



A Legal Right to Access to Medications for the Treatment of Opioid Use Disorder in the Criminal Justice System

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The opioid epidemic is a public health crisis. The overabundance of prescription and illicit opioids has caused a tidal wave of deaths, immense human suffering and significant economic impact. Poor access to clinically effective treatments for opioid use disorder (OUD), in particular treatment with medications for opioid use disorder (MOUDs), makes the epidemic worse. One area that can pose a substantial barrier to receiving MOUD is involvement with the criminal justice system. Myriad agencies and organizations—ranging the political gamut from the National Institutes of Health to associations representing prison officials, from the President’s Commission on Combating Drug Addiction and the Opioid Crisis to both houses of Congress—have advocated for expanded access to treatment with MOUDs for justice-involved individuals. Nonetheless, courts, correctional institutions, and agencies setting and enforcing conditions of bail, probation, and parole often deny access to treatment with MOUDs.

The legality of these denials of treatment is very much in question. Incarcerated individuals and others entwined in the criminal justice system who are denied access to treatment with MOUDs can bring suit under both the Eighth Amendment to the Constitution and federal civil rights laws, in particular the Americans with Disabilities Act (ADA) and the Rehabilitation Act. Litigation advancing these arguments is only beginning to work its way through the courts; however, this litigation represents a real opportunity to establish a judicial mandate for access to treatment with MOUDs. Although the most effective legal theory may vary based on the particular set of facts, the Eighth Amendment and federal civil rights laws provide ample opportunity to challenge programs that limit access to treatment with MOUDs.¹ Moreover, state and federal regulators may enforce, and in some instances have enforced, these authorities against actors in the criminal justice system that prevent access to treatment with MOUDs.

In short, actors throughout the criminal justice system—correctional institutions, courts, and other officials and institutions that enforce the terms of bail, probation, or parole—that prevent access to treatment with MOUDs for individuals may be compelled to allow access to MOUD, and at the least will face costly litigation to maintain these prohibitions.

¹ Though there may be state constitutional and statutory provisions guaranteeing access to MOUDs, this memorandum only addresses federal constitutional and statutory arguments.

The Need for Increased Access to MOUDs in the Criminal Justice System

More than 2 million Americans are addicted to opioids.² Since the 1990s, the number of individuals dying from opioid overdose, as well as the number of individuals receiving treatment for addiction, have increased by 400 to 600 percent.³ As of 2016, the Centers for Disease Control and Prevention (CDC) estimated that the economic burden of prescription opioid misuse alone is \$78.5 billion a year, including the costs of healthcare, lost productivity, addiction treatment, and criminal justice involvement.⁴ This figure stands to increase as the opioid epidemic affects more and more Americans.

One particularly troubling aspect of the opioid epidemic is the wave of fatal drug overdoses associated with it. In 2017, about 50,000 Americans died of opioid overdoses, making up nearly two thirds of all fatal overdoses in the U.S.⁵ Opioid overdoses have increased significantly in recent years. The rate of drug overdose deaths involving synthetic opioids (e.g. fentanyl, fentanyl analogs, and tramadol) increased by 88% per year from 2013 to 2016.⁶ Heroin overdose rates increased by 33% per year from 2010 to 2014, and by 19% from 2014 to 2016.⁷ Overdoses are a significant risk for individuals with OUD.

Individuals with OUD interacting with the criminal justice system are at an elevated risk of overdose. Experts assert that the relative abstinence from opioid use while incarcerated diminishes tolerance to the drugs, increasing the risk of overdose.⁸ In particular, individuals released from incarceration face an extremely high risk of overdose, especially in the time immediately after being released; individuals with OUD are three to eight times more likely to die of an overdose in the

two weeks after their release when compared to the following three months.⁹ Moreover, during this initial post-release period, individuals leaving incarceration were 40 to 130 times more likely to die of an opioid overdose than the general population.¹⁰ However, appropriate medical treatment reduces these risks.

Intervention with treatment using MOUDs reduces negative consequences for individuals with OUD when they interact with the criminal justice system. Most notably, treatment with MOUD significantly reduces the elevated risk of overdose in the immediate period after release. For individuals with OUD, treatment with MOUD corresponded to a reduction in the risk of death by 75% for all causes, and 85% for drug overdoses, in the month following their release.¹¹ A recent study of a Rhode Island statewide intervention ensuring continued access to, or initial treatment with, MOUD for incarcerated individuals with OUD found a 60.5% reduction in post-release deaths after implementation of the program.¹² In addition to reducing overdose risk on release, allowing continued access to treatment with MOUD can prevent unnecessary pain and suffering associated with forced withdrawal from these treatments, and avoid the risk of disrupting treatment for individuals with OUD.¹³ Further, research shows that treatment with MOUDs is far more effective at managing OUD than drug counseling without MOUDs.¹⁴

For the reasons above, access to treatment with MOUDs for justice-involved individuals with OUD has been embraced as a best practice by a broad array of organizations, especially with respect to the period of incarceration and immediately prior to

- 2 Ctr. for Behavioral Health Stat. and Quality (CBHSQ), *Results from the 2015 National Survey on Drug Use and Health: Detailed Tables*, SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN. (2016), <https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.pdf>.
- 3 *Opioid Addiction: 2016 Facts & Figures*, AM. SOC'Y OF ADDICTION MED. (ASAM), <https://www.asam.org/docs/default-source/advocacy/opioid-addiction-disease-facts-figures.pdf>.
- 4 Curtis Florence et al., *The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the United States*, 2013, MED CARE at 904 (Oct. 2016), <https://www.ncbi.nlm.nih.gov/pubmed/27623005>.
- 5 Mark R. Jones et al., *A Brief History of the Opioid Epidemic and Strategies for Pain Medicine*, PAIN THER. (Apr. 24, 2018), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5993682/>; *Provisional Counts of Drug Overdose Deaths as of August 6, 2017*, CTR. FOR DISEASE CONTROL & PREVENTION (Aug. 6, 2017), https://www.cdc.gov/nchs/data/health_policy/monthly-drug-overdose-death-estimates.pdf.
- 6 Holly Hedegaard et al., *Drug Overdose Deaths in the United States, 1999-2016*, CTR. FOR DISEASE CONTROL & PREVENTION (Dec. 2017), <https://www.cdc.gov/nchs/products/databriefs/db294.htm>.
- 7 *Id.*
- 8 Ingrid A. Binswanger et al., *Release from Prison – A High Risk of Death for Former Inmates*, NEW ENG. J. OF MED. (Jan. 11, 2007), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836121/>.
- 9 Elizabeth L.C. Merrill et al., *Meta-Analysis Of Drug-Related Deaths Soon After Release From Prison*, 105 ADDICTION REV. 1545, 1549 (June 23, 2010), <https://onlinelibrary.wiley.com/doi/epdf/10.1111/j.1360-0443.2010.02990.x>.
- 10 Binswanger, *supra* note 8; Shabbar Ranapurwala et al., *Former Inmates at High Risk for Opioid Overdose Following Prison Release*, UNC GILLINGS SCHOOL OF GLOBAL PUBLIC HEALTH (July 19, 2018), <https://sph.unc.edu/sph-news/former-inmates-at-high-risk-for-opioid-overdose-following-prison-release/>; *An Assessment of Opioid-Related Overdoses in Massachusetts 2011-2015*, MASS. DEP'T OF PUB. HEALTH (Aug. 2017), <https://www.mass.gov/files/documents/2017/08/31/data-brief-chapter-55-aug-2017.pdf>.
- 11 John Mardsen et al., *Does Exposure To Opioid Substitution Treatment In Prison Reduce The Risk Of Death After Release? A National Prospective Observational Study In England*, ADDICTION (Mar. 1, 2017), <https://www.ncbi.nlm.nih.gov/pubmed/28160345>.
- 12 Traci Green et al., *Postincarceration Fatal Overdoses After Implementing Medications For Addiction Treatment In A Statewide Correctional System*, JAMA PSYCHIATRY (Apr. 1, 2018), <https://www.ncbi.nlm.nih.gov/pubmed/29450443>.
- 13 David Lebowitz, "Proper Subjects for Medical Treatment?" *Addiction, Prison-Based Drug Treatment, and the Eighth Amendment*, 14 DEPAUL J. HEALTH CARE LAW 271, 303 (2012).
- 14 Peter D. Friedman & Robert P. Schwartz, *Just Call It Treatment*, ADDICTION SCI. & CLINICAL PRAC. (2012), <https://ascjournal.biomedcentral.com/track/pdf/10.1186/1940-0640-7-10>; Roger D. Weiss et al., *Adjunctive Counseling During Brief and Extended Buprenorphine-Naloxone Treatment for Prescription Opioid Dependence*, ARCH GEN PSYCHIATRY (Nov. 7, 2011), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3470422/>.

release.¹⁵ However, experience shows that access to treatment with MOUD can be, and often is, limited throughout interaction with the criminal justice system. Before trial, conditions of pre-trial release can prohibit use of MOUDs, or, if an individual is detained before trial, he or she may be prohibited from receiving treatment with MOUDs.¹⁶ When individuals with OUD are incarcerated, they are often denied access to treatment with MOUDs, even as they prepare for release or parole and are at significant risk of overdose. Last, often conditions of parole

and probation prohibit use of MOUDs.¹⁷ Together, these barriers limit access to treatment with MOUD; a 2017 study found that only 4.6% of individuals referred to treatment for OUD from the criminal justice system received treatment with MOUD.¹⁸ These denials of access to treatment with MOUD endanger the lives of individuals with OUD, expose them to unnecessary pain and suffering, and discriminate against them in the operation of the criminal justice system.

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The Questionable Legality of Denial of Access to Treatment MOUDs

In short, the legality of denial of access to treatment with MOUDs for individuals with OUD is in question. Across the country, individuals with OUD, organizations advocating on their behalf, and even the Department of Justice, have begun to challenge policies that deny access to treatment with MOUDs in litigation and enforcement actions.¹⁹ The outcome of these cases is not certain, and different legal theories will apply to the denial of access to treatment with MOUDs at different stages in the criminal justice system. Nonetheless, these suits are not without merit, and courts could easily find a right of access to MOUDs for justice-involved individuals with OUD under either the Constitution or federal civil rights laws.

treatment with MOUDs, correctional institutions fail to provide adequate medical care to individuals with OUD, and thus violate the Eighth Amendment's prohibition on cruel and unusual punishment. Scholars and advocates are increasingly making this argument, noting that as our understanding of the science of addiction evolves, the denial of access to effective and often life-saving treatment amounts to unconstitutional cruelty.²⁰ Although this legal theory may not apply to every interaction with the criminal justice system,²¹ and may face barriers to its success even in situations where it clearly applies, courts could still find that the Eighth Amendment requires access to treatment with MOUDs.

a. Challenges to Denial of Access to Treatment with MOUDs Under the Eighth Amendment

The first potential line of argument is that in denying access to

i. The Eighth Amendment requires prisons and other institutions detaining individuals to provide adequate medical treatment

Courts have been reluctant to use the Eighth Amendment to enforce protections for inmates, noting that “the primary

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- 15 Heino Stover & Andrej Kastelic, *Drug Treatment and Harm Reduction in Prisons*, PRISONS AND HEALTH (Jan. 2014), http://www.euro.who.int/_data/assets/pdf_file/0020/249203/Prisons-and-Health_-14-Drug-treatment-and-harm-reduction-in-prisons.pdf; *Addiction and the Criminal Justice System*, NAT'L INST. OF HEALTH (last updated on June 30, 2018), <https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=22>; PRESIDENT'S COMMISSION ON COMBATING DRUG ADDICTION AND THE OPIOID CRISIS, 72-73 (Nov. 2, 2017), https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf; Press Release, American Correctional Association and American Society of Addiction Medicine Release Joint Policy Statement on Opioid Use Disorder Treatment in the Juvenile System (Mar. 20, 2018), https://www.aca.org/ACA_Prod_IMIS/DOCS/ACA-ASAM%20Press%20Release%20and%20Joint%20Policy%20Statement%203.20.18.pdf.
- 16 See Redonna K. Chandler et al., *Treating Drug Abuse and Addiction in the Criminal Justice System: Improving Public Health and Safety*, 301 JAMA (Jan. 14, 2009), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2681083/>; Peter Friedmann et al., *Medication-Assisted Treatment in Criminal Justice Agencies Affiliated with the Criminal Justice-Drug Abuse Treatment Studies (CJ-DATS): Availability, Barriers & Intentions*, 33 SUBSTANCE ABUSE (2012) at 9, 12; LEGAL ACTION CTR., *Legality of Denying Access to Medication Assisted Treatment in the Criminal Justice System* at 3-5 (2011), https://lac.org/wp-content/uploads/2014/12/MAT_Report_FINAL_12-1-2011.pdf.
- 17 See Friedmann *supra* note 16 at 9, 12; Timothy Williams, *Opioid Users Are Filling Jails. Why Don't Jails Treat Them?* N.Y. TIMES, Aug. 4, 2017, <https://www.nytimes.com/2017/08/04/us/heroin-addiction-jails-methadone-suboxone-treatment.html>; *A Better Way to Treat Addiction in Jail*, THE MARSHALL PROJECT (Mar. 1, 2017), <https://www.themarshallproject.org/2017/03/01/a-better-way-to-treat-addiction-in-jail>.
- 18 See Noa Krawczyk et al., *Only One In Twenty Justice-Referred Adults In Specialty Treatment For Opioid Use Receive Methadone Or Buprenorphine*, 36 HEALTH AFF. 2046, 2046 (2017).
- 19 See Compl., Smith v. Fitzpatrick, No. 1:18-cv-288-NT, 2018 U.S. Dist. LEXIS 168950 at *1-3 (D. Me. Oct. 1, 2018); Compl., Kortlever v. Whatcom County, No. 2:18-cv-00823 at *11 (W.D. Wash. June 6, 2018); Watson v. Kentucky, No. 7:15-cv-00021-ART EBA, 2015 WL 4080062 at *2 (E.D. Ky. July 6, 2015); Settlement Agreement between the United States and Charlwell Operating, LLC, USAO No. 2018-cv-00025, DOJ No. 202-36-306 (signed May 2018), https://www.ada.gov/charlwell_sa.html; Letter from U.S. Department of Justice to New York State Office of the Attorney General (Oct. 3, 2017), <https://lac.org/wp-content/uploads/2018/02/DOJ-SDNY-ltr-to-OCA-10.3.17.pdf>.
- 20 Michael Linden et al., *Prisoners as Patients: The Opioid Epidemic, Medication-Assisted Treatment, and the Eighth Amendment*, 46 J. OF LAW, MED. & ETHICS 252, 253 (July 17, 2018), <https://doi.org/10.1177/1073110518782926>; Lebowitz, *supra* note 13 at 294.
- 21 For example, the requirement to provide adequate medical care does not clearly apply to conditions of probation, parole, or pre-trial release, where the individuals are not incarcerated. Nonetheless, litigants may be able to challenge these restrictions under the Eighth Amendment under proportionality grounds, or under the Eighth Amendment's prohibition on excessive bail.

concern of the drafters was to proscribe tortures and other barbarous methods of punishment.”²² Nonetheless, the Supreme Court has held that the Eighth Amendment requires prisons to provide adequate medical treatment to incarcerated individuals, and has applied this requirement to state facilities through the Fourteenth Amendment.²³ Further, although not explicitly covered by the Eighth Amendment, pre-trial detainees are entitled to similar protections.²⁴ For a prisoner to bring a claim of inadequate medical treatment, they “must allege acts or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs.”²⁵ The Supreme Court has noted that only “indifference that can offend evolving standards of decency” violates the Eighth Amendment.²⁶

Many circuit courts have followed the Eleventh Circuit in defining deliberate indifference to include a decision to take an easier but less efficacious course of treatment or provision of medical care that is so cursory as to amount to no treatment at all.²⁷ Circuit and district courts differ however in how they apply this definition. Courts often avoid questioning the professional judgment of a doctor in pursuing a particular treatment.²⁸ Courts have, in some instances, extended this reluctance to questioning a physician’s choice of a particular medication, even if that choice fell below the standard of care.²⁹ On the other hand, where lack of treatment or the decision to apply less aggressive treatment fails not just the relevant standard of care but has some further indicia of indifference, courts have entertained Eighth Amendment challenges.³⁰ Moreover, courts have held that, in “institutional level challenges to prison health care, systemic deficiencies can provide the basis for a finding of deliberate indifference.”³¹

ii. Access to treatment for OUD is a serious medical need

Although the circuit courts have implemented various different definitions of “serious medical needs,” these definitions typically extend to psychiatric disorders in general and treatment for OUD in particular.³² The touchstone is analysis of whether

failing to address an issue presents a serious risk of harm to the individual.³³

By that standard, access to treatment for OUD is clearly a serious medical need. For individuals with OUD not currently receiving treatment with MOUDs, access to treatment with MOUD can significantly reduce their elevated risk of overdose.³⁴ Moreover, treatment with MOUDs also reduces the risk of other accidental deaths and exposure to infectious diseases.³⁵ For patients currently receiving treatment with MOUDs, in addition to the benefits provided by proper treatment, continued access to treatment with MOUD allows them to avoid forced withdrawal from MOUD and the significant pain associated with it. Taken together, access to treatment with MOUD is clearly a serious medical need.

iii. Failing to provide access to treatment with MOUDs can demonstrate deliberate indifference that is outside evolving standards of decency

Failing to provide access to treatment with MOUDs to incarcerated individuals with OUD provides these individuals with a strong argument of deliberate indifference in violation of the Eighth Amendment. Failing to provide access to this treatment endangers the health of individuals with OUD. As discussed above, providing access to treatment with MOUDs significantly reduces a risk of harm for individuals with OUD and removing access to MOUDs mid-treatment can cause significant and unnecessary pain. Beyond simply failing to provide access to treatment with MOUDs in individual cases, systemic unwillingness to provide access to these therapies, identified as best practice, can be used to show the deliberate indifference of this behavior. Although this argument is somewhat complicated by the distant nature of harm avoided by treatment with MOUDs, the Supreme Court has held that future harm from current behavior is appropriately reviewable under the Eighth Amendment and that “a remedy for unsafe conditions need not await a tragic event.”³⁶ The same logic that finds failing to

22 *Estelle v. Gamble*, 429 U.S. 97, 102 (1976).

23 *Id.* at 103; *Wilson v. Seiter*, 501 U.S. 294, 296–97 (1991).

24 *City of Revere v. Massachusetts Gen. Hosp.*, 463 U.S. 239, 244 (1983) (holding that the due process rights of a pretrial detainee are at least as great as the Eighth Amendment protections available to a convicted prisoner).

25 *Estelle*, 429 U.S. at 106 (1976).

26 *Id.*

27 See *Tenon v. Dreibelbis*, 606 Fed. Appx. 681, 686 (3rd Cir. 2015); *King v. United States*, 536 Fed. Appx. 358, 362 (4th Cir. 2013); *McCarthy v. Place*, 313 Fed. Appx. 810, 814 (6th Cir. 2008); *McElligott v. Foley*, 182 F.3d 1248, 1255 (11th Cir. 1999); but see *Brown v. Bolin*, 500 Fed. Appx. 309, 313 (5th Cir. 2012) (declining to apply the *McElligott* standard for deliberate indifference).

28 See *Bass v. Sullivan*, 550 F.2d 229, 231–32 (5th Cir. 1977), cert. denied, 434 U.S. 864 (1977); *Westlake v. Lucas*, 537 F.2d 857, 860 n. 5 (1st Cir. 1981); *Ramos v. Lamm*, 639 F.2d 559, 575 (10th Cir. 1980); *Hamm v. DeKalb County*, 774 F.2d 1567, 1575 (11th Cir. 1985).

29 See, e.g., *Jones v. Bradshaw*, No. 17-CIV-80266, 2017 U.S. Dist. LEXIS 46829, *27 (S.D. Fla. Mar. 28, 2017); *Tarver v. McLaughlin*, No. 5:14-CV-214, 2017 U.S. Dist. LEXIS 129737, *8–*10 (M.D. Ga. July 18, 2017).

30 See, e.g., *Pesce v. Coppinger*, No. 18-11972-DJC, 2018 WL 6171881, *7 (D. Mass. Nov. 26, 2018) (noting that a jail’s decision that “ignores and contradicts [a] physician’s [individualized] recommendations” could rise to the level of deliberate indifference); *Tarver v. McLaughlin*, No. 5:14-CV-214, 2017 U.S. Dist. LEXIS 129737, *8–*10 (M.D. Ga. July 18, 2017).

31 *Rogers v. Evans*, 792 F.2d 1052, 1058–1059 (11th Cir. 1986) (citing *Todaro v. Ward*, 565 F.2d 48, 52 (2nd Cir. 1977)); *Ramos v. Lamm*, 639 F.2d 559, 575 (10th Cir. 1980).

32 See *Linden*, *supra* note 20 at 255; *Lebowitz*, *supra* note 13, at 295–99.

33 See *Helling v. McKinney*, 509 U.S. 25, 35 (1993).

34 See discussion at notes 11–12.

35 See discussion at note 13.

36 *Helling*, 509 U.S. at 33 (finding that failure to address theoretical risk of exposure to secondhand smoke could violate the Eighth Amendment and noting that “[w]e have great difficulty agreeing that prison authorities may not be deliberately indifferent to an inmate’s current health problems but may ignore a condition of confinement that is sure or very likely to cause serious illness and needless suffering the next week or month or year.”).

provide access to MOUDs for people with OUD is violative of the Eighth Amendment would also require access to this treatment in pre-trial detention.

Our evolving understanding of the benefits of treatment with MOUDs, especially for individuals on release from incarceration, also underscores this point. Courts have noted that “the constitutional minimum with respect to health care has increased over time” and now covers care that was not widely adopted even in the recent past.³⁷ To the extent that previous cases have found lack of access to treatment with MOUD, in particular methadone maintenance treatment,³⁸ failed to rise to the level of deliberate indifference, as our understanding of the impact of treatment with MOUDs on overdose rates has expanded, the failure to provide access to this treatment more clearly violates our standards of decency. We have come to understand that releasing an individual with OUD from prison without at least access to treatment with MOUDs is like releasing them in the middle of a minefield, significantly increasing their risk of injury or death; failing to take steps to reduce those risks shows deliberate indifference to their medical needs.

Providing only counseling for OUD and/or medications that treat the symptoms of withdrawal are unlikely to meet the obligation to provide adequate medical care. It is true that courts often shy away from second guessing treatment decisions, and are less likely to find a violation of the Eighth Amendment where some care has been provided. However, provision of medical care that is so cursory as to amount to no treatment at all, or care that is an easier but less efficacious course of treatment, can also be found to demonstrate deliberate indifference to an individual’s serious medical needs. Here, neither counseling alone nor medications that treat the symptoms of withdrawal bring about the same reductions in overdose risk or other attendant risks as treatment with MOUDs.

Likewise, completely ignoring a treatment regime prescribed by a physician with a treatment relationship with an individual could rise to the level of deliberate indifference. Individuals respond differently to MOUD treatments and some do not respond to certain treatments at all. Therefore, MOUD treatment is often individualized, and failing to provide that individualized treatment could amount to no treatment at all. Where a physician has prescribed a treatment with a specific

MOUD, the failure to provide that treatment could satisfy the deliberate indifference standard. For example, a federal district court judge in Massachusetts has found that a prison policy that only provided depot naltrexone, instead of allowing continued treatment with methadone as prescribed by the individual’s physician, likely violated the Eighth Amendment.³⁹

iv. Challenges to denial of access to treatment with MOUDs under the Eighth Amendment have a significant likelihood of success

Although courts have shown a reluctance to require a particular type of treatment for justice-involved individuals, litigants can marshal strong arguments that failing to provide access to MOUDs is a form of cruel and unusual punishment prohibited by the Eighth Amendment. This is especially true for individuals who are incarcerated or in pre-trial detention, though may also apply to conditions of parole or other release. Even if courts are unwilling to accept this argument however, or are unwilling to apply it to conditions of release, litigants may also advance challenges under federal civil rights legislation.

B. Challenges to Denial of Access to Treatment with MOUDs Under Federal Civil Rights Laws

In addition to constitutional claims, justice-involved individuals with OUD who are denied access to treatment with MOUDs may also pursue claims under the ADA and the Rehabilitation Act. These laws have a broader application than the Eighth Amendment and more clearly apply to terms of release relating to bail, probation, or parole. Those advocating criminal justice reform have long considered this legal approach to protect individuals with substance use disorders in the criminal justice system.⁴⁰ Since the eruption of the opioid epidemic, litigants have asserted federal civil rights claims in suits seeking to enforce access to treatment with MOUDs for individuals with OUD at various stages of interaction with the criminal justice system.⁴¹ The Department of Justice has also shown a willingness to brandish the ADA to ensure access to treatment with MOUDs, further underscoring the legitimacy of this approach.⁴²

37 *Dunn v. Dunn*, 219 F. Supp. 3d 1100, 1128 n.37 (M.D. Ala. 2016).

38 See *Lebowitz*, *supra* note 13, at 301-305.

39 *Pesce v. Coppinger*, No. 18-11972-DJC, 2018 WL 6171881, *7 (D. Mass Nov. 26, 2018).

40 See, e.g., *LEGAL ACTION CTR.*, *supra* note 16 at 8, 17.

41 See, e.g., *Compl., Smith v. Fitzpatrick*, No. 1:18-cv-288-NT, 2018 U.S. Dist. LEXIS 168950 at *1-3 (D. Me. Oct. 1, 2018); *Compl. and Req. for Emergency Inj., Pesce v. Coppinger*, No. 18-cv-11972, 2018 WL 4492200 at *7-9 (D. Mass Sept. 19, 2018).

42 Settlement Agreement between the U.S. and Charilwell Operating, LLC, USAO No. 2018-cv-00025, DOJ No. 202-36-306 (signed May 2018), https://www.ada.gov/charilwell_sa.html; Letter from U.S. Department of Justice to New York State Office of the Attorney General (Oct. 3, 2017) (<https://iac.org/wp-content/uploads/2018/02/DOJ-SDNY-ltr-to-OCA-10.3.17.pdf>).

i. Federal civil rights laws prohibit discrimination by public entities against individuals with disabilities

Federal law prohibits discrimination against individuals with OUD by actors in the criminal justice system. Specifically, the ADA and the Rehabilitation Act prohibit state and local governments and programs that are federally operated or receive federal assistance from discriminating against individuals with disabilities.⁴³ The Supreme Court has held that the ADA applies in the state prison context.⁴⁴ As a general matter, the substantive standards for determining liability under the Rehabilitation Act and ADA are the same.⁴⁵

Title II of the ADA provides that “no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.”⁴⁶ A qualified individual with a disability is a person who, “with or without reasonable modifications to rules, policies, or practices . . . meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.”⁴⁷ The ADA defines “disability” as a physical or mental impairment that substantially limits one or more major life activities.⁴⁸ People with OUD are individuals with a disability for the purposes of the ADA and Rehabilitation Act, provided that they are not currently using illegal drugs.⁴⁹ Moreover, various actors in the criminal justice setting, from the prisons to courts and others setting parole and bail conditions, are covered by the ADA or the Rehabilitation Act.⁵⁰

ii. Individuals with OUD could argue that denying access to treatment with MOUDs violates the ADA and Rehabilitation Act under a number of legal theories

Individuals denied treatment with MOUDs could pursue any of the three theories of liability under the ADA and Rehabilitation Act—disparate treatment, disparate impact, or failure to provide reasonable accommodation (or modification).

Under a disparate treatment theory, the plaintiff claims that his or her disability actually motivated the defendant’s conduct.⁵¹ Disparate treatment claims under the ADA and Rehabilitation Act are governed by the McDonnell Douglas burden-shifting analysis used to evaluate claims of discrimination under Title VII of the Civil Rights Act of 1964.⁵² The plaintiff has the initial burden to establish a prima facie case of discrimination, then the defendant must provide a legitimate, nondiscriminatory reason for the discriminatory practice, at which point the burden shifts back to the plaintiff to show that the defendant’s legitimate reason is in fact pretext.⁵³

Individuals with OUD denied access to treatment with MOUDs could establish a prima facie case of disparate treatment by showing that they were denied access to adequate medical treatment, i.e. treatment with MOUDs, while other, similarly situated individuals are not denied adequate treatment. Depending on the context, a correctional facility or court could argue that they have a legitimate, non-discriminatory purpose for limiting access to treatment with MOUDs, for example that treatment with MOUDs is too costly or not feasible. However, litigants could counter that such purposes are pretextual, noting that treatment with MOUDs is by no means cost-prohibitive and has been implemented by many correctional facilities and courts.⁵⁴

A plaintiff may also argue that a government policy has a disparate impact on individuals with a disability by having the “effect of subjecting [them] to discrimination on the basis of

43 See Americans with Disabilities Act, 42 U.S.C. § 12132; Rehabilitation, Comprehensive Services, and Developmental Disabilities Act of 1978, 29 U.S.C. § 794.

44 *Pennsylvania Dep’t of Corrections v. Yesky*, 524 U.S. 206, 210 (1999).

45 *Blunt v. Lower Merion Sch. Dist.*, 767 F.3d 247, 275 (3d Cir. 2014); *Kemp v. Holder*, 610 F.3d 231, 234–35 (5th Cir. 2010).

46 42 U.S.C. § 12132.

47 *Id.* § 12131(2).

48 42 U.S.C. § 12102(1).

49 29 C.F.R. § 35.108(b)(2) (defining “physical or mental impairment” to include “drug addiction”); 42 U.S.C. § 12210(a); *Leo Beletsky et al., Fatal Re-Entry: Legal and Programmatic Opportunities to Curb Opioid Overdose Among Individuals Newly Released from Incarceration*, 154 *NE. Law J.* 155, 201 (2015) (citing *MX Group, Inc. v. City of Covington*, 293 F.3d 326, 336 (6th Cir. 2002); *Start, Inc. v. Baltimore Cnty., Md.*, 295 F. Supp. 2d 569, 577 (D. Md. 2003)).

50 See, e.g., *Muhammad v. Ct. of Common Pleas of Allegheny County*, 483 Fed. Appx. 759, 764 (3rd Cir. 2012) (stating that “the plain language of the ADA subjects state courts to liability for violations of the statute.”); *Thompson v. Davis*, 295 F.3d 890, 898 (9th Cir. 2002) (stating that “...the parole board may not categorically exclude a class of disabled people from consideration for parole because of their disabilities,” because parole boards “fall squarely within the statutory definition of ‘public entity.’” (citing *Pennsylvania Dep’t of Corrections v. Yesky*, 524 U.S. 206, 210 (1999))); *Due v. Board of Parole Hearings*, No. CV 18-1028-JAK (E), 2018 WL 3740520, at *3 (C.D. Cal. May, 18, 2018) (observing that parole hearings are subject the ADA); *Cooper v. Mirandy*, No. 5:16cv85, slip op. at 9 (N.D. W. Va. Feb. 1, 2018) (stating that “[t]he ADA applies to state prisons and parole decisions.”); *Prakel v. Indiana*, 100 F. Supp. 3d 661, 681, 682 n. 16 (S.D. Ind. 2015) (finding that a deaf individual had the right to accommodations in order to witness a public trial because “[c]ourts have found a trial to be a service program, or activity within the meaning of [the ADA]”); *Galloway v. Super. Ct. of DC*, 816 F. Supp. 12, 15-19 (D.D.C. 1993) (explaining that public courts and their administrations, including juries, must comply with the ADA); *Crowell v. Mass. Parole Board*, 74 N.E.3d 618, 623 (Mass. 2017) (noting that the “ADA applies to parole proceedings, including substantive decision-making.”); see also *LEGAL ACTION CTR.*, *supra* note 16 at 8-10.

51 See *Raytheon Co. v. Hernandez*, 540 U.S. 44, 52-53 (2003).

52 *Id.* at 49-52.

53 *Id.*

54 See *Linden*, *supra* note 20 at 259; see also, *Pesce v. Coppinger*, No. 18-11972-DJC, 2018 WL 6171881, *6-*7 (D. Mass. Nov. 26, 2018) (pointing out that a prison’s argument that methadone could not be safely administered was undermined by the fact that it “is a common practice in institutions across the United States.”).

disability” or by screening out individuals with a disability,⁵⁵ where the policy cannot be justified by necessity.⁵⁶ Individuals with OUD could argue that excluding any individuals receiving treatment with MOUDs from particular programs (e.g. as a condition of parole or bail) would have a disparate impact on individuals with OUD. This would be particularly relevant in circumstances where an institution or actor has a blanket policy against provision of treatment with MOUDs. Public entities could attempt to argue that cost or safety needs necessitate prohibiting treatment with MOUD; however, as noted above, litigants could challenge these arguments with the experience of the myriad institutions currently allowing access to treatment with MOUDs.

Finally, a plaintiff may argue that a public entity has refused to provide a “reasonable modification” to its policies or rules where such modification was needed to provide “meaningful access to a public service.”⁵⁷ However, the public entity need not make modifications that would “fundamentally alter the nature of the service, program, or activity.”⁵⁸ An individual with OUD would argue that by refusing to provide treatment with MOUDs, the institution is failing to accommodate individuals with OUD.

This argument is more likely to succeed when a policy prohibiting access to treatment with MOUDs completely ignores a specific medical recommendation for treatment with a specific MOUD. Individual responses to different MOUD treatments vary widely and some individuals only respond to certain prescribed treatments. A policy that blindly applies only one treatment likely fails to provide meaningful medical care to those individuals who do not respond to that treatment, and thus, does not provide a reasonable modification.⁵⁹

Institutions could counter that affording this modification would fundamentally alter the nature of the service provided, but it seems unlikely that a court would find the provision of medical treatment to do so. Arguments to that extent are rooted in the antiquated belief that treatment with MOUD is substituting one addiction for another, and would not likely be given weight by the courts.

Regardless of the theory of discrimination used, preventing justice-involved individuals from using specific types of MOUD, or limiting them to only therapies for treatment of withdrawal symptoms, is an example of the type of discrimination

prohibited by the ADA and the Rehabilitation Act. As explained above, individuals respond differently to MOUD treatments. Because MOUD treatment should be individualized, failing to provide a range of options could leave individuals without access to reasonable or effective care. Such limited access therefore violates the ADA, absent a strong argument that allowing an individual to access to the MOUD that best works for them is entirely impracticable for safety reasons, or, when examined on an individualized basis, would fundamentally alter the nature of a supervised release program, a facility’s health care system, or a family court.

iii. Challenges to denial of access to treatment with MOUDs under federal civil rights laws have a significant likelihood of success

Even if Eighth Amendment claims are unpersuasive, the ADA and Rehabilitation Act claims provide a strong chance of success for justice-involved individuals with OUD challenging policies that prohibit access to treatment with MOUDs. The application of these federal laws is highly fact-specific; different theories of the violation of these federal civil rights laws will apply to different circumstances. Nonetheless, these laws broadly apply to actors in the criminal justice system, and could be applied to individuals with OUD and thus there are multiple avenues for potentially successful litigation. Moreover, the willingness of the Department of Justice to bring, or threaten to bring, litigation under these civil rights laws underscores the potential liability for actors that limit access to treatment with MOUDs.

C. Individuals with OUD Will Likely Overcome Barriers to Litigation Victories

Individuals with OUD seeking to challenge policies that deny access to treatment with MOUDs using the legal theories discussed above may face barriers to litigation; however, these barriers are not likely to prevent these suits from receiving consideration in court. Potential barriers include selection of plaintiffs and exhaustion of administrative remedies. With respect to plaintiff selection, often potential plaintiffs are only incarcerated for a short period, or are affected by pre-trial limitations that are transient in nature. However,

⁵⁵ 28 C.F.R. § 35.130(b)(3)(i), (8).

⁵⁶ See *Raytheon Co.*, 540 U.S. at 52; 28 C.F.R. § 35.130(h).

⁵⁷ 28 C.F.R. § 35.130(b)(7)(i).

⁵⁸ 28 C.F.R. § 35.130(b)(7)(ii).

⁵⁹ See *Pesce v. Coppinger*, No. 18-11972-DJC, 2018 WL 6171881, *6-7 (D. Mass. Nov. 26, 2018).

courts have been willing to consider class action suits for Eighth Amendment violations, which may obviate plaintiff selection concerns.⁶⁰ Additionally, the Prison Litigation Reform Act (PLRA), which requires inmates to exhaust all available administrative remedies before they may bring a suit in federal court,” may serve as a barrier.⁶¹ However, courts have expressed a willingness to entertain class action suits challenging health care conditions despite this barrier.⁶²

Moreover, the PLRA applies only to federal challenges to prison conditions; it would not limit challenges to conditions of pre-trial release or parole. Taken together, these barriers may complicate litigation of these claims, but will not prevent courts from considering these claims.

THREE

Regardless of The Legal Theory, Individuals with OUD Have Many Strong Avenues to Bring Suits to Expand Access to Treatment with MOUDs

The legality of denial of access to treatment MOUDs to individuals with OUD when incarcerated, or as a condition of parole or other release, is very much in question. Although challenges to these practices have only begun to work their way through the legal system, and face barriers to being adjudicated, courts could well interpret the Constitution and federal law to require access to treatment with MOUD for individuals with OUD throughout the criminal justice

system. As noted above, treatment with MOUDs is broadly seen as the standard of care and has been embraced by a wide-ranging array of decision makers across the political spectrum. Entities continuing to refuse to provide access to this treatment risk falling behind the times, being forced to implement court-mandated reforms, and facing costly litigation from individuals with OUD, advocacy organizations, and the Department of Justice.

⁶⁰ See Linden, *supra* note 20 at 254 (citing *Brown v. Plata*, 563 U.S. 493, 500 (2011)); *Madrid v. Gomez*, 889 F. Supp. 1146, 1210 (N.D. Cal. 1995); *Coleman v. Wilson*, 912 F. Supp. 1282, 1316, 1319 (E.D. Cal. 1995).

⁶¹ See Prison Litigation Reform Act, 42 U.S.C. § 1997e (a).

⁶² See, e.g., *Brown v. Plata*, 563 U.S. 493, 500 (2011).