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*Publication of contributions does not signify adoption of the views expressed therein by the Tennessee Journal of Law and Policy, its editors, faculty advisors, or The University of Tennessee.*
FOREWORD

A ROT IN HEAVEN
A POWERFUL INVESTIGATIVE PARTNERSHIP, THE OPIOID CRISIS, PILL PROFITS, AND A PULITZER PRIZE

Becky L. Jacobs*

“Almost Heaven, West Virginia”

Bill Danoff, Taffy Nivert, and John Denver¹

“All the host of heaven shall rot away, and the skies roll up like a scroll.”

Isaiah 34:4²

In the spring of 2018, when the Tennessee Journal of Law and Policy hosted the “Healing Appalachia: The Role of Professionals in Solving the Opioid Crisis” symposium, there were more than 400 lawsuits pending against corporations that manufacture, distribute, and retail opioids in just one consolidated case in the federal

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district court for the Northern District of Ohio. This single, consolidated case initially involved only claims brought by governmental entities, but the Judicial Panel on Multidistrict Litigation consolidating the cases acknowledged that the action potentially could include claims brought by individuals, consumers, hospitals, and third party payors, as well as additional categories of defendants.

It is not hyperbole to say that we can thank Eric Eyre of the Charleston Gazette-Mail, of Charleston, West Virginia, for these lawsuits and for the momentum that we now are experiencing in support of a response to the national opioid crisis. The government, the legal community, and many media outlets seemingly were willing to ignore the opiate plague that was infecting our communities, but Eric’s Pulitzer Prize-winning series of articles made it impossible for anyone to profess ignorance any longer.

As lawyers, we also should take pride in the role that our colleagues from WVU College of Law, Pat McGinley and Suzanne Weise, played in supporting Eric’s efforts to uncover the shocking data that appeared

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5 Eric also won the Scripps Howard First Amendment Award, was a finalist for the Selden Ring awards, and won a first-place award for investigative reporting from the Association for Healthcare Journalists. See Susan Heavey, Reporter’s Work Pushes Regulators, Legislators to Act on Opioids, ASS’N HEALTH CARE JOURNALISTS: COVERING HEALTH (May 8, 2017), https://healthjournalism.org/blog/2017/05/reporters-work-pushes-regulators-legislators-to-act-on-opioids/ [https://perma.cc/MDV6-FF6W].

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in his articles. Without their tireless efforts, Eric may not have been able to prevail against the well-financed political and industry resistance to accessing the data that so starkly revealed the appalling opiate prescription and distribution patterns in West Virginia.

To put the importance of Eric’s contribution, and that of Pat and Suzanne, in perspective, consider the odds against which they were fighting - and it is critical to remember that, at the time Eric, Pat, and Suzanne were seeking the distribution data, the only litigation pending against any entity or individual involved in the opioid distribution chain was the groundbreaking lawsuit filed by then-West Virginia Attorney General Darrell McGraw in 2012 against Cardinal Health. Eric’s newspaper, the Gazette-Mail, was a family-owned, daily newspaper with a print circulation of 37,000, and Pat and Suzanne were providing their services pro bono.

Thus, the odds were enormous, considering the Goliath-like financial resources of their opposition. Opioid painkillers are a nearly $9 billion-a-year market in the U.S. alone, and pharmaceutical companies such as Purdue Pharma L.P., Johnson & Johnson, Teva, Allergan PLC, and the Endo Health Solutions unit of Endo International PLC have all earned billions over the years from the sale of these drugs. Wholesale distributors like McKesson Corp., Cardinal Health, and AmerisourceBergen also have profited, as have the

9 Katie Tabeling, County Files Lawsuit Against Opioid Manufacturers, CECIL WHIG (Elkton, Md.) (Jan. 9, 2018), http://www.cecildaily.com/spotlight/county-files-lawsuit-
physicians, pain clinics, and pharmacies prescribing and dispensing these medications - some legitimately, some not.  

These profits, though, have had a very high public health cost, as Eric’s articles helped to expose. Here is just a snapshot of the scale of what is being called an epidemic and what President Trump declared, in August of 2017, to be a “national emergency.”

According

 against-opioid-manufacturers/article_9be21338-13aa-5855-b8be-caf98167bf5f.html [https://perma.cc/Y2PV-RXFU] (“Among the lawsuit’s 20 manufacturing defendants, 14 are subsidiaries of six pharmaceutical giants, including Endo, Purdue, Johnson & Johnson, Teva, Allegan [sic] and Mallinckrodt Pharmaceuticals. The remaining defendants are McKesson, Cardinal Health and AmerisourceBergen - characterized in the complaint as ‘the big three’ drug wholesale distributors.”); see also Joey Garrison, Nashville Sues Opioid Makers, THE TENNESSEAN, Dec. 23, 2017, at A5, https://www.tennessean.com/story/news/2017/12/23/nashville-sues-opioid-manufacturers-recoup-costs-fighting-epidemic/978861001/ [https://perma.cc/3CYT-3L8N] (“Cities like Nashville and their taxpayers have borne the cost of the opioid epidemic for far too long while the pharmaceutical manufacturing industry, consisting of manufacturers and distributors, has reaped astronomical profits[.]”).


12 Joel Achenbach, John Wagner & Lenny Bernstein, Trump Says Opioid Crisis is a National Emergency, Pledges More
to the CDC, more than 200,000 people in the U.S. died from overdoses related to prescription opioids from 1999 to 2016.\textsuperscript{13} In 2016 alone, more than 46 people died every day from overdoses involving prescription opioids.\textsuperscript{14} Also, in 2016, three of the six states with the highest rates of death due to drug overdose were located in close geographic proximity to Tennessee: West Virginia (52.0 per 100,000), Ohio (39.1 per 100,000), and Kentucky (33.5 per 100,000).\textsuperscript{15} Tennessee’s rate was 24.5.\textsuperscript{16}

These death rates are startling, but perhaps not as surprising as one might first imagine given that doctors prescribed enough opioids in 2016 to provide every man, woman, and child in the U.S. with 36 pills each.\textsuperscript{17} The highest prescribing rates, however, reportedly were concentrated in the more rural states that year, primarily in the South; in Tennessee, with the second highest prescribing rate in the nation, every resident could have had 70 pills each in 2016.\textsuperscript{18}

The West Virginia numbers were even more alarming. Eric’s research revealed that, “[i]n six years,
drug wholesalers showered the state with 780 million hydrocodone and oxycodone pills, while 1,728 West Virginians fatally overdosed on those two painkillers[19] Proportionately, in terms of geographical distribution and in terms of population, that “amount[s] to 433 pain pills for every man, woman and child in West Virginia.”[20] In that state, the data that Eric secured uncovered a dismaying pattern of distribution: small, independent pharmacies received a disproportionate percentage of the shipments of prescription opioids, e.g., wholesale distributors delivered 1.4 million to 4.7 million hydrocodone pills each year to locally-owned pharmacies in Mingo and Logan counties when one of the busiest Wal-Mart’s in West Virginia received only about 5,000 oxycodone and 9,500 hydrocodone pills annually.[21]

The companies involved in the opioid distribution chain fought tooth-and-nail to keep these data from being released, relying upon an impressive array of legal talent to defend them on this issue[22] and on the other claims of, inter alia, negligence, public nuisance, violations of West Virginia’s consumer act, etc. that arose in that ground-

20 Id.
21 Id.
22 AmerisourceBergen Drug Corp.’s Objection to Hearing Date and Opposition to Motion on Behalf of the Charleston Gazette to Intervene for the Limited Purpose of Moving the Circuit Court to Unseal the Plaintiff’s Second Amended Complaint at 5, State ex rel. Morrissey v. AmerisourceBergen Drug Corp., Civil Action No. 12-C-141 (W. Va. Cir. Ct. 2016) (“And if [the DEA] protect[s] any of that information from the intrusive journalistic nose of the Gazette, then its confidential nature must be respected.”).
breaking case filed against them in West Virginia.\textsuperscript{23} Highly regarded national and West Virginia firms such as Jones Day; Morgan Lewis; Steptoe & Johnson; Jackson Kelly; Bowles Rice; and Spilman Thomas & Battle were involved as defense counsel in the West Virginia litigation.\textsuperscript{24}

Pat, Suzanne, and Boone County, West Virginia lawyer Tim Conaway provided essential, legal support to the Gazette-Mail to force disclosure of the court records that revealed these staggering distribution figures.\textsuperscript{25} The sealed complaint in the State’s lawsuit contained shipment data supplied by defendants and the U.S. DEA during discovery in the case, and the West Virginia Attorney General at that time, Patrick Morrisey,\textsuperscript{26} and

\begin{itemize}
\item \textsuperscript{24} See, e.g., Docket, West Virginia v. AmerisourceBergen, Civil Action No. 2:12-CV-03760 (Closed Mar. 27, 2013).
\item \textsuperscript{25} See supra note 22. A conversation about these events between Pat and Eric took place at an event at Washington & Lee at https://livestream.com/wlu/wv-opioid/videos/165654080.
\end{itemize}
other plaintiffs apparently agreed with the defendants’ arguments that the data were proprietary. Pat et al. filed a motion on behalf of the Gazette-Mail to unseal the complaint, and, despite a vigorous and lengthy fight to maintain the confidentiality of the records, the judge ordered the first ever public release of these previously undisclosed data.

The import of this legal event cannot be overstated - these data shifted the public discourse on the opioid crisis. Opioid abuse was of course on the public radar, but opinion did not appear to have moved much beyond the “blame the addict” and “those damn pill mills” mentality. The data in the lawsuit, however, told stories of predatory practices and suffering people in pain, and they inspired a sense of outrage and urgency that prompted enforcement and reform efforts by regulators and legislators.

In West Virginia alone, for example, Cardinal Health and AmerisourceBergen, two of the nation’s “big three” drug wholesalers, agreed to pay the State a combined $36 million to settle their lawsuits, and at least one county commission has filed suit against all of the “big three” to recover costs associated with prescription drug abuse, with other West Virginia counties and cities declaring their intentions to follow suit. Beyond West

clients, including several involved in the opioid industry, such as Allergan, Johnson & Johnson, Janssen, Purdue Pharma, and the membership of the Healthcare Leadership Council; e.g., Cardinal, Sanofi, Johnson & Johnson, and Pfizer. Id.


28 See id.

29 See Heavey, supra note 5.

Virginia’s borders, nearly every state Attorney General has either filed a lawsuit against an opioid manufacturer or distributor or is involved in an investigation and has issued subpoenas for records. The MDL litigation consolidated in the Northern District of Ohio currently involves 400 cases filed by cities, counties, and states against manufacturers and distributors of opiates, but those involved have publicly acknowledged the possibility that individuals, consumers, hospitals, and third party payors might be added as plaintiffs. The distributors-to-pay-m-to-settle-wv-painkiller-lawsuits/article_b43534bd-b020-5f56-b9f3-f74270a54c07.html [https://perma.cc/AVK9-TB9E].


32 See supra note 4. The Tennessee Attorney General was not, at the time of the publication of this Foreword, a party to the federal multidistrict litigation pending in Cleveland, Ohio, but that Office has publicly stated that it is “voluntarily engaging in settlement discussions” in connection therewith. See Press
lawsuits involve claims as widely divergent as public nuisance, negligence, negligent misrepresentation, fraud, and unjust enrichment as well as violations of consumer protection laws and the state versions of the Controlled Substances Act and RICO statute(s).\footnote{Id.}

The pool of defendants is also expanding. For example, attributing blame and seeking recovery even further afield, several cities in West Virginia brought a class action suit against the Joint Commission on Accreditation of Health Care Organizations on behalf of all U.S. cities and towns.\footnote{Complaint, City of Charleston v. The Joint Commission, No. 2:17-cv-04267 (S.D.W.V. Nov. 2, 2017).} The Joint Commission is the entity that certifies U.S. health care organizations and programs. The suit alleges that the Joint Commission’s Pain Management Standards “grossly misrepresented the addictive qualities of opioids and fostered dangerous pain control practices[.]”\footnote{Id. at 2.}

Outside of the civil context, prosecutors have begun to bring charges against individuals for crimes involving opioid abuse and distribution. In 2015, the Obama-era U.S. Department of Justice issued a memo directing federal prosecutors to pursue charges against individual defendants.\footnote{Memorandum from Deputy Att’y Gen. Sally Q. Yates on Individual Accountability for Corporate Wrongdoing (Sept. 9, 2015), https://www.justice.gov/archives/dag/file/769036/download [https://perma.cc/8ARN-NPCS].} As an example of its use of this policy, the DOJ charged John Kapoor, former CEO of Insys Therapeutics, with conspiracy to commit racketeering and mail and wire fraud in connection with a bribe and kickback scheme associated with Subsys, the

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\footnote{Id.}

\footnote{Complaint, City of Charleston v. The Joint Commission, No. 2:17-cv-04267 (S.D.W.V. Nov. 2, 2017).}

\footnote{Id. at 2.}

company’s powerful synthetic opioid fentanyl in spray form.\textsuperscript{37} Closer to home, in early 2017, a Maryville doctor received a 10-year federal prison sentence for serving as the supervising and prescribing doctor at a notorious Maryville pain clinic.\textsuperscript{38}

Legislative activity is also taking place in response to the momentum generated in the wake of Eric’s articles. That activity, however, is focused primarily at the state level. As of April 2018, twenty-eight states had enacted legislation that either limited, offered guidance, or listed requirements related to opioid prescribing practices.\textsuperscript{39} Further, every state except Missouri has enacted monitoring program legislation “designed to reduce doctor shopping and identify patients at risk for substance use disorders.”\textsuperscript{40} In addition to these


legislative initiatives, states have considered, proposed, and/or adopted opioid-related legislation in a number of other categories, including opioid taxes, pain clinic licensure, training and education plans, and pill “take-back” programs. At the federal level, one hears numerous claims that actions are being taken to “combat the opioid crisis[,]” including President Trump’s plan to use the death penalty as an option for drug dealers in fatal opioid overdose cases. Not all have been deemed to be a success. For example, an earlier piece of federal legislation, the Ensuring Patient Access and Effective Drug Enforcement Act of 2016, has been subjected to scathing criticism, with even its title described as “misleading.” According to a report resulting from a joint investigation by The Washington Post and “60 Minutes,” an ex-DEA lawyer working for a pharmaceutical company drafted an early version of the

Acts 1002 (codified at TENN. CODE ANN. §§ 53-10-301 to -312 (2016)).


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law.\textsuperscript{45} The final version dramatically curtailed the DEA’s enforcement powers: the agency now must demonstrate that a company’s actions represent “a substantial likelihood of an immediate threat” before it can halt drug shipments, whereas previously it needed only to show that they posed an “imminent danger” to the community.\textsuperscript{46} The law also allows companies to submit “corrective action plans” before they can be sanctioned by the DEA,\textsuperscript{47} which one former DEA investigator called a “get out of jail free card[.\textsuperscript{48}]

More recently, the new two-year budget deal passed in early 2018 promised funding for the epidemic, the details of which were not specified.\textsuperscript{49} Additionally, a bipartisan group of senators introduced a follow-up bill to 2016’s Comprehensive Addiction and Recovery Act, commonly referred to as CARA 2.0.\textsuperscript{50} A version of the bill was introduced in the House of Representatives by Tennessee Representative Marsha Blackburn.\textsuperscript{51} If passed, CARA 2.0 would, among other things, commit more funding to the fight against the opioid crisis, restrict access to opioid painkillers, improve access for medication-assisted treatment, and increase civil and criminal penalties for opioid manufacturers if they fail to report suspicious orders or fail to prevent diversion.\textsuperscript{52}

The impact of Eric’s articles and its aftermath can be seen far beyond the nation’s courtrooms and

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\textsuperscript{45} Id.


\textsuperscript{48} See Higham & Bernstein, \textit{supra} note 44.

\textsuperscript{49} See, \textit{e.g.}, Bipartisan Budget Act of 2018, H.R. 1892, 115th Cong. \S\ 50723 (2018).


\textsuperscript{52} Id.
legislatures, with some good results and some not as
positive. Eric discussed some of these results at the
symposium. For example, while he was relieved that
many of the opioid “pill mills” in West Virginia had been
shut down or had voluntarily closed their doors, he
suspected that a number of them had simply changed the
signs on their doors and morphed into “treatment
centers” that use medication to treat the opioid addicts
that they helped to create.

Medication-assisted treatment for opioid
addiction is still very controversial. The main criticism
of using medication in this context is that it is just
replacing one drug - whether an opioid painkiller or
heroin - with another, such as methadone, buprenorphine, and naltrexone. Research clearly
demonstrates, however, that medication improves
outcomes for patients with opioid use disorders.

Along with the success of these treatments,
several tag-along legal issues have arisen which are
worthy of monitoring. One involves claims by the
Attorneys General of 35 states and the District of
Columbia that British pharmaceutical manufacturer
Indivior Inc. and U.S. company MonoSol Rx “product
hopped” in order to delay less expensive generic versions

53 See, e.g., Sameer Hassamal et al., Overcoming Barriers to
Initiating Medication-Assisted Treatment for Heroin Use
Disorder in a General Medical Hospital: A Case Report and
54 Medication and Counseling Treatment, SUBSTANCE ABUSE &
samhsa.gov/medication-assisted-treatment/treatment
[https://perma.cc/5VC4-LULF]. Buprenorphine (Subutex) and
Buprenorphine-naloxone (Suboxone) were approved by the
U.S. FDA in 2002 to treat opiate dependence. Naloxone is the
drug used to revive overdose victims.
55 Mollie Durkin, Primary Care Takes on Opioid Addiction,
archives/2017/10/primary-care-takes-on-opioid-addiction.htm
[https://perma.cc/L49U-BM2H].
of Suboxone, Indivior’s opioid addiction treatment drug.\textsuperscript{56} The defendants in that case are accused of conspiring to create a sublingual film version of its Suboxone drug shortly before its license expired in order to extend its patent; of incrementally increasing the price of its tablets and engaging in potentially misleading marketing to encourage patients and doctors to switch to the new film version; and of then announcing its intent to remove the tablets from the market entirely.\textsuperscript{57}

Another pharmaceutical manufacturer in the ever-growing opioid treatment market has drawn fire for its marketing practices. Alkermes, a Massachusetts company, makes a monthly injectable treatment medication called Vivitrol that blocks the effects of opioids and reduces cravings, and the company has taken its aggressive marketing pitch directly to drug court judges, prosecutors, and other officials in the criminal justice system who appear receptive to the “nonaddictive” qualities of its product.\textsuperscript{58} According to medical professionals, this approach is misleading and contributes to the “existing stigma on the use of opioid [methadone or buprenorphine] therapy in the treatment of opioid addiction, despite a large and robust evidence base showing [its] effectiveness . . . for opioid addiction.”\textsuperscript{59}

In addition to the potentially predatory practices of the companies and individuals seeking to exploit the market for opioid addiction treatment, there are other


\textsuperscript{57} Id.


\textsuperscript{59} Id.
obvious downsides to the successful closure of many of the unethical pill mills that blighted our rural communities. Some of the poor souls who are no longer able to access opioid prescriptions have turned to heroin or to the very deadly synthetic opioid, fentanyl. According to the CDC, “illicitly manufactured fentanyl is now a major cause of opioid overdose deaths in multiple states.”

One law enforcement officer compared it to a community weapon of mass destruction: “[i]t’s manufactured death.”

Hopefully, no one will be discouraged from seeking to combat the opioid crisis in all of its forms, whether the drug has been produced legally or illegally. We should look to Eric’s efforts, and those of our colleagues whose legal work supported him, for courage and inspiration. The unsealed data that Eric and Pat et al. secured in West Virginia are still among the only such data that are publicly-available. The industry, with support from the U.S. Department of Justice and the U.S. DEA, is still demanding that its data be protected on the grounds that disclosure could violate privacy rights, breach trade secrets, interfere with law enforcement investigations, and encourage criminal activity. This is

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despite the Justice Department’s request to participate in the settlement talks in the large MDL pending in the Northern District of Ohio.63

This reluctance is understandable. The publicly-available raw numbers in Tennessee are sobering. In Knox County alone, there were 294 suspected drug overdose deaths in 2017 and 84 so far in 2018. Those are not just numbers: those are our children, mothers, fathers, siblings, and friends, and each leaves behind grieving loved ones, all of whom deserve the best of our combined professional efforts. As painful as the truth may be, lawyers and journalists should be working to uncover it, individually and as partners. Eric and his legal support may be a tough, if not an impossible, act to follow, but it is one to which I hope that we all will aspire.

INTRODUCTION: Welcome to "Healing Appalachia, The Role of Professionals in Solving the Opioid Crisis." My name is Michael Deel. On behalf of the Tennessee Journal of Law and Policy and the University of Tennessee College of Law, thank you for attending.

Today we have gathered experts who are working to find legal and political solutions to this public health crisis while also working with individuals who are suffering on a day-to-day basis. I invite you to not only listen to their stories but to learn from them and to remember their efforts when you make your own everyday decisions, decisions like how to help a friend, how to effect policy, how to find hidden information, or simply how to vote in the next election.

I would like to thank all the panelists and moderators that are participating today and also thank everyone who helped put this event together. So many
people gave their time and energy to make this symposium possible.

Mr. Eric Eyre and Professor Patrick McGinley will deliver our keynote address which will be followed by two panel discussions and a documentary viewing. We will take a 15-minute break between each session and there will be a transcript available after we get it published in the next issue of TJLP.

Mr. Eyre won the Pulitzer Prize for investigative reporting for his articles regarding the distribution of 750 million prescription pills in West Virginia and the tragic overdoses that followed those pills. He currently works as a statehouse reporter for the Charleston Gazzette-Mail.

Professor McGinley is a Charles H. Hayden II Professor of Law at West Virginia College of Law. Professor McGinley teaches administrative law, environmental law, and appellate advocacy. He also represented the Charleston Gazzette-Mail in a lawsuit that resulted in a court order unsealing the documents that led to Mr. Eyre's articles.

Professor Becky Jacobs from the University of Tennessee College of Law will moderate this discussion. Please join me in welcoming them.

MS. JACOBS: So just to like frame our discussion this afternoon, I want to give you just a few facts. So opioid painkillers are a nine-billion-dollar-a-year market in the U.S. alone. In pharmaceutical companies such as Purdue Pharma, Johnson & Johnson, Teva, and Allergan have all earned many billions over the years from the sale of these drugs. Wholesaler distributors like McKesson, Cardinal Health, and AmerisourceBergen also have profited, as have the physicians and pain clinics that prescribe these medications, some legitimately, some not so legitimately.

These profits, though, have had a very, very high public health cost as the work of our guests today helped
to expose. According to the CDC, from 1999 to 2016, more than 200,000 people have died in the U.S. from overdoses related to prescription opioids. That's just the prescription opioids. In 2016 alone, more than 46 people every day have died from overdoses involving prescription opioids. Also in 2016, three of the five states with the highest rates of death due to drug overdoses were close to us: West Virginia had 52 per 100,000, Ohio had 39.1 per 100,000, and Kentucky had 33.5. Tennessee's rate was 24.5. And our guests today fought to make these data public. So I want to thank them very much for being here.

I want to start by asking you, for those who aren't familiar with kind of what these drugs are, can you describe the specific painkillers that we're talking about and which ones are the focus of this investigation?

MR. EYRE: Sure. The two that we primarily focused on, because we got the DEA data on were hydrocodone, which is Lortab and Vicodin, and oxycodone, which is OxyContin. And there's plenty of other pills that are distributed, but those were the two that we focused on primarily.

MS. JACOBS: Okay. So how you did you get interested in the topic, and how and when did Pat get involved?

MR. EYRE: I kind of wound up in it in a different way. I covered the legislature for West Virginia, so I'm based at the Capitol, and we had a new attorney general elected in our state. There had been a lawsuit filed about six months prior to his win by our former attorney general, and that lawsuit was against the drug wholesalers. When our new attorney general got elected, I got this phone call that this woman wanted to meet with me outside the Capitol; she had some information for me.
She brought this envelope of stuff. She had—I remember it was crazy because she had a dog with her named Bernard the Pekinese. So she's literally handing stuff out and I'm worried I'm going to get bit by this dog, Bernard the Pekinese. What it was was information about the new incoming attorney general's ties to these drug wholesalers. The one company that you mentioned, Cardinal Health, had paid for his inauguration, and then when we also looked back at contributions, a lot of these drug wholesalers after the lawsuit was filed in July of 2012 had given money to the attorney general. And so we did a story about that and he said over and over that he had recused himself from the case at the beginning of when we assume he took office, but we had heard from staff that that wasn't the case. So we actually filed a number of Freedom of Information Act requests and that wound up in court.

This photo here is—the attorney general is on the right there. This was a photo taken by a New York Times reporter, Eric Lipton, who actually won the Pulitzer Prize two or three years ago and he was writing about both the Republican Attorneys General Association and the Democratic Attorneys General Association wining and dining various attorneys general to get them—to try to persuade them to drop lawsuits or not file lawsuits. And the woman there is Pam Bondi. I believe she's still the attorney general in Florida.

And the story was about her being pushed—this was in the Hotel del Coronado in San Diego, a beautiful resort there—she was being pushed to drop a lawsuit against 5-hour ENERGY. And these guys are lobbyists. I think it was something like three thousand dollars a night to stay there. I met the reporter at the Pulitzer ceremony. And eventually when they found out what he was doing, he got kicked out of course but... So the next step was the FOIA lawsuit, and maybe Pat can talk a little bit about that. This is back in 2013, 2014.
MR. MCGINLEY: Yeah. So—

MS. JACOBS: Before you do that, step back a little bit and—

MR. EYRE: The lawsuit—

MS. JACOBS: —the first lawsuit that Darrell McGraw filed.

MR. MCGINLEY: So in was it 2012 a long-time West Virginia attorney general, Darrell McGraw, filed the first case against drug distributors of opioid drugs, recognizing the impact of opioids in West Virginia, and, really, the first public official to take some kind of action. The lawsuit, the cause of action, was new and it was suggested that this is a looser, the attorney general's office is up against Big Pharma, billion-dollar enterprises, lawyers from New York and Philadelphia and Cleveland. But that lawsuit was filed. And then in a very narrow election, Attorney General McGraw lost to Patrick Morrisey. He's pictured there in blue jeans with a lobbyist and the attorney general of Florida. And so within six months of the time that these "pill mill" cases, that's what they were referred to, were filed in the summer of 2012, a new attorney general who had formerly been a lobbyist for trade associations from the pharmaceutical industry took office.

MR. EYRE: And what I forgot to mention, his wife was the lead lobbyist for Cardinal Health in Washington D.C. and made millions of dollars.

MR. MCGINLEY: Cardinal Health being one of the three leading opioid drug distributors in the country. And she continued to be a lobbyist until after our lawsuit. There was an ethics complaint filed against the attorney general at some point and said, well, I don't have to do
this but I won't have my fingers on any of these cases. But that took a couple of years. In the meantime, Eric and the *Gazzette-Mail* are interested in what this new attorney general was going to do in terms of supervising these "pill mill" cases, considering his former relationship with the industry. And Eric filed several FOIA requests and he was basically stonewalled, the responses didn't meet the requirements of the West Virginia Freedom of Information Act. I think the first one, they said, well, if we had these documents you're requesting that relate to whether the attorney general is supervising the "pill mill" cases, if we have them, they would be exempt.

And, you know, at that point the *Gazzette* asked me to be of assistance, because I've done a lot of FOIA stuff, and so I wrote to the attorney general and I said, well, that's not good enough, you've got to look for it, you can't just say if you have it. And then there was a series of back and forth with nonresponsive answers from the attorney general, and I would say, well, let's read the law, you know, you must have something. And then, ultimately, after about six months, they said— they called Eric and said, okay, you can come and look at the documents but they are totally redacted and you can't take photographs, and they set a time for it. And we talked and we responded, that's not what the law requires, no, we're not doing that. And they said, we'll get back to you.

They didn't get back to us. We filed a FOIA suit. It went on for almost a year. We did discovery. We found out they had documents that they hadn't mentioned before but they claimed were attorney-client privilege, work product. And we thought we had a really good paper trail, a good case for joint motions for summary judgment, cross motions for summary judgment. And the judge ruled against us and granted summary judgment. And I was depressed. I thought this is a winner. Eric and the others at the *Gazzette* were taken aback. And then something happened that was interesting.
MR. EYRE: So after we lost the FOIA case, somebody—I was not home. This is a recreated—actually I found this—this is actually the envelope that it came in but somebody walked up to our house and my son texted me at work and said some man just came up to our house and dropped something in the mailbox with your name on it.

Go to the next slide. You can't see it there but that was one of the e-mails that was being withheld, and what it said in the e-mail was that the attorney general has specific instructions regarding this case. So it was hard to believe—he had done multiple interviews, not just with me but with other media, over and over again saying that he was completely recused from the case, he had had nothing to do with it since the day he took office. And this countered his assertions for sure. And then where do you want—

MR. MCGINLEY: Well, so Eric wanted to write about this of course—

MR. EYRE: Oh yeah.

MR. MCGINLEY: —because this is exactly the opposite of what the attorney general had stated in court proceedings. And so, Eric, you can tell the story. As reporters usually would do, you asked him for comment.

MR. EYRE: Yeah. They required all their questions to be e-mailed, so I e-mailed a bunch of questions about when you said that you recused yourself from the case, it would seem this contradicts what you are saying. We also found at around the same time there had been some documents saying that a court hearing related to this drug distributors lawsuit had to be canceled because Attorney General Pat Morrisey can't fit it into his schedule and can't make it. And so if he was
recused from the case, why would they be saying he couldn't be there and things like that. So I e-mailed to their press person these questions about what's going on. And then the next thing you know, their general counsel called or e-mailed you, Pat.

MR. MCGINLEY: Their solicitor general.

MR. EYRE: Became solicitor general.

MR. MCGINLEY: We never had a solicitor general in West Virginia but it sounds like a good title. Yeah, he called me, and I was actually here in Knoxville, at the time I was on my way to the Public Interest Environmental Law Conference, and I get the call on my cell phone from Misha—

MR. EYRE: Misha Tseytlin.

MR. MCGINLEY: —Tseytlin.

MR. EYRE: He's now the solicitor general at Wisconsin.

MR. MCGINLEY: —and there were documents that were in the files of the court in our FOIA case that were produced by (inaudible) and that were examined by the court, quashed by the court in camera before it granted summary judgment against us. And so he called me and he said you better tell your client not to publish this story about documents that are under seal in the court, you're going to be sanctioned, and we're not going to tolerate this. And, you know, I'm in the rental car and—

MR. EYRE: And I'm like am I going to jail or .

. .
MR. MCGINLEY: And I said, Misha, have you ever heard of the Pentagon Papers case? Misha was a law clerk to Justice Kennedy, so he knew the story. I said you do what you want but I can assure you this is going to go to print. But that wasn't the end of the story. We had to have conversations with the editor and publisher and they were concerned with are they going to sue us. And I said they can sue you, anybody can sue you, but this is a winner.

And they went ahead and Eric told the story. It didn't have much impact. He continued to deny and it just sort of went over people's heads. But we knew about that, it was clear the relationship there. The overarching concern was that the attorney general would somehow dump the "pill mill" cases, that it would settle them cheap or make errors, who knew, who knows. But he certainly with the appearance of impropriety with his prior relationships and the representations made to the Court, he shouldn't have been involved at all.

MS. JACOBS: Well, in fact, he wasn't very aggressive about the data that you guys had to intervene to get. So tell us about that. Because that's what broke—

MR. EYRE: That was—that was the next thing. So if we sort of flash forward, I kind of kept following the story and started seeing stuff in various legal filings. But in I think it was around March 2016 we got wind that there had been what was called a second amended complaint or a revised complaint. When they filed the original lawsuit back in 2012, the judge in this rural county that was handling it said we need some specifics here, we need some examples of, you know, this sending these larger quantities of drugs, these "pill mill" pharmacies. So they had filed an updated complaint called the second amended complaint and it was filed under seal. So this was the State of West Virginia filing a complaint outlining its allegations against the drug
distributors and you couldn't see it. It was just completely filed under seal. And I went to Pat and said, is this possible.

MR. MCGINLEY: Yeah. I said, well, that certainly violates the West Virginia Constitution, violates West Virginia Freedom of Information Act, and the West Virginia Rules of Civil Procedure. So the general rule is that public documents should be public when they are filed with the court. And here he had a complaint on behalf of the State that says on behalf of the people of West Virginia against these drug companies, but the people don't know what the allegations are. And so the State itself had come around to the point where it wanted the second amended complaint to be unsealed, but the Court did nothing and they didn't assert that aggressively. So I talked to Eric, and I got other things to do at the law school, and I'm thinking well they are going to act, nothing happened, so we filed a motion to intervene for the purposes of seeking unsealing of the second amended complaint, which is in the materials that you have. And we basically argued that there's no law on the side of the drug companies.

Their response, which I think is in the material as well, was that these are essentially trade secrets, confidential business information about how many pills, opioids, that we sell to pharmacies, so our competitors would find out who the pharmacies are and how much. And, you know, we read that and said, what? And not only that, it was old data. And we went to Boone County Circuit Court for a hearing. There were lawyers from everywhere. The court was filled.

MR. EYRE: It's a picture from the courtroom.

MR. MCGINLEY: That's our co-counsel from Boone County, Tim Conaway. And we were totally outnumbered. There must have been 40 lawyers there
for the various drug companies and pharmacies. And we argued the case. And the judge eventually said he was going to rule to unseal the documents, and then one of the drug companies filed a motion and wanted to have a conference call and—what did they say—

MR. EYRE: There was like this 11th hour try to block the release of this—to unseal this complaint and what they said was they wanted to redact 18 words. We had a conference call about it, and I think they filed something too. And they said—and it was probably 70 pages long. And they said we just want to redact 18 words. They just kept saying if you can keep these 18 words out, we're good with that. Well, it turned out—I'm making a spoiler alert here, I'm jumping ahead—but it turned out the 18 words were 18 numbers and it was numbers of pain pills. They said words.

MR. MCGINLEY: Yeah. And, well, the judge didn't buy that. He ordered the complaint to be unsealed. And then that gave Eric insight into the bigger story, the sheer volume of opioids that were being marketed in the places they were being marketed. When we saw that first information, we were stunned. We're talking about a couple hundred million doses over a five-, six-year period. But there was more. But Eric wrote a story that was part of the Pulitzer recognition in May of 2016. You can describe what—

MR. EYRE: That one was some of these numbers were—these orders were shipped—you have 20,000 oxycodone to one pharmacy in a little town of a couple hundred people, and then it would say on the following week they'd get another 50,000, and then the next week they'd get another 20,000. So it was just these large shipments over consecutive days or consecutive weeks. And what the average hydrocodone I think nationally is 90,000 per pharmacy per year, and oxycodone is probably
like 50,000 doses per year. So these small-town pharmacies were getting the equivalent of what they should have gotten in a year in a matter of a week or two. But what ultimately happened though, where this really opened things up, is throughout the complaint that was unsealed, they kept referring to DEA data shows, DEA data shows, DEA data shows this, that, and the other. So I did a FOIA asking the attorney general's office for all the DEA data that they used to cite all these various figures. And it turns out that there was a 2015 e-mail sent from DEA to the attorney general's office outlining every shipment to every pharmacy in West Virginia of hydrocodone and oxycodone and also it was broken down by the name of the company and how many pills they distributed to each county in West Virginia. And what we—just to sum it up, after we got this DEA data, there was a disproportionate number of pills sent to the southern part of the state, the coalfield region.

And you had these situations where you had pharmacies with—one town had a pharmacy—400 people—and got nearly nine million hydrocodone pills in two years, in just two years. There were cases like this all over southern West Virginia, Logan County, Boone County, Mingo County. They had a town of 3,000 in Mingo County, they got 20 million hydrocodone over eight years. Just these incredible numbers. And then we looked at, you know, we did the (unintelligible) maps and looked at where most of the overdose deaths were, and they don't line up perfectly, but they match up pretty closely. And these counties here, not only are they number one for prescription drug overdose deaths in West Virginia, but they are I think of the top 10 about six or seven of them were all in West Virginia in the country for overdose death rates. So it was an incredible thing. And, in addition, I don't have a slide to show it, but the DEA agent who sent the data to the attorney general's office, he also did a—he mapped out the strength of the pills of the OxyContin, the milligram levels had
increased. So you had in 2007 the most popular milligram level of OxyContin was five milligrams, and then the next year it was like 10 milligrams. So the strength of the pills were actually getting stronger too in terms of—

MR. MCGINLEY: How high did they go?

MR. EYRE: They had OxyContin 80, but that was outlawed I believe.

MR. MCGINLEY: But they went beyond 10, it went pretty far above it.

MR. EYRE: Yeah, I think it went to like 30.

MS. JACOBS: I know there's a quote from your article that there were 433 pain pills for every man, woman, and child in West Virginia.

MR. EYRE: Just those two, right. I mean, we're not even doing hydromorphone, oxymorphone, Xanax, and all the others.

MS. JACOBS: That's astounding.

MR. MCGINLEY: There's one parenthetical that Eric was— when he filed actually a Freedom of Information Act request with the attorney general seeking the DEA data in August of 2016. And under West Virginia law, a FOIA law response is required within five working days. Well, the attorney general's office kept delaying, we're looking for the data, we'll get back to you, we'll get back to you. Meantime, there's an election going on where the attorney general is running for re-election. His opponent has a lot of cash and is running— has spent several million dollars on TV ads trumpeting the relationship of the attorney general to the drug companies and the opioid epidemic. And there was an
infusion of cash into Morrisey's campaign in October of—what was it—six million dollars from the National—the Republican Attorneys General Association, more money that flowed from that association than any other attorney general race. That money is sort of dark money. The contributors are the Koch brothers, pharmaceutical companies. And so the attorney general continued to delay responding. And what happened then?

MR. EYRE: Pat came up with a good idea that we should file a FOIA asking them—because they kept responding that they are searching for the records, they are searching for the records, and they would just keep every five days saying we're still searching for the records—Pat came up with an idea just to do a FOIA saying any documents that would show you're actually searching for the records. Of course there were none. And then about two or three weeks before the election he did, to his credit, he did release the DEA data.

The backdrop, as Pat was describing, was this immense pressure in terms of ads from the democratic opponent. Actually, CBS News had picked up on our story and came to West Virginia multiple times. And the attorney general agreed to do an interview with CBS News, which I can't—I don't know who told him to do that. But of course they did the things where they are asking all these happy questions and then they say what about your wife works for Cardinal Health and you have this lawsuit and, you know, they zero in on your face and you start seeing the twitches and all that. Well, the democratic guy that was running against him just kept running that interview over and over in his ad. But that was countered by all the money from the Republican Attorneys General Association who said that the democratic opponent was big friends with Hillary Clinton and Obama and they pounded that over and over and over, which is a simple effective message that worked.
MR. MCGINLEY: And Attorney General Morrisey won the election. It was close but he prevailed. I don't know that I would give him credit because he knew that Eric and the Gazzette were going to write stories and we were considering a lawsuit against him, a FOIA suit, that would have come out right before the election. So I think he had some good political counselors in-house that said you better get this information out there. And it's really a question whether that information should be— should not be available to the public because it came from the DEA. And that's more the problem, all this information the DEA has but it's not shared, the public doesn't have access to it. So the public knows because of Eric's reporting the volume of prescription opioids that were sold in West Virginia. But we don't know, we don't have the data at this point, about the sales in Ohio, in New Jersey, Tennessee, Kentucky, and so forth. And that's a real flaw in the system. But subsequent to Eric's reporting there have been numerous lawsuits that have been filed here in Tennessee, for example, by Municipalities, Indian tribes, Cities, States, against the drug manufacturers and distributors seeking compensation for the cost of dealing with the opioid epidemic, which is enormous.

The American Enterprise Institute report just came out pegging the cost to the gross domestic product in West Virginia of eight billion dollars. That sounds high to me but I don't know. And the human cost, you can't calculate that. And, hopefully, in these cases that are, you know, following up on what West Virginia did, that litigation and exposure. But the volume— I was looking at the audience here, we were talking about how many oxycodone, OxyContin pills, and the total is 780 million. And when we saw that, I said oh my God. I think that's what a jury would do, if you've got a case where you could get it to the jury. It's a question of creative lawyering, having statute or common law remedies that will make these— hold these billion-dollar companies responsible.
And that's one of the grossest things about this whole story is the billions of dollars that these companies have made and there have been very few repercussions, certainly not to the companies. Three of the top 15 Fortune 500 companies are drug distributors and were parties in the "pill mill" litigation in West Virginia. McKesson, Cardinal Health, Amerisource Bergen, not household names, but they're right up there with Wal-Mart and Apple. And what do they do? I mean, what—

MR. EYRE: They ship drugs from factories to warehouses to pharmacies and hospitals.

MS. JACOBS: Purdue Pharma who produces OxyContin—

MR. MCGINLEY: The manufacturer.

MS. JACOBS: —they're the manufacturer, privately owned by a family, and they are I think the wealthiest, or maybe behind Bill Gates, in the country.

MR. EYRE: Well, like McKesson is the number five on the Fortune 500. And that shocked me. I didn't even figure that all out until we were in the courtroom and I turned around and introduced myself, and somebody was telling me they were from D.C. and like Cardinal Health or the other companies would have three or four lawyers there. We don't have the rankings but I think it's Wal-Mart, Apple is number two on the Fortune 500, or Berkshire Hathaway, Exxon, and then McKesson is number five. And then I'm not going to get these exactly right but I think AmerisourceBergen is 12 and Cardinal Health is 15. And they've actually climbed—since my story has come out, they've actually climbed in places in the Fortune 500. These are CEOs that are making— a guy in McKesson— there's been stories in
Fortune or Forbes—Forbes—making over 60 million dollars a year in compensation.

MR. MCGINLEY: The McKesson CEO one year was the highest paid CEO of any corporation in the United States.

MR. EYRE: And nobody had heard anything.

MS. JACOBS: I've heard another topic you've done. You were talking about the distribution outlets, some of the pharmacies. It wasn't Wal-Mart or Walgreens or—tell us about where these pills were being distributed in West Virginia.

MR. EYRE: Yeah. That was surprising. Because before I covered the—as you guys know a lot about the meth epidemic when they're doing the shake and bake bottles and making it with Sudafed, and we used to identify the pharmacies that were selling the most Sudafed in the state and they were typically the Wal-Marts and the Rite Aids. But in this case it was these independent pharmacies, these mom and pop pharmacies. They were literally drive-thru pharmacies. They didn't sell Band-Aids, they didn't sell Q-tips. They literally had names like Meds To Go Express and Larry's Drive-thru Pharmacy. And you'd see people lined up up and down the block. People would come from all over. You know, I've seen recent stories where some of these pharmacies are defending themselves saying we just didn't serve the town of 400, people came from all over. But I think that's more damning than—I mean, they were literally coming from Tennessee, Kentucky, Ohio, Pennsylvania to these little small towns in the southern part of West Virginia. Whitfield, Virginia is another place.

And you had these—you know, I wasn't there—but everybody describes these scenes that there's one
pharmacy in Kermit, which is this little town of 400 people, because there were so many people in line, they started handing out bags of free popcorn just as a bonus. They had bags for the people in town where if it was opioids, you'd get it in one color bag, and if not, like if it was blood pressure medication, you'd get it in another color bag, because they didn't want the senior citizens in town getting robbed. Because if the people would see you had the color bag that wasn't opioids, then they wouldn't rob you. They actually set up a hotdog stand with hamburgers and hotdogs while people were waiting in line. It was just an unbelievable scene from what's been described to me.

MR. MCGINLEY: What about the doctors? I refer to this as a legal cartel. You have the Mexican brown heroin cartel or Columbian cocaine cartel. You have the legal cartel, you've got manufacturers, you've got the distributors, you've got the doctors who were writing the scripts, you've got the pharmacies who were filling the prescriptions, they all had to know. With those numbers, all of them knew. And where was the law enforcement? Where is the Pharmacy Board? Where was the DEA? And this was going on for more than a decade. And I think the numbers, when we finally saw the numbers, the light went on and the country woke up to realize that this was all legal and they had— the defense was of the manufacturers, well, we're just making stuff to help people with their pain. The distributors, we're just taking them to the pharmacies. The pharmacies, we're just filling the doctors' prescriptions. And the doctors saying we're helping our patients with pain. They are all pointing fingers, they didn't do anything wrong. The doctor's office, what was that like?

MR. EYRE: Just last week or this week they busted what's called The Hope Clinic. I think at one point they had— yeah, what a name for a "pill mill" pain clinic,
The Hope Clinic, we're giving people hope— I had actually written about them. One of the prisms of my stories is they only focused on the drug wholesalers. My mom called me the day that story came out, when it first came out back in December 2016, she said what about the doctors. And I said I've been writing about the doctors for years. They had these pain clinics where the doctors didn't even show up. The one that just got busted that we wrote about back in 2014, 2015, they had former cops, retired cops, who were taking people's blood pressure, doing the weight, doing their charts. They carried guns holstered at the site. They had these special machines, I can't remember the exact name of them, but they were these electronic machines that would crank out prescriptions by the hundreds. They would have the doctor's signature on them, but they were just being reproduced through the machines. And I would get calls back in 2014, 2015 from legitimate pharmacists that would call me up and say come up and let me show you what they are doing, you know. But they would set up special relationships with some pharmacies that were disreputable, and they would fill those prescriptions. And it was an all cash basis. There was no insurance or anything like that. It was just a cash only business.

MS. JACOBS: It's astounding that— where was the Board of Pharmacy? In your third article you talked about the responsibility to file reports about large shipments. What happened with all of that?

MR. EYRE: Well, our Board of Pharmacy is almost exclusively made up of independent mom and pop, including some that were involved in this "pill mill" stuff. Their directors are all appointed by the governor and they are all independent pharmacists. So they had some rules on the books related to something called "suspicious orders" and those are orders of large numbers of drugs over consecutive days or massive quantities over one day.

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MR. MCGINLEY: Those are Federal rules; right?

MR. EYRE: It was a DEA rule that the State had copied and put into their rules at the Board of Pharmacy. And I asked our executive director of our Pharmacy Board, because it was cited in the lawsuit, I said what are you doing with that. They said that hasn't been on my radar, we just don't enforce that rule. So there had been no suspicious order reports filed by any of these drug wholesalers before 2012. But when the lawsuit was filed by the former attorney general, a couple of them—two of them started sending suspicious order reports to the Board of Pharmacy, sometimes two or three a day. I went and said can I take a look at them. I thought they would be cataloged, they'd have a total number or something. And they just came—I came into the office and they came in with two big bankers boxes full and they dropped them on the table and they said here is all our suspicious order reports. And I said, well, what have you done with them. And they said we haven't done anything with them, we just shelve them. And they hadn't cataloged them, so I literally had to count through each one to figure out how many had been filed.

MS. JACOBS: Were they included in the lawsuit, the warrant?

MR. MCGINLEY: Not at that point, no.

MS. JACOBS: That's amazing. So talk a little bit about the consequences, like the kind of after-effect. Your work had a significant impact on all the lawsuits that happened. And what else do you think you have done, your work has done?

MR. EYRE: Well, the biggest development is there is a congressional investigation in the House Energy and
Commerce Committee and what they're doing that we hadn't been able to do for the most part is linking up exact numbers from each company to each of these pharmacies, and many of them were shuttered, a lot of them are still open actually, and they've been able to sort of dovetail or expand upon our work. They were originally stonewalled by the DEA. I think in some respects the Congressional Committees were still being stonewalled. But they've come out with some more shocking numbers like McKesson over a two-year period they figured out of those nine million pills like five million were from McKesson alone, 76 percent of the business. They've gotten some real granular detail. And they've identified other regional wholesalers. Another name is Miami-Luken, H.D. Smith. They're starting to get more numbers. But what's frustrating is, we talked a little bit about this earlier, the DEA, they have all this data. I get calls from all over the country saying can we replicate what you did. And I said the DEA in a matter of I can't imagine it would take more than an hour to do the spreadsheets that we got, it's a simple sort, but they just won't do it. They point to there's data available on their Web site called ARCOS data but it's broken down by grams and by zip code prefixes. Which I tried to look up our zip code prefixes in West Virginia and they span sometimes four or five counties or they dig into half of a county, and it's very complicated to do it that way. There are ways to see the overall number of grams by state, things like that, but nothing like what we got.

MS. JACOBS: Yeah. So what do— I mean, I've noticed—

MR. MCGINLEY: Can I add something there?

MR. EYRE: Yeah.
MR. MCGINLEY: With regard to the DEA, some of you may have saw the story, the DEA had an official that was in charge of checking on the drug distributors, you know, for suspicious orders and volumes and was trying to organize enforcement actions, at least the story that's been told publicly, and wasn't permitted to go forward. I think there was pressure from higher up in the agency or political pressure in the regional offices. But there were people in the DEA enforcement that wanted to do something about the enormous volume of opioids that were being distributed. And the trade associations for the pharmaceutical industry hired a former member of the DEA's general counsel's office to draft legislation that essentially took away the DEA's enforcement power. That's the old revolving door. You know, anybody that's been around government knows about that. And that bill was written in language that was not penetrable by those who don't really understand the legal terminology and what the DEA does, and so it was sponsored by a congressman from northeast Pennsylvania and it was passed on a voice vote in both the House and the Senate unanimously. I think the attorney general did raise some question about it. President Obama signed it and nobody—clearly, no one read it and knew what was in there. So here is an effort funded by the industry to talk about DEA oversight and enforcement power and it just goes totally under the radar until the Washington Post—was it—

MS. JACOBS: 60 Minutes.

MR. MCGINLEY: —60 Minutes last fall did this exposé. At that time the congressman of Pennsylvania had been nominated by President Trump to be the new head of the DEA.

MS. JACOBS: Yeah, the drug czar.
MR. EYRE: The drug czar.

MR. MCGINLEY: Drug czar.

MS. JACOBS: It's very interesting. It's very Orwellian. The name of the legislation was "Ensuring Patient Access and Effective Drug Enforcement Act". That was the name of the legislation. It sounds really great, so if you didn't read it, you would vote for it thinking this is great for enforcement. But it basically—the DEA, to take any kind of enforcement action, they have to show a substantial likelihood of an immediate threat. Immediate. So it's a higher bar than they ever had. And they also cannot sanction any company unless they allow them first to put in place a corrective action plan.

MR. MCGINLEY: Which did not exist in the prior legislative plan.

MS. JACOBS: Yeah. So it's a very different enforcement regime than they had previously.

MR. MCGINLEY: A little bit of good news is the congressman's nomination was withdrawn a few days after the 60 Minutes show ran.

MS. JACOBS: Well, apparently, there's a lot of outrage about it in the House and Senate, so I think there's a move to repeal it. So, hopefully, that might happen. I think there's a lot on the legal side, and hopefully the next panel will talk about some of the legal fallout from this, but I think there are over 250 public lawsuits, you know, Cities, Counties, and State attorneys general. I think every state either has a lawsuit pending or they are investigating lawsuits against the opioid industry, some faction of it. And they consolidated a lot of those in this multi-district lawsuit in Ohio and— but
the companies have tried to like get settlement discussions going and to seal a lot of the data that's been coming out of that. Interesting development I read about yesterday, there's some lawsuits in Michigan on RICO, which I think is a really great kind of cause of action, a really creative theory. Hospitals have begun to sue, which is another really interesting—looks like if the cities can do it, we should be able to do it. Insurance companies are probably next. And legislatively, I think people have started—I don't know if it's happened in West Virginia—they a resetting prescribing limits, which I think should have been—

MR. EYRE: We have a bill pending that was just approved by the Senate that's been turned over to the House for seven-day. Do you guys have three-day or—

MS. JACOBS: I don't know what Tennessee is, if we have one.

MR. EYRE: Some states have three-day, some have five-day limits.

MS. JACOBS: And there are other—and just last week I think, the OxyContin manufacturer, Purdue Pharma, said they are not going to market to doctors anymore. I'm not sure at this point that makes any difference since they're firmly entrenched but . . .

MR. MCGINLEY: Marketing to doctors often means paying doctors large amounts to give a talk at some proceeding sometimes in Rome or Paris or resorts, and it can be very lucrative for doctors and inroads to doctors prescribing particular drugs. It's not only in the opioid field but certainly makes a difference. Purdue Pharma has one of the worst records in terms of they're really marketing their opioids as not being addictive. That was the first round. I mean, that's when the opioids

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really started to kick off, you know, doctors prescribing them, manufacturers saying they are not addictive. Am I right about that?

MR. EYRE: Yeah, absolutely right.

MS. JACOBS: They said it was something like ibuprofen.

MR. EYRE: Our public health commissioner is one of the champions at trying to reduce that the opioid epidemic— he's really a good guy. He's like— he actually came from Tennessee and he's like, you know, we just were fed a bill of goods, and he's regressed and he's like I was a big prescriber of OxyContin. When I talk about these "pill mills", I mean, these were guys that had been like disciplined in other states, that lost their license in other states, and then show up in southern West Virginia. These were bad, bad guys.

MR. MCGINLEY: Can I say just one thing about that?

MR. EYRE: Yeah.

MR. MCGINLEY: The legal actions now that have multiplied, I mean, they are looking for reliable legal theory, might be RICO, might be common law, whatever, but the thing that exists is intent and knowledge. You can't look at those numbers and believe that this was a legal operation. And the doctors made millions. The pharmacies made millions. The distributors and the manufacturers made billions. So, you know, there's the intent, there's the knowledge. It's looking for creative lawyers and law that would at least try to bring some money back to the communities and try to figure out what the solutions are. And I know you're going to be talking about that on panels this afternoon. I mean, this is a long
road. It's difficult. Money is important and it's just one of the parts of the puzzle.

MS. JACOBS: So we don't have tons of time left but do you have questions? Anybody have questions?

UNIDENTIFIED SPEAKER: I missed whether or not you got that all unsealed or not.

MR. MCGINLEY: Yes.

MR. EYRE: Well, actually, companies that settled previously were allowed to keep their numbers under seal, who had settled previously with the State. But we got most of the larger companies.

MR. MCGINLEY: The complaints in— the second amended complaint is in the materials and it does say redacted, that was almost wholly redacted, so we have some of the ones that settled. The judge let them off the hook. I think we could still get that through—

MR. EYRE: Miami-Luken was the one— probably the one— the largest of the ones that were nonexempt. But a lot of them are real small and didn't have large distributions in the state. And I could see from the DEA data that I had later which ones were, you know, larger. We got Amerisource Bergen, we got Cardinal Health. The McKesson case is a separate lawsuit that's still pending.

UNIDENTIFIED SPEAKER: Well, the same way that the states sue tobacco companies, is that going on yet?

MR. EYRE: Yeah. And one thing we haven't talked about yet is that there's been some evidence, in particular with McKesson and Miami-Luken, that there were concerns brought to higher-ups, to executives, from
regional managers, and things like that, that these numbers were extraordinarily high. There was something with the McKesson, there's a separate action against McKesson by shareholders in Delaware and there's allegations that there were actually concerns brought by certain employees to the Board of Directors and they didn't do anything, allegations.

MS. JACOBS: And, interestingly, one of the main tobacco lawyers, Mike Moore, is involved in a lot of these suits, the pharmaceutical suits, also on the plaintiff's side. So they're getting that same coalition together to work on these pharmaceutical cases.

MR. MCGINLEY: One of the problems with those suits is if the plaintiffs are awarded compensation, will it go to deal with the problem. That's one of the problems with the tobacco suits and the lawyers— there's a lot of good lawyers. Moore is, you know, he's effective but— and they will make money. That's what lawyers do. But will the proceeds go to help solve the problem.

UNIDENTIFIED SPEAKER: I have some family there, married into family that's from Boone County. So I guess what I'm thinking is what now. There's all of this. Obviously your work has exposed a lot of this. But what is happening in West Virginia to try to help these people?

MR. EYRE: They did take the money from the settlements and put it towards treatment beds but the sad thing is—

UNIDENTIFIED SPEAKER: The trouble with those towns, like when I go to visit my husband's grandmother who is in Madison, you know, she's lived there—
MR. EYRE: That's where all this started, in Madison.

UNIDENTIFIED SPEAKER: Yeah.

MR. EYRE: Everything started in Madison.

UNIDENTIFIED SPEAKER: Like I know where Larry's is, you know, I've driven past there. There's no one hardly left in the town, I mean, they've either moved away, died.

MR. MCGINLEY: One of the problems is that, you know, people who are disempowered who have lost their jobs in the coal industry, you know, they've lived in the area, their family has been there for generations, what do you do. And, you know, coalminers that were injured, they take painkillers, and it just steamrolls. And an economy that is already going down is plagued by this epidemic. And it's an enormous problem. I would say—I mean, there are certainly well-meaning people throughout West Virginia who are trying to come up with solutions, but there's a lot of talk too and there are people who are trying to make a profit off of the solutions.

UNIDENTIFIED SPEAKER: And not enough money, right—

MR. MCGINLEY: Right.

UNIDENTIFIED SPEAKER: —to actually help all the people that actually have problems?

MR. MCGINLEY: Right.

UNIDENTIFIED SPEAKER: So unless it's on a national level—
MR. EYRE: And the problem is it keeps shifting, you know, it went to heroin, and then it went to Fentanyl. And now—I was just a week-and-a-half ago in Madison talking to Judge Thompson—you probably knew Judge Thompson—he said now I'm seeing all this crystal meth and cocaine overdoses. So it keeps shifting when you—

UNIDENTIFIED SPEAKER: What about the pharmacists and the doctors, any disciplinary action, anything happening to the people who—

MR. MCGINLEY: A little.

MR. EYRE: The pain clinic, they—but that was like three years too late—but they finally indicted 12 doctors that were affiliated with The Hope Clinic for something that occurred back in 2012 to 2015.

UNIDENTIFIED SPEAKER: I'm from Tyler County. I did my undergraduate at WVU. I just recently last summer spent the summer working with the drug court of the Circuit of Marshall, Tyler, and Wetzel, so I've seen first-hand the experience of the issue. Just kind of piggybacking off of her question, it seems like the Suboxone is becoming a replacement for the addiction. I just wondered if you had looked into or, you know, this could speak to that issue that we are replacing a drug dependency with another prescription that has a high risk of dependency.

MR. EYRE: Well, the Boone County judge has his drug court too and he is very upset because he's directed to do the treatment with Suboxone and they are diverting the Suboxone. Another problem that's cropped up is many of these "pill mill" doctors that lost their licenses and went to jail, they are out of jail now and now they are opening up Suboxone clinics next to legitimate, you know, the more corporate Suboxone clinics. They're opening up
and they are not doing any counseling, they're not doing anything but just handing out the sublingual things that they take.

MR. MCGINLEY: That's a really important question. I know that there is some discussion in the panels this afternoon. I know Suzanne Weise is here and she's going to talk about it from her experience with the Child & Family Law Clinic at WVU. I want to give Suzanne the shoutout too because she was co-counsel in the FOIA cases and in our intervention in the "pill mill" cases. But I think that's going to come up in discussion this afternoon.

MS. JACOBS: That's another interesting legal consequence though. Suboxone's maker is a British company, Reckitt Benckiser, and they actually are being sued by 35 U.S. states for artificially inflating their prices and for fraudulently trying to delay their patent expiration so to prevent generics coming in. So the kind of collateral consequences, again, you know, they are making all this money off of the crisis and now you have to address their bad actions because they've got a product that everybody suddenly needs, so . . .

MR. EYRE: Yeah. The drug money that they distributed, they did some new grants for treatment, Suboxone people have a very strong lobby down at the Legislature, so all faith-based, peer-to-peer type programs were excluded from funding because they got it written in that you had to do medication-assisted treatment in order to qualify for funding into the grants. You've probably seen that with the drug courts; right?

UNIDENTIFIED SPEAKER: Yeah.

MS. JACOBS: One more. I think we have time for one more.
UNIDENTIFIED SPEAKER: Tell us what it's like the afternoon you get a telephone call and they tell you you've won the Pulitzer Prize.

MR. EYRE: I was in shock for about three months. Yeah. We're— unlike the— we're just a little-bitty paper, 30-some thousand in Charleston, West Virginia. I had always thought when you got the Pulitzer Prize that it was— if you've ever seen the photos in the New York Times and Washington Post, they're standing there with champagne bottles like they get tipped off. And then I realized later, they didn't really get tipped off but they just win one every year. Yeah, it was a bit crazy and . . . I don't know. The sad end of this, and I don't want to end on a sad note, but the numbers have continued to climb of the overdose deaths, as yours has as well. I think yours went up by I think 12 or 15 percent, again, because it's a moving target. But we at least have good people on the ground that are trying to work on it.

MS. JACOBS: Thank you for the work you've done, and Suzanne. Thank you, guys.
THE OPIOID EPIDEMIC
REGULATION, RESPONSIBILITY, AND REMEDIES

Tricia Herzfeld
Gerald Stranch
Zack Buck

MR. GROVES: My name is Alan Groves. I served as the Editor in Chief of the Tennessee Journal of Law and Policy from February 2017 until just a few weeks ago. My successor Editor in Chief will be moderating our second panel this afternoon. Our first panel discussion today is going to focus on some of the questions you all were asking at the end of the last session about regulation, responsibilities and remedies. So, our first two panelists to my immediate right come from the firm of Branstetter, Stranch and Jennings located in Nashville, Tennessee. In the past year, their firm has filed three different lawsuits in Tennessee against several opioid manufacturers. Tricia Herzfeld is a 2001 graduate of George Washington University Law School and is now a partner at Branstetter, Stranch and Jennings. Ms. Herzfeld has previously served as Legal Director of the American Civil Liberties Union of Tennessee where she successfully litigated dozens of high-profile civil rights cases in state and federal courts. She has also served as a public defender in Miami where she conducted over 80 criminal trials. In 2012, she was selected as one of the nation’s Super Lawyers, and among

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those with that honor, she attained Rising Star status in 2013.

Her colleague, Gerald Stranch, received his law degree from Vanderbilt University. He is now the managing member of Branstetter, Stranch and Jennings and chairs the firm’s complex litigation team. He oversees the firm’s securities, class actions, antitrust, shareholder derivative, mass tort and consumer class cases. Mr. Stranch also served as an adjunct professor at Vanderbilt University School of Law. He was named the top 40 under 40 from the National Trial Lawyers Association and was named the Mid-South Rising Star by Super Lawyers.

And finally, Professor Zack Buck at the end of the table, teaches a variety of health law classes at the University of Tennessee College of Law, including a bioethics and public health seminar, torts, health care finance and organization, health care regulation and quality, and health care fraud and abuse. His scholarship examines governmental enforcement of laws affecting health and health care in the United States. Before joining UT, Professor Buck taught at Mercer University School of Law, Seton Hall University School of Law and the University Pennsylvania School of Law. He also practiced complex commercial litigation at Sidley Austin in Chicago.

So, with this distinguished panel now introduced, let’s just jump right into our first question, and we are going to start off where the last panel ended talking about remedies and particularly the search for a cause of action in some of these lawsuits that have been filed.

So, Ms. Herzfeld, I’ll throw this first question to you. Can you talk to us a little bit about the suits that your firm has filed and particularly why you chose to bring those causes of action that you did, the statutory and the common law public nuisance claims and then also a cause of action under Tennessee’s Drug Dealer Liability Act.
MS. HERZFELD: Sure. Thanks very much for having us. We appreciate the opportunity to talk about our lawsuits. Lawyers always like to talk about their lawsuits, so we can answer any questions you all have, and we happily do so. Our lawsuit that we brought— we have actually brought three different lawsuits throughout Tennessee. They have been filed in the Tennessee state courts. So that means our lawsuits are a little bit different than the vast majority of them across the country. Those have been filed primarily in federal court or have been moved to federal court. So, we made a very, very rational, I think, and determined decision that we wanted to keep our cases in state court, and there were some reasons for that. We don’t think that a federal judge, with all due respect to the federal judiciary in Cleveland, Tennessee, where the multi-district litigation is, is going to have the same understanding of the real day-to-day impact of the opioid crisis. So, we really made a point to file our cases in Tennessee.

So, the first case that we filed is in Sullivan County, Tennessee, so up in the very, very top corner in the Appalachian region where it is really ground zero to the opioid epidemic here in Tennessee. They have the number one statistics for births of children that are born dependent on opioids, and so those children are classified as having neonatal abstinence syndrome, and that was the primary reason that we decided to file that first case there. Our cases are a little bit different than many of the others, because ours has primarily been filed by District Attorney Generals, and I think you are going to hear from one of our clients a little bit later today. We did that because we have a somewhat unique— I say unique, sort of— statute in Tennessee called the Drug Dealer Liability Act. Now, the Drug Dealer Liability Act initially was put together by an organization called ALEC. Has anybody heard of ALEC? American Legislative and Exchange Council.
So, they put together somewhat conservative proposed legislation and kind of pushed that legislation out throughout the country. I think it was 23 states ended up passing various versions of the Drug Dealer Liability Act back in the day, and Tennessee was one of them. Now, initially the Drug Dealer Liability Act was supposed to− I think the thought process at that point was, there was a crack cocaine epidemic, and the idea was to be able to go after the higher−level drug dealer chain, not just the person you’re buying from or the person at the drug house, but kind of going up until you get to the suppliers and the producers, further and further. So, we took that law and decided, well, it kind of seems like the same thing for opioids; right? You have the street-level dealers. You have the people that they are getting them from. You have the pill mill doctors who are supplying them, which is often without a legitimate prescription; that’s mostly how that happens. They get them from various pharmacies, who get them from distributors, who ultimately get them from producers. And why is that any different than a drug cartel? So that’s why we decided to file under the Drug Dealer Liability Act, because, truthfully, we think the opioid epidemic and the way that it’s impacted Tennesseans and most of the state, it really is illegal drug activity; right? That’s really what we’re talking about. It may have the veneer of being legal, because there are legal uses for opioids, but the legal uses of opioids are not what is causing this epidemic and causing so many people to die. It’s the illegal uses.

So, we’re really trying to tackle it from that way. Now, the Drug Dealer Liability Act has a lot of benefits to it. One of them that we really like is, there’s not that level of causation. So, the principles of this law are more actually rooted in antitrust, so it’s market participation. So, all we have to prove− all we have to prove− is that someone or a corporation knowingly participated in the illegal drug market, and as you have heard earlier, with those numbers, how could you not have known; right? I
mean, the diversion is clear, the news stories are clear; we simply have to prove that they knowingly participated in this illegal drug market. Now, a lot of other causes of action have been filed, a bunch of other different lawsuits across the country. They are more of a traditional negligent standard, where you would have to prove in this context that this individual got this pill from this person, there was a duty, there was a breach, and you’re going to have to work your way all the way through. That’s not required under the Drug Dealer Liability Act. So that’s why we chose that cause of action. The other one that we filed is, we filed under common law and statutory nuisance, and you will see nuisance showing up in a lot of the lawsuits throughout the country. Specifically, for us, our District Attorneys typically file nuisance lawsuits. They are the ones who file those. They shut down houses of prostitution. They shut down crack houses. They do this stuff all the time. So, it meshed very well with an additional cause that is typically within their purview infighting crime. So, the purpose of our lawsuit is to focus less kind of on consumer protection, more to really focus on the fact that these drugs are now being used illegally and everybody knows it.

MR. GROVES: Mr. Stranch, I’ll throw the next question to you. Ms. Herzfeld just talked about the state law claims that your firm has brought, the Tennessee Drug Dealer Liability Act and then the common law and statutory public nuisance claims. Some attorneys for the opioid manufacturers have argued that federal regulations actually preempt any state law claims. So, what is your response to that argument?

MR. STRANCH: Those defense lawyers are saying anything and everything they can to try to shut this litigation down. They are absolutely shameless. They are even attacking whether cities and counties have the
authority to bring the lawsuit or to hire outside counsel to do it. Their entire strategy right now is delay, delay, delay as long as possible. I don’t think the federal regulations preempt anything in our litigation in particular, because we have specific state statutory claims that don’t talk, reference or have anything to do with federal regulations. One thing that’s clear is, this is not a complete preemption area like an ERISA where any claim at all would be preempted—field preemption is what it’s called. They have not really raised federal preemption in our case in the motion to dismiss that we already argued. They did throw in the rest of the kitchen sink, though. Some of the other cases that are out there might have more of a federal preemption issue, particularly with the distributors; the McKessons, the Cardinals, the AmerisourceBergens, those entities, because those claims are often based on— you have this federal duty that you have to report when certain key things occur, you didn’t report, so now I’ve got a cause of action against you, and so you might run into some preemption issues on that. We have chosen not to file the distributor cases yet until we can get the discovery so we can point to exactly what they knew and when they knew it so that we can plead around and avoid any possible problems with preemption. But, again, it’s not really as much of an issue for our case, because we are not trying to prove you knew about this through federal regulation. We are saying, hey, look, you not only participated in the illegal drug market because you continued to ship pills to known diversion sources. So, it’s completely outside of that realm. And so, we’re a little bit different in what we do. But, yes, they are raising any and all defenses that they can to delay this as long as possible.

MR. GROVES: Thank you. Ms. Herzfeld, you mentioned the remedies that are available for some of these causes of action. Can you talk about what kind of damages that you are hoping to obtain for the clients that
you represent, and are there any procedural or legal obstacles that you face in obtaining those damages?

MS. HERZFELD: So, we are hoping to obtain really big damages for our clients, huge, huge, and there’s a lot of reasons for that, not because anybody is trying to get rich; right? When you look at these towns and you look at– Sullivan County, Tennessee, is a great example. I think someone in the audience said earlier that the towns are emptier. They are full of people that can’t get jobs, because nobody can pass a drug test, and that’s nobody’s fault; right? I mean, it’s not because you decided that you were going to become a drug addict and that’s how you wanted your world to end up. Nobody intends to become a drug addict. But you did have a workplace injury because you worked in the coal mines or you worked wherever it is, and your doctor gave you these drugs. Nobody intends to get addicted. Nobody intends to become a drug addict. And the consequences of that are just devastating, especially in a small town. We know that there are employers that have jobs they can’t fill because they cannot find sufficient people to pass a drug test. So, our case not only includes damages for the town, which I’ll talk about more specifically in a minute, but also claims for babies. So I think our case is the only case in the country, at least the last time I checked, where we have included claims on behalf of particular infants, and these are individual children whose identities are sealed; I know who they are, but their identities are sealed, and they were babies that were born dependent on these drugs, so their birth mothers took the drugs during pregnancy and at some point gave birth to these children who suffered enormously.

So, I would like to talk about their damages first. What we know about the children that are born with neonatal abstinence syndrome is actually, pardon the pun, in its infancy. It’s not something that has been studied for an extraordinary amount of time, but this
phenomenon, neonatal abstinence syndrome and opioids, hasn’t been around that long. Here’s what we know: When these babies are born, they shake, they cry uncontrollably, you cannot sooth them. That is the one thing you will hear everyone say. They scream and scream and scream to the point where their volunteers whose only job is to cuddle the babies. They just walk and cuddle and rock and walk and cuddle and rock. And why is it? Because the children have had a constant supply of these highly-addictive medications in utero, and once they are born, it’s discontinued. Do you know how they treat those babies? Morphine. They have to give those babies morphine. In the first days of their life, they are given a bit and then they wean them down and they wean them down and they wean them down, and so they end up in the neonatal intensive unit and they are being given controlled doses of morphine to wean them down. So that’s the first few weeks, which is crying and shaking and rocking and horrible. But then what comes next? You have a lifetime of learning disabilities: oppositional defiant issues, inability to concentrate, emotional outbursts that they don’t understand why that is happening; the parents, the grandparents, foster parents, no one understands why this child is just not behaving in a way that makes sense, and what we’re finding, through the studies, is that most of that can be taken back to this exposure in utero. Babies are developing; there’s stuff that happens there. So, we are trying desperately to get damages for those babies. We know that they will have a lifetime of medical needs, a lifetime of special needs. They need early intervention. The educational costs, imagine the educational costs of taking a child with needs. We don’t quite understand through essentially 20 years. We don’t know what that is going to look like. And Tennessee has the highest number of babies born with neonatal abstinence syndrome due to opioid addiction.
MR. STRANCH: It’s a baby born every other day dependent on opioids.

MS. HERZFELD: It’s so bad that the Children’s Hospital up there had to open up its own wing, its own wing with its own beds just for these babies. So, I don’t want to lose sight of that. Of course, we’re filing through District Attorneys who are seeking truth and justice and going to get the bad guys and drug dealers out of their districts; right, and that’s true and important and amazing, but also, it’s the babies; right? It’s the people who are raising the babies. It’s the families that are broken and destroyed by the fact that now the grandmother or the auntie or the cousin that’s raising these babies. And when you take that, and you multiply that not just from a one-family perspective, but from an entire community, the devastation is extraordinary. So what kind of damages are you hoping to get? Well, let’s see, prosecutors have to spend more time prosecuting, cops have to spend more time arresting, more Narcan, more ambulance costs, more emergency room costs, more overdose costs, more educational costs. Court system costs go up; right? Everything exponentially goes up. Those resources might have been used for other things, positive things, but instead they are all being diverted to deal with this completely overwhelming crisis.

So, what are the damages? Good question. They are enormous. The other thing we have asked for, in addition to damages to fix all the stuff that’s happened in the past, is, we have asked for injunctive relief going forward, and that sounds crazy; right? How do you get injunctive relief on a pill epidemic, an illegal pill epidemic? But that’s what we want. We want the drug manufacturers to stop. That’s just the answer, stop, stop doing it. You know what you are doing, you know what the harms are, stop putting profits over people, stop. And if that means that they have to pay for remediation in order to make these things happen, in order to not only
make the communities whole for the past damages, but to pay for rehab beds, education, different drug courts, these types of things going forward to kind of help fix that damage, special ed students, all these things, they all need to pay that going forward. So, the damages are huge, and I think it will probably be a bit challenging to figure out exactly how big, because there’s a lot of zeros there.

MR. STRANCH: One of the things you need to know about that, like in Hawkins County, the sheriff did an analysis at the jail. Eighty-eight percent of the jail population, which was full, was there because of pills, either DUI while high on pills, stealing to buy pills, domestic violence while high on pills. It’s all pills. It’s 88 percent of the jail in Hawkins County. And so, we really can’t emphasize enough how bad this is in the communities. It’s easy when you’re in a city like Knoxville to miss exactly what’s going on in some of these smaller communities.

MS. HERZFELD: We missed it. We didn’t know; right, until we knew? I mean, we didn’t know until we knew. It’s devastating.

MR. GROVES: Professor Buck, we have heard a little bit about the suits against these drug manufacturers. Just from a broader public health perspective, what are the similarities in this type of litigation against the drug manufacturers to the litigation that occurred against Big Tobacco in the 1990s, and are there any differences?

MR. BUCK: Sure. So, focused on manufacturers for a minute and talking federal regulations. I think there’s one kind of major similarity, and that is, in many of these claims that are the federal claims, there is a core to them that focuses on some kind of fraudulent
advertising. So the drug companies are actually advertising these drugs either direct to consumer or in doctors’ offices in some way that can be alleged to be fraudulent, and in that way we have a similarity with Big Tobacco in the 1990s. You know, they’re burying bad science, they’re minimizing poor results from clinical trials, and they may be actually misbranding these drugs through their misleading advertising. But beyond that, there are a lot of differences, and in particular there are three that I was able to kind of come up with in thinking. First, opioids have a lot of regulation around them to begin with. They actually are FDA approved to treat chronic pain, and we have been talking a lot about misuse of opioids and illegal use of opioids, but I think it’s important to also recognize that through the last generation of health law and policy, there’s been a lot of discussions about how chronic pain in this country is undertreated and how individuals have a stigma attached to them who are facing chronic pain, as well as the individuals who prescribe those drugs, and that’s complicating the regulation of these drugs in a way that never complicated the regulation of tobacco. Tobacco was not subject to FDA approval until 2009 in this country. Drugs that are sold in this country are approved by the FDA, and so we have a regulatory structure in place from the federal perspective that is different than tobacco in that regard. The second I guess you could say a way that these are very different is that these drugs are subject to a number of antifraud tools at the federal level when we’re talking about manufacturers. So, the most potent, you can talk about the False Claims Act.

The federal government is able to go after manufacturers who misbrand their drugs, who advertise their drugs to doctors in ways that are untrue, because the federal government pays for these drugs through Medicare and Medicaid, and these programs allow the federal government to empower the Department of Justice to go after manufacturing companies who make
untrue statements in their advertisement. The problem, of course, with this way or this pathway is that there’s often a desire to settle these cases, particularly of course from the drug companies’ perspective, but also from the Department of Justice. There’s been a reliance on Corporate Integrity Agreements over the last couple of years that are put in place to try to govern drug companies’ behaviors going forward and check in every quarter on pricing or advertising. And I think the biggest challenge here is that misbranding is really profitable for these manufacturing companies. So if you’re a manufacturing company and you have gotten your drug approved for a narrow segment of the population, but you can go into a doctor’s office and allegedly talk about an off-label use that the FDA has not approved your drug for, which is the case in the Purdue case around Oxycontin, they were minimizing the addictive effects of the drugs to the doctors; that’s the allegation. There’s a huge market out there for which you do not have to go through the FDA to seek approval. You can get doctors to prescribe your drug off label, and often doctors will do so. It’s a very profitable thing, if you are a private company and you owe a duty to your shareholders to maximize profits and you see that you can open up the market by eight, nine, ten billion dollars and the statutory penalties might only amount to a two or three-billion-dollar settlement, that’s a calculation that many drug manufacturing companies make. And so, I guess the thing that I would say about this is that our enforcement and regulatory system here is not potent enough and that we settle too much with drug companies in this respect.

Of course, there’s also a challenge that if you take a drug company to trial for one of these cases, what faces them, in the event of a bad verdict from their perspective, is exclusion from Medicare or Medicaid, and that means they can’t basically do any business with anybody related to the American healthcare system, to which they make the argument to the Department of Justice this is
something that will hurt a lot of people. Like the Pfizers of the world going to court and saying we do a lot of good, so you can’t exclude us because think about all the patient harm that will come. And I know I’m blowing that out of the perspective there, but that’s the heart of the argument from the pharmaceutical company. The final thing, the third I think big difference is going back to a point that I had made earlier, which is a lot of these drugs—and this is what makes this problem so complicated and much more complicated than the tobacco problem—is that, again, these drugs, some of them are indicated, some of them are legitimate. We can’t categorize them all in one way or the other. And we built the system, at least in this country, around prescription drugs that values professional autonomy, and it complicates the regulation of prescription. We trust our doctors and we give them a lot of authority and discretion to make determinations about our drugs. And so, the best way I think we can try to go about this problem is to go after the manufacturers using the tools I mentioned. I think those are the things that complicate the analysis when we’re comparing it to tobacco.

MR. GROVES: Mr. Stranch, Professor Buck just talked a little bit about the federal government’s involvement from a regulatory perspective, but let’s talk about what the Justice Department has done just in the past year. In August of 2017, the Justice Department announced the formation of the Opioid Fraud and Abuse Detection Unit, which will temporarily provide financial resources to 12 of the 94 U.S. Attorney’s Offices for the purposes of prosecuting health care fraud and abuse, and the Eastern District of Tennessee U.S. Attorney’s Office was selected to participate. So how significant of a development is this in your mind, and in general what should the role of the federal government be in combatting this crisis?
MR. STRANCH: I mean, they’re putting drapes on a burning house. You’re not going to arrest your way out of this problem. It’s way too big. The time to do that was 25 years ago. And the federal government, there’s been a complete failure of the regulatory system to do anything about this, both at the state and at the federal level. I can tell you, from representing District Attorney Generals, that they are absolutely underwater with pill problems. I mean, it’s the number one thing they deal with. We have even got one DA that we’ve talked with who says, look, if I dig hard enough on any case that comes into my office, there’s going to be pills in there somewhere, I’ve just got to dig deep enough to find it, and I take a little slightly view, I say maybe in 99 percent of the cases, but he’s adamant it’s a hundred percent. That’s how bad the problem is. So, some funding to help find opioid fraud and abuse and maybe shutdown a pill mill here or there, it will be nice, it will help, but it’s− I mean, you’re standing at a breaking dam and you’re sticking your finger in a crack. It’s going to take the full weight of the federal government, the state government, the court system through private litigation and the legislature in changing laws if we’re actually going to try to get ahead of this problem, because right now we have not even hit the crest of the tidal wave. It is still coming. It is still getting worse. Every year there’s more babies born dependent on opioids. Every year there is a rise in the number of deaths due to overdoses. And even in places where we have seen the overdose deaths start to level out, what we are seeing is a number of overdoses have continued to rise anyway, and what it is a reflection of is, now they have Narcan in the cop cars, now they have Narcan in the ambulances, so they can deploy immediately when something happens.

We have got districts that we’re working with where they’re putting it in schools because kids are overdosing at school on opioids. So, a couple of million bucks from the Department of Justice to put five or six
people looking at pill mills is not going to change anything. I mean, it’s a window dressing so that someone can stand up and say, look, we’re doing something, but they are not really doing anything at all. I will speak briefly about Purdue for a second. They pled guilty to misbranding back in 2006, and they admitted to what I call the Holy Trinity of Lies. They said we told people that if you have true chronic pain, you will not become addicted to our pills. We told doctors and people if you have true chronic pain, you won’t develop a tolerance to our pills. And we told people if you have true chronic pain, you won’t go through withdrawal when the pills are taken away. They admitted in their criminal guilty plea that those statements were all false and they knew they were false at the time they made them, and these are statements that they were training their people to go out and detail doctors and tell them this over and over and over again, and it went on for over a decade before the federal government got involved on it. And during that time, Oxycontin use went from a mid-eight figure drug to a billion dollar drug every single year and created an entire generation of doctors that believe these scientific facts that are not facts that are in fact false, and it created an entire generation of addicts, and despite that guilty plea, despite paying $600 million that they paid as part of that and agreeing that they’re not going to do that and submitting to all these monitoring programs with states and the federal government where they’re supposed to submit, here’s the list of doctors that are prescribing our pills at certain levels, there’s been no enforcement action on that at all, and they have continued to do the exact same thing. At the time we filed our first complaint, they were still pushing OxyContin for use in chronic pain, for people that have a history of substance abuse and saying they probably would not get addicted or less likely to get addicted. This is on web sites that they run that they host with their name on them that are designed for doctors to answer their questions.
about the drugs. The regulatory world failed, and they have done nothing about it. And having a couple more people in the U.S. Attorney’s Office who are focused on pill detection and finding street-level drug dealers, it’s going to do nothing.

MR. GROVES: In the second half of the discussion I want to talk about some legislative policy proposals that are percolating in the Tennessee General Assembly, but before we get to that, Professor Buck, I’m going to throw the ethics question at you. Rule 1.6(c)(1) of the Tennessee Rules of Professional Conduct requires lawyers to review information relating to the representation of a client to the extent the lawyer reasonably believes disclosure is necessary to prevent reasonably certain deaths or substantial bodily harm. So, what are the implications of this rule for attorneys that are representing the pharmaceutical companies?

MR. BUCK: Well, I think that the reasonably certain deaths or substantial body harm in 1.6(c)(1) probably is not as applicable as you might think when you take a look at it, because the individual that 1.6 contemplates is identifiable, and it’s hard to make that causal link if you’re representing a pharmaceutical company. I think that the ethical question that is perhaps more interesting is, what if you find yourself representing a pharmaceutical company that wants to engage in some kind of activity that you think is fraudulent. This happens a lot in the health care world when I talk to people who practice, and it’s one of the things that keeps them up at night. If our client determines that they have gotten overpaid by Medicare or if they find that some of their scientific statements aren’t defensible, what is my role as the attorney?

Tennessee’s rules are permissive in that instance, so you, as the attorney, have the ability to disclose, it’s not required, but it is available to you if you think that
you need to in order to prevent an ongoing crime or fraud. And withdrawal also is permissible, and so in the event that you might find yourself advising a client that’s unwilling to reconsider a course of action, the withdrawal would be permissive. There are cases in which withdrawal is required, and that is when you know that your client is using your services to perpetrate a crime, so the line between those two standards is pretty blurry, but usually there’s a lot of discretion given to the attorney to decide what he or she needs to do in that instance, but it is not an easy place to be in, and it happens I think fairly regularly, so it’s worth thinking about when you’re talking about the topic.

MR. GROVES: Now we will make that transition and we’re going to talk more about legislative policy proposals. As many of you might know, Governor Haslam recently announced his Tennessee Together Plan, which proposes a host of legislative and regulatory efforts to fight this epidemic, and the plan emphasizes three different strategies: prevention, treatment and law enforcement. So, I want to spend the rest of our time talking about this, and then at about 2:00, 2:05 we will open it up to audience questions; you can be writing those down. So, Ms. Herzfeld, some lawmakers in the General Assembly have suggested that one way to prevent future opioid addiction is to limit the supply and dosage of opioid prescription such as what was mentioned earlier, limiting new patients to a five-day supply. Others are calling for prevention education in public schools. What is your reaction to some of these preventative policy proposals?

MS. HERZFELD: I think they are all really good ideas, and they are very, very well intentioned, but I think as Gerald has made it clear, we are really just kind of nipping around the edges at this point. Legislation alone isn’t going to fix the problem. I like the
three–or–five–day limit on the ability to get those pills. That is something that we have noticed is a really big deal. The stuff that we have reviewed, I mean, just the sheer number of pills that are given to folks, it’s crazy. I mean, it’s a crazy amount, when you’re getting a 30–daysupply and five pills a day and four refills and doctors don’t even worry about it; sure, you want another refill, no problem. I had my tonsils out a couple years ago and they had given me hydrocodone, I think, and of course I had taken it for two days. I had my tonsils out; right, in my 30s, and it was painful, but after the second day, I was like my God, get me off of this stuff, like please. When I went for my follow–up a week after, the doctor is like do you want more hydrocodone? And I’m like oh, my God, no. They just hand it out to you so easily. And, again, I don’t think they mean anything by it. I think they’re trying to be helpful, at least in some circumstances. So, limiting that and limiting who can prescribe I think is really another important thing. You have a lot of nurse practitioners– and this is not to get down on nurse practitioners– but you have a lot of nurse practitioners who don’t have sufficient supervision who are running things kind of on their own and you are seeing an extraordinary number of these pills getting into the system that aren’t necessary, they are not medically necessary, it’s too much, it’s overkill, and a lot of that is coming through nurse practitioners. So, there’s a lot of things. There needs to be accountability; what is the enforcement mechanism if somebody is violating. There needs to be monitoring. There needs to be limitations on all that. I don’t think it can just kind of be one thing and here’s a little bit of education and we’re going to take the pills and make it for five days. It has to be a more omnibus kind of gigantic regulatory scheme to even begin to make a dent.

MR. GROVES: Mr. Stranch, I was going to ask you if you thought $25 million was enough to fund
MR. STRANCH: Twenty-five million bucks won’t even run a quality facility in one area of the state for a year. Again, window dressing is all it is. What you need to know about addiction when you’re dealing with opioids such as this, you actually have multiple levels of addition you have to break. You have to break the chemical dependency. For many people in Tennessee, that is actually broken while they are in jail, because they lose the opioids, they go through withdrawal in jail. Oftentimes they receive little to no medical care or therapy as part of that process. They just literally detox, go through the shakes, horrible diarrhea, headaches, nausea, throwing up in the jailcell. That’s how it normally goes. Once you break the chemical dependency, you still have a behavioral dependency that has to be broken as well, and your brain won’t go back to the way it was before you started taking opioids for 12 to 18 months after you have broken the chemical dependency, and so that’s why you have so many people that relapse in that first year, because their brain is still not back to normal and they’re feeling depressed, the hormones and things inside your brain and the way it works and the receptors are not working right again. They’re still not back to normal, so it’s easy to slide back to the addiction, because that feels good at that point. And so, if you really wanted to do this correctly, I mean, you can look at programs like the Tennessee Medical Association; they have an assistance program for doctors that become addicted.

It’s a multi-year program once you enter it, and you lose your medical license if you don’t complete it. They have an 85-percent cure rate, but it’s a multi−year program. You have to go inpatient depending on the level of your addiction. You have regular meetings with people. You have regular drug tests. You have therapy on a
regular basis, not like 12-step-type stuff, but like sit down and talk about what’s going on in your life, what are your triggers, help to identify your triggers so you can deal with them, and $25 million is not going to let you do that for a couple hundred thousand Tennesseans that are currently addicted right now. Twenty-five million is not going to let you do it for 400 or 500 Tennesseans in one small area, and it’s certainly not going to provide the aftercare once you break those addictions and you’re trying to re-enter society as— as my father would always say for me, I just want you to be a taxpayer—try to become a taxpayer again. There’s no support services for that. Twenty-five million dollars is nothing.

MR. GROVES: Professor Buck, part of the Tennessee Together Plan also involves law enforcement, and so the question that I have is, how do we enforce criminal laws that are already on the books with respect to users and distributors while also not re-enforcing the negative stigma that is associated with addiction or prescribing?

MR. BUCK: I think it’s a very hard question to answer, so I’m just going to take up a couple minutes and then we can go to the audience. But going back on what was previously said, I mean, we don’t think about this as a holistic problem, you think about physicians or dentists prescribing these drugs and you ask yourself, well, why would they? Well, first of all, they are seeking to treat some symptom that you might have, but also, they are incentivized to do that. We pay them to prescribe in this country. Medicare pays more for drugs that are more expensive to those doctors. They get a higher cut of the cost. And so, until we actually look at our own laws that actually create some of this problem in the first place and reverse them, we’re not really going to make any dent in the problem. In talking about the criminal aspect, I mean, these issues that are so interesting find
themselves on the line between public health and criminal law, and I think part of the challenge is to adequately calibrate the response.

Is it a public health problem or is it a criminal law problem? I’m somebody who approaches these issues from kind of a health policy perspective, and so I’m much more likely to treat them at least on the addict side as a public health problem. It reminds me of the case where the students, common law students in here or others who recently graduated, Ferguson versus the City of Charleston that you might do in common law. It becomes a Fourth Amendment case, but in that case the issue is a hospital is testing the blood of pregnant women who comes to the hospital against their consent, and then for women who test positive, they are given the option of either entering a drug counseling program or going to jail. Now, if you think about that and apply a public health lens, that’s a terrible program, because not only does it penalize people who might need medical assistance, but it deters people who need prenatal care from coming to the hospital in the first place. So, the first thing I would say to the governor is, do no harm, don’t have a system in place that deters people from seeking help that they need. And so, in that perspective, a public health perspective, would say let’s put more money on drug rehabilitation centers, let’s expand Medicaid in this state, let’s provide care for people who need it who don’t have access to these services, but I don’t think that’s the total answer. I think the other part of it is, you have got to calibrate the penalties for those that have the ability to change their behavior, and that’s the manufacturers, it’s the drug companies, it’s the distributors, and maybe it’s the doctors; maybe we need to change the way we pay physicians in this country, and also think about what we can do to the regulatory mechanism. Is it really doing enough to deter the pharmaceutical companies in this country to think twice about advertising their drug in a way that they can alleged to be fraudulent, even if it’s the
case that they stand to make a lot more money if they do so. So, I think we need to think about it from more of a holistic perspective. I think you have to be really careful that you don’t harm providing care for people who need it by leaning too far toward criminality for those who are struggling from addiction.

MR. GROVES: We will open it up to questions now. I believe we have a couple of microphones that are going to be walking around, so if you will just raise your hand and I’ll call on you. I think right here in the front.

UNIDENTIFIED SPEAKER: Thank you. As an attorney, if I’m working with the DPR and I’m being accused of knowingly lying three times with regard to relevant facts, even if I’m cooperating and remorseful, I’m going to lose my license for some period of time at least, and why do the manufacturers not lose their license for some period of time at least when they knowingly mislead and fraudulently tell things like that?

MR. STRANCH: Because our government is not in the business of shutting down big business. They cut a deal with them, they take some money, they let them move on. I’ll give you an example of how bad it is. In our lawsuit, we sent requests for admissions. Each one of the facts that they admitted in that criminal guilty plea, we asked them just to admit it in our lawsuit, and they refused. They denied each one of them, said they are not true facts.

UNIDENTIFIED SPEAKER: I was just wondering, you had mentioned that there are kids overdosing in schools now and I was wondering are those primary, middle or high schools? What’s the frequency that you all are seeing this now and where in the state, which schools, what area is that happening?
MR. STRANCH: It’s actually happening across the country. It’s showing up in high schools. So, one of the big things that’s going on is, school boards are now discussing whether they want to deploy Narcan in the high schools, because there’s been about a dozen or more overdoses that have occurred in high schools where kids would go to school, take a couple pills to help float their math class and OD. It’s particularly becoming a problem with the introduction of fentanyl and carfentynal, which is dangerously potent, and you don’t really know how strong it is, because they’re pressing out pills to make it look like something, sticking a little fentanyl in it, and sometimes you’re getting a dose that’s ten times what you think you’re getting. They had an outbreak down in Florida recently where I think it was 12 students 0D’d and died where they were all taking the same pills that were supposed to be one strength but were actually about 10, 12 times that strength. And so, yeah, it’s happening in high schools all over the country. I know there’s been a couple of deaths in Ohio. There were the deaths in Florida. We have talked to a couple people here in Tennessee that are looking into it for their high schools as well, as to whether they ought to be deploying Narcan for suspected overdoses in the school. It’s a real problem.

MR. GROVES: We have another question down here.

UNIDENTIFIED SPEAKER: This might be more of a rhetorical statement or rhetorical question. I’m thinking somewhat of an analogy to what’s happened with the groundswell against the NRA for what happened I guess a week and a day ago in Florida where at least the kid seemed to be — there seems to be some friction, some impetus to fix. So, here’s my analogy, and I’m not sure it works, and I’m wondering what you think about it. So if I’m a doctor in Sullivan County, or a dentist, and I’m figuring I’ve got, off the top of my head,
a hundred colleagues, maybe 50, and I'm going to the local county club once a month to meet with them just to -- I don't understand how the doctors in a smaller community like that, why there can't be some groundswell from them that would be effective in preventing this or something.

MS. HERZFELD: I think with a lot them, there actually is. We have talked to an extraordinary number of doctors who actually have an incredible amount of remorse, who have unwittingly participated in this and not realized. We were just talking about — Gerald and our other law partner, Jim, were telling the same story about doctors who have said I have prescribed so much opioids, I have given all these things, and now I'm looking back going, oh, my goodness, how many people did I hook, how many people did I harm, and they were talking about two different doctors and two completely difference conversations, which is wild; right? But it's not. There's been a million articles— you can Google it— of doctors sitting down and saying did I contribute to this, how did I do this, and how do I get out of it, because now you have patients coming to these doctors, and I'm talking about the legitimate ones, I'm not talking about the Fentanyl pill mills; that's a drive-through business. It's different. It's criminal. But for legitimate doctors, I mean, they are now trained to ask what is your pain level; right? When I was growing up, nobody asked that. It was how are you feeling, what's your blood pressure, looked at your heart rate, blah, blah, blah.

But now it's please rate your pain. So, we as a society now expect the doctors to keep us out of pain, and if you go to your doctor and say I'm in pain and I have got this root canal, you haven't given me enough medication, you're mad at your doctor for keeping you in pain, and the truth of the matter is, he's actually good; right? I mean, not all the time and not an extraordinary amount, but it is natural. There is a thing about pain. Sometimes
you’re going to be in pain. That root canal is going to hurt. So, I think that friction between the doctors and the patients of I’m expecting you to make me feel better and the doctor doesn’t want to give you something but yet needs to give you a little something and there’s a dance there. There have been some extraordinary things written that you can find online where doctors talk about that struggle.

MR. STRANCH: By the way, the whole focus on pain and how we should never have pain, there’s all these groups, Americans Against Pain, the American Society for the Prevention of Unnecessary Pain, I mean, they are all front organizations that have been funded by the opioid manufacturers, and that’s what started this fifth vital sign of your pain, because they want to be able to — they have something that they can justify, but it’s completely subjective. My grandmother, for example, every time she goes to the doctor — she’s on her fifth bout with cancer — doctor says what’s your pain on a level of one to ten. It’s ten. Every time it’s ten. The doctor finally says to her, well, it’s always ten. She says, well, yeah, either it hurts or it doesn’t. That’s what it is. That’s the way she views it. And so, what this pain thing is, it gave the doctors the ability to write down in the chart pain of eight, oxycodone and give support for it, when it’s just a completely subjective measure. There’s nothing objective about it. It’s not like your blood pressure or your white blood cell count or your temperature. It’s just a complete subjective thing that is used to justify prescribing pills. And they use these front groups to go in and train and to talk to doctors that people should not be feeling pain on a day-to-day basis. You should not ever feel pain, pain is bad. Well, that was an actual sea change in the way doctors view things.

I blew my knee out playing rugby in the ’90s and had to have a knee surgery. When the surgery was done, the doctor said to me afterwards, look, I’m going to give
you this five-day prescription for pills, but I only want you to take them when the pain gets to be too bad. The pain is supposed to be your guide. It tells you what you can and can't do with your knee. If it hurts, stop doing what you’re doing, because you’re going to over-extend and reinjure yourself. That’s what the purpose of the pain is. It’s a warning sign to you to don’t do that. And they have completely changed that. And the doctor told me you should probably only be taking these pills at night, because you’re going to be worn out, your knee is going to be hurting and it will help you fall asleep. That was it. A friend had a very similar surgery last year. He got a 30-day supply of Oxycontin and the doctor said, "And if you feel any pain at all, you call me, and I'll get you something stronger." That’s the change, and it’s this emphasis on pain that is not created through the medical community by doctors doing largescale studies, blind studies, double blind studies, observational studies, longitudinal studies, it was created by a bunch of front groups that the opioid manufacturers supported, because that’s how they can push their pills.

UNIDENTIFIED SPEAKER: The first ten years after law school, I did plaintiffs’ asbestos work and so I know what’s in front of you and I wish you well. I’m interested in causation and damages. Addicted children, they don’t all have these horrible effects later in life. Now, I’m in family law and I know that. So the test that we were stuck with is, if you’re going to say— we were faced with this: Okay, yeah, this guy has had all this asbestos exposure, he has a much, much higher risk of contracting cancer later on, but you have got to prove it’s more likely than not that this guy is going to have cancer, so how are you going to, A, prove that this baby is going to have learning disabilities and obstructive disorder eight, nine, ten years from now and there are kids that have learning disabilities and obstructive disorder who never were exposed to opioids? So, you have got to get over that too,
that it’s this and he wouldn’t have just already had it, and I can’t imagine how you’re going to do that. So how are you going to do that?

MR. STRANCH: For starters, the Drug Dealer Liability Act has a specific section that deals with assigning claims to babies that are exposed in utero. So, they have a specific test already for what you can do, and we know for the kids that we filed, they already have those problems now. They already have impulse control problems now.

UNIDENTIFIED SPEAKER: How old are they?

MR. STRANCH: They range in ages. Most of them are close to school age or in school.

UNIDENTIFIED SPEAKER: Some of them will graduate from college before you’re through.

MR. STRANCH: More than likely, more than likely. But one of the things that what we believe the current state of medicine to be on this is, look, if you’re exposed to significant amounts of opioids in utero, you’re going to have impulse control problems later in life, period, full stop, that’s going to happen. The question becomes, are you able to deal with it, control it or not, which is kind of ironic for someone with impulse control problems, but the way it works is, you have to do early childhood intervention and you have to work with the children from day one and you have to provide them with a stable environment so that they cannot have external stressors. One of the problems of the opioid epidemic is, of these babies that are born with NAS, like 25 percent of them end up in foster care within a year. Many of them end up bouncing in and out of foster care.

So, they don’t have a stable environment to start with, which only causes to exacerbate the impulse control
problems. Now, if a kid gets adopted straight out of coming out of the NICU, goes to a stable, loving family and they take care of him and they provide all of the early childhood intervention, you may see a child that is going to graduate and, as my dad said, become a taxpayer. Greatest thing you could ever want for your kid is to become a taxpayer. But that doesn’t mean that there’s not going to be problems and struggles and the behavioral therapy and other stuff that’s going to have to be done along the way. We also know from another child we represented that it can be much more than just impulse control problems. It can literally be a question of will this child ever be able to be a functioning member of society without having to have an adult doing things for them and overseeing them.

UNIDENTIFIED SPEAKER: The corporate boys are going to say prove that this kid doesn’t need $1,000 worth of treatment rather than the $500,000 worth of treatment that you say he needs ten, 15 years from now.

MR. STRANCH: We’re still struggling to get them to admit they’re selling opioids. They’re not admitting anything. But we’re going to have our experts that are going to go through and that are going to talk about what’s facing these kids, what’s going to happen, what money is going to have to be spent on them, the problems they’re going to have, and they’re going to have their experts, like in all cases where you have medical experts, who are going to say this kid was never harmed, and if there was any harm, it was because the dad had bad genetics or the mom had bad genetics and they all preexisted and had nothing to do with this, and by the way, would you like some opioids?

I mean, that’s what they’re going to do. And I just think our experts are going to be more believable than theirs, because we’re going to be putting them in front of a jury that is going to be living in a community where
they’re seeing this on a day-to-day basis, where they’re seeing the disruption in the classroom through their kids and their neighbors’ kids. Our first hearing that we went to in our case, there was three divorces on the docket, and two of them was because the spouse ran off because she was addicted to pills. These communities know this, and they are not going to be very impressed with a medical doctor that comes in and says there’s no long-term harm damage from shooting up opioids during pregnancy and that these kids are not going to have any problems, and if they do, it’s because they didn’t have a stable home life beforehand and they’ve got bad genetics.

UNIDENTIFIED SPEAKER: Baby Doe is a very sympathetic plaintiff.

MR. GROVES: That’s about all the time that we have for this panel of discussion. Join me in thanking our panelists for joining us.
RESPONDING TO THE IMPACTS OF THE OPIOID EPIDEMIC ON FAMILIES

Wendy Bach
Suzanne Weise
Barry Staubus

MR. ANDREW SCHRACK: Good afternoon, everybody, and welcome to our second panel today here at “Healing Appalachia.” My name is Andrew Schrack. I’m the current Editor in Chief of the Tennessee Journal of Law and Policy. It’s my privilege to introduce our next panel. On our left here is Professor Wendy Bach, she’s an Associate Professor of Law here at the University of Tennessee’s College of Law. She received her Bachelor’s and Master’s from the University of Pennsylvania and her JD from New York University Law School. She’s currently involved in research regarding the opioid crisis.

Sitting next to her is Professor Suzanne Weise. She’s the Director of the Child and Family Advocacy Law Clinic at West Virginia University College of Law. She received her Bachelor’s from Boston University and her JD from West Virginia University College of Law. Professor Weise has encountered a lot of the effects of the opioid crisis in her Child and Family Advocacy Clinic.

Finally, on her right is General Barry Staubus. He is the District Attorney General of Sullivan County,
Tennessee. He received his Bachelor's from East Tennessee State University and received his JD from Memphis State University Law School. He was appointed as Assistant District Attorney in May 1994 and appointed to District Attorney General by Governor Haslam on July 1st, 2011. He was elected as DA in August 2012 and re-elected in August 2014. He is also a plaintiff in the lawsuit that was discussed in the previous panel. The format for our panel is going to be that each one will have an opportunity to talk for about fifteen minutes, and then we'll open it up for questions and answers at the very end. To start us off, we have Professor Bach.

PROFESSOR WENDY BACH: Thank you. I want to thank the organizers of this wonderful Symposium and everyone that is presenting with me today. It's obviously an extremely important topic. As you just heard, I'm here today because I've been conducting a study, and that study is actually about something I'm not going to talk about which was the prosecution of women in Tennessee for fetal assault. I'm happy to take questions on that. I know General Staubus knows a lot about that and would be happy to take questions. But what I wanted to do today instead is share some information that I've learned in the course of doing research. First, I want to talk to you about the profound medical complexity in the medical and treatment literature about NAS and maternal drug use.

I want to talk to you a little bit about history because we've been here in some ways before. And then finally, I want to talk to you about the relationship between treatment and the courts. One of the things that I've done as I've conducted this study is, I've read a tremendous amount of medical literature, and I've spoken and interviewed medical experts about the use of opiates during pregnancy which you heard a lot about during the video. We're spoken about the effect on
children in the short and long-term and the best practices in the field for treating both moms and kids. And as I mentioned, at the same time that I’ve looked at history, and the last time we focused as a culture on the use of drugs during pregnancy during the late ’80s and ’90s during the crack epidemic. So going to today, beginning with NAS, I think it’s important that we know precisely what the condition is. And you’ve already heard about some of that today. How an infant gets it and what we know and don’t know right now about the facts. And I just wanted you to know that I’m going to respectfully be slightly more moderate in what I have to say about the effects of NAS on children than you’ve already heard today. And that may be me just me not being a litigant or in this moment but me being a professor. But I wanted to share at least what I’ve learned. As you’ve heard, NAS is a diagnosis given to infants when they exhibit a defined set of symptoms associated with drug withdrawal after birth.

Generally, NAS in particular is generally understood in the medical literature to be a short-term and treatable condition, the NAS infant. The infants you saw on the video were infants who were suffering some of the more extreme variations of NAS. But infants who are diagnosed with NAS have symptoms that vary significantly. So you saw some of the more severe sets of symptoms that we do see. On the less severe end, things like NAS can be treated without using drugs given to the infants, they can be treated with things like swaddling, right, comforting the infant, rooming in with their moms, if they’re still with their moms, and breastfeeding. And the literature says that for those earlier cases, those kinds of treatments are appropriate. So I think it’s just important to know that this is on a spectrum and that some of the kids look like that but not all of the kids look like that. And this is— my job is to tell you that this is complicated. We know, as you heard, that an infant is at risk for developing NAS if the mother took opiates during the pregnancy. But what I want you to know about this,
and this has been referenced a little bit today, is that in Tennessee in 2016 over half the cases, 52.5 percent, result from the use of opiates that were prescribed and lawfully used. So this is a condition that is coming from lawful conduct by moms being prescribed. And the reason of that, the majority of those 52.5 percent, 86.1 percent of that group results from something called medication assisted treatment which you've also heard referenced. Medication assisted treatment, or MAT, is the use of substances, methadone, suboxone, things like that, given in this case to pregnant women to treat their addiction. Now, this may sound like a strange choice, and it may sound counter-intuitive that a doctor would give opiates to a pregnant woman knowing that NAS might result. But what you should know is that the American College of Obstetricians and Gynecologists has long recommended MAT as the best practice treatment for women who are addicted to opiates. I'll talk a little bit more about that. Some of it is— and some of it is, in fact, illegally used. But if 52 percent result from prescription drugs, most of that is MAT.

The others result from an illegal use or a combination of legal and illegal use. Illegal use is— and you're not going to be surprised by this, because what you've seen today is almost entirely the result of prescription drug diversion. Something we've already heard a lot about, right? So that other big chunk is mostly prescription drug diversion or a combination of getting a legal prescription and then using drugs illegally that you're obtaining from some other source. Only 3.8 percent of NAS cases in 2016 were reported to be coming from heroin. So this really is what we've been talking about today, having to do with the prescription drugs. I already said that not all infants who are exposed to opiates are going to get NAS. And looking at the medical literature, at this point, I can say that we actually don't know a whole lot about why some babies get it and some babies don't. We do seem to know that MAT as opposed to
occasional use, take a couple of pills after knee surgery, you're going to be less likely to give birth to an infant than if you're on medication assisted treatment or long-term opiates throughout your pregnancy, that can make it a little more likely. We also know, and this is important, that exposure to multiple substances not only makes it more likely, it appears to make it more likely, they could give birth to an infant with NAS, but that the NAS is more severe if you take different things as opposed to the same thing. That actually leads to an issue that a lot of people are talking about, because although I told you that the American College of Obstetricians and Gynecologists has always—has since the heroin epidemics, really, in the ’70s, have said that methadone is the right thing to do, it might have been later than that, actually, but for a long time. There are some early research, some of it going on at UT, that says you can safely detox moms. And that if you detox moms during pregnancy, you will reduce the chance that you give birth to an infant with NAS. But this is difficult; right? It's difficult to do well.

And if that mom relapses, as people often do when they detox, and then she goes and starts to use street drugs, then she's taking multiple substances. So, it's a very difficult set of decisions. And, you know, the more I got into this literature, the more complexity of this problem of what a mom should do when she's pregnant if she's an addict, of what she should do in terms of what medication she should take or not take, how the infant should be treated, are really difficult decisions, and they are very specific to that mom and to that baby. And the more I thought about this, the more I thought, these are decisions that we have to leave between, hopefully competent medical professionals—now we've heard a lot about not so competent medical professionals today—but hopefully good docs and their patients who are helping to understand this very complicated field and helping moms make the best choices they can make in those circumstances. Another thing I've learned a lot about is
this data research on the longer-term effects of NAS, and this is where I might differ just a tad. It's a very complicated question to answer; right? We know what it looks like at first, right, we know what it looks like in the infants.

We don’t know who's going to look like that, but we do know what it looks like. There are some studies that show some developmental delays correlating with exposure. There’s lots and lots of stories; right? There's lots and lots of anecdotal evidence that the kids are suffering. But the studies aren't there yet, and I don't know if they’re going to get there. And what's interesting is, when you look carefully at the medical literature, several researchers have suggested that once you account for things like socioeconomic status, exposure to violence, inadequate nutrition, prenatal and postnatal psychiatric stress, alcohol use, maternal education, lots of which we call the social determinants of health, it's really unclear, right, whether the issues we are seeing are as a result just of the opiate exposure or a combination of factors or something else. It is true, and this was said before, that infants with NAS or with any of those negative social determinants of health, are going to do better in stable environments with support.

I promised you I would turn to history. I think it's important to look at history and know that we have been here as a society before. In the late '80s and early '90s, we've labeled a generation of mothers and children crack moms and crack babies. At the time— and it’s interesting because I've gone back to read the science. And at the time, scientists and doctors sounded a lot like the scientists and doctors today. They were conducting careful studies, they were seeing some early correlations, but the majority of those folks were appropriately cautious about what their findings meant, not so though the press, the public and the courts. The media building on the stereotypes of what were then majority poor black moms, predicted a generation of destroyed children who
would grow up with a whole host of behavioral problems. There were crack kids, and the assumption was that this would be a lost generation. But here's the thing, that turned out not to be true. After following those kids for over two decades, we've learned a good deal. There are effects smaller than predicted in development and cognition that are far less severe.

And one long-term study I think is tremendously important. Dr. Hallam Hurt and her team conducted at twenty-five year longitudinal study comparing the development of infants exposed to crack cocaine to similarly situated infants who were not exposed. The study was launched in Philadelphia in 1989. Dr. Hurt and her team followed two hundred and twenty-four babies born between '89 and '92, half had been exposed to cocaine in utero and the other half had not been, and they were demographically incredibly similar. All the infants were born near full-term and were from low income, predominantly African American families. And at the time Philadelphia— and this is going to sound really familiar— was experiencing a drug epidemic similar to the opiate epidemic of today, nearly one in six born at the time at city hospitals had mothers that tested positive for cocaine. What her and her team found after twenty-five years were that there were "no significant differences between the cocaine exposed children and the controls."

What they did find, however, was that both groups of children, poor kids, predominantly African Americans, those who had been exposed to cocaine and those who had not, lacked developmental and intellectual measures compared to their non-socioeconomically non-racially similar compatriots. So, Dr. Hurt started to look at what else may be harming those children. They looked at environmental factors and found that while being raised in a nurturing home led to better outcomes, significant proportions of the children by age seven who had been exposed to violence, gunshots, witnessing a shooting and seeing a dead body, that exposure correlated with depression and anxiety and delays. Ultimately, her and
her team turned their focus to the effects of the condition of poverty on developmental growth and since has gone on to focus her research on these issues. I tell you this story not because I didn't know whether history is repeating itself but as a cautionary tale.

Those kids and the kids today absolutely need enormous support and services. I hope General Staubus and his fellow plaintiffs win lots and lots and lots of money to put into communities to support kids and families. But I think we need to be really cautious about labeling these kids and labeling these moms, and knowing, right, and be very cautious about the science of it, because the last time we did this, we labeled a whole generation of kids and we turned out to be wrong largely. This leads me to my final point, and that’s about the relationship between child welfare cases, family courts, criminal courts and treatment. A lot of the focus in the conversation has been on turning courts into hubs for accessing treatment. Drug courts and other problem-solving courts explicitly embrace this model, and other courts use other staff, probation officers, drug treatment coordinators and the like, that helps folks in the system access treatment.

Similarly, the Department of Children’s Services, DCS, has a duty to avoid placement, and as part of that work, they will often provide folks access to treatment. I just want to be clear, I think this is all wonderful and really, really important. There's no question that folks in those systems need access to treatment. But I do wonder if we're going too far, and I'll tell you why. During my study I have talked to lots of folks in the criminal justice system across East Tennessee. General Staubus is one of them. And during one of the interviews, I interviewed a drug treatment coordinator at a rural northeast Tennessee court about how she gets folks access to treatment. It was clear from the interview done in this very small community she was it, she was the one who could access treatment. What became clear in the
conversation is that it took criminal charges to access her services. She explained that if a mom called her and said that she wanted to get help for her son or daughter, or whoever was needing treatment resources, the first thing she would ask is, can you catch him on a little charge, because then I can help him. She also explained that she had three grants available to her to pay for what is pretty much short-term detox treatment, and two of them required judicial signoff. So you had to have an open criminal case in order to get access to those treatment resources in their community. And then I started asking, I actually had been asking all along, and every actor in the criminal justice system that I have asked this question to so far agreed with me when I asked, is it true that it's easier to get treatment once you're in court. And everybody says, yes, that is how it works, right. That's where the caseworkers are, that's where the ones are that know how to work with the system. And I think courts should have access to treatment resources. But I get worried about the zero-sum game. I think if we are constantly thinking—and this is what Professor Buck was talking about, our public health systems to our child welfare and criminal justice systems, we might be drawing people into those courts that could be seeking help outside of those courts. So I'm going to stop for now. I'm happy to take questions. And I'll turn it over to my co-panel.

PROFESSOR SUZANNE WEISE: Good afternoon. I should never have Power Points, so hopefully I will be able to do this correctly. So, I'm coming at this from a different angle, because, obviously, I think everyone would agree that fighting the opioid epidemic in Appalachia must occur on several fronts. So, the primary focus of my presentation is the role of family law clinics in cases where opioid addiction is the cause of child custody disputes in family court. In those cases, our clinic has been called upon to address substance abuse issues and the need for the players in custody cases to obtain
treatment for opioid addiction. As you heard earlier from Eric Eyre and Pat McGinley, in 2016, West Virginia had the highest death rate from opioid overdose. And according to the American enterprises, West Virginia's economic burden from the opioid crisis amounts to four thousand seven hundred and ninety-three dollars per resident. Children in foster care, according to the West Virginia Department of Health and Human Resources, eighty-four percent of the children in foster care in West Virginia are in there because of the opioid problems of their parents. These children's adverse experiences raise their risk of substance abuse as adults. The 2016 report of the Surgeon General has recognized that the experiences a person has in early childhood and in adolescence sets the stage for future substance use and sometimes escalation to a substance abuse disorder or addiction. Early life stressors, such as the ones that I see that the children experience in the cases in which I'm involved, involve parents who may have an opioid addiction. Maybe it's another family member. They have a parent or family member who may be incarcerated on drug related charges. There's several factors, but those are a lot of what we're seeing happen.

Research suggests that the stress caused by these risk factors may act on the same stress circuits in the brain as addictive substances which may explain why they increase the addiction rate. And as you've heard today, people who are affected by the opioid epidemic enter the legal system in many different ways. It may be because of drug charges, it may be because of abuse and neglect or it may be in family court and child custody cases. You usually have counsel appointed in criminal cases, at least in West Virginia, and in abuse and neglect cases in West Virginia where the party cannot afford counsel. However, under the current system, many affected by the opioid epidemic cannot afford counsel in family court proceedings. These families typically seek pro bono representation from Legal Aid and often they
will come to law clinics. We only have one law school in West Virginia in Morgantown, so we only have one university child and family law clinic. So, the WV Child and Family Advocacy Clinic that I direct represents children and families in custody and education matters but also other family related matters. Family courts in Monongalia and Preston Counties in West Virginia often appoint me and my students to serve as guardian ad litem to represent minor children in family custody cases. And importantly— and I'll talk about this in a few minutes— our clinic partners with Chestnut Ridge Center at the West Virginia University psychiatric facility and also with WVU Medicine/Pediatrics. And what we have is a medical-legal partnership with them, which I'll discuss in a minute. So, in the majority of cases that my clinic students and I litigate, at least one family member of someone involved in the case is suffering from some form of abuse, whether it's prescription painkillers, heroin. We're seeing a lot more heroin and meth.  

Also, many of the children we see, they have a family member, parent, member of the household— we have a lot of mixed households in West Virginia, where not everybody is biologically related, they just come together because they all need a place to live, so they experience that some member of that household may be incarcerated. A lot of these children bounce from household to household, maybe because a parent can't provide shelter, a parent can't keep a job, so these kids are shuffled around. And these are the adverse childhood experiences that increase the likelihood that the children in these situations will also become addicts as a result. And I want to give you an example of a couple of cases that we're currently working on now as we serve as guardian ad litem for the children. In one case, all parties have tested positive for drugs at some point in the past two years. The biological mother tested positive for painkillers at the birth of her child. The biological father tested positive for marijuana at the initial court hearing.
And I have to tell you, in family court, testing positive for marijuana these days is not that big of a deal. The judges aren’t as concerned about that because of the problems with these other substances. A biological parent actually raised this child up until this point, and that biological father, along with the fiancée, tested positive in court for opiates. There are also allegations that the psychological father sells and/or makes meth, and all parties have been arrested at some point, but are not currently in prison, and the parties have also called the police on each other as part of the dispute over child custody. So, our role in this case is to try to figure out the best interest of the child in every respect. In another case where we serve as GAL for the child, the mother tragically overdosed and died in 2012. The father claims he is recovering from his heroin addiction and wants to regain custody. There are allegations that his sister, who is the aunt, is selling heroin, and the child is currently living with the grandparents.

So as guardian ad litem in both of these cases, I mean we can look at the facts, interview the people, talk to their teachers, talk to the healthcare providers, and then we can figure out where is the safest place for this child to be. At this particular time, what’s going to be the best nurturing environment, what the options are. But resolving that is not going to resolve the drug addiction that is the root cause of the family problems, nor does the resolution of these issues address the children’s exposure to drug addiction and the effect it may have on them. And these children need healthy parents.

When we are representing a client in a custody case, and we have some of those right now where the other party is struggling with addiction, we have asked the family court to make treatment a part of the relief given in the case. For example, encouraging the other party if you seek treatment for your addiction, this will help you with your visitation with your child, we can move from supervised visitation to unsupervised, maybe
we can move to overnight visits, maybe we can move to a weekend, maybe you can regain every other week and if you can regain custody. And we’ve asked the court to do this. And surprisingly, we’ve had very mixed results. The court, and one judge in particular, has seemed reluctant to make that part of the relief granted. In one case, said that we were somehow trying to gain an advantage. There’s no advantage to be gained in these cases. Nobody wins. The win would be for the parent who is suffering to get the help he or she needs and for the best interest of the child. So this has prompted my clinic students and I to talk about what is our role. I mean, obviously, we’ll be in a role as a lawyer. But do we have more of a role, a more important role in addition to just helping with—you know, with the legal issues that the parties have. So, I’m citing the West Virginia Rules for Professional Conduct, but ours are based on the Model Rules, and they’re exactly like the Model Rules. So, under Rule 2.1 of the Model Rules, "In rendering advice, a lawyer may refer not only to the law but to other considerations such as moral, economic, social and political factor that may be relevant to the child’s situation"— or to the "client"—sorry. And then the comments to that Rule recognizes that family matters can involve problems within the professional competence of psychiatry, clinical psychology or social work, and with consultation with a professional in another field is something that a competent lawyer would recommend, the lawyer should make such recommendations.

And finally, the Rule also provides that the lawyer ordinarily has no duty to initiate an investigation of the client’s affairs Or to give advice that the client has indicated is unwanted. The lawyer may initiate advice to a client, but in doing so, appears to be in the client’s best interest. So how do we help our clinic clients or parties involved in the clinic cases get the help that they need? And this is where we believe our medical/legal partnership comes in to help with the treatment side of the opioid epidemic. According to key findings in the
Surgeon-general’s 2016 report on addiction, only one in ten people suffering from a drug use disorder get specialty treatment. And really, the low grade is really because of the resources—the lack of resources and what's available. And what happens is, because the limited resources are so limited, there can be waiting periods of weeks or even months just to get help. So medical/legal partnerships like the one WVU law has with, especially with Chestnut Ridge Center, which is a psychiatric facility, may be one way where we can work together to help these folks get the treatment that they need. And for those of you who don't know what a medical/legal partnership is, these are basically doctors and lawyers, and we have a memorandum of understanding that we’ve entered into, and doctors and lawyers are working together to address the communities' health-related social needs. Professor Val Vojdik established our first MLP at WVU Pediatrics in 2010, and then she was stolen from us by the University of Tennessee. And she is now here. So, when she was taken away, I assumed her role as director in 2011. And I established our second MLP with Chestnut Ridge psychiatric facility in 2016.

How does it work? The way it initially started with these medical/legal partnerships is the healthcare providers were referring their patients to us. And so it was really basically a one-way street. They were sending us their client, their patients to us and we were helping with their issues. And also, with the client’s consent, the healthcare providers were allowed to be involved with the client. And usually, we got the formal consent, but they were confiding in them anyway. But to get the formal consent for them to do that. And so what our goal is now is to now have it a two-way street, so that we’re able to consult with healthcare providers through the MLP to refer clients either to the Chestnut Ridge programs or to the other programs that they feel are more appropriate. And the reality is that simply referring the client to a
treatment program is not going to solve all the addiction issues. They've got to want to be helped. They've got to go through— most of them through a long process of recovering. Unlike drug court where you have the incentive, okay, you either go to jail or you're going to complete this drug treatment program. So you have the incentive, yeah, I don't want to go to jail, I'll complete the program. Or in family treatment courts where they say, you're going to lose your kids, we're going to terminate your parental rights if you don't go through the treatment program. Those are incentives. You don't have that in family court, because the worst thing that can happen in family court is that they're no longer the primary custodian, maybe they have just now supervised visitation or limited visitation or just visitation based on what the other parent will allow. And sometimes that incentive is not going to be enough. And so we have to help encourage them to want to get help for the sake of their children and to work with healthcare providers to make that happen. So I believe working together that we might be able to accomplish this.

We were talking earlier, what does this long-term treatment involve. There are many stages to it, it’s not something that you just do in a couple of weeks. The one with Chestnut Ridge goes on for at least two years under this program. I mean it has stages where they taper off and then if they get through, then they can just go to meetings, have their follow-ups, and they are also treated with suboxone usually. And a law student— I don't think he’s here now, but he raised it earlier, and I think he raised a really important issue that's a subject for another whole another session, is the use of suboxone in treatment. Because what we've done, we've replaced, you know, the opioid with another drug. And so a lot of folks are on this for life.

Originally, suboxone was used just to taper— the original use of it, at least my understanding is, it was just to taper a person off of the opioids, and now it's become the long-term solution. And I'm not a doctor, and I'm not
going to—I know there are cases where they try to take them off and other cases where they say it's not possible. But I think that's something that we really need to examine in the future as well. So a combination of this, I think that working together we can do this. But then the big question is, who is going to pay for this, which is always the question. In West Virginia, Medicaid will cover the cost of inpatient or detox partial hospitalization, care coordination and case management and they'll have prescription drugs like suboxone. We are still working in my clinic to try to figure out other resources that are available to help pay for these services, what services are available. Because just going to a suboxone clinic is not going to help you, they need counseling. They need somebody working with them to find out—you know, people don't just wake up one morning and say, oh, I'm going to become an opioid addict. There's something underlying, and it could be something as simple as a car accident. We had a client that came in addicted as a result of pain resulting from a car accident, or some really underlying serious problems.

We have another case where a woman who had a perfectly normal life, hooked up with her old high school boyfriend who happened to be a drug dealer and her life is a mess now. So there's all these reasons that you have to help the person and not just get the suboxone treatment but really needs counseling. Another tool to combat the opioid addiction in family court is—and I think we need to call upon the Bar for a better representation by lawyers. Rule 1.6, "Every lawyer has a professional responsibility to provide legal services to those unable to pay." And this is really an ethical commitment that has to be made by every lawyer. So I think that we need to call upon members of the Bar to step up. I think the family courts need to come up with a list of lawyers who are willing to provide pro bono legal assistance in family courts to help these folks with their custody cases. And finally, as part of the seminar
component of our family law clinics, I think we've got to start educating our law students about substance abuse and its origins so that they may counsel their clients where such a role is appropriate. Thank you very much.

GENERAL BARRY STAUBUS: Thank you for inviting me. This is my second time here. Actually, I was here— The Federalist Society invited me in this very room to talk about legalization of drugs. Which we do have legalized drugs. All these opioids almost are legally given, and we can see what kind of disaster it is. But that's for another day, another topic with another group. You all have been here a long time. I'm going to try to be short. So I'm going to start off with a clip of a video, and it's my appearance on the Today Show. It's not an— making an attempt at self-promotion, but I thought it was a well-done video of the clip, segment that the Today Show had been doing on opioids. And it's done by Ronan Farrow. You may know him. He's the guy who broke the Harvey Weinstein story. Also, you may know him as the stepson of Woody Allen.

And secondly, I would say, if I knew he was going to say Appalachia, I would have taught him to say it the right way. So be forewarned, he says it wrong. And third, I never had any physical contact with Matt Lauer during the filming and the presentation. So with that, I'm going to let them play the video. So I don't want to plow the same ground. You've heard from my lawyers who filed the lawsuits. I hope I don't repeat what they said. But how did I get involved in this thing? Well, the State of Tennessee passed a law years ago, Drug Dealers Liability Act. I've been a lawyer since 1985. I had never been a party to a lawsuit. I had filed some lawsuits for other people, and I signed my name on indictments, but I had to think long and hard, did I want to do this lawsuit.

And I got to thinking, it's a good thing that they gave the jurisdiction to DAs to file this lawsuit, because I feel like as a prosecutor, I have a unique perspective. There are a lot of perspectives out here. I see the families...
of the people that die of the overdoses. I've been to the NIC units, and I've seen the babies, I've talked to the nurses, I've talked to the doctors, I've talked to the rehab people. I've talked to the mothers who gave birth to those babies. I have met with the victims of many, many crimes. Probably ninety percent of all crimes in Sullivan County result in drug abuse. You know, if there's a burglary, somebody breaks into a car or a house, a building because they're looking for drugs. When they break in, they take stuff from people that's not theirs. When they shoplift—we have robberies where they don't even ask for the money out of the pharmacy, they just want the pills. We have many, many impaired drivers, not on alcohol anymore, I see them pill ed up, and they kill people. They wreck, they harm people, they kill people that are minding their own business in a car. I see people that are under the influence of drugs when there's a domestic violence event. Elder abuse, when older people are abused. There's a number of ways.

It's sometimes a family member is pill ed up and they take their money, they take their drugs, they take their credit cards, or they neglect them, let them starve, put them in perilous condition. I've got one where one died. And the mother sat there and watched it happen. I attribute that to drug abuse because she was more concerned about getting out and getting pill ed up every day. Almost every identity theft I see, worthless check, under the criminal—other crimes like that. Almost all of them relate back to people that are addicted to drugs. So I see that. Then I saw the pain pills. I don't know if this statistic was given, we have a number of pain pill clinics in our jurisdiction, and we have thirty-five suboxone providers in one single county. And one of the pain clinics was prescribing fifty thousand pills per week, fifty thousand, and a hundred and fifty thousand prescriptions a month in a county that has a hundred and fifty-eight thousand people. So I saw that, and I would see the people driving from West Virginia down to my
county and from southwest Virginia and other parts of East Tennessee and getting off the interstates, sitting in the parking lot with their kids having fights, eating chicken and pizza, playing cards, standing in line on New Year’s Eve. You know that’s a legitimate doctor. All medical providers have people sitting in their parking lots from multi states on New Year’s Eve. So I see that, I saw that. And I see people going in there and getting their suboxone and getting their opioids. I talked to one mother who gave birth to a baby. She got opioids because she had hepatitis. She got morphine for hepatitis. Now, tell me that’s a legitimate medical practice. That’s the kind of things as a prosecutor I’m seeing across the board day-in and day-out. And Sullivan County leads the state in drug dependent babies. Tennessee is one of the top opioid users and abusers. One of the other statistics you may have heard, in Sullivan County, forever man, woman, and child, there's prescribed 5.5 opioids. Think about that. Three Tennesseans die per day by overdose. It exceeds the murder rate and car wrecks. And now we’re flooded with fentanyl and heroin. So a lot of these addicts have gone beyond that. I talked to the health department. They said, we're on the cusp of a hepatitis C, HIV epidemic. Our prison population— our population since the ’90s, in some cases, I think increased two percent, but our jail population seventy percent, almost seventy percent.

You crowd that— you put seven hundred people in a five-hundred-person facility filled with drug addiction and intravenous drug users and hepatitis and you're having another health crisis. So those are the things that I see, that I saw, and they're not getting any better. I'm seeing it become worse. For the first two months, according to March, we’ve had about three overdose deaths a week, and almost everyone of them are fentanyl and heroin, where we used to see oxycodone and a mixture of drugs. And a good book that— I don’t know if you've heard about it, but a book that I read several years ago that was also a catalyst for me getting involved
in this lawsuit was a book called *Dreamland* by a guy by the name of Sam Quinones, and it tells how the first pill mills got established in Portsmouth, Ohio. And he tracked how everywhere these pill mills come, there's heroin right behind it. And when I read the book, we weren't seeing heroin, we weren't seeing fentanyl. We are now. And people are dying. We had one provider—you may not know this, but nurse practitioners can prescribe opioids for pain clinics. We had one nurse practitioner who prescribed to at least seven people who have died from drug overdose. When I talked to the family of one of those people that died, she went personally into the pain clinic and said, don't give any more drugs to my daughter, please do not. And she says, as long as the law allows me to do it, I'll do it. And the mother was right, she predicted she would die, and she did. So I hear these stories and I see these facts and I see these events, and so I had to make a decision, do I want to file this lawsuit or not, do I want to stick my neck out. And I was lucky to bring in my DA buddies from next door, Tony Clark and Dan Armstrong, and we sat down and we had a meeting, and I told them I was onboard. And they said, why are you doing it?

And I said, look, I woke up in the middle of the night and it just seemed like it was the right thing to do. What have I got to lose? And I hope we win, because I want a hair transplant. No, I hope we win, and I hope we win big, because it has been devastating to our county. It's been devastating to our area and outstate. I read that there's been a five hundred and forty percent increase in the prescribing of opiates. Do you think there's been a five hundred and forty percent increase in pain that people have? I don't think so. When you see the devastation and the death and the babies—and another story I'll tell about, and we touched on it, NAS babies. And I'm not here for that today, I don't want to really get into that. But I know a lady in a place called Stoney Creek, and she walked the walk. She adopted one of these babies. And
not only did she adopt these babies, but she set up a clinic for the women that I met that had drug addiction. And she tries to get those women the resources that they need. She’s a model for what we ought to be doing in West Virginia and Tennessee and across the country. But she went a step further, she adopted one of those babies. She already had raised her kids, had grandkids, she adopted one of these babies. So, then she decided, right next door to the clinic where I treat the moms, where are they going to drop the kids off, next door. So, she has made a facility just for these babies for their unique problems that they have developmentally. She’s designed a little— she’s near Stoney Creek, which Professor White knows, is next to Elizabethton. So, she had a man who volunteered, and he’s built a little town, looks like a little speck there. And they’ve got a little place where if they get sensory overload, they can go. And one of the things— and a lot of these kids are freaked out by doctors because they go a lot, and stethoscopes and rubber gloves are a big problem. So, they have a veterinarian place, so they get to play veterinarian, the kids do. When they play veterinarian, they want to treat the little Teddy Bears and the dogs. They let them wear gloves and stethoscopes, just small things like that. They have a restaurant and they have a grocery store, so they handle food, because they have a lot of weird things about food.

Those are the kinds of things that need to be done. If I win this lawsuit, she’s a model for the kind of things that need to be done. There are a lot people that could help. There’s a lot of people that are helping. There’s a lot to be done. But these companies, in my opinion, my humble opinion, is they created this problem. Now, they didn’t make anybody take the drugs, I know that. When people say, everybody needs treatment. Well, no, if somebody is doped up and they run into the back of a car with your mom or your wife and your two kids and kill them, I’m sorry, I’m not in the mood for rehabilitation right then. But there are many, many that do need rehabilitation, either in the facility— but they need help,
and they need money. And we've seen the devastation. So that's what I hope the lawsuit will provide is a statement that you push these drugs— and you heard, I'm sure, from Mr. Stranch and Ms. Herzfeld, they pushed these drugs, miracle drugs that had no side effects. And they make lots and lots of money. And I'm not against making lots of money, but I am when you're lying to people and you're destroying people's lives, and then you claim you're not doing it when you are. So that's why I filed the lawsuit. And I guess that's why I'm here today. So, I guess I've taken up my fifteen minutes, right. So, in the words of Kurt Monagan, thank you for your sweetly faked attention. Thank you.

MR. SCHRACK: Thank you. We'll now open it up for questions from the audience. We do have two microphones available if anyone has any questions.

UNIDENTIFIED SPEAKER: I actually have a question for Wendy Bach about one of the things you said very early on in your speech. You said that one of the NAS treatments that you had run into was breastfeeding, which I found very interesting given that we have a judicial system that tends to take the children away from the mother as soon as they are tested positive for any kind of drugs. So, I guess my question would be, is the justice system worsening the effects that they have by our reaction?

PROFESSOR WENDY BACH: I don't have any data. I know what you're saying. I think we have to be—I mean one of the points I'm trying to make is, every baby, every mom is unique, right? And when you have a policy like you just said— and DCS's policy is not every time an infant is affected, you take the baby away immediately. They do go in and they assess the situation. That's a little bit of an overstatement. But I think when we blame the moms, we maybe won't see something like rooming in or
breastfeeding as something good if we're worried that the mom is the source of the problem or can't do that. And that mom may need a lot of support to support that baby. But there are good programs where moms and babies can be together, and both get the support they need. But I think we have to look at this through a public health and medical care lens for that circumstance and look at every mom and kid and figure out what’s most appropriate and just be very mindful about the science of what works and what doesn't.

UNIDENTIFIED SPEAKER: Barry, before you got here, your lawyers were describing (inaudible) in a way I found particularly unflattering and were talking about issues such as the doctors all going down to Ridgefield County Club and continuing to perpetuate this problem. So, my question is, you know, you and I both know that area, so how has the community reacted to your activism and what, if anything, has the medical profession in Sullivan and Washington and Carter County done to help you?

GENERAL BARRY STAUBUS: One, I want to say that I think the vast majority of doctors are legitimate doctors and don't want any part of this. Doctors were put in a bad spot in 2001 when the pharmaceutical companies pushed for a thing called for "The Retractable Pain Act." And it said you've got to do one of two things. If somebody comes to you and says, I want a narcotic, you've either got to give it to them or send them to somebody else. So, the legit doctor said look, I think you're a drug seeker, maybe you need rehab, maybe you need to just wait, maybe you need an anti-inflammatory. They're, no, I want it. So that's how the drug— most of the pill mills are, to me, they're an outlier in the medical community. The medical community that I— the people that I've talked to, particularly the ones that are serving these babies, you know, they're as involved as you could be. And I have talked to a lot of doctors, and what's the general reaction
been? Sullivan County, it's my home, my family has been here for generations, and the people there are generous and have been generous. And I get a lot of atta-boys for doing this. The response has been positive, except for—when after the Today Show a guy from Iowa called me and said, because of you, I can't get my pills. And I said, well, move to Tennessee. He said he was reporting me to the Board. But my experience with—there are a lot of doctors that are in the rehabilitative business and that are supportive of what I'm doing, and they've told me that. And many of the medical providers said, part of the problem was we had this fifth vital sign that you heard about that the juvenile judge was talking about. And basically, the other thing is, doctors are judged by patient satisfaction. Imagine if you were a professor and you were graded—your pay increase and your promotions were just totally the result of how well the teacher liked you. So, what would that do? That would incentivize passing everybody, not giving out homework, not being critical. So that's what's happened in the medical profession is that—I've talked to ER doctors that said, if I don't give them, they fill this out, they'll complain on me.

So, if I'm looking for a promotion or I'm looking for a pay raise, and they're saying, your patient satisfaction is low. Well, who's giving the grade? The dope head, the pill heads, the drug seekers, the addicts. So I find that the vast majority of the community has been supportive of the lawsuit, they want to fight this problem. I think the biggest problem I have is that people don't realize the magnitude of the problem. I think some people are still doubters. And it's easy to understand. It's just like when people come and sit in the grand jury thinking, my gosh, I didn't know we had this much crime. The only thing that gets reported in the paper if you’re in Knoxville, it's going to be the murder cases, the sexy cases, I guess you would say, high publicity cases. Well, nobody goes to sessions court or juvenile court and sees twenty, thirty,
forty, fifty thousand cases, depending on the size of the municipality. So, my biggest challenge has been people who work at Eastman, work at school, they go home, they go to ballgames and they go to movies, soccer, church, civic groups, and they don't see a lot of it. But that’s changing because more and more people are saying, you know what, I've got a relative, I've got a friend that had a car wreck or—I think of the example you gave, a job-related injury. We're seeing more and more people get addicted because the access is so huge. And doctors have over-prescribed. Classic example, I had meniscus surgery. When I went in—it’s one of those things you go in and go out the same day. They gave me a prescription for ten Percocets. I took one and it hurt my stomach, I threw them away. So, I came back for my ten-day checkup, what did they give me, thirty-day supply of Percocet. And the new studies that have come out and say that if someone takes Percocet drugs for a thirty-day period or more, there's almost like a thirty percent chance a year later they're going to be taking that drug, which is the sign of addiction. So those are the kinds of things that—I think that the denial or the misunderstanding or the lack of understanding is changing because there's so many people across the board. It's not just your traditional drug culture people, but now we're seeing professionals and nurses diverting, doctors diverting, so we're seeing it across the board professionals, middle class and lower-class. I hope I answered your question.

UNIDENTIFIED SPEAKER: Can other DAs join in, like Bradley County—

GENERAL BARRY STAUBUS: Yes. Sixteen DAs have now joined. We started with three, we've gone to sixteen—

UNIDENTIFIED SPEAKER: I have to say it was an unintended consequence that I'm the sponsor of
Senate Bill that set up the Drug Dealer Liability Act in the State of Tennessee.

GENERAL BARRY STAUBUS: Congratulations. Thank you.

UNIDENTIFIED SPEAKER: Thank you. I have a question. I have a question just about your lawsuit. You have targeted as defendants the manufacturers. Is that because of the Tennessee statute, and why not the distributors?

GENERAL BARRY STAUBUS: Well, I think my lawyers could be of much more—

UNIDENTIFIED SPEAKER: I don't want you to breach your attorney/client privilege.

GENERAL BARRY STAUBUS: Well, we've done the manufacturers, but we've also done a pain clinic, we've also filed against individuals as well. And the reason we felt like— the center point of our theory right now is the manufacturers and the unregistered distributors. And that's why, that we had to focus, we had to stick with our theory. And what also makes our lawsuit unique, and I'm sure they told you this, but we filed on behalf of a drug dependent baby. Nobody else has done that, so now other people will. A lot of people have asked for copies of our Complaint. But that's one thing that may bind me in, it's not just the DAs, but that baby stands in for all the babies that got addicted, for me. It stands there as a representative for all these babies that you heard about. It's been estimated that a third or fourth of the babies in Sullivan County are born addicted to drugs.

And I understand what Dr. Bach is saying, we don't have the studies in. But common sense will tell you this much, that if a woman gives birth to a baby and the drugs normally dissipate within forty-eight hours at
.birth, that tells you that many of these women within two to three days of giving birth, on the cusp of a birth, they're still taking serious drugs. And you just know that if that happens—and usually in bad circumstances where the women are under anxiety, they're addicted to drugs, they're afraid of crimes, they're afraid of being picked up, they're afraid of losing the kids, from pillar to post. They may be in an abusive relationship—and I'm sure you see a lot of that. You know that's not the ideal circumstances to have a baby. So that's why it's so important, I think, for that baby to stand in as a plaintiff, because it represents the hell that they may have to endure, that they did endure just being—the first sensation out of the womb is either I'm addicted—either been addicted, high or withdrawn, and that's not a good place to be. So, I think we have a very strong claim for the baby and all babies that it stands for.

MR. SCHRACK: We'll do one more question over here.

UNIDENTIFIED SPEAKER: My question is for the General too. You talked about suboxone earlier and I know you probably have a lot to talk about it. There are a lot of people who believe that is the key to fixing this problem. And do you know of any known cases of overdose that are exclusively to suboxone and no other drugs involved?

GENERAL BARRY STAUBUS: No, not exclusively.

UNIDENTIFIED SPEAKER: And what are the negative effects that you believe suboxone has, and are they included in your lawsuit?

GENERAL BARRY STAUBUS: No, suboxone dealers are not, the pain clinic is. I'm not a big believer, I'll be honest, in suboxone in the way I've seen it used in
Sullivan County. I'm not saying it's not a tool, it's not an aid. But many of our suboxone clinics, you go in and you get your twenty-eight-day supply of suboxone. You come back in twenty-eight days and get it. There's no individual therapy, there's no counseling, there's no really effective drug screening or for risks, there's no penalties. You know, if you end up having other drugs in your system. There's no end game. Most of the suboxone providers will say, we don't have a game plan to try to get this person back to being productive. See, I think the goal ought to be—and it may not always happen. But, you know, if you're on suboxone for ten years, there's something wrong. I mean you're either on the same amount or you're going higher, and you're having dirty drug screens but you're still getting it. And that's not right. To me, the goal ought to be, we want to make you a productive citizen. Our highest goal is to get you completely off of dope of every kind so you can live productively. But if we can't, we need to get it to a level where you can get a job and you can raise your family and you can stay out of trouble.

I'll give you another example. Suboxone is a lot like methadone except methadone is more highly regulated. I had a guy who was committed. He had a sentence, and he was on methadone. He had court approval to go to Asheville, which is the closest facility to get methadone. Of course, if they put him on suboxone, he's going to give it to somebody. This guy comes back, he's been on methadone ten years, and he's still getting that substance for his addiction. And he goes to a party, and he puts that thing in a glass of Kool-Aid, and his buddy drinks it, and he's not used to the power of that, methadone, and he had another drug in his system, and he lays down on the couch and he goes to sleep, and he never wakes up. To me, no one should do that. I guess the moral of the story is, nobody should be on methadone for ten years. I mean it seems to me—I mean if it's a step-off drug to productivity, that's the problem. That's what I
have the problem with. Suboxone is given out— as someone said, it's just another substitute— I'm not doing— you know, I'm not on opioids and I'm on suboxone. What we find out— and I've talked to the toxicologists over at the ETSU Medical Center, and what they tell me is, that suboxone is really a bartering drug for many people. What that means is, is that you take the drug of your choice, and when you need another drug, you trade suboxone. When you're jonesing, you know, you're coming off of it, you take that as a temporary bridge until you can go find a man and get what you need. And the man often is, you know, I'm waiting my twenty-eight days out, or I'm going to go to heroin. And people say, why would anybody go to heroin when you've got these legally, you know, regulated drugs of certain purity, because they're after the high. And that's why it's so hard to combat with just another pill because they're not rationally thinking. I mean people will take drugs that are fifty to a hundred times more potent, like fentanyl, which is so powerful that if a drug dog smells it, it kills them. If you touch it and an officer touches it in a wrong way, exposed to it, they can overdose from it.

And you say, well, why would anybody do that when they can get it? Because they want more. And I think suboxone is the same thing. It's like a temporary magic bullet, but it's not a long-term solution, it's not to their benefit in the long run. They're not getting off drugs, they're just getting a respite from the addiction. Now, there are clinics, there are legit clinics that treat with suboxone and other methods, there are. But there are a lot of them that are just making lots of money. As a matter of fact, we convicted one pill mill in Morristown. You all probably— Morristown is just a little further east, if you don't know where that's at. He pled guilty and he paid a fine, agreed to pay a fine, seven hundred and fifty thousand dollars as part of his plea deal. Now, when you can crank out— voluntarily pay seven hundred and fifty thousand dollars, does that not tell you that it's a lucrative business for them? So that's why a lot of people
in the suboxone and pain pill business is in it, for money. It's a legalized drug dealer.

MR. SCHRACK: Let's thank our panelists for coming today. At this time, I would also like to thank our Symposium Director, Mr. Michael Deel, for putting this together. If you all are interested in this topic, the Baker Center across the street will be hosting Mr. Eric Eyre tomorrow for another presentation on this. Thank you all for coming.
DEFINING THE ROLE OF CLINICAL LAW STUDENTS, MEDICAL–LEGAL PARTNERSHIPS, AND PRO BONO LAWYERS CONFRONTING THE OPIOID EPIDEMIC IN FAMILY COURT

Suzanne Weise*

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I. Introduction

Opioid addiction fractures entire families and leaves children orphaned by overdoses.1 There is no stereotypical family of an opioid addict.2 The abuse of prescription opioids over the last two decades has grown to epidemic proportions reaching every corner of society while crossing gender, racial, ethnic, class, and geographical lines. As a distraught mother who lost her daughter to a prescribed opioid overdose observed, “Could be you, could be me.”3 Opioid addiction is a chronic

3 Id. (quoting Kate Grubb discussing her daughter’s tragic overdose death). Jessie Grubb, daughter of Kate and David Grubb, died of an overdose of Oxycodone prescribed following surgery by a physician who failed to read her medical chart carefully and did not realize that she was a recovering opioid
disease requiring long-term treatment. Medical specialists in addiction have observed, “Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.”

Nowhere has the impact of the opioid epidemic been clearer than in West Virginia. According to the Center for Disease Control and Prevention, West Virginia had the highest percentage of drug overdose deaths in 2016. Adults aged twenty-five to fifty-four had the highest percentage of drug overdose deaths, which in many cases likely left children deprived of a parent. According to the Secretary of the West Virginia Department of Health and Human Resources, eighty-three percent of the children in foster care placed in West Virginia were addicted. Her parents were instrumental in the introduction of a bill entitled “Jessie’s Law,” which would require prominent display of opioid addiction history in a patient’s medical records. Id.; see also Jessie’s Law, S. 581, 115th Cong. (2017) (as passed by Senate and referred to H. Subcomm. on Health, Aug. 11, 2017).


5 Eric Eyre, an investigative reporter for The Charleston Gazette-Mail, was awarded a Pulitzer Prize for investigative journalism. The 2017 Pulitzer Prize Winner in Investigative Reporting: Eric Eyre, of Charleston Gazette-Mail, Charleston, WV, THE PULITZER PRIZES, http://www.pulitzer.org/winners/eric-eyre [https://perma.cc/CS49-AQ9R]. Eyre exposed to the public for the first time the enormous flood of hundreds of millions of doses of prescription opioids flowing into small towns in rural West Virginia.


7 Id.
Virginia are there because of drug problems within the family. These adverse experiences increase the children’s risks of substance abuse and have an enormous impact on their development. In addition to exposure to

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West Virginia is not the only state where children whose parents suffer from opioid addiction have flooded foster care. An eight percent increase in foster children occurred in the United States from 2011 to 2015:

In 14 states, from New Hampshire to North Dakota, the number of foster kids rose by more than a quarter between 2011 and 2015, according to data amassed by the Annie E. Casey Foundation. In Texas, Florida, Oregon, and elsewhere, kids have been forced to sleep in state buildings because there were no foster homes available, says advocacy group Children’s Rights. Federal child welfare money has been dwindling for years, leaving state and local funding to fill in the gaps.


9 The 2016 Report of the Surgeon General has recognized, the experiences a person has early in childhood and in adolescence can set the stage for future substance use and, sometimes, escalation to a substance use disorder or addiction. Early life stressors can include
substance abuse, the Center for Disease Control recognizes other childhood experiences that may adversely impact child and adolescent development: (1) emotional abuse, (2) physical abuse, (3) incarceration of a household member, (4) emotional neglect, (5) physical neglect, (6) divorced or separated parents, (7) domestic violence, (8) depression or mental illness of a family household member, and (9) sexual abuse.\textsuperscript{10}

Because of the risks associated with adverse childhood experiences (“ACEs”), some states have enacted statutes acknowledging the impact such experiences have on “the development of the brain and other major body systems.”\textsuperscript{11} Recent legislation proposed

\begin{quote}
physical, emotional, and sexual abuse; neglect; household instability (such as parental substance use and conflict, mental illness, or incarceration of household members); and poverty. Research suggests that the stress caused by these risk factors may act on the same stress circuits in the brain as addictive substances, which may explain why they increase addiction risk.
\end{quote}


\textsuperscript{10} About the CDC-Kaiser ACE Study, CTRS. FOR DISEASE CONTROL & PREVENTION (June 14, 2016) https://www.cdc.gov/violenceprevention/acestudy/about.html [https://perma.cc/4NNF-2SSJ].

\textsuperscript{11} WASH. REV. CODE § 70.305.010(1) (2014). “Adverse Childhood Experiences” are statutorily defined in Washington as follows: (1) “Adverse childhood experiences” means the following indicators of severe childhood stressors and family dysfunction that, when experienced in the first eighteen years of life and taken together, are proven by public health research to be powerful determinants of physical, mental, social, and behavioral health
in the United States House of Representatives recognized that adverse childhood experiences can lead to opioid abuse.\textsuperscript{12} Legislation proposed in Tennessee sought to address “the adequacy of resources to assist children and youth impacted by the opioid epidemic and adverse childhood experiences.”\textsuperscript{13} An early version of a bill recently passed by the Vermont Legislature found that “[w]hile much is yet to be learned about the specific

across the lifespan: Child physical abuse; child sexual abuse; child emotional abuse; child emotional or physical neglect; alcohol or other substance abuse in the home; mental illness, depression, or suicidal behaviors in the home; incarceration of a family member; witnessing intimate partner violence; and parental divorce or separation. Adverse childhood experiences have been demonstrated to affect the development of the brain and other major body systems.

\textit{Id; see also Act of May 22, 2017, 2017 Vt. Acts & Resolves 43 § 1(1)} (“Adversity in childhood has a direct impact on an individual’s health outcomes and social functioning. The cumulative effects of multiple adverse childhood experiences (ACEs) have even more profound public health and societal implications. ACEs include physical, emotional, and sexual abuse; neglect; food and financial insecurity; \textit{living with a person experiencing} mental illness or \textit{substance use disorder}, or both; experiencing or witnessing domestic violence; and having divorced parents or an incarcerated parent.” (emphasis added)).

\textsuperscript{12} H.R. 3291, 115th Cong. § 2(3) (2017) (“As the number of adverse childhood experiences increases so does the risk for . . . opioid abuse . . . ”).

\textsuperscript{13} H.R. 2580, 110th Gen. Assemb., 2d Reg. Sess. (Tenn. 2017) (“On or before January 15, 2019, the commissioner of mental health and substance abuse services shall report to the health committee of the house of representatives and the senate health and welfare committee on the adequacy of resources to assist children and youth impacted by the opioid epidemic and adverse childhood experiences.”).
DEFINING THE ROLE

developmental pathways and predictor variables of opioid addiction, programs that reflect the needs of people who have suffered from traumatic experiences must be part of any comprehensive strategy to attack the opioid epidemic.”

A hearing of the Health, Education, Labor, and Pensions Committee of the United States Senate recently focused on the opioid epidemic’s impact on children. Hearing testimony addressed infants experiencing neonatal abstinence syndrome and children of opioid-afflicted families now in foster care, as well as the remedial actions that need to be taken on the federal, state, and local levels.

Going forward, efforts to address the opioid epidemic must necessarily occur on numerous fronts.

16 Courts burdened by an increased caseload as a result of the opioid epidemic have implemented new programs. For example, in Florida, trial courts have established “Early Childhood Courts” in response to the increased number of dependency court cases:

This epidemic has influenced Florida’s child welfare system and has resulted in an increased number of dependency court cases throughout the state. Many trial courts have established Early Childhood Courts for families affected by the opioid epidemic by offering a continuum of evidence-based services, including Child–Parent Psychotherapy—an intervention aimed at healing trauma. According to the Florida Department of Law Enforcement, Florida Medical Examiners Report, in 2016, six of the seven Florida counties with the most opioid-
For example, family treatment drug courts have been established throughout the United States to ensure that parents immersed in the child welfare system because of substance abuse issues receive treatment and are reunified with their children.\textsuperscript{17} The responsibility of family drug treatment courts is to address abuse and neglect issues by treating underlying drug addictions in collaboration with child welfare and substance abuse professionals.\textsuperscript{18}

related deaths have an Early Childhood Court in place.

\textit{In re Certification of Need for Additional Judges,} 230 So. 3d 1164, 1165 (Fla. 2017) (footnotes omitted).


\textsuperscript{17} See generally Family Treatment Drug Courts, NAT’L CTR. ON SUBSTANCE ABUSE & CHILD WELFARE, https://ncsacw.samhsa.gov/resources/resources-drugcourts.aspx [https://perma.cc/7QMX-946M] (information on family treatment courts).


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However, in many states, family courts possess limited jurisdiction, and collaborations with substance abuse professionals are rare. Indeed, a family court may have authority to order drug testing of parents where there is credible evidence of substance abuse and also may order a parent to undergo and complete a drug treatment program as a condition precedent to being allowed to regain custody of her children or to have (or increase) visitation with her children. But, typically the parent ordered to undergo drug treatment is left to her own devices in seeking a treatment program and finding

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19 For example, the Supreme Court of Appeals of West Virginia has recognized the limited jurisdiction of family courts in the state:


the means to pay for it. Given these challenges, this article focuses primarily on the evolving roles of family law school clinics, medical-legal partnerships, and the availability of pro bono lawyers where opioid-affected families are entangled in cases litigated in a family court system.

II. Treating Opioid Addiction to Resolve Custody Issues in Family Court Cases.

A. Family Law School Clinics

Family law clinics are a staple of the curricula of many American law schools, including states with the highest rates of opioid overdose fatalities.²⁰

For example, the West Virginia University College of Law Child and Family Advocacy Clinic (“CFAC”) has represented children and families in cases involving custody, guardianship, education, and domestic violence that are litigated in the state’s family courts. In addition, family court judges appoint the CFAC to serve pro bono as guardian ad litem (“GAL”) in child custody cases.

²⁰ According to the CDC, the five states with the highest rates of death due to drug overdose in 2016 “were West Virginia (52.0 per 100,000), Ohio (39.1 per 100,000), New Hampshire (39.0 per 100,000), Pennsylvania (37.9 per 100,000) and []Kentucky (33.5 per 100,000).” Drug Overdose Death Data, CTRS. FOR DISEASE CONTROL & PREVENTION (Dec. 19, 2017) https://www.cdc.gov/drugoverdose/data/statedeaths.html [https://perma.cc/695M-V3UC]. All five of these states have law schools that are legal partners in a medical-legal partnership: University of Louisville Brandeis School of Law, Cleveland-Marshall College of Law, Case Western Reserve University School of Law, University of New Hampshire Law School, University of Pittsburgh School of Law, and University of Pennsylvania Law School. The Partnerships, NAT’L CTR. FOR MEDICAL-LEGAL P’SHIP, http://medical-legalpartnership.org/partnerships/ [https://perma.cc/8UWL-LGXC].
The West Virginia Constitution was amended to create “a unified family court system . . . to rule on family law and related matters.” In addition to many other family-related actions, family courts in West Virginia have jurisdiction over “actions for the establishment of a parenting plan or other allocation of custodial responsibility or decision-making responsibility for a child[.]”

21 Article 8, section 16 of the West Virginia Constitution provides:

There is hereby created under the general supervisory control of the supreme court of appeals a unified family court system in the state of West Virginia to rule on family law and related matters. Family courts shall have original jurisdiction in the areas of family law and related matters as may hereafter be established by law. Family courts may also have such further jurisdiction as established by law.

W. VA. CONST. art. VIII, § 16; see also W. VA. CODE ANN. § 51-2A-2.

22 W. VA. CODE ANN. § 51-2A-2(a)(6). The West Virginia Code enumerates the actions over which family courts have jurisdiction:

(a) The family court shall exercise jurisdiction over the following matters:
(1) All actions for divorce, annulment or separate maintenance brought under the provisions of article three, four or five, chapter forty-eight of this code except as provided in subsections (b) and (c) of this section;
(2) All actions to obtain orders of child support brought under the provisions of articles eleven, twelve and fourteen, chapter forty-eight of this code;
(3) All actions to establish paternity brought under the provisions of article twenty-four, chapter forty-eight of this code and any dependent claims related to such actions regarding child support, parenting plans or
other allocation of custodial responsibility or decision-making responsibility for a child;
(4) All actions for grandparent visitation brought under the provisions of article ten, chapter forty-eight of this code;
(5) All actions for the interstate enforcement of family support brought under article sixteen, chapter forty-eight of this code and for the interstate enforcement of child custody brought under the provisions of article twenty of said chapter;
(6) All actions for the establishment of a parenting plan or other allocation of custodial responsibility or decision-making responsibility for a child, including actions brought under the Uniform Child Custody Jurisdiction and Enforcement Act, as provided in article twenty, chapter forty-eight of this code;
(7) All petitions for writs of habeas corpus wherein the issue contested is custodial responsibility for a child;
(8) All motions for temporary relief affecting parenting plans or other allocation of custodial responsibility or decision-making responsibility for a child, child support, spousal support or domestic violence;
(9) All motions for modification of an order providing for a parenting plan or other allocation of custodial responsibility or decision-making responsibility for a child or for child support or spousal support;
(10) All actions brought, including civil contempt proceedings, to enforce an order of spousal or child support or to enforce an order for a parenting plan or other allocation of custodial responsibility or decision-making responsibility for a child;
(11) All actions brought by an obligor to contest the enforcement of an order of support through the withholding from income of amounts
In approximately eighty percent of the cases litigated by the CFAC, at least one family member, or someone integrally involved in the case, suffers from some form of opioid abuse, including prescription opioids, heroin, fentanyl, or other opioid addiction. Also, many of the children the CFAC has served as GAL have had a parent or parents, family member, or immediate member of the household incarcerated on drug-related charges. The children in such family circumstances may bounce from household to household because the parent is unable to hold onto a job or to provide food and/or shelter for them. These situations exemplify the types of adverse childhood experiences that increase the likelihood payable as support or to contest an affidavit of accrued support, filed with the circuit clerk, which seeks to collect an arrearage;

(12) All final hearings in domestic violence proceedings;

(13) Petitions for a change of name, exercising concurrent jurisdiction with the circuit court;

(14) All proceedings for payment of attorney fees if the family court judge has jurisdiction of the underlying action;

(15) All proceedings for property distribution brought under article seven, chapter forty-eight of this code;

(16) All proceedings to obtain spousal support brought under article eight, chapter forty-eight of this code;

(17) All proceedings relating to the appointment of guardians or curators of minor children brought pursuant to sections three, four and six, article ten, chapter forty-four of this code, exercising concurrent jurisdiction with the circuit court; and

(18) All proceedings relating to petitions for sibling visitation.

Id. § 51-2A-2.
children involved will eventually become addicts as adults.

For example, in one case where the CFAC served as GAL, all adult parties tested positive for drugs at some point during a two-year period. The biological mother tested positive for painkillers at the birth her child, and the biological father tested positive for marijuana at the initial court hearing. As a consequence of court-ordered testing, the psychological father who had raised the child and his fiancée were found to be opioid users. The family court also was faced with allegations that the psychological father sold and/or manufactured methamphetamines. All parties had been arrested at some point but were not currently incarcerated at the time of the CFAC’s involvement. Further complicating matters, the parties had also sought police intervention against each other as a tactical strategy to gain advantage as they sought custody of the child. In another case where the CFAC served as GAL for a child, the mother of the child died after overdosing on opioids. Sadly, the father suffered from heroin addiction, and there were allegations that an aunt was selling heroin. At the time of the guardianship, the child was living with grandparents.

As GAL in these cases, the CFAC helped provide guidance to the family court as it attempted to decide where the children would be safest and receive the best care. However, resolving such issues does nothing to resolve the underlying drug addiction issues that lie at the root of a family crisis, nor does the determination of legal issues like custody, divorce, or child abuse and neglect address the threat drug addiction poses to the children. The optimal solution is for children to have physiologically and mentally healthy family members who have been able to escape from opioid addiction.

In its representation of a parent in a custody case where the other parent is struggling with drug addiction, the CFAC has sought a family court order making drug
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treatment part of the relief granted. This request envisioned court-imposed treatment as a condition to, and an inducement for, the addicted parent to achieve increased visitation with his/her children without supervision. In this context, the CFAC clinic students and staff attorneys considered what, if any, role lawyers should play in addressing substance abuse when it is the cause of the families’ problems.

In order to address opioid issues in family court cases, clinic student attorneys and supervising lawyers should be recognized as having counseling responsibilities beyond the representation of their clients regarding only the immediate legal issues.\textsuperscript{23} Rule 2.1 of the Model Rules of Professional Conduct mandates that a lawyer representing a client “shall exercise independent professional judgment and render candid advice.”\textsuperscript{24} The rule further provides, “In rendering advice, a lawyer may refer not only to law but to other considerations such as moral, economic, social and political factors, that may be relevant to the client’s situation.”\textsuperscript{25}

The comments to the model rule recognize that “[f]amily matters can involve problems within the professional competence of psychiatry, clinical psychology or social work” and that we should consult with persons in these professions when a “competent lawyer” would do so.\textsuperscript{26} While lawyers do not have a “duty

\textsuperscript{23} Numerous articles have addressed a lawyer’s responsibilities when a client suffers from addiction. See, e.g., Erin Sparks, Comment, Attorney-Client Relationships: Ethical Dilemmas with Clients Battling Addiction, 36 J. Legal Prof. 255 (2011); Jean Marie Leslie, Understanding Addiction, Helping Clients and Colleagues, 69 Ala. Law. 348 (Sept. 2008); Timothy David Edwards, The Lawyer as Counselor Representing the Impaired Client, GPSolo, Oct./Nov. 2004, at 34.

\textsuperscript{24} MODEL RULES OF PROF’L CONDUCT r. 2.1 (AM. BAR ASS’N 1983).

\textsuperscript{25} Id.

\textsuperscript{26} The Comment to Rule 2.1 observes:
to initiate investigation of a client’s affairs or to give advice that the client has indicated is unwanted, . . . a lawyer may initiate advice to a client when doing so appears to be in the client’s best interests.”

Advising a client to seek treatment for opioid addiction is clearly in the client’s best interests, though it is acknowledged that the client may not be receptive to such counseling. I contend that encouraging a client to seek drug addiction treatment falls within an attorney’s ethical responsibilities. Helping clients or other parties in litigation gain access to needed treatment programs and encouraging their completion of these programs is also part of the attorney’s ethical responsibilities as a

Matters that go beyond strictly legal questions may also be in the domain of another profession. Family matters can involve problems within the professional competence of psychiatry, clinical psychology or social work; . . . Where consultation with a professional in another field is itself something a competent lawyer would recommend, the lawyer should make such a recommendation.

MODEL RULES OF PROF’L CONDUCT r. 2.1 cmt. (AM. BAR ASS’N 1983).

27 The Comment to Rule 2.1 also instructs:
When a lawyer knows that a client proposes a course of action that is likely to result in substantial adverse legal consequences to the client, the lawyer’s duty to the client under Rule 1.4 may require that the lawyer offer advice if the client’s course of action is related to the representation . . . . A lawyer ordinarily has no duty to initiate investigation of a client’s affairs or to give advice that the client has indicated is unwanted, but a lawyer may initiate advice to a client when doing so appears to be in the client’s best interests.

Id.
counselor. Assuming that such counsel is an ethical imperative, it must be recognized that the clinical lawyer’s efforts can be exceptionally challenging without the support provided by relationships with healthcare partners who can assist in attaining treatment goals. Lawyer-healthcare partner relationships must be developed and nurtured to achieve the highest possible likelihood of successful treatment.

B. Using Medical-legal Partnerships to Assist Clients in Seeking and Receiving Treatment of Opioid Addiction.

Medical Legal Partnerships (“MLPs”) were first established in Massachusetts in 1993 at Boston City Hospital (now Boston Medical Center). The National Center for Medical-Legal Partnership was founded in 2006 and is now housed in the Department of Health Policy and Management at the Milken Institute School of Public Health.

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28 In helping clients seek and obtain the treatment they need for addiction, attorneys also must comply with the provisions of Rule 1.14 governing their responsibilities to clients with diminished capacities. MODEL RULES OF PROF’L CONDUCT r. 1.14 (AM. BAR ASS’N 1983). Rule 1.14(b) provides that an attorney may take “reasonably necessary protective action” when “the lawyer reasonably believes the client has diminished capacity.” MODEL RULES OF PROF’L CONDUCT r. 1.14(b). Importantly, Rule 1.14(c) provides that “[w]hen taking protective action pursuant to paragraph (b), the lawyer is impliedly authorized under Rule 1.6(a) to reveal information about the client, but only to the extent reasonably necessary to protect the client’s interests.” MODEL RULES OF PROF’L CONDUCT r. 1.14(c).

Public Health at the George Washington University.  

Currently, there are 155 hospitals, 139 health centers, 34 health schools, 126 legal aid agencies, and 52 law schools and pro bono partners operating MLPs to address patients’ health-related social needs.

The development of MLPs was based on the recognition that many patients suffering from illness also face social and legal dilemmas that often impact their recovery. In MLPs, healthcare professionals and lawyers work together as an integrative team to treat patients medically and to meet their legal needs.  

“Patients are often able to receive legal assistance in areas such as addressing personal safety from exposure to domestic violence, gaining access to entitled benefits such as food subsidies, disability benefits, or necessary educational services, and repairing poor housing conditions through MLP services.”

As an example of such collaborations, the CFAC has entered into a medical-legal partnership with two healthcare providers: Chestnut Ridge Center (“Chestnut Ridge”), a West Virginia University Medicine psychiatric facility, and with West Virginia University Medicine

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32 Cohen et al., supra note 29, at 136 (“Medical-legal partnerships (MLPs) bring together medical professionals and lawyers to address social causes of health disparities, including access to adequate food, housing and income.”).

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Pediatrics (“WVU Pediatrics”). The CFAC’s MLP with Chestnut Ridge and WVU Pediatrics allows these healthcare providers to refer patients to the family advocacy clinic when the stress of legal problems poses a threat to the patients’ healing process.

Medical-legal partnerships, like the one CFAC has established at West Virginia University, present one way to assist clients in seeking and obtaining needed treatment for opioid addiction. This partnership allows the CFAC to work with healthcare providers in developing a strategy for referring family law clients to addiction treatment programs. The goal, of course, is to facilitate clinic clients in confronting and overcoming the addiction issues that adversely affect their relationships with their familial relationships and entangle them in legal problems, like child custody and divorce.

According to key findings set forth in the Surgeon General’s 2016 report on addiction, only one in ten people


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suffering from a drug use disorder obtain specialty treatment. Moreover, a study funded by the National Institute on Alcohol Abuse and Alcoholism (“NIAAA”), an arm of the National Institutes of Health, reported that seventy-five percent of adults in the United States suffering from a drug use disorder never receive treatment. The low rate of treatment is attributed to diverse causes such as the “inability to access or afford care, fear of shame and discrimination, and lack of screening for substance misuse and substance use disorders in general health care settings.” Moreover, many who suffer from drug addiction are not able to realize they need treatment or they otherwise reject treatment.

Simply referring clients to a treatment programs will not solve their addiction issues—clients will have to affirmatively desire help and be able to summon the

37 U.S. DEPT OF HEALTH & HUMAN SERVS., supra note 9, at 4-2. Of those who did not receive treatment but needed it, “over 7 million were women and more than 1 million were adolescents aged 12 to 17.” Id. at 4-8 (citing CTR. FOR BEHAVIORAL HEALTH STATISTICS & QUALITY, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., Results from the 2015 National Survey on Drug Use and Health: Detailed Tables, (2016), https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.pdf [https://perma.cc/JH2V-U9X9]).


40 U.S. DEPT OF HEALTH & HUMAN SERVS., supra note 9, at 4-9.
willpower to endure the long process of treatment leading to recovery. Some clients may prefer seeking medication at Suboxone clinics where treatment drugs are provided but counseling is not.\textsuperscript{41}

In criminal drug courts, addicts charged with crimes face jail time if they do not complete their court-mandated treatment program. In family treatment courts, addicted parents often face termination of their parental rights in abuse and neglect cases if they fail to finish the treatment program.\textsuperscript{42} In family court proceedings, jail time or termination of parental rights is beyond the family court’s jurisdiction if an addicted party fails to participate in a substance abuse treatment program. Instead, the addicts face loss of their role as the primary custodian of their children or are limited to supervised visitation. Such sanctions may not provide a sufficient incentive for them to persevere to completion of the difficult process of treatment and recovery. But, in cases where the parents have a strong desire to have their children living with them, rather than with a grandparent, other family member, or in foster care, completing treatment and escaping addiction may be a powerful incentive that will help heal the family.

Effective treatment requires an active recovery program that includes behavioral and cognitive changes. For example, Chestnut Ridge, the CFAC’s medical-legal partner, has developed a program called the Comprehensive Opioid Addiction Treatment (“COAT”).

\textsuperscript{41} Stand-alone Suboxone clinics have emerged as a new business to address opioid addiction. In Ohio, where stand-alone Suboxone clinics are allowed to accept cash only, there is a growing concern that these clinics will simply become the next “pill mills.” Marty Schladen & Rita Price, \textit{Cash-Only Suboxone Clinics Fuel Fears of New “Pill Mills”}, COLUMBUS DISPATCH (Oct. 8, 2017, 5:55 AM), http://www.dispatch.com/news/20171008/cash-only-suboxone-clinics-fuel-fears-of-new-pill-mills/1 [https://perma.cc/QW64-GV92].

\textsuperscript{42} See discussion of family treatment courts, supra pp. 4–6.
program. This is not a treatment program individual addicts can complete in a few weeks. COAT is a long-term treatment procedure comprised of stages during which the addicted patient is prescribed Suboxone to manage his or her withdrawal from opioids. Of course, it is important to understand that no single treatment program will fit every person struggling with addiction.

Treating opioid addiction should begin with a healthcare professional’s assessment and diagnosis. This clinical assessment may be based on several different models, such as the Addiction Severity Index.

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44 Treatment professionals debate how to properly use Suboxone as an effective treatment for opioid addiction. When it was first introduced, Suboxone was intended to be used only during initial detoxification. However, the more prevalent treatment process currently followed is to use Suboxone as long-term maintenance to suppress an addict’s opioid cravings. Nat’l Inst. on Drug Abuse, Short-Term Opioid Withdrawal Using Buprenorphine: Findings and Strategies from a NIDA Clinical Trials Network (CTN) Study, https://www.drugabuse.gov/sites/default/files/files/BupDetox_Factsheet.pdf [https://perma.cc/3TF7-R2LC].

45 U.S. Dep’t of Health & Human Servs., supra note 9, at 4-14.

46 Id. at 4-15.
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(“ASI”), the Substance Abuse Model (“SAM”), the Global Appraisal of Individual Needs (“GAIN”), and the Psychiatric Research Interview for Substance and Mental Disorders (“PRISM”). The Surgeon General’s report recommends that a diagnosis of drug abuse be based on eleven symptoms of substance abuse disorder that are defined in the Fifth Edition of the Diagnostic and


48 SAM is “[d]esigned to assess mental disorders as defined by the Diagnositic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV).” Id. SAM “[i]ncludes questions about when symptoms began and how recent they are, withdrawal symptoms, and the physical, social and psychological consequences of each substance assessed.” Id.

49 GAIN is a “[s]eries of measures (screener, standardized biopsychosocial intake assessment battery, follow-up assessment battery) which integrate research and clinical assessment.” Id. GAIN “[c]ontains 99 scales and subscales, that are designed to measure the recency, breadth, and frequency of problems and service utilization related to substance use (including diagnosis and course, treatment motivation, and relapse potential), physical health, risk/protective involvement, mental health, environment and vocational situation.” Id.

50 PRISM is a “[s]emi-structured, clinician-administered interview” that “[m]easures the major DSM-IV diagnoses of alcohol, drug, and psychiatric disorders” and “[p]rovides clear guidelines for differentiating between the effects of intoxication and withdrawal, substance-induced disorders, and primary disorders.” Id.
Statistical Manual of Mental Disorders (DSM-5).\textsuperscript{51} Patients may also be assessed in the context of their “family environment.”\textsuperscript{52}

Once a healthcare provider has completed an assessment and diagnosis, an individualized treatment plan should be developed taking into consideration the person’s specific needs, strengths, weaknesses, financial resources, family support, and other physical or mental health issues.\textsuperscript{53} The individualized treatment program should also have measures in place to engage and to motivate the patient to remain in the program.\textsuperscript{54}

\textsuperscript{51} Id. at 4-15.
\textsuperscript{52} Laura Lander, Janie Howsare & Marilyn Byrne, The Impact of Substance Use Disorders on Families and Children: From Theory to Practice, 28 SOC. WORK PUB. HEALTH 194, 195–205 (2013) (“Treating the individual without family involvement may limit the effectiveness of treatment for two main reasons: it ignores the devastating impact of [substance use disorders] on the family system leaving family members untreated, and it does not recognize the family as a potential system of support for change.”).
\textsuperscript{53} U.S. DEP’T HEALTH & HUMAN SERVS., supra note 9, at 4-16.
\textsuperscript{54} The 2016 Surgeon General’s report observed:

A typical progression for someone who has a severe substance use disorder might start with 3 to 7 days in a medically managed withdrawal program, followed by a 1- to 3-month period of intensive rehabilitative care in a residential treatment program, followed by continuing care, first in an intensive outpatient program (2 to 5 days per week for a few months) and later in a traditional outpatient program that meets 1 to 2 times per month. For many patients whose current living situations are not conducive to recovery, outpatient services should be provided in conjunction with recovery-supportive housing.

In general, patients with serious substance use disorders are recommended to stay engaged for at least 1 year in the
Treatment may include inpatient care, residential care outside a hospital setting, “partial hospitalization and intensive outpatient care,” and “outpatient services.” 55 Where appropriate, in order to increase the effectiveness of treatment, the patient’s family should be involved because it can provide “a potential system of support for change.” 56

Treatment programs may involve medication and behavioral therapies. 57 FDA approved medications might

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include buprenorphine,\textsuperscript{58} methadone,\textsuperscript{59} or extended-release naltrexone\textsuperscript{60} in treatment programs.\textsuperscript{61} Suboxone and Vivitrol are two frequently prescribed medications for treatment of opioid addiction. Suboxone, taken daily, contains buprenorphine hydrochloride and naloxone hydrochloride,\textsuperscript{62} while Vivitrol is delivered by an injection of naltrexone lasting twenty-eight days. Recent studies have found, once started, both medications are equally effective treatments for preventing relapse.\textsuperscript{63} Forty-three

\textsuperscript{58} Following the introduction of buprenorphine, the number of opioid treatment programs “offering buprenorphine increased from 11 percent [of OTPs] in 2003 [(121 OTPs)] to 58 percent [of OTPs] in 2015 [(779 OTPs)].” Cathie E. Alderks, \textit{Trends in the Use of Methadone, Buprenorphine, and Extended-Release Naltrexone at Substance Abuse Treatment Facilities: 2003-2015 (Update)}, SAMHSA: CBHSQ REP. (Substance Abuse & Mental Health Serv. Admin., Rockville, Md.) Aug. 22, 2017, https://www.samhsa.gov/data/sites/default/files/report_3192/ShortReport-3192.pdf [https://perma.cc/7FD7-AN67]. Only about five percent of non-OTP facilities offered buprenorphine treatment in 2003; however, that number grew to twenty-one percent (2625 facilities) by 2015. \textit{Id.}

\textsuperscript{59} The Substance Abuse and Mental Health Services Administration has found that the number of patients who receive methadone treatment has “steadily increased from about 227,000 in 2003 to 356,843 in 2015” and “accounted for approximately 21 to 25 percent of all substance abuse treatment clients each year.” \textit{Id.}

\textsuperscript{60} “In 2013, 359 clients in facilities with OTPs and 3,422 clients in facilities without OTPs received extended-release, injectable naltrexone services, and in 2015, a total of 712 clients in facilities with OTPs and 6,323 clients in facilities without OTPs received these services.” \textit{Id.}


\textsuperscript{62} Buprenorphine is an opioid that treats withdrawal symptoms, while naloxone is an opioid antagonist used to reverse opioid overdose. \textit{Id.}

\textsuperscript{63} \textit{See} Joshua D. Lee et al., \textit{Comparative Effectiveness of Extended-Release Naltrexone Versus Buprenorphine-Naloxone
states limit daily total milligram dosages of buprenorphine and buprenorphine/naloxone combination drugs, while seven do not.

Opioid treatment plans should be expected to include behavioral therapies that may involve only the individual; other plans may include family or group sessions. Therapies such as Cognitive Behavioral

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65 The following seven states do not have these limits: HI, NM, OR, RI, SC, SD, WI. Id.

66 U.S. DEPT HEALTH & HUMAN SERVS., supra note 9, at 4-26.
Therapy (“CBT”),\textsuperscript{67} Contingency Management (“CM”),\textsuperscript{68} Community Reinforcement Approach (“CRA”),\textsuperscript{69}

\textsuperscript{67} The Surgeon General’s 2016 report explained CBT as follows:
The theoretical foundation for Cognitive-Behavioral Therapy (CBT) is that substance use disorders develop, in part, as a result of maladaptive behavior patterns and dysfunctional thoughts. CBT treatments thus involve techniques to modify such behaviors and improve coping skills by emphasizing the identification and modification of dysfunctional thinking. CBT is a short-term approach, usually involving 12 to 24 weekly individual sessions. These sessions typically explore the positive and negative consequences of substance use, and they use self-monitoring as a mechanism to recognize cravings and other situations that may lead the individual to relapse. They also help the individual develop coping strategies.

\textit{Id.} (citing H.D. Kleber et al., Practice Guideline for the Treatment of Patients with Substance Use Disorders 42 (2006)).

\textsuperscript{68} Contingency Management involves awarding tangible items to patients to reinforce positive behavioral changes. \textit{Id.} at 4-27 (citing Nat’l Inst. on Drug Abuse, Principles of Drug Addiction Treatment: A Research-Based Guide (3d ed. 2012)) (“In this therapy, patients receive a voucher with monetary value that can be exchanged for food items, healthy recreational options (e.g., movies), or other sought-after goods or services when they exhibit desired behavior such as drug-free urine tests or participation in treatment activities.”).

\textsuperscript{69} The Surgeon General 2016 report explained CRA as follows:
Community Reinforcement Approach (CRA) Plus Vouchers is an intensive 24-week outpatient program that uses incentives and reinforcers to reward individuals who reduce their substance use. Individuals are required to attend one to two counseling sessions each week that emphasize improving relations, acquiring skills to minimize substance use, and

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Motivational Enhancement Therapy ("MET"),\textsuperscript{70} the Matrix Model,\textsuperscript{71} Twelve-Step Facilitation therapy ("TSF"),\textsuperscript{72} and family therapies may be employed reconstructing social activities and networks to support recovery. Individuals receiving this treatment are eligible to receive vouchers with monetary value if they provide drug-free urine tests several times per week. 

\textit{Id.} at 4-27 (endnotes omitted) (citing NAT'L INST. ON DRUG ABUSE, \textit{supra} note 68).

\textsuperscript{70} This counseling approach “uses motivational interviewing techniques to help individuals resolve any uncertainties they have about stopping their substance use. MET works by promoting empathy, developing patient awareness of the discrepancy between their goals and their unhealthy behavior, avoiding argument and confrontation, addressing resistance, and supporting self-efficacy to encourage motivation and change.” \textit{Id.} at 4-28 (endnote omitted) (citing CTR. FOR SUBSTANCE ABUSE TREATMENT, TREATMENT IMPROVEMENT PROTOCOL SER. 35, ENHANCING MOTIVATION FOR CHANGE IN SUBSTANCE ABUSE TREATMENT, ch. 3 (1999)).

\textsuperscript{71} The surgeon general’s 2016 report explained the Matrix Model:

The Matrix Model is a structured, multi-component behavioral treatment that consists of evidence-based practices, including relapse prevention, family therapy, group therapy, drug education, and self-help, delivered in a sequential and clinically coordinated manner. The model consists of 16 weeks of group sessions held three times per week, which combine CBT, family education, social support, individual counseling, and urine drug testing. \textit{Id.} (endnote omitted) (citing NAT'L INST. ON DRUG ABUSE, \textit{supra} note 68).

\textsuperscript{72} TSF is “an individual therapy typically delivered in 12 weekly sessions” and “designed to prepare individuals to understand, accept, and become engaged in . . . Narcotics Anonymous (NA), or similar 12-step programs.” \textit{Id.} (citing Kimberly S. Walitzer et al., \textit{Facilitating Involvement in Alcoholics Anonymous During Outpatient Treatment: A
depending upon the individual and the severity and duration of the addiction.\textsuperscript{73}

The Substance Abuse and Mental Health Services Administration ("SAMHSA") is "the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation" in order "to reduce the impact of substance abuse and mental illness on America's communities."\textsuperscript{74} The number of opioid treatment programs regulated by SAMHSA "increased from approximately 1,100 in 2003 to almost 1,500 by the end of 2016."\textsuperscript{75} SAMHSA has compiled a National Directory of Drug and Alcohol Abuse Facilities that contains information on "federal, state, and local government facilities and private facilities that provide substance abuse treatment services," including "codes that represent the services offered" by each facility listed.\textsuperscript{76}


Family therapies include family behavior therapy ("FBT"), which "is a therapeutic approach used for both adolescents and adults that addresses not only substance use but other issues the family may also be experiencing, such as mental disorders and family conflict. FBT includes up to 20 treatment sessions that focus on developing skills and setting behavioral goals." \textit{Id.} at 4-30 (endnote omitted) (citing NAT’L INST. ON DRUG ABUSE, supra note 68).

\textsuperscript{74} \textit{About Us}, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICE ADMINISTRATION, https://www.samhsa.gov/about-us [https://perma.cc/DLG3-KUWR].

\textsuperscript{75} Alderks, supra note 58.

SAMHSA also tracks the number of state admissions of patients for opioid treatment.\footnote{Treatment Episode Data Set, Substance Abuse and Mental Health Service Administration, Client Level Data / Treatment Episode Data Set, https://www.samhsa.gov/data-we-collect/teds-treatment-episode-data-set [https://perma.cc/ASZ6-K6DB].} For example, in 2011 in West Virginia, SAMHSA reported that 1,294 male and female patients over the age of twelve were admitted for treatment for opioid abuse.\footnote{Substance Abuse & Mental Health Servs. Admin., Treatment Episode Data Set (TEDS) 2001–2011: State Admissions to Substance Abuse Treatment Services 134 (2013), https://www.samhsa.gov/data/sites/default/files/TEDS2011St_Web/TEDS2011St_Web/TEDS2011St_Web.pdf [https://perma.cc/Y6VZ-ARMX]. This number includes 158 patients admitted for treatment of heroin addiction and 1,136 for treatment for “other opiates.” Id. It is noteworthy that the total number of admissions for treatment for opioid abuse in Tennessee was more than triple the admissions in West Virginia. In Tennessee, a total of 4,121 patients over the age of twelve were admitted for treatment of opioids in 2011, the substantial majority of which were white. Id. at 128.} Of those West Virginia patients admitted for opioid abuse, ninety-nine percent were white, and eighty-nine percent were between the ages of twenty to forty-four.\footnote{Id.}

Obviously, before referring their clients to any treatment program, clinical law students and their supervising attorneys should know the applicable law as well as the rules, regulations, and requirements of each program. They also should identify and be aware of the recovery services each program provides as well as program treatment success and failure rates. In addition to connecting their clients with treatment programs

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through an MLP, the clinic’s supervising attorneys, law students, and staff also should be able to connect clients to community recovery support services that provide ongoing support during and after treatment. The students and their supervisors may consider obtaining a medical release from the client to enable them to consult with healthcare providers and to receive treatment updates that would allow them to support the client through the treatment and recovery process.

Opioid treatment programs work when the patients recognize they have a substance abuse problem and desire to overcome their addiction. For example, one CFAC client became addicted to prescription pain medication after she was injured in a car accident. As part of her treatment after the accident, the doctor prescribed pain medication as part of her treatment. She subsequently recognized that she had developed an opioid dependence and sought treatment for the sake of her children. She completed her treatment plan and continues to attend counseling sessions. She also continues to take Suboxone and will be medically evaluated to determine whether and when she should taper off the drug.80

Thus, beyond their role of advising on legal strategy and litigating on behalf of their clients, law school clinics with established MLPs should work with their healthcare partners to ensure that— if available— their clients will have access to treatment and will have

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80 As noted earlier, healthcare professionals debate whether recovering opioid addicts will need to take medications like Suboxone for life. Suboxone was originally proposed for short-term use during the detoxification process. See NAT’L INST. ON DRUG ABUSE, supra note 44. However, Suboxone is also regarded as an opioid treatment with a “dark side” because of the health complications it can cause and because it is subject to abuse like other drugs. Deborah Sontag, *Addiction Treatment With a Dark Side*, N.Y. TIMES, Nov. 17, 2013, at A1.
support to complete the program and the recovery process.

C. Helping Clients and Other Party Litigants Cover the Cost of Treatment

Beyond these challenges of supporting addicted clients in seeking and obtaining treatment, the client will need assistance in identifying sources of financing treatment. Treatment costs vary based on a number of factors, but likely are expensive. Law school clinics like the CFAC represent clients who, because of their socio-economic status, cannot afford to pay attorney fees; the financial ability to pay for addiction treatment programs is likely well beyond their reach.

Like the CFAC clients, the great majority of law school clinic clients probably have no private health insurance. Indeed, one study reported that in 2015 almost “441,000 non-elderly adults with opioid addiction were uninsured.”81 That number likely understates the level of non-elderly uninsured opioid addicted patients.

The medications used for treating opioid addiction alone are costly. For example, the United States Department of Defense estimated that a patient receiving treatment in a certified opioid treatment

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81 Julia Zur, 6 Things to Know About Uninsured Adults with Opioid Addiction, KAISER FAMILY FOUND., https://www.kff.org/uninsured/fact-sheet/6-things-to-know-about-uninsured-adults-with-opioid-addiction/ [https://perma.cc/7T6H-AXMX].
program\textsuperscript{82} using buprenorphine\textsuperscript{83} and requiring twice-weekly visits could incur costs of \textdollar$115 per week or \textdollar$5980 per year.\textsuperscript{84} Patients receiving treatment in a certified opioid treatment program using naltrexone and receiving related services could incur costs of \textdollar$1,176.50 per month or \textdollar$14,112.00 per year.\textsuperscript{85}

State Medicaid programs have and hopefully will continue to play a key role in supporting opioid addiction treatment for those who cannot afford it.\textsuperscript{86} The most recent data from the Agency for Healthcare Research and Quality indicates that Medicaid expansion under the Affordable Care Act ("ACA") significantly increased

\textsuperscript{82} Certification of opioid treatment programs is governed by federal regulations. 42 C.F.R. § 8.1 (2016). Certified opioid treatment programs are overseen by SAMHSA’s Division of Pharmacologic Therapies. \textit{See generally Certification of Opioid Treatment Programs (OTPs), SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/medication-assisted-treatment/opioid-treatment-programs [https://perma.cc/TX2M-EDUX].}

\textsuperscript{83} Over a billion dollars’ worth of Suboxone are sold annually. \textit{In re Suboxone (Buprenorphine Hydrochloride and Naloxone) Antitrust Litig.}, 64 F. Supp. 2d 665, 673 (E.D. Pa. 2014).


\textsuperscript{85} \textit{Id.}

access to and coverage for opioid treatment.\textsuperscript{87} Medicaid expansion under the ACA now provides coverage for adults in some states who are suffering from opioid addiction that were not eligible for treatment under the previous state programs.\textsuperscript{88} According to data collected by the Kaiser Family Foundation, Medicaid covers four in ten “nonelderly adults with opioid addiction.”\textsuperscript{89}

Under the expansion in West Virginia,\textsuperscript{90} Medicaid will cover inpatient or detox treatment, partial hospitalization, care coordination and case management, and prescription drugs like Suboxone.\textsuperscript{91} Starting in January of 2018, Medicaid expansion in West Virginia included “a new screening tool to identify treatment


\textsuperscript{88} Id.

\textsuperscript{89} Zur, \textit{supra} note 81. The report recognizes “[t]hat number may become substantially larger as a result of the GOP’s efforts to restructure the Medicaid program through the American Health Care Act, which may decrease eligibility and coverage, setting back states’ efforts to address the epidemic.” Id.


needs and Medicaid coverage for providing methadone for opioid addiction withdrawal.” The Medicaid expansion will also “allow West Virginia to cover methadone, naloxone, peer recovery support, withdrawal management, and short-term residential services to all Medicaid enrollees.”

Significantly, West Virginia’s Medicaid will also cover the treatment costs of infants who are born to addicted mothers. The West Virginia Department of Health and Human Resources announced on February 13, 2018, that its Bureau for Medical Services had received “approval from the U.S. Centers for Medicare and Medicaid Services (“CMS”) to offer Neonatal Abstinence Syndrome (“NAS”) treatment services. West Virginia is the first state in the nation to receive such an approval.” To treat their opioid withdrawal symptoms, the program will allow NAS babies to receive (1) a “[c]omprehensive assessment to determine a plan of care”; (2) “[l]ow or reduced stimulus environment, slow introduction to sensory stimulation (both site and sound)”; (3) “Pharmaceutical Withdrawal Management, with tapering protocol as referenced by the American Academy of Pediatrics”; and (4) Monitoring Withdrawal

92 Associated Press, West Virginia Expands Medicaid Drug Treatment, WHSV (Harrisonburg, Va.), http://www.whsv.com/content/news/West-Virginia-expands-Medicaid-drug-treatment-469605873.html [https://perma.cc/NS3U-B57Q] (“The program waiver from the U.S. Centers for Medicare and Medicaid Services is more than 80 percent federally funded.”)  
94 Associated Press, West Virginia Medicaid Will Now Cover Babies in Drug Rehab, MODERN HEALTHCARE (Feb. 14, 2018), http://www.modernhealthcare.com/article/20180214/NEWS/180219963 [https://perma.cc/4L29-M232] (“The Centers for Disease Control and Prevention says the rate of babies born dependent on drugs in West Virginia was 33.4 per 1,000 hospital births in 2013, the latest year available, compared with the national average of 5.8.”)  
DEFINING THE ROLE

Objective Assessment, at least twice, daily.”96 In addition, the babies will receive non-pharmaceutical interventions such as “[t]herapeutic swaddling,” “[v]estibular stimulation/vertical rocking,” “C-position,” “[h]ead-to-toe movements,” “[c]lapping,” “[e]xercise to relieve gas discomfort,” and “[n]ewborn massage.”97

However, unlike West Virginia, access to treatment in other states is not increasing. The American Society of Addiction Medicine conducted a benefits survey of states, receiving responses from thirty-seven states.98 The survey revealed that “[c]overage for [Medically-Assisted Treatment] clearly depends on which state Medicaid agency, which medication and which official is involved, whether or not counseling and medical monitoring is covered and required.”99 Another study found “several clusters of counties with higher than average rates of opioid use disorder (OUD) and lower than average treatment admissions among [opioid treatment programs] that accept Medicaid . . . [in] Arkansas, Kentucky, Louisiana, Mississippi, and Tennessee.”100

Some states have sought and obtained grants to increase access to treatment services.101 Three-year grant

96 Id.
97 Id.
99 Id. at 36.
101 For example, Arkansas has obtained a grant from the SAMHSA Center for Substance Abuse Treatment to fund the Arkansas Access to Recovery Program:

The initiative provides vouchers through the Arkansas Department of Human Services for
programs are available to “states with high rates of primary treatment admissions for heroin and opioids per capita.”

SAMHSA has compiled state-by-state abstracts of “State Targeted Response to the Opioid Crisis (Opioid STR) Grant Awards.”

Types of treatment programs available vary in each state that provides affordable or free treatment

patients to purchase treatment for substance use disorders and for support services. The program's goal is to ‘expand capacity, support client choice, and increase the array of faith-based and community-based providers for clinical treatment and recovery support services.’ Currently, the program provides vouchers that patients use to obtain treatment and support services in thirteen counties, including Benton, Craighead, Crawford, Faulkner, Garland, Independence, Jefferson, Lonoke, Pulaski, Saline, Sebastian, Washington, and White counties. A Care Coordinator assists each patient in obtaining the services needed. The funds support medical care, dental care, addiction treatment, mental health treatment, childcare, drug-free housing, life-skills training, peer coaching, and some other recovery services.


services. Some programs provide “sliding scale treatment” where the fees charged are based upon a patient’s income and ability to pay. There are also non-profit treatment centers that are able to provide free treatment or lower cost treatment because of their non-profit status. Faith-based treatment programs are another alternative that may be a source of free treatment or may offer payment assistance for those who cannot afford treatment as part of their ministry services. Treatment programs are also available to veterans for free or at lower costs. Finally, most larger treatment programs offer payment assistance based upon need.

D. Pro bono Representation by Clinical Law Students and Members of the Bar in Family Court.

People affected by the opioid epidemic enter the legal system in different ways. They may face criminal drug charges, allegations of abuse and neglect, or the loss of primary custody of their children by family court order.

Counsel is usually appointed in criminal cases and in abuse and neglect cases where the party cannot

104 SAMHSA has a free national hotline that provides treatment referral and information services for families facing opioid addiction issues. The hotline refers those who have no insurance or are underinsured to state offices “responsible for state-funded treatment.” The hotline can also refer callers to treatment programs that charge on a sliding scale or that accept Medicaid and Medicare. National Helpline, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/find-help/national-helpline [https://perma.cc/F5HH-HEUR].

105 See Griffen, supra note 101.

afford counsel.\textsuperscript{107} Under the present system, many people affected by the opioid epidemic cannot afford the

\textsuperscript{107} For example, criminal defendants in West Virginia may be eligible for court-appointed counsel:

“A court of record may appoint counsel to assist an accused in criminal cases at any time upon request . . . In every case where the court appoints counsel for the accused and the accused presents an affidavit showing that he cannot pay therefor, the attorney so appointed shall be paid for his services and expenses in accordance with the provisions of article twenty-one, chapter twenty-nine of this Code.”

W. Va. Code Ann. § 62-3-1 (2015). In addition, respondents in abuse and neglect cases in West Virginia have a right to counsel if they cannot afford one:

(f) Right to counsel. –

(1) In any proceeding under this article, the child, his or her parents and his or her legally established custodian or other persons standing in \textit{loco parentis} to him or her has the right to be represented by counsel at every stage of the proceedings and shall be informed by the court of their right to be so represented and that if they cannot pay for the services of counsel, that counsel will be appointed.

(2) Counsel shall be appointed in the initial order. For parents, legal guardians, and other persons standing in \textit{loco parentis}, the representation may only continue after the first appearance if the parent or other persons standing in \textit{loco parentis} cannot pay for the services of counsel.

(3) Counsel for other parties shall only be appointed upon request for appointment of counsel. If the requesting parties have not retained counsel and cannot pay for the services of counsel, the court shall, by order entered of record, appoint an attorney or attorneys to represent the other party or parties and so inform the parties.
assistance of legal counsel when they become involved in family court proceedings, and there is no constitutionally or statutorily-based right to court-appointed counsel in family court custody cases. Therefore, if the adults in these family court matters desire the assistance of lawyers, they generally have no alternative but to seek pro bono legal services from legal aid and law school clinics.

It is axiomatic that the best interests of children in family court cases are served when parents suffering from addiction are connected with treatment services and are provided legal representation in their custody matters. Under Rule 6.1 of the Model Rules of Professional Conduct, the family court could and should call upon private-sector attorneys to undertake pro bono representation of individuals struggling with opioid addiction who face losing visitation rights or custody of their children in family court.\footnote{108} Rule 6.1 of the Model Rules of Professional Conduct recognizes that “[e]very lawyer has a professional responsibility to provide legal services to those unable to pay.”\footnote{109} To fulfill their ethical responsibilities, law school clinicians, clinical law students, and members of the bar in private practice should be strongly encouraged to provide legal services to persons of limited means in such family court cases where addiction lies at the root of a family’s legal problems.

For lawyers who are not schooled in family court issues or otherwise unable to provide pro bono representation to clients for practical reasons, Rule 6.1 provides that they can participate “in activities for improving the law [or] the legal system” as it relates to

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\footnote{108} MODEL RULES OF PROF’L CONDUCT r. 6.1 (AM. BAR ASS’N 1983).
\footnote{109} Id.
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opioid addiction and treatment.110 “Because the provision of pro bono services is a professional responsibility, it is the individual ethical commitment of each lawyer.”111 Despite this “ethical commitment,” the provision of pro bono services has only been mandated in one state.112

Many lawyers may be hesitant to commit to pro bono representation in cases involving parties or clients suffering from opioid addiction because it may prove difficult and/or require prolonged services. A lawyer volunteering to represent a client experiencing addiction to opioids undertakes what is a difficult, but exceedingly important assignment. She should be fully aware of the potential difficulties that such representation may present: the client may have an underlying untreated psychiatric disorder that led to the addiction; the client may be in denial about his addiction and the impact it is having on the family; the client may not be able to comprehend the severity of the situation he faces; and the client’s addiction may impair his ability to participate effectively in the case. Lawyering in such circumstances can present considerable challenges not faced by many in private civil practice, but such work is honorable and provides a vital public service.

Legal aid lawyers and clinical law students already provide pro bono legal services in family court

110 Id. One author has described this provision as a “loophole to excuse them from doing pro bono work.” Spencer Rand, A Poverty of Representation: The Attorney’s Role to Advocate for the Powerless, 13 Tex. Wesleyan L. Rev. 545, 565 (2007).
111 Id. at cmt. 9.
cases involving substance abuse issues. Moreover, many state bars, as in West Virginia, have established pro bono assistance projects. However, because the opioid epidemic is fracturing families and increasing caseloads, family courts should identify and compile a list of attorneys who are willing to work pro bono specifically in family court cases where addiction and custody are at issue. Recognition is needed for a specialized bar of pro bono attorneys who are willing to take on cases where the need to help the addiction-afflicted family is great, the

113 For example, West Virginia has established the Pro Bono Referral Project.

The State Bar approved an aspirational goal for each active practicing lawyer in West Virginia to provide 20 hours of legal work to assist our low-income men, women and children. The legal aid programs at that time—there were four of them—agreed to work with the State Bar in setting up the program. The legal aid offices would determine the financial eligibility of our citizens, ascertain if the legal case was a priority matter and match a volunteer lawyer with the case to handle the legal responsibilities. The Pro Bono Referral Project was born.


114 Attorneys who volunteer for such pro bono representation would have to be those that the family court can rely upon to provide the same quality of representation that they give their paying clients. See Barbara Graves-Poller, Is Pro Bono Practice in Legal “Backwaters” Beyond the Scope of the Model Rules?, 13 U.N.H. L. REV. 1, 5–6 (2015).
work is challenging, and the attainability of the goals is uncertain. 115

E. Educating Law Students About Counseling Clients with Substance Abuse Issues and About Educating Themselves.

Finally, as part of the seminar component of family law clinics, students should be educated about substance abuse and its origins so that they may counsel their clients where such a role is appropriate. Students can be trained by attending live or videotaped lectures and presentations on substance abuse treatment offered by their medical-legal partners, like Chestnut Ridge and WVU Pediatrics referenced above. As part of such training, clinicians should assign students research projects on treatment options and programs, as well as identification of funding for treatment of clients who cannot otherwise afford it.

Typically, at the beginning of the first semester of the clinic’s training component, students should learn the skills necessary to effectively interview clients who are addicts or are affected by addiction in the context of their family. As part of this process, students should also learn how to ask the right questions to gauge whether and to what extent substance abuse is an issue. Further, students should be sensitive to their potential clients’ responses, family situation, and needs.

Clinic law students should communicate with community programs helping those with substance abuse disorders and develop working relationships with programs providing recovery services. Additionally,

115 This would not be the first occasion for a specialized pro bono bar to be created to meet a crucial need. See, e.g., Barbara Hart, DV and the Law: Creating a DV Bar, NAT'L BULL. ON DOMESTIC VIOLENCE PREVENTION, Feb. 2017, at 4; Chandlee Johnson Kuhn, Pro Bono Work in the Family Court, 23 DEL. LAW. 28, 28 (2005). [420]
students should develop a list of local treatment facilities and community programs, become familiar with the services they provide, and update the list each year. Students should also have information available to provide to their clients regarding programs such as Alcoholics Anonymous and Narcotics Anonymous. Of course, it goes without saying that clinical faculty should supervise such tasks assigned to law students.

As part of the clinical law seminar, clinicians can invite guest speakers, including drug court and family court judges, healthcare professionals, and community service providers to speak with their students and engage them in a dialogue about mutual professional responsibilities to the families who are the focus of clinical efforts.

Clinical law students also could organize continuing legal education seminars for practitioners and other law students to educate them on state-of-the-art treatment, developing trends in the family court system for addressing opioid addiction, as well as information relating to clients’ access to treatment while they help them resolve their legal issues.116

Drug courts may also have a need for pro bono assistance by clinical law students.117 To determine

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whether the need exists, clinical law supervisors could obtain approval from judges to allow students to observe juvenile drug and adult drug court.\footnote{118} Because of their closer proximity in age, clinical law students may be uniquely able to help youth entangled in juvenile drug court,\footnote{119} many of whom have been subjected to adverse childhood experiences.\footnote{120} Should the court determine a


\footnote{119} In addition to helping resolve their legal issues, law students could serve as positive adult role models and help these youthful offenders recognize their potential and set goals for the future. See generally SCOTT BERNARD PETERSON, \textit{TEEN/YOUTH COURT PROGRAMS AND MENTORING: THE REFERRAL STAGE} (2018), https://www.globalyouthjustice.org/wp-content/uploads/sites/19/2018/01/Teen_Court_and_Mentoring_TA.pdf [https://perma.cc/N3ZZ-46NP].

\footnote{120} The Office of Juvenile Justice and Delinquency Prevention conducted a study examining the prevalence of adverse childhood experiences and their negative repercussions among youth involved with the juvenile justice system in Florida. Michael Baglivio et al., \textit{The Prevalence of Adverse Childhood Experiences (ACE) in the Lives of Juvenile Offenders}, J. JUV. JUST., Spring 2014, at 1, https://www.researchgate.net/publication/284889607_The_prevalence_of_Adverse_Childhood_Experiences_ACE_in_the_lives_ofjuvenile_offenders [https://perma.cc/Y6FT-7R7B]. The study found that the
need, clinical law students could supplement the list of pro bono attorneys volunteering their time. This representation should include encouraging and helping youth obtain treatment and counseling to address their drug abuse and the ACEs that may have led them to experiment with opioids in the first place.

III. Conclusion

Clearly, children’s best interests are not served when they are in the care of parents impaired by opioid addiction. Few would dispute that parents’ opioid addiction can lead to custody disputes that cause scarring adverse childhood experiences for the children in their care. Nor would many disagree the proposition that medication-assisted treatment, behavior counseling, and community support for opioid-affected families can help them ultimately remain together in a healthy home environment. Legal and healthcare partners who collaborate in medical-legal partnerships hopefully would agree that combining their resources and working together to provide access to treatment and recovery can lead to positive, long-term outcomes for clients and patients. Moreover, attorneys should appreciate and embrace the ethical and moral dimensions attendant providing wise counsel and legal assistance to opioid-impaired clients who seek treatment and long-term recovery.

Clinical law students and pro bono family court attorneys have the opportunity to identify resources available to clients for treatment and counseling and to identify programs that clients can afford that will motivate them to engage in the long-term process of recovery. As a practical matter, clients in family court will have to desire treatment if they are to have a realistic hope of recovery. While the availability of affordable

number of ACEs of youths in the juvenile justice system in Florida is higher than the general youth population. Id.
treatment and counseling will present serious challenges to client and attorney alike, the greatest challenge is likely to be the ability of the parents or other addicted caregivers to summon their inner strength and resolve to overcome their opioid affliction for the sake of their children and families.

The Rules of Professional Conduct should, in my view, be interpreted as imposing an ethical responsibility on student attorneys and their supervisors to counsel and assist clients who are struggling with addiction but willing to do what is necessary to heal their children and their families. Notwithstanding whether such a formal ethical duty flows from the Rules of Professional Conduct, it surely is a higher calling for clinical law programs to explore all available options within their charters to add their professional expertise to the exceedingly important struggle to bring the nationwide opioid epidemic under control. Helping to restore families shattered by the opioid-fed crisis and protecting innocent children ensnared as the collateral damage of addiction can be empowering to law students and their institutions and bring honor to our profession.
**BIG PHARMA, PRESCRIPTION OPIOIDS, AND THE DEA DRUG DEALING IN PLAIN VIEW**

*Patrick C. McGinley*

[This symposium article is forthcoming and will be published in Volume 13 Issue 2 (Winter 2019).]

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[425]
Abstract

The U.S. Center for Disease Control reports that from 1999–2016 more than 350,000 people died from overdoses involving prescription and/or illicit opioids. In 2016 alone, deaths from prescription opioids and illegal opioids like heroin and illicitly manufactured fentanyl totaled almost 42,000. The number of overdose deaths involving opioids was 5 times higher in 2016 than in 1999. On average, 115 Americans die every day from an opioid overdose. In this article, Professor McGinley examines the evolution of the nationwide opioid epidemic over the last two decades focusing on the role played by drug manufacturers, drug distributors and the U.S. Drug Enforcement Administration in the flood of literally billions of “legal” prescription opioid pills inundating communities across the nation.