such need; to provide treatment and prevention services, with special emphasis on currently underserved populations, such as racial and ethnic minorities, Native Americans, youth, female alcoholics, and individuals in geographic areas where such services are not otherwise available; and to give special consideration to applications (for funding) for programs and projects for prevention and treatment of alcohol abuse and alcoholism by women and for programs and projects for prevention and treatment of alcohol abuse and alcoholism by individuals under the age of eighteen.”

**Judicial Response to Increased Illegal Drug Activities**

Between 1975 and 1995, all fifty states and the U.S. Congress had limited the discretion available to judges in terms of sentencing an individual to jail. The reduction in discretion encompassed a variety of crimes, which required that mandatory minimums apply. The lack of discretion, in turn, enforced the “truth in sentencing and the three-strikes laws.” At this same time, most states enacted conspiracy laws, which mandated harsher sentences. The enactment of the conspiracy laws meant that women who had minor or peripheral roles in the sale or manufacturing of drugs found themselves receiving just as harsh a sentence as the primary individual perpetrator.

Substance abuse and the enforcement of laws to curb it has been an ongoing process since the late 1800s. Regardless of the laws that have been enacted, the use of illegal and legal substances continued to rise. From late 1800 to the 1970s, significant strides were made in combating the

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50 Sawyer, 2014
sale and use of cocaine, heroin, and opium. Everything from incarceration to rehabilitation and back to incarceration has been implemented with nothing really working. Programs geared toward men were offered to women without the special considerations that women would need. In the 1990s programs begin to be implemented that treated individuals based on their gender. These programs were implemented because of the realization that women did not respond the same as men to male-centered treatment and that women experienced substance use differently and that their pathways to crime were much different than men which warranted special attention to treatment modalities.51

**Substance Abuse in the South Central Region of Appalachia**

Overdose death has increased in the United States since 1999. Comparing the Appalachian region, as defined by the Appalachian Regional Commission (ARC) with regions that are not part of Appalachia, the data show that from 2008-2014, the Appalachian region outranks the non-Appalachian of the United States with a score of 20.4 vs 14.4 for the non-Appalachian region per 100,000 people. The South Central Region of Appalachia, which consist of counties in West Virginia, Southwest Virginia, Eastern Kentucky, Southeast Ohio, East Tennessee, and Western North Carolina housed some of the most distressed counties as defined by the Commission. These counties have earned this distinction of being distressed because of various economic measures in terms of unemployment rates, wage levels, numbers of persons and families living below the federal poverty rate, and other measures that fall far below the US averages and thus in what the ARC defines as “distressed economic conditions; and these

counties show the most increase in substance abuse from 2008-2014.” 52 East Tennessee State University and the National Opinion Research Center (NORC) issued a brief which stated other causes that are associated with high prescription drug use such as, a high rate of injury-prone employment (coal-mining), aggressive marketing of prescription pain medication to physicians, an insufficient supply of behavioral and public health services that target opioid misuse, and limited access to treatment.53

**Tennessee’s “Best Practices”**

Based on a policy brief published in 2018 by the University of Tennessee’s Howard H. Baker, Jr Center for Public Policy, despite enactment of Tennessee prescribing policies to reduce the number of prescriptions written for opioids, in 2016 the state still ranked the third highest in the country behind Alabama and Arkansas.54 In combating the addiction crisis in Tennessee, legislators have instituted “best practices.” These policies include requiring pharmacists to use and update the state’s prescription drug database and to allow law enforcement and officials from other states to have access; raised the offense of ‘doctor-shopping’ from a misdemeanor to a felony in some cases, and require that prescription pads

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utilize tamper-proof paper. Another practice is that before writing a prescription, the physician must check the Controlled Substance Monitoring Database and prescribing of Schedule II and Schedule III drugs are limited to a 30-day supply. Tennessee also has limited the number of licenses issued for pain management clinics and prohibit the clinics from seeing patients without the referral of an independent healthcare provider. The most prominent best practice incentive is that pregnant women can seek help without fear of losing custody of their child.55

Opioid addiction has expanded outside of the scope of the physician’s office. When states begin putting limits on prescribing and monitoring databases, addicts transitioned to family and acquaintances to obtain the pain killers that were no longer readily available.

Based on a 2018 report by the Tennessee Department of Health, in 2017, 1,776 Tennessee individuals lost their lives as a result of a drug overdose. Of these deaths, 1,268 involved opioids- 644 involved opioid pain relievers (i.e. Codeine, Hydrocodone, Oxycodone, Oxymorphone, and Morphine); 311 involved heroin, and 500 involved the drug fentanyl. 56

The Office of Informatics and Analytics derived this data from vital statistics death certificates and from Tennessee’s prescription drug monitoring program, the Controlled Substance Monitoring Database. The data were broken down into counties (counties in red are counties within the Appalachian region), with Davidson 236 (184 opioid), Shelby 207 (159 opioid), and Knox’s 242 (196 opioid), counties reporting the most overdose incidents and Weakley, Crockett, Decatur, Obion, Perry, Pickett, and Johnson reporting at least one incident,

55 University of Tennessee at Knoxville, Howard H. Baker, Jr. Center for Public Policy, 4.

with the deaths in Johnson, Perry, and Weakley being one of opioid. The six counties of Northeast Tennessee reported the following overdose numbers: Johnson 1(1); Carter 21(16); Greene 21(17); Sullivan 42 (29); Unicoi 10 (7); and Washington 33(24).57

Tennessee poses many barriers to individuals suffering from addiction and for those who are incarcerated. For example, in rural areas, the barriers consist of lack of employment, transportation, and childcare; and because of the lack of employment there is a problem of not having insurance to pay for treatment. Accessibility to treatment can be a problem if the individual does not have adequate transportation because the treatment facilities are most likely located in the metropolitan areas. For those incarcerated, access can be very limited or nonexistent. In the YouTube video Revolving Door: Drugs Land More Women in Jail, women incarcerated in Campbell County, Tennessee, local jail discuss being in jail and not having services available to help them to overcome or cope with the issues that landed them in jail in the first place. They speak of being afraid of returning to the same environment because they have nowhere else to go. They speak of the fear of returning to jail and losing the fragile bond that they currently have with their children and their parents. The jail administrator during the filming stressed that she wished she could offer the services needed for the women to learn the skills they need to survive on the outside without the use of drugs or participating in criminal activities.58 On the other side of the country in Los Angeles, California, the YouTube video Visiting The Largest Women’s Jail Facility in the US tells a different story. The women have opportunities to participate in services that include, counseling, cosmetology, food preparation,

57 Tennessee Department of Health, 10-12.

GED classes, and substance abuse treatment. The women participate in medically-assisted drug treatment (MAT) and have the opportunity to get unwanted tattoos removed. The women have access services that will help them to reenter the community. There is no difference between the needs of the women in Campbell County, Tennessee, and Los Angeles, California, except for the amount of money available to provide for the services needed in the facilities to help the inmates on their way to sobriety and living a crime-free life. In both situations, the majority of the women are incarcerated for drug-related crimes and they wish for a different life and the skills to pursue that life.

**Literature Review**

The literature review will focus on women’s foray into the criminal justice system via drug arrest and convictions, the argument for female-centered treatment modalities and how these modalities should operate, as well as the different paths that brought women into the criminal justice system and the barriers that they face upon re-entry.

The National Resource Center on Justice-Involved Women reports that although women's incarceration rates are steadily increasing, they pose the least threat to society. The women who came in contact with the criminal justice system are there because of non-violent crimes that are drug-related or driven by poverty. Their crimes seldom involved aggressive acts. The report suggests that if violence is committed, it is usually in a domestic or school setting and includes family members or their intimate partner. Belknap et al. completed a study in which jail

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personnel responded to what they believed brought women into the criminal justice system. The study summarized their responses as

Trauma across the board: physical, sexual, neglect and emotional. They are also victims of domestic violence. Just a lot of dysfunction and chaos in their upbringing. Lack of stability with relationships and housing (Mental Health Staff). Other pathways expressed were multiple generations of offending, lack of educational opportunities, homelessness and self-esteem issues.61

The increased incarceration of women since the 1970s has warranted research expansion as to why women are coming into the criminal justice system and the research has come to the same conclusion, women’s pathways are different, and there need to be different approaches for addressing the paths that got them there.

Emily J. Salisbury and Patricia Van Voorhis describe the pathways as childhood victimization, leading to mental health and substance use disorders; experiencing violence in intimate relationships as adults; and challenges in education, family support, and employment.62 Jenna Rodda and Dawn Beichner conducted a study to ascertain the program needs for women detainees in a jail environment. The study consisted of three questions: “What are the women’s perceived needs and are their needs met?” What did the women’s lives look like leading up to detention or incarceration in the jail?” and “What are their challenges in returning home to their families and communities?”63 The authors found that the women interviewed stressed the following barriers during incarceration: worry about their children, lack of opportunities for


counseling, and reintegration back into the community. Sonia A. Alemagno took this same idea and expanded on it by concluding that women faced, obstacles such as having stable housing or a legal source of income played prominently, then the likelihood of them continuing treatment outside of the jail would be highly unlikely because their focus would be elsewhere. It would be safe to surmise that the chances of returning to jail would most likely be very high.

The 1980s and 1990s saw more of a significant increase in the incarceration of women for drug offenses. This phenomenon was a result of the elimination of judicial discretion in the sentencing of the convicted. Michelle Alexander in *The New Jim Crow: Mass Incarceration in the Age of Colorblindness* states that the increased rate of incarceration of African Americans as a result of the “War on Drugs” and the policies that resulted, “deny the convicted felons equal access to employment, housing, education, and public benefits which create a permanent under caste based largely on race.” Although Alexander was mainly speaking in reference to African American males, this same stance can be used to describe what the war on drugs did to African American women and women in general. With the drug convictions, they were and continue to be, denied the same benefits as men but are hurt even more because the majority of them are single mothers who already struggled to care for their children before they were drawn into the criminal justice system. While incarcerated, they struggle to maintain contact with their families and especially their children through letters and phone calls which can be quite expensive. They also struggle when they are released to complete everything that is required of them in order to resume custody of their children. This is equally tough when their convictions

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may disqualify them from not only certain employment opportunities but also housing, public assistance, and education opportunities.

With the jails and prisons becoming overcrowded and treatment protocols that were in place being insufficient, clinicians and researchers began to take notice that a new mode of treatment needed implementing especially in the terms of how women were receiving treatment. Research initiated in the 1970s at the beginning of the declaration of war on drugs which facilitated in the increased numbers of women entering the criminal justice system, according to Kandall, “to delineate the broad range of medical, emotional, and social problems faced by addicted women and the support services these women required,” came back into the forefront of addiction treatment during the 1980s and 1990s. During the 1980s, practitioners began to see progress made and women saw treatment modalities change that explicitly geared to help them get the treatment that they needed for their addictions.

Before the 1980s and 1990s, research into the causes for women’s substance abuse was practically non-existent and what was available just barely touched the surface. Stephanie Covington, a leading expert in women’s addiction and treatment states “the issues of women’s addiction, were not new, but until recently it has been characterized by silence, not openly discussed, even by those in the field of addiction recovery.” Exposing women as alcoholics or 

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66 Kandall, 181


drug addicts opposed the societal norms of how women were looked upon and obliterated the concept of the saintly woman and of women being natural-born nurturers.

Through research, treatment practitioners learned that instituting what came to be termed as “gender-specific and trauma-focused treatment” would offer different treatment options for women and allow addressing the barriers that women often face before, during, and after the treatment phase; Covington noted that barriers can be anything from personal obstacles such as social stigma, lack of childcare, lack of family support, trauma, lack of financial means to transportation and treatment, and what is known as formal barriers, such as the location of the treatment center, agency, funding, and lack of personnel. An additional obstacle that can hinder treatment is the lack of integrating substance abuse treatment with mental health treatment. There is a sense of which came first, the chicken or the egg; practitioners have a problem trying to decide which to treat first.69

Studies revealed that gender-specific treatment allowed the women to participate in treatment that would be geared toward her needs only. She would participant in a group that consisted only of women. Covington, together with other researchers found that women tend to open up about their addictions and their past traumas when the groups were female only. The researchers found that having the women-only focused groups allowed the women to share life experiences and therefore work toward getting to the root of their addictions much faster. The researchers also found that the women tended to become a support for each other because of their shared experiences. Covington supports the idea that “if we are to develop effective programs

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for women in prison and community corrections, we need to develop a theoretical approach to addiction treatment that is gender-sensitive, addressing itself to the realities of women’s lives.”

In developing a successful gender-responsive program, researchers suggest the following variables need to be in place: site placement; staff selection, program development, and program content and materials that reflect an understanding of the realities of female’s lives and that addresses and responds to their challenges and strengths. In 2004, Bloom et al concluded in their article. “Women Offenders and the Gendered Effects of Public Policy” that addressing the realities of women’s lives through the policy that is gendered responsive and constructing programs that adhere to this principle is fundamental for positive outcomes. They concluded that there are six guiding principles that are designed to address concerns about the management, operations, and treatment of women offenders.

The principles are as follows: 1. Acknowledge that gender makes a difference; 2. Create an environment based on safety, respect, and dignity; 3. Develop policies, practices, and programs that are relational and promote healthy connections to children, family, significant others, and the community; 4. Address the issues of substance abuse, trauma, and mental health through comprehensive, integrated, culturally relevant services and appropriate supervision; 5. Provide women with opportunities to improve their socio-economic conditions; and 6. Establish a system of community supervision and reentry with comprehensive, collaborative services.

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71 Covington, 388-387.

These principles are as relevant today as they were in 2004. Another variable that needs to be taken into account with addressing gender-responsive treatment is how did the women get here, how did they end up involved with the criminal justice system?

Evelyn McCoy and Megan Russo presented a case study in their article entitled, “Implementing Alternatives to Incarceration for Women in Rural Communities: Lessons Learned from Campbell County, Tennessee.” The case study involved the Women in Need Diversion (WIND) program. WIND was a 9-12 month specialized court program that was designed to give women an alternative to incarceration. The program, funded through the John D. and Catherine T. MacArthur Foundation’s Innovation Fund, addressed the needs of women in the local jail. One of the recipients of this grant was the Jacksboro jail located in Campbell County, Tennessee. Campbell County is located along the Tennessee/Kentucky border and is one of the most economically distressed counties in Tennessee. The women selected were eighteen and older, arrested on drug offenses or incarcerated for crimes committed to support their drug addiction. They could not have any violent offenses or weapon convictions and they had not been convicted in a court of law. The women were referred by the jail staff, probation, the district attorney’s or public defender’s office, or by direct jail in-reach by the project coordinator. Once selected, the women were administered the Service Planning Instrument for Women (SPIIn-W), a gender-responsive assessment and case-planning tool and the Addiction Severity Index (ASI), an assessment to measure addiction severity and treatment needs. The SPIIn-W instrument addressed the women’s criminal history, response to supervision, family and children, social network, substance use, vocational/employment, attitudes, social/cognitive skills, mental health, violence and community living. The ASI instrument addressed, medical status, employment/support status, alcohol/drug use, legal status, family/social relationships, and
psychiatric status. Once the results of the assessment were reviewed and the women-selected for
the program, they were then presented before the judge who granted them permission into the
program. The women were then required to attend counseling/education sessions, appear in
court periodically and complete community service hours. The WIND program was a perfect
type of the concept of forming partnerships to achieve a specific goal. The program was a
example of the concept of forming partnerships to achieve a specific goal. The program was a
collaboration between the leading service provider in Campbell County, the Community Health
of East Tennessee, the Campbell County Department of Children’s Services (DCS), the Sheriff’s
Office, LaFollette Police Department, LaFollette Housing Authority, and other community
service providers. The most critical component to the program was the existing drug court. The
program not only required participation from the women but also required that the stakeholder be
trained so that the program could be administered effectively. The stakeholders together saw a
need to implement programming that would be gender-specific and would address the major
needs and concerns of the women. The stakeholders also recognized that there were few
opportunities for the women who came in contact with the justice system in Campbell County.
There was little that was addressed within the jail setting and that carried over out into the
community. As with all programs, there were some successes and some failures. Some of the
women welcomed the chance to improve their lives and break the intergenerational cycles of
trauma and poverty and the revolving cycle of incarceration, while others felt that the program
ask too much and it was easier to just do the jail time. 73

73 “Implementing Alternatives to Incarceration for Women in Rural Communities: Lessons
Learned from Campbell County, Tennessee,” (Washington, DC: Justice Policy Center, Urban Institute
https://www.urban.org/research/publication/implementing-alternatives-incarceration-women-rural-
communities.
The Center for Substance Abuse Treatment developed a list of issues that should be addressed in a comprehensive treatment model for women. The list consisted of the following:

- the etiology of addiction, especially gender-specific issues related to addiction (including social, physiological, and psychological consequences of addiction and factors related to onset of addiction); low self-esteem; race, ethnicity and cultural issues; gender discrimination and harassment; disability-related issues, where relevant; relationships with family and significant others; attachments to unhealthy interpersonal relationships; interpersonal violence, including incest, rape, battering, and other abuse; eating disorders; sexuality, including sexual functioning and sexual orientation; parenting; grief related to the loss of alcohol or other drugs, children, family members, or partners; work; appearance and overall health and hygiene; isolation related to a lack of support systems (which may or may not include family members and/or partners); life plan development; and childcare and custody.74

Covington emphasizes that “a continuity-of-care model integrates services that address their histories of poverty and trauma, recognize their mental and physical health issues, and incorporate the emotional and psychological components that women and girls need to heal and recover.”75 Once incarcerated, women have to deal with not only their barriers to treatment but also those that become entrenched within the criminal justice system such as being able to afford bail costs or an attorney.

The women’s concerns are the foundation on which a workable treatment plan would be successful. Once the practitioner knows what events happened that lead the women to use alcohol and drugs with the added result of criminal justice involvement, the barriers that they face inside the facility and outside in the community, then the treatment can begin. There has been a tremendous effort to remove these barriers over the years, and this is especially true in the


urban areas, but there is still a great lacking in the rural areas of the country. While incarceration in the local jails is short-lived, it would be feasible to utilize the services that are readily available and accompany that with wrap-around services provided through partnerships with national, state and local community agencies. The formation of these partnerships is important in every area of the world, but as important as in the rural areas of the country and in particular in Appalachia. The problems that face the Jacksboro Jail in Campbell County are prevalent across the state, especially in the small rural areas. What does it look like for a facility in Appalachian (Northeast) Tennessee? What barriers exist that make it impossible to meet the needs of the women housed in these facilities?

Methodology

To assess the availability of treatment or education of substance abuse within local lock-ups, I proposed to see what was available and what could be done to alleviate the non-existence or enhance the existing program(s) and to see if the idea of a referral service could be implemented upon release of the inmate(s). The primary objective of this project was to explore the possibility of establishing a partnership with the local jails in Northeast Tennessee to implement a referral service to direct substance abusers to community resources that would help them in their efforts to get assistance to address not only their addiction but also their everyday needs, such as housing, food, employment and education. The first step was to ascertain what, if any, programs were available within the correctional setting, programs such as, but not limited to, Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings, parenting classes, educational classes, or anger management and mental health counseling. The second step was to find out if there was a referral service available, what it entailed, who is in charge, and when the service was implemented (that is, when the inmate arrived or when they leave). With the
continuance or implementation of programs, I needed to find out if the facility administrator was willing to establish a referral service to help inmates become aware of and utilize wraparound services upon release if one did not exist. I also inquired about the willingness on the part of the jail administration to establish partnerships with various community entities who could supply the needed resources. The establishment of referral services beneficial to both male and female inmates is pertinent to the treatment of substance abuse and improving the quality of the inmates’ lives.

I sent an email request to the three local sheriffs’ offices, but only one responded positively to the request for participation in a survey of jail administrators and correctional officers. Once I obtained permission by the facility to conduct the study, I completed the required online paperwork for the University’s Institutional Review Board. The process took a couple of months to complete because IRB’s request for additional information about the project necessitated revisions. IRB classified the study as one that involved human subjects. The review required a short review and once I received approval, I contacted the facility and scheduled a date to complete the surveys.

The instrument consisted of questions that would solicit short answers from both the correctional officers and the administrators. The survey for the correctional officers consisted of 11 questions, while the one for the administrators consisted of 10. Being cognizant of the time constraints of the correctional officers and the administrators, I designed the survey to take no more than 30 minutes total to complete. The time frame included ten minutes to explain the study and the informed consent and another ten to give the correctional officers an opportunity to decide if they wanted to participate in the study. The study questions inquired about what programs were available to the inmates, how often were the programs offered, how familiar were
the correctional officers with community resources that would benefit the inmate and what the administration would like to see with any future endeavors that would steer inmates in the direction of sobriety and success from recidivism. The survey was given to the officers and I left the room so that the participants would not feel obligated to complete the surveys since I was present. Upon completion the surveys were returned to me.

**Study Results**

Forty correctional officers were given the opportunity to complete the survey, and twelve (30%) chose to participate. There were no surveys completed by the administrative staff. Each respondent gave a positive answer to the question of providing the inmates with a list of community resources, if such a list was made available. One respondent went further and stated that, “If they are willing to seek help, then I am more than happy to provide all the help I can give them. I don’t like to see all the same faces on a reoccurring scale. I’d rather see someone on the streets doing well for themselves and for their families.”76 Two of the questions asked were gender-specific. Each question asked what programs were offered for the males and the females---the answer were the same with the exception of the parenting class being offered to the females only.

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76 Written quote of a research participant.
### Table 1: Survey Questions and Responses for Correctional Officers

<table>
<thead>
<tr>
<th>Questions</th>
<th>Responses</th>
<th>Number of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>What type of substance abuse programs exist in your organization</td>
<td>Alcohol and drug education</td>
<td>12</td>
</tr>
<tr>
<td>How often are substance abuse classes offered in your facility</td>
<td>once per week (only if CO available to monitor)</td>
<td>12</td>
</tr>
<tr>
<td>What type of non-substance abuse programs exists in your organization?</td>
<td>GED, parenting</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often are non-substance abuse classes offered in your facility</td>
<td>once per week (only if CO available to monitor)</td>
<td>12</td>
</tr>
<tr>
<td>What other classes other than the one mentioned above offered?</td>
<td>none</td>
<td>12</td>
</tr>
<tr>
<td>Which classes are available for males?</td>
<td>GED and alcohol and drug education</td>
<td>12</td>
</tr>
<tr>
<td>Which classes are available for females?</td>
<td>GED, alcohol and drug education and parenting</td>
<td>12</td>
</tr>
<tr>
<td>On average, how many inmates attend the classes</td>
<td>12-15 depending on personnel available for supervision</td>
<td>12</td>
</tr>
<tr>
<td>What type of assessments are conducted upon the inmate's arrival at the</td>
<td>mental health, alcohol/drug, physical health - officers have to rely on</td>
<td></td>
</tr>
<tr>
<td>jail? For example, mental health, alcohol, and drug, physical health, etc.</td>
<td>answers that are given to them by the inmate</td>
<td></td>
</tr>
<tr>
<td>How familiar are you with resource services (dental and medical,</td>
<td>Very Familiar - 0</td>
<td>12</td>
</tr>
<tr>
<td>substance abuse treatment, employment, and housing services) that are</td>
<td>Familiar - 3</td>
<td></td>
</tr>
<tr>
<td>available for inmates outside of the correctional setting? Choose one.</td>
<td>Somewhat Familiar - 4</td>
<td></td>
</tr>
<tr>
<td>If a resource list were available, would you be willing to make the list</td>
<td>Yes</td>
<td>12</td>
</tr>
<tr>
<td>to the inmates upon their release from the facility?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

At a previous meeting with the jail personnel to explain the purpose of my study, I was asked if I would like a tour of the jail to add perspective to my study, with my answer being a resounding yes. I explained what I was doing to my daughter, who is an undergraduate in college and she asked if she could be a part of the tour also. It was during the tour that I gained first-hand knowledge regarding the conditions that the staff and inmates had to navigate. The women were locked down in their cells. The guide explained that the women were locked in the cells twenty-four hours a day, seven days a week because there are not enough officers to

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77 The following section is based on observations made by me during the tour as well as commentary by the tour guide and some of the correctional officers that I encountered.
supervise them, which would have allowed them some time outside of their cell. Each cell held about 15-25 women with some of them sleeping on “boats” (mattress made of rubber that is turned up on all sides) on the floor. Some of the women were gathered around a table and turned to wave, but the anguish could be seen in their faces and the smiles did not reach their eyes. There were two suicide watch cells located near the cells. In one there were three women; according to the tour guide this was not the most appropriate setup and did pose a safety risk for both the inmates inside and the guards who checked on them every fifteen minutes.

There was a definite difference in the degree of freedom that the men had compared to the women. The men could be seen working in the kitchen, on the grounds, and in the laundry, while the women were confined to their cells at all times. The only females present on the first floor were the correctional officers and the civilian staff. On the second floor, there was a control room monitored by one officer. In this room monitors allowed the viewing of the entire facility. The second floor also housed both the medical and mental health rooms. The tour guide explained that a local doctor came twice a week and the mental health personnel (although out on maternity leave at the time of this tour) were there multiple times per week. The inmates had access to one doctor and one mental health provider. This was disheartening, considering that at the time there were over 930 inmates housed in the facility. It was evident that the majority of the inmates could not receive adequate medical or mental health services with the personnel available. This was one of the concerns for the captain. Requests have been made for additional funding to provide more personnel in both positions, but those requests have remained unanswered.

The second floor also housed the male inmates. The men’s cells held twenty-five to thirty at a time with some sleeping in “boats” on the floor. These cells appeared to be much
larger than those for the females. There were two suicide cells. The officer who was monitoring the inmates on this floor relayed that there can be as many as seventeen inmates in the suicide watch cells on any given day. In listening to the officers and seeing the facility and the inmates, it was evident how palpable the stress and the strain was for both the officers and the inmates.

**Facility Limitations**

In a requested meeting to explain the purpose of this study, the facility personnel who agreed to participate stated that there are a few programs offered by their facility. The programs are geared in the direction of education more than treatment. The inmates have limited opportunities to participate in the programs, because of the limitations imposed by the building’s infrastructure. The first barrier is space. Because of the large number of inmates present on a regular basis, the areas designated as classrooms now serve as sleeping or holding quarters. Second, there is a lack of volunteers to teach the classes, which implies that there is a lack of funding to pay for certified instructors. Third, there is a shortage of correctional officers to watch over the inmates as they travel back and forth and attend the classes. On the day of the meeting, there were 900+ inmates in the facility. Of that total, 230+ of them were females, with only two guards to watch about 300 inmates at a time. The shortage of correctional officers to monitor the classes has dictated whether or not the classes can take place and the number of inmates who would be allowed to participate in the classes at any given time. Another barrier that affects participation in programs is time. Most of the inmates are there for only a short period, then released back into the community or transferred to a state or federal prison. Finally, the inmates themselves pose a barrier because most of them are not participating because they do
not have to unless the court orders them to, and they do not go into the class with the mindset to learn and apply the content to their lives.\textsuperscript{78}

The guide acknowledged that it would be wonderful if the programming that was available could be enhanced to encompass a real treatment modality. The need is significant within the detention center. The guide also acknowledged that the majority of the females housed in the detention center were there not only because of their addiction and the crimes that they committed to obtain the drugs, but also because they associated themselves with someone embedded in the sale and distribution, so that they got caught up in the net, so to speak. The guide acknowledged that this was sadly a generational issue because there are instances in which mother, daughter, and granddaughter have occupied the facility at the same time. The guide also stated that it is heartbreaking to see the same individuals over and over again.\textsuperscript{79}

So what is the answer? How can the cycle be broken and the chains of addiction be destroyed? It is apparent that the methods implemented at present are not working. How does one address all of this within the confines of a local jail, with limited time, space, funds, and supervision? The answer is that trying to break the cycle, especially with the barriers that currently exist within the local facilities, is not something that can be done within the foreseeable future. Services can not be offered effectively or adequately to combat the effects of drugs and alcohol within the confines of a local jail setting without the use of proper resources and the partnerships of the state, regional and local communities.

There is a power within the local correctional systems that is not fully utilized. Michele Foucault theorized that power in society is exercised mainly through discipline and this form of

\textsuperscript{78} Interview with jail personnel, February 11, 2019.
\textsuperscript{79} Tour guide (names are withheld in confidence).
power/discipline is instituted through the use of prisons, schools, hospitals, and the military, for example. Foucault asked the question, “How do we rehabilitate him?”80 The most recognized form of power through discipline exists within the correctional system and it is there that the inmate, although there for punishment, should also be there to make the changes to turn his/her life around, to become a better person. The purpose of the penitentiary system is to correct bad behavior by locking up the perpetrators as punishment. There have been times in history, during the Progressive Era for example, when social activists persuaded officials to look at prison not as a means to discipline but as a way to rehabilitate and offer treatment, with the goal of lessening the occurrence of repeat offending. One example that stands out during this era was the prohibition of convict leasing throughout the southern states and the implementation of penal farms and road work. This was the formation of the chain gangs, a term that in itself conjures up horrible images and thoughts; but, in fact the chain gangs proved to be beneficial to the convicts. The 1910 report from the Virginia Board of Charities and Corrections “told of the marked improvements in the physical condition and general welfare of the prisoners. . . adequate medical attention, sanitary surroundings and cleanliness, sufficient food and clothing and work in open-air” had not only contributed to the “physical welfare of the prisons” but had been “long steps in the direction of moral reform.”81 In essence, placing the convicts on the road crews and on the farms to work, offering them opportunities to learn skills that they could parlay into viable work

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opportunities upon the completion of their sentences. The pendulum has constantly swung between punishment and rehabilitation, but from the 1970s to 2000s the swing was toward punishment that has resulted in the overcrowding of the nation’s correctional system. Efforts to address overcrowding and to curb the incarceration rates have resulted in the need to address the overwhelming numbers of individuals who enter the system because of drug addiction and the crimes committed to feed the addiction.

Several options are circulating through the treatment paradigm and one that is being offered routinely is medically-assisted (MAT) drug treatment. Given to released inmates, the drug naloxone helps to prevent overdosing, while methadone, buprenorphine, and naltrexone help with the cravings and to facilitate the effects of the real drug without the ingesting of the actual drug. The establishment of more methadone and suboxone clinics, especially in the rural areas would elevate the issues of lack of transportation which is one of the major barriers to treatment. Some counties have gone as far as allotting space for centers within the local jails that provide not only drug abuse education but also treatment that includes both abstinence and MAT. The programs not only address alcohol and drug addiction issues but also mental health problems. Many states have passed legislation that now allows for MAT programs in the jails and prisons, states that are now offering this substance abuse tool are: Rhode Island, Pennsylvania, New Jersey, Connecticut, Vermont, and Massachusetts.83


The concept of medication-assisted treatment is not new. Research conducted regarding drug addiction has shown through trial and error physician would taper addicts off of drugs by giving them other drugs to substitute for the drug of choice or the physician would allow the addict to have their drug of choice but will monitor how much they would ingest at a time. Blum et al. reported in 2014 that rehabilitation centers used “Disulfiram (widely known as Antabuse) to help alcoholics refrain from drinking. The centers also used drugs such as Naltrexone, Buprenorphine and Selective Serotonin Reuptake Inhibitors. These medications had been shown in research studies to be effective and had been accepted as evidence-based practices.” At the time these medications had not been adopted by all practitioners until in 2002 when opiate abuse was coming to the forefront of addiction. Alicia A. Jacobs and Michelle Cangiano reported that the Drug Addiction Treatment Act (DATA) was signed in 2000 in response to the increasing prevalence of opioid addiction and heroin overdoses. This legislation allowed office-based treatment by allowing physicians to prescribed medication such as buprenorphine. Jacob and Cangiano went on to explain that the medication is not just given to the patient haphazardly, that the physician has to follow three specific guidelines when administrating.

The first guideline or step is induction. Induction is the process of switching from the drug of abuse to buprenorphine. The goal is to find the minimum dose at which the patient stops opioid use and has no side effects or cravings. The second guideline or step is stabilization, which occurs when the induction criteria have been met. The physician has to meet with the patient frequently and this can last up to five weeks. The last guideline or step is maintenance in

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which the focus is on psychosocial issues that have been identified during treatment that may be contributed to the person’s addiction. At this phase, it is important to utilize trauma-informed care so that the patient will not re-suffer trauma.86

All of these efforts could not take place without the cooperation of both federal and state governments providing funding and community agencies and treatment centers partnering with the local jails to provide the services. The depressing part about funding is that it rarely, if ever, is funneled down to the local jails because most of the funding for substance abuse education or treatment has been allocated toward state and federal prisons. It seems that the local jails are an afterthought and then the monies are no longer available, this has forced jail administrators to have to requisition the already strapped county governments to provide the funding for the needed resources. Jail administrators have to do battle with the local governments for added funding for programs and personnel. A case in point is the housing of Tennessee state prisoners in local jails.

According to Tennessee Advisory Commission on Intergovernmental Relations (TACIR), 2017 report on housing state prisoners reported that local jails in Tennessee house about a quarter of Tennessee’s state prisoners and almost sixty percent of all those incarcerated in the state. This puts a strain on the resources that the local jails in terms of funding, personnel and space. Although the state pays the local jails per diem for each inmate, the amounts ranging from $37 to $39 dollars per day, the average cost is estimated in expense to the jails to be $43 to $45 dollars per day.87 The report acknowledged that “although the state is saving money by

86 Jacobs and Cangiano, 736-737.

keeping felons in the county jails rather than state prisons, most jails are not able to provide the same level of programming for mental health, substance abuse, and education, among other services that are available in prison.” 88 The programs that are offered at the state level are intensive and required as a part of the inmates' needs assessment. The state also offers group therapy, substance abuse treatment, mental health treatment, adult basic education, and high school equivalency test preparation, college programs that lead to an associate’s degree, and vocational training. Based on the 2017 TACIR report, funding these programs are included in the annual Department of Corrections budget, funding that does not including programming at the local level. The report states that due to these programs not being available at the local level, there is evidence of higher recidivism rates among state prisoners held in county jails. 89

**Recommendations for Actions**

What options exist when the funding, space, and or partnerships are not available? The local jails offer programs as best that they can with the resources that are available. One option that can be made available is a comprehensive list of services that are provided in the community that would be of assistance to the inmate upon release. An excellent resource that administrators can use for guidance in formulating and implementing a jail education and re-entry program is the *Guidelines for Successful Transition of People with Mental and Substance Use Disorders from Jail and Prison: Implementation Guide*. This guide was produced by the Substance Abuse and Mental health Services Administration, an agency within the United States Department of Health and Human Services. The purpose of the guide “is to provide behavioral health, correctional, and community stakeholders with examples of the implementation of successful strategies for

88 TACIR, 4

89 TACIR, 27
transitioning people with mental or substance use disorders from institutional correctional settings into the community.” The content of the guide relies heavily on examples of programs that have been implemented by other jurisdictions and offers strategies and step-by-step guidelines to consider that can be beneficial to the inmate. One of the most important guidelines suggests offering assessments that require more than just observing the inmates and their behaviors. Make available assessments for both mental and physical health. These assessments can be conducted through partnerships with the local mental health agency and the state health department. Second, community resources that could be possible partnerships for these assessments could be the local mental health and health departments. The assessments do not have to be comprehensive; that can come later when and if the inmate decides on further treatment, but this can be a jumping-off place. Administering the assessments can give an idea of what services the inmate would benefit from, and provide the practitioners with a place to start. The assessments would help in finding out who is in the inmates’ social network. Do they have children? Do they have parents and siblings whom they have maintained contact? Is there an extended family that could be used as informal support. Finding out who is in their social network would determine if they would benefit from parenting classes, family therapy or other therapeutic interventions to enhance their social and family systems. The third is to find out what is available within the facility and to explore ways to improve those programs so that when and if there is a choice to pursue treatment, the inmate will be headed in the right direction. Last but not least, there should be a concerted effort to ask the individual what they would like to see happen in their life, what are their wants and needs. There should be “what if” questions asked.

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to find out what resources can be made available so that the inmate would have a good chance of being successful in reaching goals that they set for themselves.

It is not enough to want to offer programs to benefit the inmates, but there has to be funding to cover the cost of these endeavors. The opioid crisis in America has left the funding agencies no choice but to open the coffers to help eliminate or in the least hinder its’ growth. Grants are awarded through the state, federal, and local governments to fund prevention, treatment and recovery support services. Press releases dated June 15, 2018, and September 19, 2018, from the Department of Health and Human Services (HHS), reported that over $1 billion in grant funding had been awarded to combat the crisis. These monies were allocated so that states, Native American tribes, and communities would be able to advance what HHS terms the “Five-Point Strategy to Combat the Opioid Crisis.” The strategy consists of 1. Better addiction prevention, treatment, and recovery services; 2. Better data; 3. Better pain management; 4. Better targeting of overdose-reversing drugs; and 5. Better research.”91 “The Department of Health and Human Services’ Substance Abuse and Mental Health Services Administration (SAMHSA) has awarded grants in the amount of about $50 million to the American Indian and Alaska Native tribes to help strengthen the efforts in fighting the opioid overdose epidemic.”92

The efforts of the funding agencies are phenomenal but where does that leave the correctional system, especially the local jails? How much of that money will filter down? Not very much unless the administrators can come up with a reasonable plan based on one or more of


the HHS’s five-point strategy, to support services they would like to offer in their facility and to solicit funding to obtain those goals. For example, one barrier for the Northeast Tennessee facility was one of obtaining someone to teach the classes. The current classes are taught by volunteers and it has been a hardship to find someone to come into the detention center to perform that task. Using the first strategy of HHS’s plan, the facility administrations could construct a grant supporting the need for funding to pay instructors who could teach alcohol and drug prevention courses. Another option would be to provide funding for someone to teach basic skills. The grant could be written to provide the financing of a therapist, whose job description would consist of monitoring the administering of assessments and working with the women on self-esteem issues, which is the essential first step toward addressing problems of substance abuse and mental health. The American Counseling Association lists federal funding opportunities on its website to help fund counseling positions. The funding sources for the opportunities listed on the page are through the Department of Health Resources and Services Administration (HRSA), the National Council for Behavior Health (NCBH) and the US Department of Justice. Tennessee offers Substance Abuse Prevention and Treatment block grants (SABG), which are blocks of monies distributed by the Federal Government to address specific issues.93

While the facility is researching grant opportunities, there is an untapped resource in the community that is underutilized. Many students at the local universities and colleges are always on the lookout for internships. Why not use this resource as a means to get assessments accomplished. Students in criminal justice, public health, medicine, psychology, sociology, business, and social work fit this bill. The students could also be used to get referrals to

community services set up and also assist with follow-ups to see if the inmates utilized the referred services. Taking an interdisciplinary approach, the facility administrator could set up an advisory board made up of community leaders from across the spectrum. The board could comprise of, but not limited to members from law enforcement, medicine, mental health, social work, education, workforce development and many others that would have a stake in making sure that whatever programs are instituted successful. Last but not least, the facilities should form partnerships with existing community services. These partnerships could provide the link that the inmate will need to continued exposure to services outside of the correctional setting. Partnerships will also provide the inmate with the means to break down barriers such as unemployment, homelessness, lack of transportation, childcare, and education. An example of services that are currently available include NetTrans, a rural transportation service that helps with transportation to and from appointment for a nominal fee; the Department of Human Services helps with childcare assistance; and AB&T offers assistance in job training and in obtaining a GED.

It is imperative for service providers to be strong advocates for equal treatment for both males and females. Services need to be geared strongly toward women’s well-being as it is for men and vise versa. There is no room for gender-based stereotypes based on societal norms.

At this time, the best possible solution can be to inform incarcerated individuals of the services that are available and let them make the decision to participate or not. In doing this, the information may find its way into the hands of friends, acquaintances, and family members who would benefit from the referrals. The programs offered in the facilities need to be on an equal basis insofar as both men and women who are parents need to participate in the parenting classes. Both should have alcohol and drug education and both should be required to participate
in counseling sessions (individual or group). Practitioners must be qualified to present the
information in a way that is easy to understand and with a certain amount of empathy toward the
participants so to achieve optimal benefits for the participants and the program. Volunteers
should be trained in not only how to keep themselves safe, but also in how to present the
information to this very diverse population.

The funding agencies must be willing not only to fund programs on the local level, but also
to provide funding that would ensure that facilities are adequate to house the increasing numbers
of those incarcerated for drugs and to provide the caretakers the means (increased personnel) to
protect not only the inmate but also themselves, therefore allowing for the administration of
programs without limitations. The facility personnel must be willing to form partnerships with
outside entities to ensure that whatever education the inmate receives inside the facility will
continue to be an opportunity to continue on the outside. The norm is that if given the choice,
most inmates would not voluntarily continue with treatment or education outside of the jail
setting, so there is a definite need for judicial intervention to require continued program
participation as a condition of their release. As expected for the incarcerated to take
responsibility for achieving their sobriety, it is also expected that the State of Tennessee and the
Federal Government continue to do their part in providing the policies and funding that would
condition to assist in combatting this crisis.

In an executive summary entitled, *Prescription for Success: Statewide Strategies to Prevent
and Treat the Prescription Drug Abuse Epidemic in Tennessee*, then governor Bill Haslam
outlined seven goals in a “Plan for the Future” to prevent and treat prescription drug abuse:

1. Decrease the number of Tennesseans that abuse controlled substances.
2. Decrease the number of Tennesseans who overdose on controlled substances.
3. Decrease the number of controlled substances dispensed in Tennessee.
4. Increase access to drug disposal outlets in Tennessee.
5. Increase access and quality of early intervention, treatment, and recovery services.
6. Expand collaborations and coordination among state agencies.
7. Expand collaboration and coordination with other states.\textsuperscript{94}

The state seems to be taking an interdisciplinary approach to combat this epidemic. The objective is to incorporate and solicit the assistance of other states and various community agencies to enhance established programming and initiate new programming that would not only serve diverse individuals but also allow services in locations where they have not been available.\textsuperscript{95}

In 2016, the President of the United States Barack Obama issued a presidential memorandum that provided the directive and guidance for the creation of the Federal Interagency Reentry Council. This council was and is designed to promote rehabilitation and reintegration for former inmates by constructing a strategic plan to reduce recidivism and victimization, assist individuals who return from prison or jail to become productive citizens and save taxpayer dollars by lowering the direct and collateral costs of incarceration.\textsuperscript{96} The memorandum stated that “providing incarcerated individuals with job and life skills, education programming, and mental health and addiction treatment increases the likelihood that such individuals will be successful


\textsuperscript{95}Tennessee Department of Mental Health and Substance Abuse Services (Summer 2014).

when released. Removing barriers to successful reentry helps formerly incarcerated individuals compete for jobs, attain stable housing, and support their families.”

The War on Drugs has proven to be a never-ending battle. Since the late 1800s to today, the battle wages on. The same sentiment can be said about the opioid epidemic of today. It is a problem that is not only strangling the United States but also countries worldwide. Combating this problem by government legislation, incarceration, confiscating personal property, monitoring prescription issuance, and redesigning of drugs, has done nothing to hinder the spread of this disease. The best option available is education. Continue to educate not only the user but also the public on the dangers of the drug and also the treatment options that are available. Because the length of time spent in the county lockups presents a barrier for adequate treatment, make substance abuse education an immediate response to the presenting problem. To take it one step further, make the programs gender-based because of the differences in how and why males and females become addicted and deal with substance abuse disorders. Make treatment and follow-up care available to everyone who wants to change to a lifestyle that does not involve drugs or crime.

To provide immediate assistance to the individuals who inhabit the local jails, it would be a step in the right direction to offer a list of services within the local area to provide assistance with mental health, alcohol and drug abuse problems, housing, physical health needs, employment, food, and financial assistance. The first step in the right direction is knowing where to go to find the help that is needed.

A final thought is that instead of going after the victim who has succumbed to the throws of drug addiction, the legal system needs to start at the top. The manufacturers of harmful

97 Barack Obama, 2016.
narcotics, when armed with the information regarding the adverse effects of these medicines, as in the case of Purdue Pharma as depicted in Barry Meir’s *Pain Killer: An Empire of Deceit and the Origin of America’s Opioid Epidemic* should be prosecuted to the fullest extent of the law.\(^98\) Allowing this to happen with repercussions is a matter of betraying public trust and safety.

Beth Macy in her book, *Dopesick: Dealers, Doctors, and the Drug Company That Addicted America*, which focuses on opioid addiction in Southwest Virginia and Northeast Tennessee, tells the tale of how opioid addiction ensures the hopes and dreams for families not just in the inner cities, but in the quiet townships and in suburbia. She speaks of how high school standouts die before their time, how mothers and fathers mourn their children as they place them in their graves. She tells of how blame is placed on the shoulders of one man (one African-American man) only to discover that it was not he that started the epidemic that engulfed a small community, but the trust and gullibility that the people had in their doctors not to do them any harm. She eludes to the greed of a Pharmaceutical company and the deceit and strong-armed selling of the pharmaceutical reps who encouraged the doctors to prescribe powerful painkillers to their patients with the belief that the pills were non-addictive. Ms. Macy touches on the response time that it took for anyone to realize the dangers of the narcotics and the disparity in how that response was enacted across racial and socioeconomic lines. She touches on how many turned to crimes to support their habits and the battle that waged between all the players on how to put a stop to the epidemic when there seem to be no end in sight.\(^99\)


The research has been done and continues to be done to enhance the knowledge needed to provide appropriate services to both women and men, especially women who suffer from substance abuse disorders. Research has shown that individuals incarcerated in the local jails do benefit from being exposed to substance abuse education and available treatment. Specialized programs geared toward gender, sexual orientation, race, and ethnicity would be of great benefit to those who require something different from the norm because this is not a case where one size fits all.

Just imagine, walking out of jail, six months clean and you have never felt better in your life and you want to stay that way. You look down at the piece of paper in your hand and smile and ask whoever is looking down on you to help you keep it going.
Works Cited


Interview with jail personnel. February 11, 2019.

[https://www.clinicalkey.com/#!/content/playContent/1-s2.0-S0095454318300757?returnurl=null&referrer=null](https://www.clinicalkey.com/#!/content/playContent/1-s2.0-S0095454318300757?returnurl=null&referrer=null).


“Revolving Door: Drugs Land More Women In Jail”| AP, 8:03, Associated Press,” May 20, 2018. https://www.youtube.com/watch?v=kHe8r4-X5XI.


Appendix 1: Survey Questions for Correctional Officers

1. What type of substance abuse programs exist in your organization?  
   Please list:

2. How often are substance abuse classes offered in your facility?

3. What type of non-substance abuse programs exist in your organization? For example, parenting classes, GED courses, or anger management.  
   Please list:

4. How often are non-substance abuse classes offered in your facility?

5. What other classes other than the ones mentioned above offered?  
   Please list:

6. Which classes are available for males?  
   Please list:

7. Which classes are available for females?  
   Please list

8. On average, how many inmates attend the classes?

9. What type of assessments are conducted upon the inmate’s arrival at the jail? For example, mental health, alcohol and drug, physical health, etc.  
   Please list:

10. How familiar are you with resource services (dental and medical, substance abuse treatment, employment, and housing services) that are available for inmates outside of the correctional setting? Circle one:  
    Very familiar  Familiar  Somewhat Familiar  Not Familiar

11. If a resource list were available, would you be willing to make the list accessible to the inmates upon their release from the facility?
Appendix 2: Survey Questions for Administrators

1. What are the types of programs do you offer in your facility, i.e., education/GED; HIV/AIDS education/treatment; mental health counseling; vocational training; life skills; transitional housing; and/or work release?
   Please list:

2. Of the services offered to inmates in your facility, how many are administered by outside entities, i.e. parenting class instructor, A&D counselor; mental health counselor; etc.?
   Please list:

3. What type of assessments, if any are administered once the inmate enters your facility?
   Please list

4. How familiar are you with referral services (mental, dental and physical health services; substance abuse treatment services; employment services, housing, etc.) that can be utilized by inmates upon release? Circle one.

   Very familiar  Familiar  Somewhat Familiar  Not Familiar At All

5. Does your facility provide case management services?

6. Would you be willing to allow your correctional officers to give inmates, upon release a list of resources that they can utilize to help with re-entry in the community?

7. Would you be willing to offer programs, services and/or initiatives designed to address multiple offender needs?

8. If given the opportunity would you be willing to form partnerships with outside resources in order to upgrade existing programs or initiate programs that would offer various services to inmates upon their release? Outside resources may consist of courts; district attorney’s office; community corrections programs; substance abuse treatment programs, mental health programs, health care programs, housing authority, faith-based organizations, vocational/educational services, etc.

9. Is there someone in your organization who is responsible for coordinating existing programs and implementing others to serve the various needs of the inmate?

10. If one does not exist within your organization, would you be willing to form an advisory board to help provide guidance and to help implement programs geared toward reducing the recidivism rate due to inmates with substance abuse and/or mental health issues?
## Appendix 3: Northeast & East Tennessee Community Services

<table>
<thead>
<tr>
<th>Substance Abuse and Mental Health Care Agency</th>
<th>Address</th>
<th>Services</th>
<th>Northeast &amp; East Tennessee Community Services Agency</th>
<th>Address</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Families Free</td>
<td>P O Box 56, Johnson City, TN 37602</td>
<td>Intensive Outpatient, Pregnant Intensive Outpatient, Women’s Recovery Services</td>
<td>Frontier Health</td>
<td>1167 Spratlin Park Dr, Box 9054, Gray, TN 37615</td>
<td>Intensive Outpatient, Women’s Recovery Services</td>
</tr>
<tr>
<td>ReVIDA Recovery</td>
<td>3114 Browns Mill Road, Johnson City, TN 37504</td>
<td>Medication Assisted Treatment, Structured Outpatient Programs, Family and Group Individual Therapy</td>
<td>The River Ministry</td>
<td>125 W. Main Street, Johnson City, TN 37601</td>
<td>Help women meet basic needs; a safe place, laundry services; showers; feminine hygiene products; referrals; snacks/ beverages and a supportive presence</td>
</tr>
<tr>
<td>James H Quillen, VA Center</td>
<td>Sidney and Lamont Sts Mountain Home TN 37684</td>
<td>Substance abuse treatment, outpatient detox, short-term residential, hospital inpatient, long-term residential, relapse prevention from naltrexone, Buprenorphine used in treatment, Naltrexone (oral), Vivitrol, Co-occurring Mental Illness, Lifestyle Issues, Individual and Family Therapy</td>
<td>Comprehensive Community Services</td>
<td>702 East Sullivan St, Kingsport, TN 37660</td>
<td>Intensive Outpatient, Trauma-related Counseling</td>
</tr>
<tr>
<td>Magnolia Ridge Alcohol &amp; Drug Treatment Center</td>
<td>900 Buffalo Street, Johnson City, TN 37601</td>
<td>Inpatient Treatment, Alcohol and Drug Detox, Help with interview and resume writing skills; offer meals and snacks; assisting released from incarceration individuals in finding housing, medical care and meeting court-ordered appointments; provide transportation to Red Legacy, AA and NA meetings, Outpatient, Telemedicine therapy</td>
<td>Helen Ross McNabb, Inc at Child and Family Tennessee</td>
<td>901 E. Summitt Hill Dr, Knoxville, TN 37915</td>
<td>Intensive Outpatient, Partial Hospitalization, Pregnant Women (Opiates Only), Women’s Recovery Services, Pregnant Intensive Outpatient</td>
</tr>
<tr>
<td>Johnson County Counseling Center</td>
<td>318 Donnelly Street, Mountain City, TN 37683</td>
<td>Outpatient, Intensive Outpatient Treatment, Cognitive/behavior therapy, Substance Abuse Counseling, Trauma-related Counseling</td>
<td>Compressed Community Services Treatment Center</td>
<td>6145 Temple Star Rd, Kingsport, TN 37660</td>
<td>Residential, Outpatient, Short &amp; Long-term, Residential, detox, Intensive Outpatient Cognitive/behavioral therapy, Trauma-related Counseling, Rational Emotive Behavior Therapy, Gender-Specific Program Family Systems &amp; Parenting Concerns Trauma triggers Domestic violence &amp; sexual abuse Self-esteem &amp; self-value Professional pressures Spirituality MMW/Crisis Detox, Medical &amp; Social Detox, Adult Residential Intensive Outpatient Women’s Intensive Outpatient HIV/AIDS Outreach, Medication Assisted Treatment (Opiates only) VIVITROL (opiates only), Women’s Intensive Outpatient, Women’s Recovery Services</td>
</tr>
<tr>
<td>English Mountain Recovery (Men)</td>
<td>1096 Alpine Drive, Sevierville, TN 37876</td>
<td>Gender-Specific Recovery Program Family systems &amp; Parenting, Anger Management, Conflict Resolution, Health emotional exploration, Workplace &amp; Profession Pressures, Spirituality, Role of Masculinity in Recovery</td>
<td>English Mountain Recovery (Women)</td>
<td>1096 Alpine Dr, Sevierville, TN 37876</td>
<td>We assistance, mental &amp; emotional, support, treatment for men and women, Substance Abuse Counseling, Trauma-related Counseling, Helping men and women meet basic needs, a safe place, laundry services; showers; feminine hygiene products; referrals; snacks/ beverages and a supportive presence</td>
</tr>
<tr>
<td>Cherokee Health Systems</td>
<td>2018 Western Avenue, Knoxville, TN 37921</td>
<td>Adult Outpatient, Adult Intensive Outpatient, Medication Assisted Treatment (Buprenorphine) VIVITROL (opiates only)</td>
<td>Helen Ross McNabb, Inc</td>
<td>201 West Springdale Ave, Knoxville, TN 37917</td>
<td>Substance Abuse Counseling, Trauma-related Counseling, Helping men and women meet basic needs, a safe place, laundry services; showers; feminine hygiene products; referrals; snacks/ beverages and a supportive presence</td>
</tr>
<tr>
<td>Hope of East Tennessee</td>
<td>188 Raleigh Road, Oak Ridge, TN 37830</td>
<td>Halfway House, Intensive Outpatient</td>
<td>Parkwest Medical Center</td>
<td>6800 Baum Drive, Knoxville, TN 37919</td>
<td>Substance Abuse Counseling, Trauma-related Counseling, Helping men and women meet basic needs, a safe place, laundry services; showers; feminine hygiene products; referrals; snacks/ beverages and a supportive presence</td>
</tr>
</tbody>
</table>
Medical and Dental Care

Johnson City Community Health Center
2151 Century Lane
Johnson City, TN 37604
423-926-2500

Acute, chronic and preventive care for all family members
Behavioral health services
Breastfeeding assistance & support
Dental services
Diabetes Management & Education
Diagnostic testing, Health education
Health insurance application assistance
Infectious disease, Mammography
Medical legal partnership
Medication assistance
Mental health counseling
NICU follow-up clinic
Pediatrics/newborn primary care
Pharmacy services. Physical therapy
Prenatal/Postpartum care
Radiology services, Social work services
Telehealth for specialty referrals
Women’s health

Mountain City Extended Hours Clinic
1901 South Shady St
Mountain City, TN 37683
Phone: 423-727-1152

Acute, chronic and preventive healthcare
Screening programs
Treatment for common illnesses and injuries
Routine gynecological care
Prenatal care, Newborn care
Mental/Behavioral health counseling
Health education
Home visits
Complete physical examinations
Including:
-- “Well-child check-ups”
-- Pediatric and adult immunizations
-- School and employment physicals
-- CDL/DOT Certified Examinations

Johnson City Downtown Day Center
202 W. Fairview Avenue
Johnson City, TN 37604
Phone: 423-439-7371

Acute, chronic and preventive care for all family members
Diabetes management and education
Diagnostic testing (referral to JCCHC)
Health education, Medication assistance, Mental health counseling
Psychology & Social work services

Carter County Health Department
403 East G Street
Elizabethton, TN 37643
Phone: 423-543-2521

Primary Care Dental Clinic

Green County Health Department
810 West Church Street
Greeneville, TN 37745
Phone: 423-798-1749

Primary Care

Johnson City County Health Department
715 West Main St
Mountain City, TN 37683
Phone: 423-727-9731

Primary Care Dental Clinic

Unicoi County Health Department
101 Okolona Drive
Erwin, TN 37650
Phone: 423-743-9103

Primary Care Dental Clinic

Washington County Health Department/Johnson City Health Center
219 Princeton Road
Johnson City, TN 37601
423-975-2200

Primary Care Dental Clinic

Hawkins County Health Department – Rogersville Office
201 Park Blvd.
Rogersville, TN 37257
Phone: 423-272-7641

Primary Care Dental Clinic

Hawkins County Health Department – Church Hill Office
247 Silver Lake Road
Church Hill, TN 37642
Phone: 423-357-5341

Primary Care Dental Clinic

* When contacting providers ask about their fee payment options. Most will take insurance or help you get the insurance that you need such as TnCare if not, contact the Department of Human Services in the county that you live to apply for health insurance, food stamps and medical insurance.
Homeless Shelters:

**Haven of Mercy (men),** 123 W Millard Street, Johnson City, TN 37604, Phone: 423-929-0616  
http://www.havenofmercy.com/

**River’s Edge Dream Center,** 1200 E 19E Bypass, Elizabethton, TN 37643, Phone: 423-543-4901  
http://dreamcenterag.org

**Hope Haven Ministries Inc.,** 670 Dale Street, Kingsport, TN 37663, Phone: (423)246-6012  
http://hopehavenkpt.org/

**Family Promise of Greater Kingsport (families),** 601 Holston Street, Kingsport, TN 37660, Phone: 423-246-6500, http://fpgk.org/

**Hospitality House of Boone,** 338 Brook Hollow Rd, Boone, NC 28607, Phone: (828)264-1237  
http://hospitalityhouseofboone.org/

**Ministerial Association Temporary Shelter (M.A.T.S.) (men, women, & children)**  
324 North Hill Street, Morristown, TN 37814, Phone: (423) 587-9215  
www.matstn.org

**CEASE, Inc - Domestic Violence Shelter,** 929a W. First N. Street, Morristown, TN 37815, Phone: 800-303-2220, https://ceaseabuse.sitey.me/

Food – Daily Meals:

**Melting Pot Munsey** - United Methodist Church, East Market Street, Johnson City, TN 37601  
Phone: 423-461-8070  
Lunch: Mon-Fri @ 11:30 am, Breakfast: Saturday @ 8:15 am

**Salvation Army,** 200 Ashe Street, Johnson City, TN 37601, Phone: 423-926-8901/423-926-2101  
Lunch: Mon-Fri @ 11:30 am – 12:00pm; Dinner 4:00pm – 5:00pm

**Salvation Army,** 505-517 Dale Street, Kingsport, TN 37662, Phone 423-246-6671  
Email: joe.may@uss.salvationarmy.org Website: http://salvationarmykingsport.org

**Haven of Mercy,** 123 W Millard Street, Johnson City, TN 37604, Phone: 423-929-0616

“Don’t ever be ashamed or scared to ask for help, we all have needed it at some point in our lives because none of us are traveling through this world alone.”