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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 to16address 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 Orto 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 terminateyour 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 pilled 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 pilled 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 pilled 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 feltlike— 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, he 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.