U.S. Department of Justice

United States Attorney
Southern District of New York

86 Chambers Street
New York, New York 10

October 3, 2017

By First Class Mail
New York State Office of the Attorney General
One Civic Center Plaza, Suite 401
Poughkeepsie, NY 12601

Re: Medication-Assisted Treatment and the ADA

Dear New York State Office of the Attorney General:

It has come to our attention that the Family Court and Surrogate's Court in Sullivan County, New York, as well as the stakeholders involved with those courts, may benefit from further information about the ADA's application to individuals receiving medication-assisted treatment ("MAT"), such as treatment with methadone or buprenorphine, for substance use disorders.

Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12131-34, protects qualified individuals with a disability from discrimination by public entities—including state and local courts—on the basis of their disability. As explained below, a MAT participant will often be a "qualified individual with a disability" under the ADA, either because the person has a current or past history of an opioid use disorder that substantially limits a major life activity, or because the person is regarded as having a disabling impairment by reason of her participation in MAT. If a MAT participant is a qualified individual with a disability, then the ADA prohibits the Sullivan Family Court and Sullivan Surrogate's Court from (1) denying the MAT participant the benefits of their services, programs, or activities; (2) excluding the MAT participant from their services, programs, or activities; or (3) otherwise subjecting the MAT participant to discrimination, by reason of her disability. *See* 28 C.F.R. § 35.130. For example, a court generally could not deny a parent visitation with her child by reason of the parent's past history of opioid use disorder or current use of MAT. Nor could a court impose a blanket rule requiring parents to stop participating in MAT in order to gain custody of their children.

We recognize that safety concerns are paramount when courts make decisions about the care and custody of children and other vulnerable individuals. Under the ADA, a public entity is not required to allow someone to participate in or benefit from its services or programs if the person poses a "direct threat to the health or safety of others." 28 C.F.R. § 35.139. Thus, in the above example, a court could deny a MAT participant custody or visitation rights if the parent posed a direct threat to her child. Crucially, the ADA requires a public entity to base its assessment of "direct threat" on an individualized evaluation that is grounded in current medical knowledge and the best available objective evidence. *Id.* A court may not conclude that a MAT participant poses a "direct threat" based on generalizations or scientifically unsupported assumptions about MAT or persons who receive MAT for opioid use disorders.

As discussed further below, the Sullivan Family Court and Sullivan Surrogate's Court should ensure that their policies and practices with respect to individuals receiving MAT—including assessments of safety and risk—are consistent with the ADA.

I. Overview of Medication-Assisted Treatment

MAT is a safe and widely accepted strategy for treating opioid use disorders. Individuals who participate in MAT receive FDA-approved medication, often in combination with behavioral health and other social services, to treat opioid dependence.[1] There is broad agreement in the medical and scientific communities that MAT successfully reduces illegal opioid use and enables participants to lead more productive, healthier lives.[2] The federal Substance Abuse and Mental Health Services Administration has highlighted the importance of expanding access to MAT and reducing public stigma against individuals who participate in MAT.[3]

A. Medications Used for MAT

In the United States, three medications are used most commonly to treat opioid use disorders: methadone, buprenorphine, and naltrexone.[4] All are federally approved for use in MAT.[5]

Methadone is a full opioid agonist, which means that it activates the opioid receptors in the brain. Methadone achieves a steady state in a patient's system after about five to seven days. When used properly, methadone suppresses cravings for opioids and prevents withdrawal symptoms. Methadone also blocks the euphoric effects of other opioids. Generally, patients can

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[1] Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration ("SAMHSA"), U.S. Dep't of Health & Human Servs., *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*, Treatment Improvement Protocol (TIP) Series 43, at 2, 113-17 (2005), *available at* https://store.samhsa.gov/shin/content//SMA12-4214/SMA12-4214.pdf (hereinafter "TIP Series 43"); *see* 42 C.F.R. § 8.2 (defining medication-assisted treatment for purposes of federal regulations).

[2] TIP Series 43, *supra* n.1, at 3-5; Harlan Matusow *et al.*, *Medication Assisted Treatment in US Drug Courts: Results from a Nationwide Survey of Availability, Barriers and Attitudes*, 44 Journal of Substance Abuse Treatment 473 (2013); *Effective Medical Treatment of Opiate Addiction*, NIH Consensus Statement, Nov. 17-19, 1997, at 18-21, 24; Jeannia J. Fu *et al.*, *Forced Withdrawal from Methadone Maintenance Therapy in Criminal Justice Settings: A Critical Treatment Barrier in the United States*, 44 Journal of Substance of Abuse Treatment 502 (2013).

[3] TIP Series 43, *supra* n.1, at 5-10.

[4] U.S. Dep't of Health & Human Services, Office of the Surgeon General, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health* 4-21 (2016), *available at* https://addiction.surgeongeneral.gov/surgeon-generals-report.pdf (hereinafter "Surgeon General's Report").

[5] 42 C.F.R. § 8.12(h); *Naltrexone*, Substance Abuse and Mental Health Services Administration, https://www.samhsa.gov/medication-assisted-treatment/treatment/naltrexone (last visited Aug. 24, 2017).

obtain methadone only at a certified clinic, with the medication administered under a physician's supervision.[6]

Buprenorphine is a partial agonist that may be taken alone or in a form that combines buprenorphine with a substance called naloxone.[7] Like methadone, buprenorphine activates the brain's opioid receptors to reduce cravings and stave off withdrawal symptoms, and when used properly, it does so without causing a "high."[8] Unlike methadone, which must be dispensed in a certified clinic, any qualified medical practitioner who meets certain statutory requirements can prescribe buprenorphine. The Comprehensive Addiction and Recovery Act, enacted in 2016, expanded access to buprenorphine by broadening the types of practitioners who can prescribe buprenorphine and the number of patients that each practitioner can treat.[9]

Naltrexone is an opioid antagonist, rather than an agonist. Instead of activating the brain's opioid receptors, it simply blocks the euphoric effects of opioids. Any healthcare provider can administer naltrexone. However, naltrexone is used less commonly than methadone or buprenorphine, in part because patients receiving naltrexone historically have had lower rates of treatment retention than patients receiving methadone or buprenorphine.[10]

B. Guidelines for Administering MAT

MAT must be individualized for each patient.[11] For example, different patients will require different doses of medication for MAT to be effective.[12] The length of time that patients receive MAT will also vary by individual. Experts generally recommend that pregnant women with opioid use disorders receive MAT throughout their pregnancies, because sudden cessation of opioid use or MAT can cause health risks, including premature labor and miscarriage.[13] Some patients may need to take medication to treat their opioid use disorders for years—even

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[6] TIP Series 43, *supra* n.1, at 28, *Methadone*, Substance Abuse and Mental Health Services Administration, https://www.samhsa.gov/medication-assisted-treatment/treatment/methadone (last visited Aug. 24, 2017).

[7] The product marketed as Suboxone is a combination of buprenorphine and naloxone. *What is Suboxone Film?*, https://www.suboxone.com/Treatment/Suboxone-film (last visited Aug. 24, 2017). Naloxone (also known by its brand name, Narcan) is also used to prevent opioid overdose. *Naloxone*, Substance Abuse and Mental Health Services Administration, https://www.samhsa.gov/medication-assisted-treatment/treatment/naloxone (last visited Aug. 24, 2017).

[8] Center for Substance Abuse Treatment, SAMHSA, U.S. Dep't of Health & Human Servs., *The Facts About Buprenorphine for Treatment of Opioid Addiction* 3 (2011), *available at* https://store.samhsa.gov/shin/content/SMA09-4442/SMA09-4442.pdf.

[9] Surgeon General's Report, *supra* n.4, at 4-23.

[10] TIP Series 43, *supra* n.1, at 30-31. An injectable, extended-release version of naltrexone is marketed as Vivitrol. *Naltrexone*, Substance Abuse and Mental Health Services Administration, https://www.samhsa.gov/medication-assisted-treatment/treatment/naltrexone (last visited Aug. 24, 2017).

[11] TIP Series 43, *supra* n.1, at 6, 22; *see* 42 C.F.R. § 8.12(i) (directing individualized consideration of appropriate medication use); NIH Consensus Statement, *supra* n.2, at 16.

[12] TIP Series 43, *supra* n.1, at 123.

[13] U.S. Dep't of Health & Human Servs. and Administration for Children & Families, *A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders* 1-2 (2016).

indefinitely—just as persons with other chronic medical conditions, like diabetes, may need to take medication regularly throughout their lives.[14]

C. Stigma Against MAT

Despite the broad support for MAT among medical and substance use experts, individuals participating in MAT are often subjected to public stigma.[15] This stigma arises, in part, from common misunderstandings about MAT. For instance, it is sometimes believed that taking methadone or buprenorphine (or buprenorphine combination products, like Suboxone) simply "replaces one addiction with another."[16] In fact, when methadone and buprenorphine are used as prescribed, they do not produce a "high," and instead block the euphoric effects of illegal opiates.[17] Another frequent misperception is that individuals should use MAT only as a short-term tool to transition from opioid dependence to opioid abstinence.[18] But as discussed above, different patients will require treatment with MAT for different periods of time. Indeed, research suggests that patients who participate in MAT for at least one year have better treatment outcomes, including less illegal substance use and less involvement in the criminal justice system.[19] By contrast, individuals who are forced to withdraw early from MAT are more likely to relapse.[20] If a public entity were to make decisions about MAT participants based on these misperceptions, those decisions would therefore be unsupportable.

II. The ADA Protects from Discrimination MAT Participants Who Are Qualified Individuals with a Disability

Under Title II of the ADA, the Sullivan Family Court and Sullivan Surrogate's Court may not exclude qualified persons with disabilities from participation in, or deny such persons the benefits of, the courts' services, programs, or activities, by reason of disability.[21] Nor may the Sullivan Family Court and Sullivan Surrogate's Court otherwise discriminate against such persons by reason of their disability.[22] Further, the Sullivan Family Court and Sullivan

[14] TIP Series 43, *supra* n.1, at 113-117 (describing recommended treatment protocol involving multiple phases and possibly years of treatment, and recommending that tapering off of medication entirely be considered an "optional" part of this protocol); SAMHSA, U.S. Dep't of Health & Human Servs., *Federal Guidelines for Opioid Treatment Programs* 52 (2015) ("Medication-assisted treatment should continue as long as the patient desires and derives benefit from treatment. There should be no fixed length time in treatment. For some patients, indefinite medication-assisted treatment may be clinically indicated."); NIH Consensus Statement, *supra* n.2, at 16; *see* 42 C.F.R. § 8.12(i)(3)(iv)-(v) (regulations contemplate that some patients will be maintained on MAT for one to two years or more).
[15] Matusow *et al.*, *supra* note 2; William L. White, *Long-Term Strategies to Reduce the Stigma Attached to Addiction, Treatment, and Recovery within the City of Philadelphia (with Particular Reference to Medication-Assisted Treatment/Recovery)* (2009).
[16] TIP Series 43, *supra* n.1, at 8; White, *supra* n.16, at 29.
[17] White, *supra* n.16, at 38; *Effective Treatments for Opioid Addiction*, National Institute on Drug Abuse, https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction/effective-treatments-opioid-addiction (last visited Aug. 24, 2017).
[18] White, *supra* n.16, at 34-35.
[19] TIP Series 43, *supra* n.1, at 122; Matusow et al., *supra* note 2.
[20] Fu, *supra* n.2, at 502.
[21] 42 U.S.C. § 12132.
[22] *Id.*

Surrogate's Court generally must make reasonable modifications to their policies, practices, and procedures when such modifications are necessary to avoid discriminating against a qualified individual with a disability.[23] Depending on their individual circumstances, patients receiving MAT may qualify for protection under the ADA. As a result, the Sullivan Family Court and Sullivan Surrogate's Court should ensure that their policies and practices with respect to individuals participating in MAT are consistent with ADA requirements.

A. Title II's Application to Sullivan Family Court & Sullivan Surrogate's Court

Title II of the ADA bars discrimination by "public entities" against any qualified individual with a disability.[24] "Public entity" is defined broadly to include state and local governments, as well as "any department, agency, special purpose district, or other instrumentality" of a state or local government.[25] Title II thus applies to state and local courts.[26]

The range of "services, programs, or activities" covered by Title II is similarly broad and reaches all state and local government activities, including areas that traditionally are under local control.[27] Of particular note here, the U.S. Department of Justice and U.S. Department of Health and Human Services have issued guidance explaining that the ADA applies throughout child welfare proceedings.[28]

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[23] 28 C.F.R. § 35.130(b)(7). A public entity is not required to make a reasonable modification to its policies, practices, or procedures if the public entity can show that making those modifications would "fundamentally alter" the nature of its services, programs, or activities. *Id.* Also, a public entity is not required to reasonably modify its policies, practices, or procedures for individuals who meet the ADA's definition of disability solely because they are "regarded as" having a disability. 42 U.S.C. § 12201(h).
[24] *Id.*
[25] *Id.* § 12131.
[26] *See, e.g., Galloway v. Superior Court of D.C.*, 816 F. Supp. 12, 19 (D.D.C. 1993); *see also Tennessee v. Lane*, 541 U.S. 509, 527, 531 (2004) (noting that Congress learned of "numerous examples of the exclusion of persons with disabilities from state judicial services and programs" before passing the ADA, and holding that Title II "unquestionably is valid § 5 [of the Fourteenth Amendment] legislation as it applies to the class of cases implicating the accessibility of judicial services").
[27] *See Thompson v. Davis*, 295 F.3d 890, 899 (9th Cir. 2002) (applying Title II to the decisions of parole boards); *Bay Area Addiction Research & Treatment, Inc. v. City of Antioch*, 179 F.3d 725, 732 (9th Cir. 1999) (applying Title II to zoning decisions, a "traditionally local activity," and noting that Title II "should not be construed to allow the creation of spheres in which public entities may discriminate on the basis of an individual's disability") (hereinafter "*BAART*"); *Innovative Health Systems, Inc. v. City of White Plains*, 117 F.3d 37, 44-46 (2d Cir. 1997), *superseded on other grounds as recognized in Zervos v. Verizon N.Y. Inc.*, 252 F.3d 163, 171 n.7 (2d Cir. 2001) (citing the House Committee on Education and Labor's statement that "Title II of the [ADA] makes *all activities of State and local governments* subject to . . . prohibitions against discrimination").
[28] U.S. Dep't of Health & Human Services and U.S. Dep't of Justice, *Protecting the Rights of Parents and Prospective Parents with Disabilities: Technical Assistance for State and Local Child Welfare Agencies and Courts under Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act* (2015).

B. MAT Participants as Individuals with a Disability

A person is an "individual with a disability" under the ADA if the person (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 regarded as having such an impairment.[29] "Major life activities" include working and caring for oneself.[30]

Addiction to drugs—defined as addiction to controlled substances listed in the Controlled Substances Act[31]—is a "physical or mental impairment" under the ADA.[32] Thus, MAT participants may qualify as "individuals with a disability" in one of several ways. First, if a person receiving MAT is addicted to controlled substances, and that addiction when active substantially limits one or more major life activities, the person is an "individual with a disability" under the ADA. The person still meets the statute's requirements if methadone or buprenorphine ameliorates the addiction such that it does not substantially limit any major life activity while the person is taking the medication.[33]

Second, MAT participants usually have a "record of" a physical or mental impairment, because they have a history of addiction to controlled substances.[34] For example, under federal regulations, in order to receive MAT in an opioid treatment program for longer than 21 days, a person generally must have become addicted to opiates at least one year earlier.[35] If the person's past addiction substantially limited a major life activity, then the person is an "individual with a disability" under the ADA.[36] Multiple federal courts have concluded that the ADA protects persons receiving MAT because they have a "record of" an addiction that substantially limited a major life activity.[37]

Finally, persons receiving MAT may qualify as "individuals with a disability" because they are "regarded as" having a physical or mental impairment that substantially limits a major life activity. A person is "regarded as" having an impairment that substantially limits a major life activity if the person is treated by a public entity as having such an impairment.[38] This may be the case, for example, if a public entity treats MAT participants as being addicted to drugs due

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[29] 42 U.S.C. § 12102(1).
[30] *Id.* § 12102(2).
[31] *Id.* § 12210(d)(2).
[32] 28 C.F.R. § 35.104.
[33] 42 U.S.C. § 12102(4)(E)(i) ("The determination of whether an impairment substantially limits a major life activity shall be made without regard to the ameliorative effects of mitigating measures such as . . . medication."); *cf. Karatzas v. Herricks Union Free Sch. Dist.*, No. 15-CV-2888 (ADS) (AKT), 2017 WL 3084409, at *14 (E.D.N.Y. July 18, 2017) ("[T]he degree to which the Plaintiff is able to effectively control his epilepsy with medication may not be considered in determining whether he is disabled under the statute.").
[34] 42 U.S.C. § 12102(1)(B); 28 C.F.R. § 35.104.
[35] 42 C.F.R. § 8.12(e)(1); *see also id.* § 8.2 (defining "maintenance treatment").
[36] *See, e.g.*, *MX Group, Inc. v. City of Covington*, 293 F.3d 326, 339-40 (6th Cir. 2002).
[37] *See, e.g.*, *Thompson*, 295 F.3d at 896; *MX Group*, 293 F.3d at 339-40; *A Helping Hand, L.L.C. v. Baltimore County*, No. Civ. A. CBB-02-2568, 2005 WL 2453062, at *13 (D. Md. Sept. 30, 2005).
[38] 42 U.S.C. § 12102(3); 28 C.F.R. § 35.104.

to a mistaken belief that the ongoing use of methadone or buprenorphine is itself an "addiction" that significantly impairs MAT participants' ability to carry out major life activities.[39]

The ADA excludes from its protection individuals who are "currently engaging in the illegal use of drugs, when the covered entity acts on the basis of such use."[40] However, while methadone and buprenorphine are controlled substances, and therefore fall within the ADA's definition of "drugs," MAT participants are not engaging in "illegal" drug use if they are receiving methadone or buprenorphine pursuant to a valid prescription. Under the ADA, an individual's use of controlled substances is not an "illegal use of drugs" if the person takes those substances "under supervision by a licensed health care professional" or for "other uses authorized by the Controlled Substances Act or other provisions of Federal law."[41] Further, the ADA makes clear that the carve-out for current illegal drug use should not be construed as applying to individuals who are no longer using illegal drugs and who (1) have successfully completed drug rehabilitation, (2) are participating in a supervised rehabilitation program, or (3) are erroneously regarded as currently using illegal drugs.[42] Thus, MAT participants who are not using other controlled substances illegally are not excluded from the ADA's protection.

C. Preventing Discrimination Against Qualified MAT Participants

To receive protection under Title II, an individual with a disability must be a "qualified" individual with a disability. A person is "qualified" if she "meets the essential eligibility requirements for the receipt of services or the participation in [the relevant] programs or activities provided by [the] public entity," either "with or without reasonable modifications . . . , or the provision of auxiliary aids and services."[43] Thus, the Sullivan Family Court and Sullivan Surrogate's Court should ensure that MAT participants who (1) are "individuals with a disability" under any of the analyses laid out above, and (2) meet the essential eligibility requirements for the courts' services, programs, or activities, with or without reasonable modifications, are not excluded from or denied the benefits of those services, programs, or activities, or otherwise subjected to discrimination.

There are numerous ways in which the ADA's protections could be relevant to the Sullivan Family Court's and Sullivan Surrogate's Court's policies and practices regarding MAT. The following examples are by no means exhaustive. First, if a court provides certain services to parents (or prospective parents) seeking custody of a child, then a court may not deny those services to otherwise eligible parents receiving MAT.[44] Thus, for example, a court could not

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[39] *See, e.g.*, *Thompson*, 295 F.3d at 896; *MX Group*, 293 F.3d at 340-41; *A Helping Hand*, 2005 WL 2453062, at *14.
[40] 42 U.S.C. § 12210(a).
[41] *Id.* § 12210(d)(1).
[42] *Id.* § 12210(b).
[43] *Id.* § 12131(2); *see also Thompson*, 295 F.3d at 896 (plaintiffs who pled that they were denied parole based solely on their past drug addiction but were otherwise eligible for parole adequately pled that they were "qualified" individuals with a disability).
[44] *See* 42 U.S.C. § 12132; 28 C.F.R. § 35.130(b)(1)(i) (a public entity may not "[d]eny a qualified individual with a disability the opportunity to participate in or benefit from the [public entity's] aid, benefit, or service").

deny a parent visitation rights by reason of the parent's history of addiction or participation in MAT, if the parent would otherwise be eligible for visitation.[45]

Additionally, under the ADA, a public entity may not impose eligibility criteria that tend to screen out a class of individuals with a disability, unless the public entity can show that those criteria are necessary to the entity's programs or services.[46] Thus, for example, if a court were to impose a blanket rule requiring parents or prospective parents to stop receiving MAT, based on the misperception that MAT merely "substitutes one addiction for another," that rule would violate the ADA, either because it would tend to screen out persons with addictions to opiates whose addictions substantially limited a major life activity, or because it would tend to screen out persons who may be regarded by the court as being impaired due to their use of MAT.[47]

Similarly, a public entity may not use criteria for its programs that have the effect of defeating or substantially impairing the objectives of those programs for individuals with disabilities.[48] Thus, for example, an objective of some family court proceedings is to facilitate reunification between parents and their children. If a parent needs MAT because MAT is the treatment that most effectively enables her to function unimpaired by opiate addiction, then requiring the parent to stop receiving MAT could defeat the goal of reunifying that parent with her children.

D. Risk Assessments Must Be Individualized, Not Based on Generalizations About MAT Participants

Certainly, the ADA allows public entities to take into account legitimate safety concerns in their decision-making. Of particular relevance here, safety concerns will be of the utmost importance when a court makes decisions about the care and custody of children or other vulnerable citizens. Under the ADA, a public entity is not required to permit an individual to participate in or benefit from its services, programs, or activities if the individual poses a "direct threat to the health or safety of others."[49] An individual poses a "direct threat" if he or she presents a significant risk to the health or safety of others, and that risk cannot be eliminated by

[45] *Cf. Beeken v. Fredenburg*, 44 N.Y.S.3d 259, 263 (3d Dep't 2016) (reversing a family court order denying a mother's request for unsupervised visitation, and noting that the "[f]amily [c]ourt's findings— gleaned from its 'many years of experience in "Drug Court"'—as to the implications of the mother's treatment with Suboxone... [we]re not supported by a sound and substantial basis in the record").
[46] 28 C.F.R. § 35.130(b)(8) (a public entity may not "impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any service, program, or activity, unless such criteria can be shown to be necessary for the provision of the service, program, or activity being offered").
[47] Such a rule could also be facially discriminatory under the ADA. *See, e.g., New Directions Treatment Servs. v. City of Reading*, 490 F.3d 293, 305 (3d Cir. 2007) (statute barring the operation of methadone treatment facilities within 500 feet of certain areas unless allowed by a majority vote of the municipality's governing body facially discriminated under the ADA); *BAART*, 179 F.3d at 727-28, 737 (ordinance prohibiting methadone clinics from operating within 500 feet of residential areas was facially discriminatory).
[48] 28 C.F.R. § 35.130(b)(3)(ii).
[49] *Id.* § 35.139(a).

modifying certain policies, practices, or procedures, or by providing the person with auxiliary aids or services.[50]

Crucially, the conclusion that an individual poses a "direct threat" must be based on an individualized assessment of the person, grounded in current medical knowledge or other objective evidence.[51] These requirements reflect the ADA's overarching goal of protecting individuals with disabilities from unfounded generalizations about their disabilities.[52] A public entity should evaluate the nature, duration, and severity of the risk posed, as well as the probability that the harm will actually occur.[53] Additionally, the assessment of whether an individual poses a "direct threat" must be current. The fact that a person previously was found to present some kind of risk does not mean that the person currently poses a risk to the health or safety of others.[54] Analogously, a public entity may impose "legitimate safety requirements" that are necessary to the safe operation of its programs, but those requirements must be based on actual risks, rather than stereotypes or generalizations.[55]

Thus, for instance, public entities may not presume that individuals receiving MAT pose threats to others based on assumptions that MAT participants are likely to relapse to using illegal drugs, are unable to care for themselves or others, or are likely to be associated with crime.[56] If a court determines that a person receiving MAT is not capable of taking care of a child due to a substance use disorder, the court must base that conclusion on the best available objective evidence about that particular person's functioning and substance disorder treatment. Similarly, to the extent information about MAT factors into a court's assessment of "direct threat," the court must base that assessment on current medical knowledge and other objective, credible evidence about MAT.

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[50] *Id.* § 35.104.

[51] *Id.* § 35.139(b); *Wright v. N.Y. State Dep't of Corrections*, 831 F.3d 64, 78 (2d Cir. 2016); *Hargrave v. Vermont*, 340 F.3d 27, 35-36 (2d Cir. 2003).

[52] *MX Group*, 293 F.3d at 340.

[53] 28 C.F.R. § 35.139(b); *Hargrave*, 340 F.3d at 36.

[54] *See Hargrave*, 340 F.3d at 36 (the fact that civilly committed persons were previously determined by the court to pose a risk of harm to themselves was insufficient for the public entity to conclude that the same individuals posed a "direct threat" to the health or safety of others at the time the public entity took the challenged action).

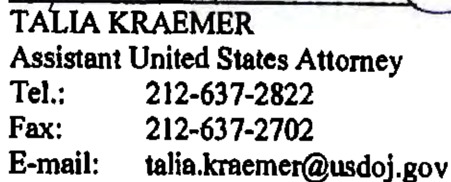
[55] 28 C.F.R. § 35.130(h); *see Leiken v. Squaw Valley Ski Corp.*, No. Civ. S-93-505 (LKK), 1994 WL 494298, at *9-*10 (E.D. Cal. Jun. 28, 1994) (rejecting as discriminatory a resort's rule banning wheelchair users from riding in a cable car, which was based on the resort's "unsupported subjective judgment" rather than "studies or other evidence" that "objectively identified [an] 'actual risk'").

[56] *New Directions Treatment Servs.*, 490 F.3d at 306 (rejecting City's presumptions, unsupported by evidence, that a methadone clinic would be associated with "high crime rates" and "loitering, noise pollution . . . and jaywalking"); *A Helping Hand*, 2005 WL 2453062 at *15 ("[G]eneralities about the criminal behavior of heroin addicts will not satisfy the standard of demonstrating that a methadone clinic is directly associated with severe and likely harms to the community." (internal quotation marks and alterations omitted)); *Bay Area Addiction Research & Treatment, Inc. v. City of Antioch*, No. C98-2651 (SI), 2000 WL 33716782, at *11 (N.D. Cal. Mar. 16, 2000) (rejecting witness evidence expressing concerns about prospective methadone clinic based on "hypothetical or presumed risk[s]").

As federal courts have recognized, it is "particularly important" to ensure that decisions about persons receiving MAT are not based on stereotypes, as "few aspects of a [disability] give rise to the same level of public fear and misapprehension as the challenges facing" persons recovering from substance use disorders.[57] We hope that this letter is of assistance to the Sullivan Family Court and Sullivan Surrogate's Court in ensuring compliance with the ADA.

Sincerely,

JOON H. KIM
Acting United States Attorney for the
Southern District of New York

By: 
TALIA KRAEMER
Assistant United States Attorney
Tel.: 212-637-2822
Fax: 212-637-2702
E-mail: talia.kraemer@usdoj.gov

Enclosures

cc: Hon. Thomas A. Breslin
District Administrative Judge

[57] *BAART*, 179 F.3d at 736.