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ARTICLE

DEFINING THE ROLE OF CLINICAL LAW STUDENTS, MEDICAL-LEGAL PARTNERSHIPS, AND PRO BONO LAWYERS CONFRONTING THE OPIOID EPIDEMIC IN FAMILY COURT

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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

¹ *Opioid Crisis Strains Foster System as Kids Pried from Homes*, NBC NEWS (Dec. 12, 2017, 4:53 PM), <https://www.nbcnews.com/storyline/americas-heroin-epidemic/opioid-crisis-strains-foster-system-kids-pried-homes-n828831> [<https://perma.cc/7ANS-P7HQ>].

² Stephano Dipietrantonio, *Exclusive Interview Part I: Parents Talk About Daughter’s Drug Overdose Death*, WCHS EYEWITNESS NEWS (Charleston, W. Va.) (Mar. 31, 2016), <http://wchstv.com/news/local/exclusive-tv-interview-part-1-parents-talk-about-daughters-overdose-death> [<https://perma.cc/FY8R-VW6M>].

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

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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.”⁴

Nowhere has the impact of the opioid epidemic been clearer than in West Virginia.⁵ According to the Center for Disease Control and Prevention, West Virginia had the highest percentage of drug overdose deaths in 2016.⁶ Adults aged twenty-five to fifty-four had the highest percentage of drug overdose deaths,⁷ 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

addict. 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).

⁴ Am. Soc’y of Addiction Med., *Treating Opioid Addiction as a Chronic Disease*, <https://www.asam.org/docs/default-source/advocacy/cmm-fact-sheet---11-07-14.pdf> [<https://perma.cc/Z826-6F5K>].

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.

⁶ Holly Hedegaard et al., *Drug Overdose Deaths in the United States, 1999–2016*, NCHS DATA BRIEF, No. 294 (Dec. 2017), <https://www.cdc.gov/nchs/data/databriefs/db294.pdf> [<https://perma.cc/Q2WD-ECQH>].

⁷ *Id.*

Virginia are there because of drug problems within the family.⁸ These adverse experiences increase the children's risks of substance abuse and have an enormous impact on their development.⁹ In addition to exposure to

⁸ Eric Eyre, *Opioid Epidemic Costs WV \$8.8 Billion Annually, Study Says*, The Charleston Gazette-Mail (Feb. 6, 2018), https://www.wvgazettemail.com/news/health/opioid-epidemic-costs-wv-billion-annually-study-says/article_1cd8aaa5-78eb-5fd5-8619-3a0a1c086e66.html [<https://perma.cc/5AHF-RY3E>]. 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.

Julia Lurie, *Children of the Opioid Epidemic Are Flooding Foster Homes. America Is Turning a Blind Eye*, MOTHER JONES (July/Aug. 2017), <https://www.motherjones.com/politics/2017/07/children-ohio-opioid-epidemic/> [<https://perma.cc/QWJ5-7EL4>]. Some children are more fortunate than others to have grandparents who are willing and able to step in. *See, e.g.*, Brenda Breslauer & Hannah Rappleye, *Opioid Crisis Forces Grandparents to Raise Their Kids*, NBC NEWS (Oct. 20, 2017, 5:01 AM), <https://www.nbcnews.com/storyline/americas-heroin-epidemic/opioid-crisis-forces-grand-parents-raise-their-grandkids-n808991> [<https://perma.cc/G9TB-PGV8>].

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

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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.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.”¹¹ Recent legislation proposed

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.

U.S. DEPT OF HEALTH & HUMAN SERVS., *FACING ADDICTION IN AMERICA: THE SURGEON GENERAL’S REPORT ON ALCOHOL, DRUGS, AND HEALTH*, at 2-21 (2016), <https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf> [<https://perma.cc/7S2C-VUH2>].

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

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.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.”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.

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; *living with a person experiencing* mental illness or *substance use disorder*, or both; experiencing or witnessing domestic violence; and having divorced parents or an incarcerated parent.” (emphasis added)).

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

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.”).

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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.”¹⁴ 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.¹⁵

Going forward, efforts to address the opioid epidemic must necessarily occur on numerous fronts.¹⁶

¹⁴ S. 261, 2017—2018 Leg. Sess. (Vt. 2017) (as introduced in Vermont Senate, Findings deleted by amendment).

¹⁵ The Senate hearing was held in February 2018 and televised on C-Span. *The Opioid Crisis Impact on Children and Families: Hearing Before the S. Comm. On Health, Educ., Labor & Pensions*, 115th Cong. (2018), <https://www.c-span.org/video/?440882-1/senate-hearing-impact-opioid-crisis-children> [<https://perma.cc/7C9U-4GNW>].

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.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.¹⁸

related deaths have an Early Childhood Court in place.

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

On the federal level, in September of 2017, the United States Department of Justice (“DOJ”) awarded “\$58.8 million to strengthen drug court programs and address the opioid epidemic nationwide.” Press Release, U.S. Dep’t of Justice, Department of Justice Awards Nearly \$59 Million to Combat Opioid Epidemic, Fund Drug Courts (Sept. 22, 2017), <https://www.justice.gov/opa/pr/departement-justice-awards-nearly-59-million-combat-opioid-epidemic-fund-drug-courts> [<https://perma.cc/S2PR-594F>]. DOJ awarded grants to the Supreme Court of Ohio, the Colorado Judicial Department, the Judiciary Courts for the State of Iowa, and the New York State Unified Court System as part of the Family Drug Court Statewide System Reform Implementation Program with the goal of helping these states improve the outcomes for families in the child welfare system who are affected by the opioid epidemic. Press Release, Dep’t of Justice, OJJDP FY 2017 Family Drug Court Statewide System Reform Implementation (Sept. 21, 2017), <https://ojp.gov/newsroom/presreleases/2017/ojp-news-09212017.pdf> [<https://perma.cc/A4CQ-PLJ3>].

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).

¹⁸ Elizabeth Joanne Gifford, *How Does Family Treatment Court Participation Affect Child Welfare Outcomes?*, 38 CHILD ABUSE & NEGLECT 1659 (2014) (citing BUREAU OF JUSTICE ASSISTANCE, U.S. DEP’T OF JUSTICE, FAMILY DEPENDENCY

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However, in many states, family courts possess limited jurisdiction,¹⁹ 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

TREATMENT COURTS: ADDRESSING CHILD ABUSE AND NEGLECT CASES USING THE DRUG COURT MODEL (2004), <https://www.ncjrs.gov/pdffiles1/bja/206809.pdf> [<https://perma.cc/P396-X838>], <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4194264/> [<https://perma.cc/YN9J-ZTB4>].

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

The power of family courts to exercise jurisdiction over various matters is narrowly prescribed by the Legislature. “The jurisdiction of family courts is limited to only those matters specifically authorized by the Legislature, while circuit courts have original and general jurisdiction and other powers as set forth in Article VIII, § 6 of the Constitution of West Virginia.” Syl. pt. 5, in part, *Lindsie D.L. v. Richard W.S.*, 214 W.Va. 750, 591 S.E.2d 308 (2003). *Accord* Syl. Pt. 2, *State ex rel. Silver v. Wilkes*, 213 W.Va. 692, 584 S.E.2d 548 (2003) (“A family court is a court of limited jurisdiction. A family court is a court of record only for the purpose of exercising jurisdiction in the matters for which the jurisdiction of the family court is specifically authorized in this section and in chapter forty-eight [§§ 48-1-101 et seq.] of this code.’ W. Va. Code § 51-2A-2(d) (2001), in part.”).

Deitz v. Deitz, 659 S.E.2d 331, 339 (W. Va. 2008).

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 [K]entucky (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’SHP, <http://medical-legalpartnership.org/partnerships/> [<https://perma.cc/8UWL-LGXC>].

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The West Virginia Constitution was amended to create “a unified family court system . . . to rule on family law and related matters.”²¹ 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[.]”²²

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

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- 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

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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.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."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."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.²⁶ While lawyers do not have a "duty

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.

²⁴ MODEL RULES OF PROF'L CONDUCT r. 2.1 (AM. BAR ASS'N 1983).

²⁵ *Id.*

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."²⁷

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.

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counselor.²⁸ 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).²⁹ 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

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).

²⁹ Ellen Cohen et al., *Medical-Legal Partnership: Collaborating with Lawyers to Identify and Address Health Disparities*, 25 J. GEN. INTERN. MED. 136 (2010).

Public Health at the George Washington University.³⁰ 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.³¹

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.³² "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."³³

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

³⁰ *About the National Center*, NAT'L CTR. FOR MEDICAL-LEGAL P'SHIP, <http://medical-legalpartnership.org/about-us/> [https://perma.cc/22AF-RV5Z].

³¹ *The Partnerships*, NAT'L CTR. FOR MEDICAL-LEGAL P'SHIP, <http://medical-legalpartnership.org/partnerships/> [https://perma.cc/8UWL-LGXC].

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.").

³³ TIRSHA BEESON ET AL., NAT'L CTR. FOR MEDICAL-LEGAL P'SHIP, MAKING THE CASE FOR MEDICAL-LEGAL PARTNERSHIPS: A REVIEW OF THE EVIDENCE (2013), <http://www.medical-legalpartnership.org/wp-content/uploads/2014/03/Medical-Legal-Partnership-Literature-Review-February-2013.pdf> [https://perma.cc/42BB-EBK3].

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Pediatrics (“WVU Pediatrics”).³⁴ 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.³⁵ 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.³⁶

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

³⁴ *Partners Across the U.S.: West Virginia*, NAT’L CTR. FOR MED.-LEGAL PARTNERSHIP, http://medical-legalpartnership.org/partnerships/?fwp_states=west-virginia [<https://perma.cc/8JC7-RBRM>].

³⁵ For more information on Medical-Legal Partnerships, see *Brief: How Medical-Legal Partnership Services Can Help Address the Opioid Crisis*, NAT’L CTR. FOR MEDICAL-LEGAL P’SHIP, <http://medical-legalpartnership.org/mlp-resources/opioid-crisis-brief/> [<https://perma.cc/HSM2-XDQR>]. The National Center for Medical-Legal Partnership hosted a federal round table in the fall of 2017 to discuss the opioid epidemic and the role MLPs can play in helping those afflicted. See *National Center Convened Federal Agency Roundtable on the Opioid Crisis*, NAT’L CTR. FOR MEDICAL-LEGAL P’SHIP (Sept. 27, 2017), <http://medical-legalpartnership.org/opioid-round-table/> [<https://perma.cc/GZ4E-BPSN>].

³⁶ JAY CHAUDHARY ET AL., NAT’L CTR. FOR MEDICAL-LEGAL P’SHIP, *THE OPIOID CRISIS IN AMERICA & THE ROLE MEDICAL-LEGAL PARTNERSHIP CAN PLAY IN RECOVERY* (2018), <http://medical-legalpartnership.org/wp-content/uploads/2018/02/MLP-and-the-Opioid-Crisis.pdf> [<https://perma.cc/3TVN-PM3V>].

suffering from a drug use disorder obtain specialty treatment.³⁷ 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.³⁸ 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.”³⁹ Moreover, many who suffer from drug addiction are not able to realize they need treatment or they otherwise reject treatment.⁴⁰

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. DEP’T 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 AUBSE & 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/NSDUH-DetTabs-2015.pdf> [<https://perma.cc/JH2V-U9X9>]).

³⁸ *10 Percent of US Adults Have Drug Use Disorder at Some Point in Their Lives: 75 Percent Report Not Receiving Any Form of Treatment*, NAT’L INST. OF HEALTH (Nov. 18, 2015), <https://www.nih.gov/news-events/news-releases/10-percent-us-adults-have-drug-use-disorder-some-point-their-lives> [<https://perma.cc/2P7V-ZHT4>].

³⁹ *Executive Summary of the Surgeon General’s Report on Alcohol, Drugs and Health*, SURGEON GEN., <https://addiction.surgeongeneral.gov/executive-summary> [<https://perma.cc/99HC-M5D6>].

⁴⁰ U.S. DEP’T OF HEALTH & HUMAN SERVS., *supra* note 9, at 4-9.

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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.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.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")

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, *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>].

⁴² See discussion of family treatment courts, *supra* pp. 4–6.

program.⁴³ 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.⁴⁴ Of course, it is important to understand that no single treatment program will fit every person struggling with addiction.⁴⁵

Treating opioid addiction should begin with a healthcare professional's assessment and diagnosis.⁴⁶ This clinical assessment may be based on several different models, such as the Addiction Severity Index

⁴³ *Behavioral Medicine and Psychiatry: Outpatient Programs*, WVU MED., <http://wvumedicine.org/ruby-memorial-hospital/services/wvu-specialty-clinics/behavioral-and-mental-health/chestnut-ridge-center/adult-addiction-services/comprehensive-opioid-addiction-treatment-coat/> [https://perma.cc/E39P-LCHQ].

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"),⁴⁷ the Substance Abuse Model ("SAM"),⁴⁸ the Global Appraisal of Individual Needs ("GAIN"),⁴⁹ and the Psychiatric Research Interview for Substance and Mental Disorders ("PRISM").⁵⁰ 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*

⁴⁷ "The Addiction Severity Index (ASI) is a structured interview widely used by substance abuse clinicians and researchers for client screening, determining treatment needs, and assessing treatment outcomes." Bertrym E. Stoffelmayr, Brian E. Mavis & Rafa M. Kasim, *The Longitudinal Stability of the Addiction Severity Index*, 11 J. SUBSTANCE ABUSE TREATMENT 373, 373 (1994). The ASI "[a]ddresses seven potential problem areas in substance using individuals: medical status, employment and support, drug use, alcohol use, legal status, family/social status, and psychiatric status." U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 9, at 4-16.

⁴⁸ SAM is "[d]esigned to assess mental disorders as defined by the *Diagnostic 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 (screeners, 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.*

⁵⁰PRISM 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).⁵¹ Patients may also be assessed in the context of their “family environment.”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.⁵³ The individualized treatment program should also have measures in place to engage and to motivate the patient to remain in the program.⁵⁴

⁵¹ *Id.* at 4-15.

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.”).

⁵³ U.S. DEP’T HEALTH & HUMAN SERVS., *supra* note 9, at 4-16.

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

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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

treatment process, which may involve participation in three to four different programs or services at reduced levels of intensity, all of which are ideally designed to help the patient prepare for continued self-management after treatment ends. This expected trajectory of care explains why efforts to maintain patient motivation and engagement are important.

Id. at 4-18.

⁵⁵ *Id.*

⁵⁶ 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 (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.”).

⁵⁷ U.S. DEP’T HEALTH & HUMAN SERVS., *supra* note 9, at 4-19 to -31.

include buprenorphine,⁵⁸ methadone,⁵⁹ or extended-release naltrexone⁶⁰ in treatment programs.⁶¹ Suboxone and Vivitrol are two frequently prescribed medications for treatment of opioid addiction. Suboxone, taken daily, contains buprenorphine hydrochloride and naloxone hydrochloride,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.⁶³ Forty-three

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, *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. *Id.*

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.” *Id.*

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.” *Id.*

⁶¹ Spencer Bujarski et al., *Prevalence, Causes, and Treatment of Substance Use Disorders*, Judges J., Winter 2018, at 10, 14.

⁶² Buprenorphine is an opioid that treats withdrawal symptoms, while naloxone is an opioid antagonist used to reverse opioid overdose. *Id.*

⁶³ See Joshua D. Lee et al., *Comparative Effectiveness of Extended-Release Naltrexone Versus Buprenorphine-Naloxone*

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states limit daily total milligram dosages of buprenorphine and buprenorphine/naloxone combination drugs,⁶⁴ while seven do not.⁶⁵

Opioid treatment plans should be expected to include behavioral therapies that may involve only the individual; other plans may include family or group sessions.⁶⁶ Therapies such as Cognitive Behavioral

For Opioid Relapse Prevention (X:BOT): A Multicentre, Open-Label, Randomised Controlled Trial, 391 THE LANCET 309, 317 (2018); Lars Tatum et al., *Effectiveness of Injectable Extended-Release Naltrexone vs. Daily Buprenorphine-Naloxone for Opioid Dependence: A Randomized Clinical Noninferiority Trial*, 74 JAMA PSYCHIATRY 1197 (2017).

⁶⁴ The following states have limits in place: AK, AL, AR, CA, CO, CT, DC, DE, FL, GA, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NV, NY, OH, OK, PA, TN, TX, UT, VA, VT, WA, WV, WY. CTR. FOR MEDICAID & CHIP SERVS., MEDICAID DRUG UTILIZATION REVIEW STATE COMPARISON/SUMMARY REPORT FFY 2016 ANNUAL REPORT: PRESCRIPTION DRUG FEE FOR SERVICE PROGRAMS 49 (2017), <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/prescription-drugs/downloads/2016-duration-summary-report.pdf> [<https://perma.cc/MM7V-BX2C>].

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

⁶⁶ U.S. DEP'T HEALTH & HUMAN SERVS., *supra* note 9, at 4-26.

Therapy (“CBT”),⁶⁷ Contingency Management (“CM”),⁶⁸
Community Reinforcement Approach (“CRA”),⁶⁹

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.

Id. (citing H.D. KLEBER ET AL., PRACTICE GUIDELINE FOR THE TREATMENT OF PATIENTS WITH SUBSTANCE USE DISORDERS 42 (2006)).

⁶⁸ Contingency Management involves awarding tangible items to patients to reinforce positive behavioral changes. *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.”).

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”),⁷⁰ the Matrix Model,⁷¹ Twelve-Step Facilitation therapy (“TSF”),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.

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

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.” *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)).

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.

Id. (endnote omitted) (citing NAT'L INST. ON DRUG ABUSE, *supra* note 68).

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.” *Id.* (citing Kimberly S. Walitzer et al., *Facilitating Involvement in Alcoholics Anonymous During Outpatient Treatment: A*

depending upon the individual and the severity and duration of the addiction.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.”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.”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.⁷⁶

Randomized Clinical Trial, 104 ADDICTION 391 (2009); L.A. Kaskutas et al., *Effectiveness of Making Alcoholics Anonymous Easier: A Group Format 12-Step Facilitation Approach*, 37 J. SUBSTANCE ABUSE TREATMENT 228 (2009).

⁷³ 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.” *Id.* at 4-30 (endnote omitted) (citing NAT’L INST. ON DRUG ABUSE, *supra* note 68).

⁷⁴ *About Us*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICE ADMINISTRATION, <https://www.samhsa.gov/about-us> [<https://perma.cc/DLG3-KUWR>].

⁷⁵ Alderks, *supra* note 58.

⁷⁶ SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., BEHAVIORAL HEALTH SERVICES INFORMATION SERIES: NATIONAL DIRECTORY OF DRUG AND ALCOHOL ABUSE TREATMENT FACILITIES 2017, at iv (2017), <https://www.samhsa.gov/data/sites/default/files/2017%20SA%20Directory.pdf> [<https://perma.cc/2U4Y-4SLV>].

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SAMHSA also tracks the number of state admissions of patients for opioid treatment.⁷⁷

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.⁷⁸ 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.⁷⁹

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

⁷⁷ *Treatment Episode Data Set*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICE ADMINISTRATION, CLIENT LEVEL DATA / TREATMENT EPISODE DATA SET, <https://www.samhsa.gov/data/data-we-collect/teds-treatment-episode-data-set> [<https://perma.cc/ASZ6-K6DB>].

⁷⁸ 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 of 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.

⁷⁹ *Id.* The exclusive treatment of white people by West Virginia is problematic. It strongly suggests a need to analyze treatment programs to determine if barriers to access exist, and if they exist, whether they may be rooted in racial discrimination, poverty, racial preference or other factors.

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 of 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

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

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>].

program⁸² using buprenorphine⁸³ and requiring twice-weekly visits could incur costs of “\$115 per week or \$5980 per year.”⁸⁴ Patients receiving treatment in a certified opioid treatment program using naltrexone and receiving related services could incur costs of “\$1,176.50 per month or \$14,112.00 per year.”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.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

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. *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>].

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

⁸⁴ *How Much Does Opioid Treatment Cost?*, NAT’L INST. ON DRUG ABUSE, <https://www.drugabuse.gov/publications/research-reports/medications-to-treat-opioid-addiction/how-much-does-opioid-treatment-cost> [<https://perma.cc/86GS-6QX5>] (citing TRICARE, Mental Health and Substance Use Disorder Treatment, 81 Fed. Reg. 61,068 (Sept. 2, 2016) (codified at 32 C.F.R. pt. 199), <https://www.federalregister.gov/documents/2016/09/02/2016-21125/tricare-mental-health-and-substance-use-disorder-treatment> [<https://perma.cc/4TQ8-4YDX>]).

⁸⁵ *Id.*

⁸⁶ *Medicaid’s Role in Addressing the Opioid Epidemic*, KAISER FAMILY FOUND., <https://www.kff.org/infographic/medicaids-role-in-addressing-opioid-epidemic/> [<https://perma.cc/HZ9P-FRK9>].

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access to and coverage for opioid treatment.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.⁸⁸ According to data collected by the Kaiser Family Foundation, Medicaid covers four in ten “nonelderly adults with opioid addiction.”⁸⁹

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

⁸⁷ Matt Broaddus, Peggy Bailey, & Aviva Aron-Dine, *Medicaid Expansion Dramatically Increased Coverage for People with Opioid-Use Disorders, Latest Data Show*, CTR. ON BUDGET & POLICY PRIORITIES, <https://www.cbpp.org/research/health/medicaid-expansion-dramatically-increased-coverage-for-people-with-opioid-use> [https://perma.cc/RG5X-BGMB].

⁸⁸ *Id.*

⁸⁹ Zur, *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.*

⁹⁰ In October of 2017, the Centers for Medicare & Medicaid Services approved a waiver for West Virginia to help the state cover substance abuse treatment for more people. Press Release, W. Va. Dep’t of Health & Human Res., DHHR’s Medicaid Program to Expand Substance Use Treatment and Services (Oct. 10, 2017), <https://dhhr.wv.gov/News/2017/Pages/DHHR’s-Medicaid-Program-to-Expand-Substance-Use-Treatment-and-Services.aspx> [https://perma.cc/8QYR-7KTQ].

⁹¹ Press Release, W. Va. Dep’t Health & Human Res., DHHR Receives CMS Approval for Neonatal Abstinence Syndrome Treatment Services (Feb. 13, 2018), <https://dhhr.wv.gov/News/2018/Pages/DHHR-Receives-CMS-approval-for-Neonatal-Abstinence-Syndrome-Treatment-Services.aspx> [https://perma.cc/5XYF-HRUW].

needs and Medicaid coverage for providing methadone for opioid addiction withdrawal.”⁹² 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.”⁹³

Significantly, West Virginia’s Medicaid will also cover the treatment costs of infants who are born to addicted mothers.⁹⁴ 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.”⁹⁵ 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.”)

⁹³ W. Va. Dep’t of Health & Human Res., *supra* note 90.

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.”)

⁹⁵ W. Va. Dep’t Health & Human Res., *supra* note 91.

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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.*

⁹⁸ AM. SOC'Y OF ADDICTION MED., *ADVANCING ACCESS TO ADDICTION MEDICATIONS: IMPLICATIONS FOR OPIOID ADDICTION TREATMENT* 21 (2013), <http://www.asam.org/docs/advocacy/implications-for-opioid-addiction-treatment> [<https://perma.cc/YLR7-Y5WB>].

⁹⁹ *Id.* at 36.

¹⁰⁰ Amanda J. Abraham et al., *Geographic Disparities in Availability of Opioid Use Disorder Treatment for Medicaid Enrollees*, 53 HEALTH SERVS. RES. 389, 389 (2017).

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.”¹⁰² SAMHSA has compiled state-by-state abstracts of “State Targeted Response to the Opioid Crisis (Opioid STR) Grant Awards.”¹⁰³

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.

Frankie M. Griffen, *Prescription Opioids in Arkansas: Finding a Legislative Balance*, 68 ARK. L. REV. 913, 952–53 (2016).

¹⁰² *State Grant Programs*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., <https://www.samhsa.gov/programs-campaigns/medication-assisted-treatment/training-materials-resources/state-grant-programs#mat-pdoa> [<https://perma.cc/U5R-TBXF>].

¹⁰³ *State Targeted Response to the Opioid Crisis (Opioid STR) Grant Awards*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., <https://www.samhsa.gov/sites/default/files/grants/.../ti-17-014-opioid-str-abstracts.pdf> [<https://perma.cc/4NE7-AWDC>].

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services.¹⁰⁴ 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.¹⁰⁵ Treatment programs are also available to veterans for free or at lower costs.¹⁰⁶ 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.

¹⁰⁶ See *Substance Use Disorder (SUD) Program Locator*, U.S. DEPT OF VETERAN AFFAIRS, <https://www.va.gov/directory/guide/sud.asp> [<https://perma.cc/S3KM-8Q4B>].

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

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 *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 *loco parentis*, the representation may only continue after the first appearance if the parent or other persons standing in *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.

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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.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.”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

W. VA. CODE ANN. § 49-4-601(f) (2015).

¹⁰⁸ MODEL RULES OF PROF'L CONDUCT r. 6.1 (AM. BAR ASS'N 1983).

¹⁰⁹ *Id.*

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.

¹¹² Only New Jersey requires practitioners to perform some form of pro bono work. Lydia Chan, *New York’s New Rule: A Novel Approach to Closing the Access to Justice Gap*, 26 GEO. J. LEGAL ETHICS 597, 600, 610 (2013) (citing Deborah L. Rhode, *Cultures of Commitment: Pro Bono for Lawyers and Law Students*, 67 FORDHAM L. REV. 2415, 2418 (1999)). See also Cory H. Morris, *Access to Justice, Observations and Thoughts from the Incubator—A New York State of Mind*, 83 UMKC L. Rev. 883, 884 (2015).

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cases involving substance abuse issues. Moreover, many state bars, as in West Virginia, have established pro bono assistance projects.¹¹³ 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.¹¹⁴ 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.

Thomas R. Tinder, *The Tinder Box: A Case in Point*, W. VA. LAW., Sept./Oct. 2005, at 46, 46. The American Bar Association has an online state-by-state directory of pro bono legal programs: https://www.americanbar.org/portals/public_resources/aba_home_front/directory_programs.html [<https://perma.cc/YB5M-RG2L>].

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).

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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

¹¹⁶ For example, clinical law students could organize a continuing legal education seminar on representing impaired clients. See Annemarie E. Kill, *Representing Impaired Clients: Challenge and Opportunity*, THE CATALYST, Mar. 2009, at 10 <https://www.isba.org/committees/women/newsletter/2009/03/representingimpairedclientschalleng> [<https://perma.cc/9GLA-Z7X R>].

¹¹⁷ Law schools have externship programs where law students are exposed to drug courts. See, e.g., Gregory Baker & Jennifer Zawid, *The Birth of a Therapeutic Courts Externship Program: Hard Labor but Worth the Effort*, 17 ST. THOMAS L. REV. 711 (2005). Some clinical law programs represent clients in drug court. See, e.g., Tamar M. Meekins, *Risky Business: Criminal Specialty Courts and the Ethical Obligations of the Zealous Criminal Defender*, 12 BERKELEY J. CRIM. L. 75, 75 n.2 (2007).

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

¹¹⁸ Incarceration alone is not the solution to drug-addicted offenders. There is evidence that in-prison treatment for those who are not diverted to drug court can decrease opioid abuse and “reduce associated criminal behavior.” Redonna K. Chandler, Bennett W. Fletcher & Nora D. Volkov, *Treating Drug Abuse and Addiction in the Criminal Justice System: Improving Public Health and Safety*, 301 JAMA 183 (2009), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2681083/> [<https://perma.cc/BM2X-5PVG>]; *see also* Catherine D. McKay, Steven T. Davis & Adam Taylor, *Confronting Delaware’s Heroin Epidemic: In-Prison Treatment, Methadone Maintenance and Providing Post-Release Support and Counseling Can Reduce Recidivism and Discourage a Return to Addiction*, DEL. LAW., Spring 2015, at 14.

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, 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>].

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., *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_of_juvenile_offenders [<https://perma.cc/Y6FT-7R7B>]. The study found that the

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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.