

# End-of-Day Question & Answer Session

ALL CONTRIBUTORS\*

**Rachel Barenie (“RB”):**<sup>1</sup> Alright, at this time, we are going to open up the floor for questions, and we’re also going to ask that all of our speakers come down to the front. So, we have six seats with microphones and we are going to pull a couple chairs on the side and have a traveling microphone, so all the attendees can ask questions to anyone. I’m going to walk around with a microphone, so we can hear your question, but this is really your time to ask them about whether it was their presentation or something of interest, and that’s the time we will use to finish off the program. So, we’ll all get gathered around here to the front.

**Audience Member (“AM”) 1:** Thank you. I’m just interested to know if you all are aware of any research out there, or anything that addresses why this issue is such a big problem in the United States versus in other countries across the globe?

**Taleed El-Sabawi (“TE”):** I do comparative health policy, too, because I have to. There’s a book called *Governance of Addictions*,<sup>2</sup> and it is a typology of all drug policy systems across the world. The authors talk about why the—and my next paper is on this topic, too—so, why do we have a big problem? Because our drug policy system, by standards, are considered draconian. We are still doing what other

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\* *Editor’s Note:* This is a lightly edited transcript of a question-and-answer session to conclude the symposium event at the Cecil C. Humphreys School of Law on March 16, 2018. Memphis Law Review, *Presenters Answer Audience Questions*, YOUTUBE (May 20, 2018), <https://www.youtube.com/watch?v=0B2URq20qfA>.

1. Symposium Editor, Volume 48 *The University of Memphis Law Review*.  
2. See generally TAMYKO YSA ET AL., GOVERNANCE OF ADDICTIONS: EUROPEAN PUBLIC POLICIES (2014).

countries were doing in, maybe up to 1985, now with CARA, but we are very behind. We're very behind.

**Melissa McPheeters (“MM”):** I would just add to that, however, that, literally in the last few weeks, a number of studies have come out showing that the problem is actually rising in other countries as well. It's just that we were the first, and so, as we—

**TE:** I have to disagree, it's not the same level though.

**MM:** Not yet, but the increases seem to be becoming a serious concern, and the hope is that people will learn from what we have seen in the United States, and stop it, you know, at the head here. While it is far worse in the United States, we are seeing it in some other countries that the same issues—there is also some evidence that pharmaceutical companies being restricted more in the United States—are targeting other parts of the world for their sales of their drugs that are being, because of all the information that has come out in the US are being more restricted. So we will wait and see.

**TE:** Definitely check out that book, though, because it's by Oxford Press. It's called *Governance of Addictions*,<sup>3</sup> and it's by the leading drug policy scholars in the world, and it goes over all the typologies.

**AM 2:** Thank you so much for coming. If anything, today has shown me just how much misinformation I've been fed over the years, so, building on the question that was just asked, do you all have recommendations of books or authors that we can look at leaving this symposium for further research on these issues?

**TE:** My dissertation is on this topic. I had to build my coursework. When I started doing this, there were no books published. I started it before we decided we had an opioid epidemic, and I had to go rebuild them. So, the famous works are by Musto, David Musto,<sup>4</sup> Dave

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3. *Id.*

4. *See generally, e.g.*, DAVID F. MUSTO, *THE AMERICAN DISEASE: ORIGINS OF NARCOTIC CONTROL* (3d ed. 1999).

Courtwright<sup>5</sup>—those are the big policy historians. I don't know about treatments and efficacies, you guys can talk about that, but those are the must-reads for any drug policy student.

**MM:** If you want a good read that will really kind of give you the history in the United States, get *Dreamland*<sup>6</sup> by Sam Quinones, whose—it's not like a scientific book so much, but it sort of will tell you some of the story and give you some perspective.

**TE:** So, I come from Ohio. I would not, you know, it's a narrative—

**MM:** It is what it is.

**TE:** It's a narrative.

**MM:** He's a journalist. It's not a scientific book, but in terms of sort of helping people understand the human side of some of this, it has some good stories to it.

**Stefan J. Padfield (“SP”):** The other thing, too, I think this Symposium Issue is actually going to have a lot, right? Because I think most of us are submitting papers that are probably going to be heavily footnoted, and so Maria Pagano has got the website—what is it? *Helping Others Live Sober*<sup>7</sup>—that's got a lot of resources, so that's sort of an upcoming resource that's going to have, I think, a lot of other sites in it, right? Other papers and other books—that sort of thing.

**RB:** And going off that, there is a *Memphis Law Review* subscription form in everyone's attendee packet, and we have the credit card reader here today.

[LAUGHTER]

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5. See generally, e.g., DAVID T. COURTWRIGHT, *DARK PARADISE: A HISTORY OF OPIATE ADDICTION IN AMERICA* (2001).

6. See generally SAM QUINONES, *DREAMLAND: THE TRUE TALE OF AMERICA'S OPIATE EPIDEMIC* (2016).

7. See generally [HELPING OTHERS LIVE SOBER](http://www.helpingotherslivesober.org/), <http://www.helpingotherslivesober.org/> (last visited Dec. 2, 2018).

Thank you, Professor Padfield.

**TE:** I'm happy to email you a reading list if you email me.

**AM 3:** So, well, I'm going to try to sneak two questions in. One is for the BlueCross BlueShield representative. So the Mental Health Parity Act,<sup>8</sup> are you all honoring that? I mean as far as—

**Dakasha Winton (“DW”):** So are you really asking me do we comply with the law?

[LAUGHTER]

**AM 3:** You better believe it . . . .

[LAUGHTER]

**DW:** So, the answer to that is going to be “yes.” We have a full legal team and outside counsel as well, so yes.

**AM 3:** And then my other question is for Doctor El-Sabawi—

**TE:** I'm not a doctor yet, I'm a J.D. You know, they don't like us to be called doctors.

**AM 3:** So I'm curious, so what is—I've heard what you are kind of against—what is your proposed solution? That's what I would like to hear.

**TE:** My proposed solution would be in the *Governance of Addiction*<sup>9</sup> book. I hate to refer to it again, but they—like I said, they have looked at all the measures. For health policy, we do a lot of comparative studies, because, I say, systems. But we don't do it in drug policy, and I don't know why. They do that in that book, and they look at all

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8. Mental Health Parity Act of 1996, Pub. L. No. 104-204, §§ 701–703, 110 Stat. 2874, 2944–50 (1996) (requiring that annual and lifetime benefits for mental health services not be less than other medical or surgical procedures and treatments).

9. YSA ET AL., *supra* note 2.

measures. It's a little dated, about 2014 maybe, but not that dated. So, I would recommend looking at that. It's what they call the public health approach, which does focus—it decriminalizes for the user, but focuses on stopping supply from coming into the country and taking—redefining it so it's problem drug use, and making services free and available, having wrap-around services. It's pretty in depth. It's much more of a wrap-around, more holistic definition of solutions, so, I would take a look at it.

**AM 4:** I had a question for the physicians, but it appears that they've left the room.

**Katherine Steuer (“KS”):** I'm sorry, they had to leave.

**AM 4:** Okay, Ms. Winton from BlueCross, since BlueCross has instituted the requirement for the pre-authorization, has BlueCross done any analytics about the effects of that? Do we know numbers that were denied as a result of that requirement? The opioid load for the enrollees, do we have that kind of analytics?

**DW:** Yes, we do have a lot of analytics on it. One of the things that I can tell you is that we saw a 6% reduction in long-acting opioids, which is what we have the prior authorization [requirement] on. But we saw a complete uptick in short-acting opioids, because we don't have a prior authorization [requirement] on that. So, it's “no good deed goes unpunished,” but we have seen a significant decrease in the number of claims that have come across as a result of people requesting that type of information.

We also saw—it allowed us to have dialogue with the physicians to say, “okay, here are some the things that we need from you from the outset,” which allowed us to make better policies in terms of what the prior authorization is asking for. So, yes, and we continue to look at that data.

**AM 5:** Quick question, BlueCross BlueShield. I'm Ben, I'm from Lakeside.<sup>10</sup> I'm wondering: I've had patients come in, heroin addicts,

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10. See generally LAKESIDE BEHAVIORAL HEALTH SYS., <https://lakesidebhs.com/> (last visited Dec. 2, 2018).

and we are not able to get them certified through insurance because they are not detoxing, and we have had to literally let patients wait in our hallway for—and the guy just said it earlier—for an extended length of time. Most of them don't make it. They walk out, and we cannot commit someone for drug addiction, so has there been any talk on trying to—a little bit more compassion in that area, just because, you know, I'm losing too many friends.

**DW:** I honestly don't know that issue. That's not something that we even get complaints or inquiries about. This is the first time that I'm hearing that. So if you could, could you let me have that information or send me some—

**AM 5:** Yeah, we'll email back and forth.

**DW:** Yes, that'd be perfect, thank you.

**AM 5:** Thank you.

**AM 6:** Hi, my name is Kailee Thacker. I'm a proud Memphis Law alum. Thank you all so much for being here. I'm beaming with pride today. I know that we were talking about the opioid crisis today, and it seems like most everyone has talked about it from an abstinence-only perspective, and I'm wondering if any of you have considered harm-reduction models, and how that might be beneficial to lessening the number of people and lives who are lost on an annual basis in America to this issue?

**MM:** I think we flew over a lot of stuff here today. A couple of the presentations talked about medication assisted treatment or therapy using buprenorphine, using methadone. The way that works best is when it is highly personalized for the patient, and for some patients there is a goal of abstinence, of getting to abstinence, and for some patients there is not. Sometimes it is a maintenance therapy at some level for a long period of time, and sometimes it's for some period of time, and then you have to make a shift with that patient. So, I think that there is a lot of thought in that regard about harm reduction.

I will say the thing that we didn't talk about today for which there is truly no good evidence is the use of marijuana as a harm

reduction, and that is certainly in the public conversation. But, you know, having reviewed very carefully the scientific evidence, there is not good evidence for that as a solution at this time.

**Michael C. Barnes (“MB”):** That sure is a good narrative.

[LAUGHTER]

**TE:** I actually talk about that in my paper. Yes I do, but, you know, I was just going to say that, the public health approach, when drug policy people say that, they mean “harm reduction.” So, that’s the book, the *Governance of Addictions*<sup>11</sup> book, the European approach by the two top nations that had the best outcomes [both] use a harm-reduction approach. I’m not saying they have injection rooms necessarily. Our view as Americans of what harm reduction is and the European view of harm reduction is very different. Their view of harm reduction is, “we are not going to legalize it. What we are going to do is look at all the social determinants of the problem. We are trying to reduce the harms around the drug user. So, we don’t want our addicts to be homeless, let’s get them housing. We want to make sure they have some type of insurance to help pay for the services. Let’s teach them job skills so that they can work and have a purpose.” That is what the harm reduction idea, in drug policy, is very different from the narratives we are using about like, “let’s legalize it,” or “let’s have injection rooms.”

**MM:** Yeah, safe injection exchange.

**Thomas N. Farmer (“TF”):**<sup>12</sup> I would encourage you to go to Colorado and see it first-hand.

**TE:** I’m not saying marijuana’s good, I’m just saying—

**TF:** I would encourage you to go see it first-hand. And I would also say about the MAT, and—listen, law enforcement is going to struggle

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11. YSA ET AL., *supra* note 2.

12. Special Agent and Dir., Tenn. Dangerous Drugs Task Force, Tenn. Bureau of Investigation.

for us to also, and we are embracing—but there’s a—ah, I don’t think we need—my personal opinion is—jumping into another replacement drug because we are seeing a lot.

We also have to remind ourselves, guys on our toxicology and our forensics, examples and things where I’ve also re-indicated that heroin is going up. Fentanyl is going up. Buprenorphine is going up. And buprenorphine going up, as mentioned in those overdosed deaths, it’s also going up. Now, I’m not saying that’s—you’re naturally going to see that when you’re seeing more and more of it being used. There’s going to be a natural diversion of it, and that’s okay. I’d rather see that than the heroin, but we still have to remember that that’s a very addictive and powerful drug in itself.

**Maria E. Pagano (“MP”):** I’d like to clarify something from overseeing an addiction medicine residency program. The replacement therapies, they’re not considered to give a high. They’re not classified as, you know, the same drug, and one of the things we care deeply about is if a person can function as opposed to their skin crawling with the cravings. If a person gets a drug that allows them to participate in their life and show up for work and show up for their relationships, we care about that. And so, the methadone maintenance, yes, you have to go as a daily commitment, but if you are showing up for your life in other areas where you would [otherwise] be crawling out of your skin, I think it’s a better alternative—an expensive one—but it’s a better one.

**AM 7:** What’s the street value for methadone?

**MP:** I think that’s another symposium . . . .

[LAUGHTER]

**TE:** I think there is kind of a misunderstanding a little bit. I think we miscommunicated from the public health angle, so I want to just clarify. The role of public health, we agree that there should be some supply reduction. However, we want to know why some people are using drugs. Why does somebody take a drug? To alter their consciousness. Why are people trying to alter their consciousness? The harm reduction, or the true public health, approach says, “are these



people depressed? Do they lack hope? Do they need job re-training? What do they need so that, even if they successfully finish a program, they are not tempted to reuse again because their environment hasn't changed?" Let me know if you think I'm misquoting the public health perspective, but that's—

**MM:** Yeah, that's true primary prevention. I think the reality is that, if we look at public health practice, it crosses the entire spectrum of that care though.

**MB:** And there's been a significant demonization in some regard of industry today, but I have to say the industry is also trying to make products that will provide these treatments that allow people to get their lives back and be productive parents and workers that also would not be divertible—injections, for example, and implants. So, that could solve the problem that law enforcement has and give people time to focus on their psycho-social recovery.

**RB:** I think we have two more questions, and it is 4:30, that have been waiting.

**AM 8:** I just have a quick question, thank you. Have you noticed any overlap between drug users and low-level drug dealers? And for individuals that might fall into both categories, is the solution that you all propose, treatment programs? Or would it be incarceration?

**TF:** There's no question that there is overlap there. There is no doubt. And each situation is going to be a little bit different assessment. By all means, if we can get to them early, it's going to be small amounts, low-level amounts, then absolutely, we do encourage treatment. We want to get to that person early on, before it elevates to a point, because anybody—there's a rule of thumb, if you can afford to do dope, you can't do the dope that you can afford. Most people can't afford it, so they have to resort to crime or criminal activity to feed their addiction. Obviously, we would much rather divert them in the beginning. But down the road, if that unfortunately results in the death of someone else, or their crimes elevate to a point, then we have no problem prosecuting that person.

**RB:** And the last question?

**AM 9:** John Dolan, criminal defense lawyer in Memphis and Mississippi for now approaching 40 years. I'll take away from this today that there are a lot more facets to this problem than even I thought about, and Dr. El-Sabawi a moment ago almost summarized what's going on. I spoke with one of the presenters earlier, and my question is almost more philosophical. Will we, as a society, get to a point where, from an economic premise, we simply have to allow the maladaptive behaviors to have its natural and normal consequences? Will we have to allow these addicts to die so that we can stop sending them into the emergency room—and I'm sorry the physicians are not still here—time after time after time again and stop utilizing our resources to treat these people who won't behaviorally or cannot behaviorally comprehend and adapt to something that will fit into our societal norms?

**MB:** You get a hard no from me. A hard no.

**AM 9:** Sir? A "hard no" that we should never get there?

**TE:** Well, if you're talking economically, our division is run by economists, and what I will tell you right now is that loss of life costs money, and that the cost of loss of life, even if it is just a death on the community, is an economical cost that you have to factor into that question.

**KS:** I think the physicians would definitely say "no" to that, despite the use of resources, just from my conversations with them. And I would pose a question: "is that really the world that we want to create?"

**AM 9:** All of us love life.

**RB:** On that note, I am going to wrap up our day here.