LAPPA

MEDICATION FOR ADDICTION TREATMENT AND THE AMERICANS WITH DISABILITIES ACT

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Approximately 65 percent of people in U.S. prisons or jails have a substance use disorder; many of whom are addicted to opioids.[1] The National Institutes of Health (NIH) recommend that all individuals with opioid use disorder (OUD) and are under legal supervision have access to medication for addiction treatment (MAT).[2] However, in reality, very few states offer any form of MAT to those who are incarcerated.[3] The lack of MAT in correctional settings results in many inmates going through a painful withdrawal process, with a high risk of relapse upon reentry.[4] Moreover, without the assistance of MAT, former inmates are nearly 130 times more likely than the general population to suffer a drug overdose within the first two weeks after release from prison.[5] Recently, inmates started fighting back against state prison policies that ban MAT medications in correctional facilities by arguing in court cases that these policies violate the Americans with Disabilities Act and the Eighth Amendment of the United States Constitution. As courts begin to rule in favor of the inmates, states will need to reconsider their policies on MAT in correctional settings to avoid future lawsuits.

MEDICATION-ASSISTED TREATMENT

MAT is commonly used for the treatment of OUD and uses medications to normalize brain chemistry and bodily functions, block the euphoric effects of opioids, and relieve physiological cravings.[6] There are three Food and Drug Administration (FDA)-approved drugs used to treat OUD: methadone, buprenorphine, and naltrexone.[7]

- Methadone, an opioid agonist, has been used for the treatment of OUD since 1964.[8] The use of methadone is highly regulated, and the drug can only be dispensed at an opioid treatment program that is registered with the Drug Enforcement Administration (DEA).[9]

There is an exception for emergency treatment, however, in which an entity that is not DEA-registered can provide methadone for up to three days to help relieve acute opioid withdrawal symptoms.[10]

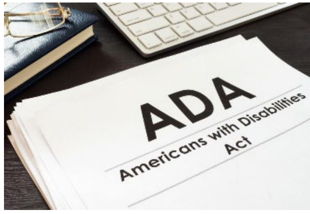
- Buprenorphine, a partial opioid agonist, was first approved by the FDA for the treatment of OUD in 2002.[11] Unlike methadone, buprenorphine can be prescribed and dispensed in physicians' offices. It is commonly prescribed in a combined formulation with naloxone (brand name Suboxone). Suboxone is taken sublingually, but if an individual injects Suboxone, the naloxone will block the buprenorphine from producing any euphoric effects, which decreases the likelihood of misuse.[12]
- Naltrexone, unlike the other two drugs, is an opioid antagonist.[13] Instead of mimicking the effects of opioids, naltrexone blocks the effects of opioids.[14] Naltrexone can only be used on patients who have been detoxified from opioids.[15] This medication is available in oral form or as an extended-release injection (brand name Vivitrol).

THE AMERICANS WITH DISABILITIES ACT

Title II of the Americans with Disabilities Act (ADA) prohibits discrimination against qualified individuals with disabilities in all programs, entities, and services of public entities.[16] A public entity includes any state or local government and any department, agency, district, or other instrumentality of a state or local government.[17] To establish a claim under Title II of the ADA, a person must prove that he or she: "(1) has a disability; (2) is otherwise qualified to participate in or receive the benefit of some public entity's services, programs, or activities; (3) was either excluded from participation in, or denied the benefits of, the public entity's services, programs, or activities, or was otherwise discriminated against by the public entity; and (4) such exclusion, denial of benefits, or discrimination was by reason of the individual's disability."[18] A person has a disability under the ADA if he or she:

(1) has a physical or mental impairment that substantially limits one or more major life activities; (2) has a record of such an impairment; or (3) is being regarded (even erroneously) as having such an impairment.[19]

ADA and State Correctional Systems



In *Pennsylvania Department of Corrections v. Yeskey*, the U.S. Supreme Court held that Title II of the ADA applies to state prisons.[20] Since this ruling, courts have also determined that the ADA applies to medical services provided within state prisons, as well as other programs and services that are made available to individuals in state jails and prisons.[21] Additionally, parole and probation conditions, drug courts, and alternative sentencing programs are required to comply with Title II of the ADA.[22]

ADA and MAT Interaction

Substance use disorder has long been considered an impairment, but just because someone has such an impairment does not mean he or she is automatically considered disabled under the ADA.[23] In fact, a person who is currently using illegal drugs and is discriminated against because of their illegal drug use is not protected under the ADA.[24] When a person stops using such drugs and transitions to recovery with the assistance of MAT, he or she no longer has an impairment that limits their major life activities. However, people engaged in MAT do have a record of impairment due to their previous drug use.[25] Courts have ruled that a person in recovery from OUD who is on MAT might face discrimination due to his or her record of impairment and thus, Congress intends for the ADA to protect those individuals from discrimination.[26] Additionally, someone on MAT may be discriminated against because he or she is regarded as having an impairment by others due to myths and stereotypes surrounding OUD treatments; this type of discrimination is also prohibited by the ADA.[27]

THE DENIAL OF MAT IN PRISONS AND ADA REPRECUSSIONS

Historically, only pregnant females had access to MAT, or more specifically methadone, in correctional facilities.[28] Because methadone is an opioid agonist, a person who has been taking methadone and suddenly stops will experience withdrawal symptoms. If a woman goes through withdrawal while pregnant, there is an increased risk of fetal abnormalities, miscarriage, or premature birth.[29] Traditional correctional facility policies are such that male and non-pregnant female inmates taking methadone prior to incarceration do not continue to receive it while in prison; the denial of methadone forces them to go through the painful withdrawal process.
In 2018, Geoffrey Pesce was to be incarcerated in a Massachusetts state prison for a minimum of 60 days.[30] At the time, Pesce was two years into active OUD recovery with the assistance of methadone. Prison officials informed him that he would not continue to receive methadone once he went to prison.[31]

The prison prohibited methadone and instead had a protocol of forced withdrawal combined with non-opioid medications to mitigate symptoms.[32] Pesce filed suit claiming that the policy of denying inmates access to methadone for the treatment of OUD violates Title II of the ADA.[33] Pesce asserted that it would be necessary for him to have access to methadone while in prison because it is the only medication that effectively treats his OUD. Pesce's physician supported this assertion, explaining that Pesce risked relapse and death if denied his medication.[34] The defendants argued that the denial of methadone to inmates is not improper discrimination but rather is a case of medical judgment.[35] However, the court rejected the defendants' argument because their proposed treatment program for Pesce involved strategies known to be ineffective and potentially harmful to him.[36] Therefore, the court held that applying this policy to Pesce would be arbitrary and likely implies that it is pretext for a discriminatory motive.[37]

In a similar case in Maine, *Smith v. Aroostook County*, plaintiff Brenda Smith was on a regimen of twice-daily buprenorphine for the treatment of her OUD prior to being sentenced to a 40-day term in jail.[38] The jail prohibits

the use of MAT by inmates in the facility, except for those inmates with OUD who are pregnant.[39] Smith brought a claim against the jail asserting that the jail's policies violate her rights under the ADA "by denying her the benefit of the jail's health care program because of her disability or by refusing to make reasonable modifications to a policy or practice in order to allow her to access necessary treatment for her disability."[40]

The defendants in the case argued that security concerns necessitate the prohibition against MAT. The court, however, disagreed with the defendants, noting that there are several ways in which the jail could provide inmates with MAT that would reduce or eliminate any security concerns.[41] The court determined that the denial of Smith's medication was unjustified and unreasonable "as to raise an inference that the defendants denied the plaintiff's request because of her disability."[42] Alternatively, the court found it likely that the plaintiff would succeed in her case based on the theory that she was denied a reasonable accommodation by the jail.[43] Because the jail already provides an MAT accommodation for pregnant inmates, it would be reasonable for the jail to provide the same accommodation to Smith.[44] In April 2019, the U.S. Court of Appeals for the First Circuit affirmed the case, making it the highest court to rule on the issue.[45]

A class action lawsuit on behalf of people in a Washington county jail who claimed that the denial of their MAT was a violation of the ADA reached a final settlement in July 2019.[46] The settlement requires the Whatcom County Jail to provide MAT services to "medically appropriate" inmates with OUD, which includes maintaining people on MAT as well as starting people on medication in the jail before release.[47] As of this writing there are no other pending MAT cases involving the ADA.

THE DENIAL OF MAT IN PRISONS AND EIGHTH AMENDMENT REPRECUSSIONS

In addition to ADA claims, inmates who are denied access to MAT in correctional facilities are also bringing claims that the denial violates the Eighth Amendment of the U.S. Constitution's protection against cruel and unusual punishment.[48] The Eighth Amendment applies to state activity by virtue of the Fourteenth Amendment.[49] Inmates' Eighth Amendment allegations are based on a claim of deliberate indifference due to inadequate or delayed medical care. In order to successfully make such a claim, the plaintiff must satisfy both an objective and subjective inquiry.[50] The objective element requires that the plaintiff establish that his or her medical need is "sufficiently serious."[51]

For a medical need to be viewed as sufficiently serious it must have been either diagnosed by a physician as requiring treatment or be so obvious that a layperson would recognize the need for medical assistance.[52] For the subjective element, the plaintiff needs to show that the defendants acted with intent or wanton disregard when providing inadequate care, *i.e.,* "deliberate indifference."[53] Deliberate indifference requires more than just negligence.[54] Inadequate medical care or care that is different from what the plaintiff requested generally does not violate the Eighth Amendment because courts are "reluctant to second guess medical judgments and to constitutionalize claims that are sound in state tort law."[55]

In *Pesce*, the plaintiff asserted that the denial of his MAT violated the Eighth Amendment and the ADA in that it ignored and contradicted the recommendations of his physician.[56] Under First Circuit precedent, "allegations that prison officials denied or delayed recommended treatment by medical professionals may be sufficient to satisfy the deliberate indifference standard."[57] Based on this precedent, the Massachusetts district court determined that Pesce would likely succeed on his Eighth Amendment claim.

In comparison to the *Pesce* case, a 2009 Ohio case, *Nauroth v. Southern Health Partners, Inc.*, provides an example of a rejected Eighth Amendment complaint. The plaintiff in the *Nauroth* case took methadone for OUD but was not allowed to continue his treatment in prison; instead, he faced drug withdrawal protocol.[58]
The Ohio district court held that the plaintiff did not sufficiently make a claim for an Eighth Amendment violation because he "was placed on a standard opioid detoxification protocol, was offered medication to alleviate his pain, and was taken to the hospital and to see his treating physician."[59] The court stated that if the plaintiff's needs were completely ignored while he was going through withdrawal, then that might suffice to create a properly established Eighth Amendment claim.[60]

THE AVAILABILITY OF MAT IN PRISONS IS VARIED AMONG STATES

An inmate's ability to access MAT while in prison is dependent on the state in which he or she is incarcerated. The majority of states do not offer MAT to inmates with OUD, with some arguing that these policies stem from the myths and stigma associated with addiction and MAT.[61] Of the states that offer MAT, most of them only offer naltrexone.[62] As noted above, naltrexone can be given only after a patient detoxifies, meaning inmates must go through the withdraw process before treatment.[63] Naltrexone treatment is given through an injection that blocks the effects of opioids for up to 28 days.[64] Facilities that offer inmates naltrexone usually offer the treatment shortly before release.[65] While offering naltrexone treatment is better than not offering any medication, studies suggest that naltrexone is difficult for people to start because of the detox requirement.[66] Some states have established MAT pilot programs to offer inmates access to MAT medications other than naltrexone, but these programs are limited to only certain prisons in the state or a select group of inmates.[67]

Rhode Island's policies regarding MAT in correctional facilities is considered the gold standard by many OUD experts. Rhode Island began its MAT program in 2016 and is currently the only state to offer all three MAT medications in all its correctional facilities.[68]

The fact that Rhode Island offers all three forms of MAT medications is what experts say is the key to the program's success.[69] By providing medication options, inmates are able to have access to the medication that works best for them and allows them to remain compliant.[70] An evaluation of Rhode Island inmates in the MAT program showed that methadone was the most popular medication followed by buprenorphine; very few inmates chose naltrexone.[71] It costs $2 million a year to operate the Rhode Island MAT program.[72]

While many states cite costs as a reason not to implement an MAT program in their prisons, Rhode Island claims the program helps to save money in other ways by reducing overdoses and recidivism.[73] The *Pesce* and *Aroostook* cases are a signal to states that denying MAT to prisoners can result in serious legal consequences. Because of these cases, states may want to begin to implement policies surrounding MAT in correctional facilities to avoid future lawsuits.

ENDNOTES

[1] "Legality of denying access to medication assisted treatment in the criminal justice system." *Legal Action Center*, December 1, 2011, at.1.
[2] *Ibid.* at 3.
[3] *Ibid.* at 4.
[4] *Ibid.* at 7.
[5] Andrew Joseph, "One state takes a novel approach to opioid addiction: access to treatment for all inmates," *Stat*, August 3, 2017.
[6] *Legal Action Center* at 2.
[7] "Medication-assisted treatment (MAT)," *SAMHSA*, last updated September 9, 2019.
[8] Vestal, Christine, "New momentum for addiction treatment behind bars," *Stateline* – a publication of *Pew Charitable Trusts*, April 4, 2018.
[9] "Medication assisted treatment (MAT)," *Pennsylvania Department of Corrections*, https://www.cor.pa.gov/About%20Us/Initiatives/Pages/Medication-Assisted-Treatment.aspx, last accessed December 12, 2019.
[10] 21 C.F.R. § 1306.07 (2005).
[11] *PA Department of Corrections.*
[12] *Ibid.*
[13] *Ibid.*
[14] *Ibid.*
[15] *Ibid.*
[16] 42 U.S.C.A. § 12132 (1990).

[17] 42 U.S.C.A. § 12131 (1990).
[18] *Legal Action Center* at 9.
[19] 42 U.S.C.A. § 12102 (2009).
[20] 524 U.S. 206, 210 (1999).
[21] *See, e.g., Kiman v. N.H. Dep't of Corr.*, 451 F.3d 274, 287 (1st Cir. 2006) (it is well settled that medical care in prisons is one of the "services, programs, or activities" covered by the ADA).
[22] *Legal Action Center* at 9-10.
[23] *MX Group, Inc. v. City of Covington*, 293 F.3d 326, 337 (6th Cir. 2002).
[24] "Know your rights: Rights for individuals on medication-assisted treatment," *U.S. Department of Health and Human Services*, http://atforum.com/documents/Know_Your_Rights_Brochure_0110.pdf, last accessed December 12, 2019.
[25] *MX Group, Inc. v. City of Covington*, 293 F.3d 326, 339 (6th Cir. 2002).
[26] *Ibid.*
[27] *Ibid.* at 340.
[28] *Legal Action Center* at 4.
[29] *McNamara v. Lantz*, 2008 WL 4277790, 6 (D. Conn. 2008).
[30] *Pesce v. Coppinger*, 355 F. Supp.3d 35, 39 (D. Mass. 2018).
[31] *Ibid.*
[32] *Ibid.* at 42.
[33] *Ibid.*
[34] *Ibid.* at 45.
[35] *Ibid.* at 46.
[36] *Ibid.* at 47.
[37] *Ibid.*
[38] *Smith v. Aroostook County*, 376 F.Supp.3d 146, 149 (D. Me. 2019).
[39] *Ibid.* at 153.
[40] *Ibid.* at 158.
[41] *Ibid.* at 159.
[42] *Ibid.* at 159-60.
[43] *Ibid.* at 160.
[44] *Ibid.*
[45] *Smith v. Aroostook County*, 922 F.3d 41 (1st Cir. 2019).
[46] *Kortlever et al v. Whatcom County, Washington et al*, Case No. 2:18-cv-00823-JLR (W.D. Wash. 2019).
[47] "Whatcom County Jail to provide medications necessary to treat opioid addiction in landmark settlement proposed in civil rights lawsuit," *ACLU of Washington*, April 30, 2019.
[48] *McNamara*, 2008 WL at 9 (Although the Eighth Amendment does not apply to pretrial detainees, "the due process rights of a pretrial detainee are at least as great as the Eighth Amendment protections" provided to prisoners).
[49] *Nauroth v. Southern Health Partners, Inc.*, 2009 WL 3063404, 9 (S.D. Ohio 2009).
[50] *Pesce*, 355 F.Supp.3d at 47.
[51] *Ibid.*
[52] *Ibid.*
[53] *Ibid.*
[54] *Davis v. Carter*, 452 F.3d 686, 696 (7th Cir. 2006).
[55] *McNamara*, 2008 WL at 10.
[56] *Pesce*, 355 F.Supp.3d at 48.
[57] *Ibid.*
[58] *Nauroth*, 2009 WL at 2.
[59] *Ibid.* at 11.
[60] *Ibid.*
[61] German Lopez, "How America's prisons are fueling the opioid epidemic," *Vox*, March 26, 2018.
[62] *Ibid.*

[63] *Ibid.*
[64] *Ibid.*
[65] *Ibid.*
[66] *Ibid.*
[67] *Ibid.*
[68] *Ibid.*
[69] *Ibid.*
[70] *Ibid.*
[71] *Ibid.*
[72] *Ibid.*
[73] *Ibid.*

ABOUT THE LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

The Legislative Analysis and Public Policy Association (LAPPA) is a 501(c)(3) nonprofit organization whose mission is to conduct legal and legislative research and analysis and draft legislation on effective law and policy in the areas of public safety and health, substance use disorder, and the criminal justice system.

LAPPA produces up-to-the-minute comparative analyses, publications, educational brochures, and other tools ranging from podcasts to model laws and policies that can be used by national, state, and local criminal justice and substance use disorder practitioners who want the latest comprehensive information on law and policy. Examples of topics on which LAPPA has assisted stakeholders include naloxone laws, law enforcement/community engagement, alternatives to incarceration for those with substance use disorder, medication for addiction treatment in correctional settings, and the involuntary commitment of individuals with alcohol or substance use disorder.

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