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Defense Lawyers and the Opioid Epidemic: Advocating for Addiction Medication

Over 115 Americans likely will die today from an overdose involving opioids.¹ The death and destruction caused by the current opioid epidemic has impacted every stage of the criminal justice system. Nearly two-thirds of incarcerated people have substance use disorders, including up to 25 percent with opioid use disorder (OUD),² and drug overdose is the leading cause of death for individuals leaving prisons.³ Courts, probation and parole agencies are also seeing surging numbers of people with OUD.

Defense lawyers can play a critical role in stemming this harm by challenging courts and others who prohibit medication-assisted treatment for people under criminal justice supervision. Doing so will not only help save lives, families and communities, but also will often improve criminal case outcomes.

Medication-assisted treatment (MAT) is the treatment of opioid use disorder with medication, in combination with counseling and behavioral therapies. MAT

stabilizes brain chemistry, blocks the euphoric effects of opioids (the “high”), relieves physiological cravings, and normalizes body functions. Numerous studies have shown that MAT reduces overdoses, drug use, diseases, and criminal activity.⁴ Yet despite the overwhelming medical evidence in support of MAT, courts and probation officials routinely order individuals to stop MAT against their physicians’ recommendations. These practices put people’s recovery and lives at risk. Defense lawyers can help put a stop to them.

This article provides an overview of opioid use disorder and its effective treatment, the ways in which criminal justice agencies prohibit that treatment, the reasons for such practices, why they are harmful, and how they can run afoul of the Americans with Disabilities Act, Rehabilitation Act of 1973, constitutional due process, and State laws. The article also provides straightforward steps defense lawyers can take to advocate for their clients’ access to MAT and offers the Legal Action Center’s support in that process.

What Is Medication-Assisted Treatment?

Medication-assisted treatment involves the treatment of opioid use disorder with medication in combination with counseling and behavioral therapies. The three FDA-approved medications are methadone, buprenorphine (which most commonly has the brand name Suboxone®), and long-acting injectable naltrexone (brand name Vivitrol®).

Methadone. Methadone has been used to treat opioid use disorder since the mid-1960s and is one of the most highly researched treatments for substance

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use disorders.⁵ Methadone is a synthetic opioid that attaches to the brain's opioid receptors and blocks the euphoric effect of other opioids, such as heroin, morphine, and oxycodone, so that the person does not get "high." Methadone also lessens the painful symptoms of opiate withdrawal.⁶ Methadone to treat addiction can only be dispensed in an opioid treatment program (OTP). OTPs are certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) in conformance with 42 C.F.R. Part 8, and are required to provide an array of services, such as drug testing, counseling, and behavioral therapies, in addition to medication. OTPs typically dispense methadone in liquid form as a daily dose taken under observation. As treatment progresses, an individual may earn "take home" privileges that permit taking several days' doses between clinic visits.

Methadone is also available as a prescription for pain, generally as a pill. Most of the methadone used and sold illegally is associated with methadone pills prescribed for pain, and not methadone OTPs dispense for addiction treatment.⁷

Buprenorphine (Suboxone®). Buprenorphine is opioid-based, like methadone. But unlike methadone,

buprenorphine can be dispensed in an OTP or provided by an office-based physician who has completed an eight-hour training or a physician's assistant or nurse practitioner who has completed a 24-hour training. As a result, buprenorphine is available in private doctors' offices, OTPs, and other licensed treatment programs. Buprenorphine is normally taken in a sublingual strip that dissolves in the mouth. A typical prescription is for 30 days, but doctors can give more or less depending on the patient's needs. In 2016, the FDA approved a six-month buprenorphine implant, and in November 2017 it approved a once-monthly buprenorphine injection. Both formulations are available to patients stabilized on buprenorphine.⁸ Because they are implanted or injected, the potential for illicit diversion will be minimized or eliminated.

Naltrexone (Vivitrol®). Naltrexone, like methadone and buprenorphine, attaches to the brain's opioid receptors and blocks other opioids so that individuals cannot experience a high by using opioids. But unlike methadone and buprenorphine, naltrexone is not an opioid. For this reason, it is sometimes favored by criminal justice agencies. Another reason it is preferred by

some criminal justice agencies is that it is usually delivered through a monthly injection by a physician. It can be delivered in many settings, including doctor's offices, opioid treatment programs, and other drug treatment settings. People who are dependent on opioids must stop their drug use at least seven to 10 days prior to starting naltrexone.⁹

Medication-Assisted Treatment Is Highly Effective

Dozens of studies have shown that medication-assisted treatment reduces drug use, disease rates, overdose deaths, and criminal activity among people with opioid use disorder.¹⁰ Research demonstrates that MAT patients experience dramatic improvements while in treatment and for several years following, including decreases in narcotic use, drug dealing, and other criminal behavior as well as increases in marriage and employment.¹¹ One study found a 50 percent reduction in fatal overdoses among people receiving methadone or buprenorphine as part of their treatment.¹² Another showed a 75 percent decrease in illicit opioid use among those receiving buprenorphine and counseling for one year, compared with

Medication	How/Where Administered	Mechanism of Action
Methadone	Oral solution taken daily; provided at OTP	Full mu-opioid agonist — competes with other opioids by suppressing withdrawal symptoms and cravings
Naltrexone extended release (Vivitrol®)	Monthly injection; provided at physician's office, OTP, or other health care setting	Mu-opioid antagonist — blocks the effect of opioids at the receptor sites
Buprenorphine (Subutex®, Probuphine®, Sublocade®)	Sublingual tablet (Subutex®), implant with six-month duration (Probuphine), or monthly injection (Sublocade); provided by physician's office, OTP, or other health care setting	Partial mu-opioid agonist and kappa-opioid antagonist — competes with other opioids by suppressing withdrawal symptoms and cravings
Buprenorphine/naloxone (Suboxone®)	Oral tablet or sublingual film (Suboxone), provided by physician's office, OTP, or other health care setting	Partial mu-opioid agonist and mu-antagonist — competes with other opioids by suppressing withdrawal symptoms and cravings

those who received buprenorphine for only six days, followed by counseling.¹³

MAT's critical benefits for people involved in the criminal justice system are also well established. Numerous studies show MAT reduces drug overdose deaths, recidivism, and infectious disease among criminal justice involved persons.¹⁴ For example, one study showed that people receiving

has fielded calls from people in over 30 states after a judge or probation official ordered them off methadone or buprenorphine. Drug courts often require participants to stop taking addiction medication prior to graduation. Or they set some other arbitrary deadline, for example, to be off buprenorphine in 90 days. Some courts require participants to lower their dose

court, he was enrolled in a methadone program and had finally stopped taking heroin and other illicit opioids. But the judge required Mr. Leipolski to get off methadone as a condition of graduation. The judge held the common mistaken belief that methadone was "substituting one addiction for another." Within six months, Mr. Leipolski relapsed and died of an overdose in the bed of his childhood home.²²

Some people forced off MAT are ultimately incarcerated for long sentences simply because they could not titrate off addiction medication against their doctor's recommendations. Such was the fate of a man who contacted LAC after applying for admission to the Horry and Georgetown County Drug Court in South Carolina. He was being treated with buprenorphine, prohibited under the court's written policy. The court instructed him to stop buprenorphine treatment within three weeks — a timetable with no clinical basis — or be violated from probation and required to serve his full sentence. He tried to taper off but experienced extreme physical withdrawal symptoms, including a seizure that landed him in the emergency room. The doctor placed him back on buprenorphine, which led the judge to terminate him from drug court for violating the no-buprenorphine policy. He was incarcerated and is serving a seven-year sentence — all because he could not comply with the taper requirement.

Stopping MAT is also frequently a condition of probation. As with drug courts, probation officials and judges often set arbitrary timetables for ending MAT or arbitrary dosage limitations. People who cannot successfully comply are violated and incarcerated — usually in facilities that do not provide MAT. For example, an attorney called LAC after a Dayton County, Indiana, probation officer informed his client that she would need to stop her successful buprenorphine treatment as a condition of probation. She had been receiving treatment for almost three years, during which time her urine screens had been negative for illicit drugs. None of this mattered to the probation officer or the judge, who had a prohibition against buprenorphine. The woman was considering opting for a jail sentence where she would withdraw cold turkey from buprenorphine rather than a probation sentence that required tapering off. She feared she would relapse while attempting the taper and receive an even longer sentence.

Imagine a judge ordering an individual to alter the dose of physician-prescribed heart or blood pressure medication. No one would tolerate such conduct.

methadone maintenance treatment with counseling in a Baltimore prison and continuing it upon release reported half the rate of illicit opioid use compared to those who received only counseling.¹⁵ They also were almost three times less likely to spend time in jail or prison.¹⁶ Another study showed that the use of injectable naltrexone in a New York City jail decreased illicit opioid use by more than 50 percent following release.¹⁷

Another study documented that "treatment with [methadone and buprenorphine] is life-extending. ..." Access to buprenorphine was associated with declines in overdose deaths from heroin of more than 50 percent in France and 37 percent in Baltimore, Maryland.¹⁸ There are no scientific studies showing successful treatment of opioid use disorder without medication — a notable fact, considering the widespread opposition to MAT.

Denial of MAT in the Criminal Justice System

MAT is often disallowed at all stages of the criminal justice system. Surveys conducted in 2014 showed that about half the nation's drug courts did not permit methadone and other effective doctor-prescribed medications to treat opioid use disorder.¹⁹ These addiction medications are also prohibited in many probation and parole settings and are largely absent from the nation's jails and prisons.²⁰

Criminal justice agencies deny access to these life-saving medications in several ways. The Legal Action Center (LAC), a nonprofit law and policy organization that seeks to expand access to substance use disorder care,

to a level the judge (not doctor) decides is appropriate. Judges may embrace viewpoints that are belied by scientific evidence. For example, judges may wrongly perceive that a participant is taking "too high" of a dose and suspect (without evidence) that the individual's hidden motive is to get intoxicated. Judges also might mistakenly believe that a person who is not complying with the judge's order to lower his/her dose is not "trying hard enough" or is not committed to living "drug free." Some drug courts do not enroll people on MAT in the first instance, or they give them an arbitrary time period to taper off as a condition of enrollment. Others insist that individuals change their MAT medication (for example, change from methadone to injectable naltrexone). In a growing trend, some drug courts require people to begin treatment with injectable naltrexone and do not permit methadone or buprenorphine.²¹

Drug courts that engage in these practices generally do so in contravention of the prescribing physician's recommendation. The prescribing physician often has submitted a letter detailing the dangers of stopping treatment with these medications and the rationale for their use. But many judges ignore physician recommendations and assert their own view of how to treat opioid use disorder — views that have zero evidentiary basis.

MAT prohibition in drug court causes tremendous harm to individuals directly affected as well as their families and communities. At age 28, Robert Leipolski sought to enroll in a drug treatment court in Nassau County, New York, following an old drug arrest. At the time of his admission to drug

The tide is beginning to shift toward more acceptance of MAT. In 2015, the U.S. Department of Justice's Bureau of Justice Assistance and Substance Abuse and Mental Health Administration began requiring all drug courts receiving federal money to permit MAT. Even though most drug courts are not federally funded, LAC has received anecdotal information that many drug courts have heard the message that they may not prohibit MAT. MAT is also inching its way into jails and prisons, but is still prohibited in the vast majority of them,²³ with some exceptions for pregnant women.

All criminal justice agencies need to embrace MAT as an essential tool in fighting the opioid epidemic and crime. Until they do so, policies that block access to MAT will continue to increase the likelihood of relapse to illicit opioid use, criminal conduct, and death.

Rebutting Common Myths About Medication-Assisted Treatment

Criminal justice officials often prohibit MAT because they do not understand the science of opioid use disorder and its effective treatment. Some hold beliefs that addiction treatment should never involve medication, even though scientific research unequivocally establishes the efficacy of MAT. Some also have concerns about illicit diversion of methadone and buprenorphine. Each of these issues is addressed below.

MAT does not 'substitute one addiction for another.'

Some people believe that because methadone and buprenorphine are opioid-based, people who use them are substituting one addiction for another and that individuals receiving addiction medication are not really in recovery. This perception, however, flies in the face of overwhelming scientific evidence and the opinions of virtually all public health authorities.²⁴

Methadone and buprenorphine are opioids, but they are fundamentally different from short-acting opioids such as heroin and prescription painkillers. The latter travel directly to the brain and narcotize the individual, causing sedation and the euphoria known as a "high." In contrast, methadone and buprenorphine, when properly prescribed and utilized, reduce drug cravings and prevent relapse without causing a "high." They

help patients disengage from drug seeking and related criminal behavior and become more receptive to behavioral treatments.²⁵

The physical dependence associated with methadone and buprenorphine is markedly distinct from addiction. Individuals who are physically dependent on these medications experience withdrawal if they stop taking them. They must taper off under careful medical supervision to avoid dangerous medical complications, including life-threatening relapses.²⁶ Addiction, on the other hand, involves the compulsive use of a substance despite harmful consequences and is characterized by cravings (overwhelming desire to use) and loss of control. Individuals who are stabilized at the right dose of methadone or buprenorphine do not have cravings and do not use these substances compulsively. Neither does their use result in harmful consequences. To the contrary, the medications allow them to focus on the productive parts of their lives and engage in counseling, work, and family life.²⁷ As one of LAC's clients noted, "With Suboxone, I take my pill in the morning and then go about my day."

Injectable naltrexone is not opioid-based and does not result in physical dependence. For this reason, criminal justice agencies often prefer it. But MAT medications are not interchangeable; there is no one-size-fits-all approach. Injectable naltrexone should not displace the appropriate use of methadone and buprenorphine because of the misperception that people receiving treatment with them are not truly in recovery.

Dosing is a clinical, individualized decision.

Judges and probation officials often question why someone is taking what they perceive to be a high dose of methadone or buprenorphine. (This issue does not arise with injectable naltrexone, which has a standard dose.²⁸) These beliefs lead judges and other officials to arbitrarily set lower dosages without consulting a medical professional and without any clinical rationale. Imagine a judge ordering an individual to alter the dose of physician-prescribed heart or blood pressure medication, or other treatment prescribed for a chronic medical condition. No one would tolerate such conduct. Yet these directives occur with methadone and buprenorphine on a regular basis.

As with any chronic medical condition, dosing of methadone and buprenorphine requires an individualized medical decision. A certified health care professional determines the appropriate dose of methadone and buprenorphine, in conjunction with the patient, and calibrates the dose to the individual's medical and physiological needs. After individuals are stabilized on the appropriate dose, they may be maintained on that dose for as long as medically necessary, as is the case with other medications for chronic health conditions.²⁹ Most patients require a methadone dose of 60-120 milligrams per day, and buprenorphine patients require a dose of at least 8 milligrams per day; studies show that patients on higher doses stay in treatment longer and use less heroin and other drugs than those on lower doses.³⁰

MAT often is long-term (and that is fine).

There is a widespread misperception in the criminal justice system that MAT — if allowed — should be short term. Some refer to this approach as a "bridge to abstinence" even though people successfully on MAT are "abstinent" from illicit opioid use. Because there is no evidentiary basis for this view, there are wildly different perceptions of what length of time is sufficient. A judge in Sullivan County, New York, told one of LAC's clients that methadone was only permissible for withdrawal, and therefore, she should have ended methadone treatment after 30 to 60 days. He did not seek input from her physician. LAC has heard of other timeframes deemed "long enough" by courts.

Arbitrary timetables are harmful, as there is no one-size-fits-all duration for MAT. The Substance Abuse and Mental Health Services Administration (SAMHSA) recommends three phases: (1) stabilization, which consists of withdrawal management, assessment, medication induction, and counseling; (2) middle phase, consisting of medication maintenance and deeper counseling, and (3) ongoing rehabilitation, when the provider and patient can choose to taper off medication or pursue long-term maintenance, depending on the patient's needs.³¹

Shorter is not necessarily better. The National Institute on Drug Abuse (NIDA) states that some individuals may need addiction medications "indefinitely."³² For methadone maintenance, 12 months of treatment is the minimum, according to NIDA.³³ Studies show that longer term partici-

pation in MAT leads to less illicit drug use and a decrease in overdose deaths.

Forced taper is harmful.

Forced taper — a common practice in the nation’s courts — increases the risk of relapse and deadly overdose because opioid tolerance fades rapidly. It is for this reason that the risk of overdose death the first two weeks after people leave prison (where they had no access to opioids) is 12 times that of other individuals.³⁴ There is never a medical justification for a court or probation official to require someone to taper off MAT against a doctor’s recommendation.

Prohibiting MAT Is Illegal

Policies prohibiting MAT are not only harmful to public health and safety, but also can be illegal. Courts and probation agencies that prohibit MAT can violate the Americans with Disabilities Act, Rehabilitation Act of 1973, constitutional due process, and State laws. While no court has yet ruled on this issue, the U.S. Department of Justice (DOJ) recently began an Opioid Initiative to remove discriminatory barriers to care. The DOJ press office has declined to confirm the initiative, yet DOJ attorneys in the Civil Rights Division have discussed it at conferences, stating publicly that criminal justice policies prohibiting MAT can violate the ADA. In the context of family courts, the acting U.S. attorney for the Southern District of New York wrote a letter to the New York State Office of the Attorney General, explaining why courts that deny parents visitation or custody because they receive MAT may run afoul of the ADA.³⁵ Additionally, the U.S. Attorney’s Office in Boston, Massachusetts, settled a case against a skilled nursing facility in nearby Norwood for refusing to accept a patient because the patient received Suboxone to treat OUD³⁶ and commenced an investigation of the State correctional system for failing to provide MAT in jails and prisons.³⁷ In the private context, there were two pending lawsuits in August 2018 against jails and prisons for failing to provide MAT.³⁸

Below are the legal arguments defense attorneys can put forth. LAC believes they all are meritorious, but should be argued carefully as they could set critical legal precedent. LAC can provide back-up support to attorneys making these arguments.

Americans with Disabilities Act and Rehabilitation Act of 1973

Title II of the Americans with Disabilities Act (Title II or the ADA) prohibits discrimination against qualified

individuals with disabilities, 42 U.S.C. § 12132, and Section 504 of the Rehabilitation Act of 1973 (the RA) prohibits federally operated or funded “programs and activities ... from excluding, denying benefits to, or discriminating against otherwise qualified” individuals with disabilities.³⁹ Together, these two federal laws prohibit discrimination against individuals with disabilities, including persons with opioid use disorder.⁴⁰

To establish a violation of these statutes, someone denied MAT by a court or probation agency would need to show that (a) she or he is a qualified individual with a disability; (b) the act complained of (e.g., probation condition or drug court eligibility/graduation requirement) is subject to the ADA or the RA; and (c) the person is being denied the opportunity to participate in or benefit from the entity’s services, programs, or activities or is otherwise discriminated against because of disability.⁴¹ Individuals denied access to MAT can establish all of these elements.

Opioid use disorder is a recognized disability under Title II and the RA,⁴² and most individuals prohibited from receiving MAT by the criminal justice system are “qualified.” An individual is “qualified” if, “with or without reasonable modifications to rules, policies, or practices,” she or he “meets the essential eligibility requirements for the ... programs or activities provided by the public entity.”⁴³ Individuals denied access to MAT usually meet the “essential eligibility requirements” for drug court, probation, or other alternative sentence because the only requirement they do not meet is the discriminatory requirement to stop MAT. Moreover, the MAT prohibition is not essential to the objectives of these programs. To the contrary, the evidence demonstrates that barring enrollment in MAT or forcing people to taper off MAT against a physician’s recommendation increases the chances of relapse and criminal activity.

It is also well established that courts, probation, and parole, and all their activities and functions are subject to these laws. The ADA and the RA apply to all activities of state and local governments,⁴⁴ and courts regularly apply these statutes to probation, parole, and sentencing decisions.⁴⁵ Prohibiting MAT could constitute discrimination “because of” disability (the final element) under any or all three theories of liability under the

ADA and the RA: disparate treatment, disparate impact, and failure to make a reasonable accommodation.⁴⁶

Disparate treatment. Courts and probation agencies that disqualify opioid-addicted individuals who receive MAT are disqualifying them “because of” disability. Their actions are similar to zoning authorities that single out methadone programs for exclusionary treatment. Numerous federal courts of appeals across the country have concluded that such zoning restrictions constitute disparate treatment discrimination under the ADA.⁴⁷ These categorical exclusions are only justifiable if the persons with disabilities pose a “direct threat” to others. The zoning authorities generally fail to establish “direct threat,” which is a “rigorous objective inquiry” that requires reliance on current medical knowledge or the best available objective evidence, and not subjective speculation.⁴⁸ As with these zoning cases, courts and agencies that prohibit a class of people with a disability — opioid use disorder — from using physician-prescribed medication engage in classic disparate treatment discrimination. MAT prohibitions single out people in need of MAT and deprive them of their medications even though MAT does not create a “direct threat.” To the contrary, it lessens any threat associated with illicit opioid use. (See “Medication-assisted treatment is highly effective” and “Rebutting common myths about MAT,” above.)

Courts that do not prohibit MAT but restrict it in arbitrary ways also discriminate “because of” disability. Title II prohibits public entities from using eligibility criteria that defeat or substantially impair accomplishment of the program’s objectives for individuals with disabilities.⁴⁹ Restrictions on MAT, such as dosage limitations, taper requirements, and allowing only one FDA-approved medication but not others, are discriminatory because they make it harder for individuals to achieve the programs’ objectives of abstinence from illicit drug use and crime.

Disparate impact. Some courts and probation agencies prohibit the use of all prescribed controlled substances, not just those used to treat opioid addiction. Individuals who are denied access to MAT pursuant to these policies may have a claim for “disparate impact” discrimination. Title II regulations prohibit government entities from imposing eligibility criteria “that screen out or tend to

screen out” individuals with disabilities (i.e., have a disparate impact on such individuals) unless the criteria are necessary for the provision of the service, program, or activity offered.⁵⁰ Therefore, even a neutral eligibility criterion for participation in criminal justice programs, such as no use of prescribed controlled substances, violates the ADA and Rehabilitation Act if it “screens out or tends to screen out” opiate-addicted individuals receiving or in need of MAT. Criminal justice agencies could only defeat such a claim by proving that the requirement is necessary for the program or activity. This would be a difficult showing to make for the reasons discussed above (see “Medication-assisted treatment is highly effective”).

Reasonable accommodation. Title II also requires government agencies to make “reasonable modifications” to their policies, practices, or procedures in order to avoid discrimination. This reasonable modification requirement applies unless the modifications would “fundamentally alter the nature of the service, program, or activity.”⁵¹ If drug courts or probation departments deny access to MAT because of a general policy prohibiting treatment with any controlled substance, individuals could demonstrate that the failure to make a reasonable modification of the policy for individuals in need of MAT violates the ADA. Allowing MAT would not require a fundamental alteration of the program.

Constitutional Due Process

Prohibition of MAT can also violate substantive due process protections found in the Fourteenth Amendment of the Constitution, and with respect to the federal government, the Fifth Amendment. The Fourteenth Amendment and some state constitutions recognize the fundamental right of an individual to control his or her medical care. In *Cruzan v. Dir., Mo. Dep’t of Health*, the Supreme Court recognized that “the Due Process Clause protects an interest in life” and in decisions related to medical care.⁵² Similarly, federal appellate courts, such as the Second Circuit, have observed that it “is a firmly established principle of common law of New York that every individual of adult years and sound mind has a right to determine what shall be done with his own body and to control the course of his medical treatment.”⁵³ The Fourteenth Amendment and New York law have thus been invoked to permit a patient to refuse life-saving treatment,⁵⁴ to prevent the

“unwanted administration of antipsychotic drugs,”⁵⁵ and to protect a parent’s right to direct a child’s medical care.⁵⁶ Even though these cases addressed the Fourteenth Amendment, the “substantive due process” elements of the Fifth and Fourteenth Amendments are generally considered to be coextensive.⁵⁷

When courts and probation require individuals to discontinue treatment with MAT, they substitute their own judgment for that of the individuals and their physicians. Under established law, the court may do so only to serve a “compelling” state interest.⁵⁸ Examples of such interests include protection of life,⁵⁹ protection of an unborn child’s life,⁶⁰ prevention of “imminent danger to a patient or others in the immediate vicinity,”⁶¹ “prevention of suicide,” or “protection of minor children.”⁶² No remotely similar compelling interest justifies prohibiting the use of MAT — a treatment widely accepted by the medical and public health communities as the standard of care for treating opioid addiction. To the contrary, prohibiting MAT increases the risk of relapse, overdose and death, and undermines the state’s compelling interests in protecting life and reducing crime.

State Laws

State laws governing probation, parole, drug court, and sentencing may also provide a legal basis for challenging the prohibition of MAT. New York’s Penal Law, for example, requires that conditions on a sentence of probation be, *inter alia*, “reasonably necessary to ensure that the defendant will lead a law-abiding life,” “reasonably related to his rehabilitation,” or “necessary and appropriate to ameliorate the conduct which gave rise to the offense.”⁶³ Requirements to discontinue MAT or change to a different MAT medication against a physician’s recommendations do not meet these standards. Laws governing sentencing often have similar parameters and may be harnessed for challenges to those who prohibit MAT as a condition of a sentence.

How Defense Lawyers Can Advocate for Life-Saving Treatment

Defense lawyers are in a unique position to challenge prohibitions and limitations on MAT. The payoff can be enormous. Accessing MAT enhances the likelihood of clients’ compliance with probation or other court condi-

tions, while also decreasing the likelihood of relapse, overdose, death, and recidivism. The Legal Action Center can provide back-up support to defense attorneys, as it did in two New York cases described below.

As a threshold matter, defense attorneys may need to educate both themselves and the other criminal justice stakeholders about MAT. LAC’s MAT Advocacy Toolkit⁶⁴ contains a host of useful resources, starting with *Attorney’s Guide: Addiction Medication and Your Client and Medication-Assisted Treatment in Drug Courts: Recommended Strategies*. The latter reviews practices in New York drug courts from rural, urban, and suburban areas and mirrors issues faced in all regions of the country. It shares insights from prosecutors, judges, and other treatment team members to help all courts — not just drug courts — successfully incorporate evidence-based treatment for opioid addiction.

Education may not be sufficient in many cases, however, and defense attorneys will need to engage in zealous advocacy. Defense attorneys should object on the record to any orders or conditions that interfere with MAT as recommended by the individual’s treating physician. Dozens of individuals have contacted LAC for help after being ordered to taper off methadone or buprenorphine. In almost no case had their defense attorney objected on the record. This lack of an objection made it difficult for LAC to bring an appeal or otherwise challenge the requirement. Attorneys do not need to make an elaborate argument in conjunction with their objection, and indeed, most defense attorneys will not have the time to learn ADA and constitutional jurisprudence. The attorney can simply state that the requirement violates the ADA (and Rehabilitation Act if the court is federally funded) because the client is an individual with a disability (opioid use disorder), violates constitutional due process, and violates whichever state law is applicable. If the criminal justice agency has a policy prohibiting MAT, the attorney should ask for the “reasonable accommodation” of modifying the policy because of the client’s disability.

In addition to objecting on the record, it is essential to provide competent evidence from the treating provider in support of the client’s use of MAT. LAC’s MAT Advocacy Toolkit⁶⁵ contains a sample letter for treatment

providers. Many providers do not know how to write a letter that will provide sufficient information to support a legal argument and create a strong record on appeal. The sample letter, therefore, is vital. Expert testimony is ideal, but not always necessary. LAC may be able to help defense attorneys procure expert testimony.

Because courts and criminal justice officials deny access to MAT at many different stages of criminal cases, attorneys may need to be creative about the procedural vehicle for challenging MAT prohibitions. The most typical scenario involves a judge requiring someone to taper off methadone or buprenorphine as a condition of probation or drug court graduation/admission. Advocacy options include making a motion to modify the probation condition, seeking appellate review or mandamus, or raising the issue at a return date, but this list is by no means exhaustive.

In 2017, LAC successfully provided back-up support in two cases in which judges had clients taper off buprenorphine as a condition of probation. The first case was in Clinton County, New York — a mostly rural area along the Canadian border. The client contacted LAC after the condition had been imposed without objection from his assigned counsel. The judge gave the client — who had been receiving treatment with buprenorphine for 13 years and never had a positive urine screen for opioids — 90 days to stop. The judge voiced concern that 13 years was too long for treatment with buprenorphine. The client was afraid he would relapse if he tapered, but also knew he would be incarcerated without buprenorphine if he did not.

LAC worked with the New York State Defender Association to locate pro bono counsel to appear in the case; the client was not entitled to assigned counsel until he was being violated. LAC then joined with law firm Paul Weiss Rifkind Wharton & Garrison (Paul Weiss), acting pro bono, to provide back-up support to local pro bono defense counsel.

Authors' Note: The Legal Action Center is ready to help defense attorneys advocate for their clients' addiction medication. For assistance, attorneys may contact Sally Friedman at sfriedman@lac.org or 212-243-1313 or complete LAC's online form at www.lac.org/MAT-advocacy.

Defense counsel moved by order to show cause to modify the probation condition on the ground that it violated the ADA, constitutional due process, and New York's Penal Law provision concerning probation conditions. LAC and Paul Weiss secured affidavits from the client's Suboxone prescriber (modeled after the sample letter in LAC's MAT Advocacy Toolkit) and primary care doctor, as well as from a world renowned addiction expert, who provided his services pro bono. Defense counsel secured a client affidavit and the assistant district attorney's decision not to oppose the motion. At the hearing, the judge asked no questions about the written submission, but later issued a decision revoking the buprenorphine taper requirement. Unfortunately, the judge's decision did not supply any legal analysis that could be cited in other cases.

The second case was in Sullivan County, New York, another rural area, with a judge who had a reputation for prohibiting MAT in all cases. This client had been convicted of DWIs and sentenced to probation. After violating probation due to positive drug screens, the court permitted her to enter residential treatment, where she began successful treatment with buprenorphine. When she contacted LAC, she had been free of illicit drug use for over a year. But when the judge learned that she was being treated with buprenorphine, he ordered her off, saying, "If you're continuing on Suboxone, you're continuing on heroin. Same thing."

Her attorney had submitted letters from her treatment providers in support of continued treatment with buprenorphine and had persuaded the judge to extend the tapering timetable, but the attorney had not formally objected to the taper requirement or argued that it was illegal. The client contacted LAC a short time before her sentencing hearing. She had begun tapering but was struggling. She had a young child and a job, but with the drastically reduced dose, was exhausted, anxious, and suffering from cravings. While on the appropriate dose of buprenorphine, she had felt "normal." Her doctor strongly believed that tapering was putting her health at grave risk. The client herself feared relapse but did not want to risk prison because of noncompliance with the judge's taper requirement.

LAC and Paul Weiss again joined as co-counsel, securing affidavits from her

physician and the same expert witness as well as preparing a submission to the judge in advance of sentencing. The submission outlined why the taper requirement was inconsistent with medical evidence, in violation of the ADA, Rehabilitation Act, constitutional due process and penal law, and inconsistent with the principles of New York's sentencing law. After a short hearing, the judge agreed to permit the client to continue probation while following her doctor's recommendations, though he did not issue a written decision.

In addition to conducting advocacy with the court or criminal justice agency prohibiting MAT, LAC encourages defense attorneys and their clients to file complaints with DOJ's civil rights unit, which is charged with enforcing Title II of the ADA. Through its Opioid Initiative, the Disability Rights Section (DRS) of the Civil Rights Division has been responding to such complaints. DRS is also working with several U.S. Attorney's Offices around the country to engage stakeholders on these issues. A higher volume of complaints could help spur more action. Complaints can be filed at www.ada.gov or with a local U.S. Attorney's Office. The letter sent by the U.S. attorney in the Southern District of New York to the State of New York and DOJ's settlement of a MAT discrimination case against a skilled nursing facility near Boston demonstrate how DOJ can help remove discriminatory denial of MAT.

At bail hearings, defense attorneys also may want to argue that the lack of access to MAT in jails (if applicable) should be an important consideration by the judge when making bail determinations. Someone who is forced to stop MAT in jail not only faces a disruption in treatment, but also has a greatly increased chance of fatal overdose.

Conclusion

The criminal justice system needs to be part of the solution to the opioid epidemic and not a hindrance to vital treatment. Defense attorneys can play a crucial role by advocating that judges and other officials do not block their clients from receiving evidence-based, life-saving medications.

Notes

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38. See *Kortlever v. Whatcom County, Wash.*, 2:18-cv-00823 (W.D.Wash.) and *Smith v. Fitzpatrick, et al.*, 1:18-cv-00288-NT (D. Me.).

39. *McElwee v. Cnty. of Orange*, 700 F.3d 635, 640 (2d Cir. 2012).

40. This article uses the term “opioid use disorder,” the diagnostic term used in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (Copyright 2013) (“DSM-V”). Most case law uses the term “addiction,” which was the term commonly used prior to publication of the DSM-V.

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42. *MX Group, Inc. v. City of Covington*, 293 F.3d 326, 336–42 (6th Cir. 2002); *Bay Area Addiction Research & Treatment, Inc. v. City of Antioch*, No. 98 Civ. 2651, 2000 WL 33716782 at *6–7 (N.D. Cal. Mar. 16, 2000); *START, Inc. v. Baltimore Cnty.*, 295 F. Supp. 2d 569, 576–77 (D. Md. 2003).

43. 28 C.F.R. § 35.104 (2018); see also 42 U.S.C. § 12131(2) (2018).

44. *Innovative Health Sys., Inc. v. City of*

White Plains, 117 F.3d 37, 44–45 (2d Cir. 1997).

45. See, e.g., *Thompson v. Davis*, 295 F.3d 890, 896–97 (9th Cir. 2002) (parole hearings are “public programs or activities” covered by Title II); *Bogovich v. Sandoval*, 189 F.3d 999, 1002 (9th Cir. 1999) (challenges based on arguments that parole decisions violate Title II are appropriate); *Rosen v. Pallito*, No. 13 Civ. 277, 2015 WL 4665628, at *3–4 (D. Vt. Aug. 6, 2015) (plaintiff stated claim for relief under the ADA and the RA with respect to conditions for probation); *Giraldi v. Board of Parole*, No. 04 Civ. 877, 2008 WL 907321, at *5 (N.D.N.Y. Mar. 31 2008) (applying the ADA and the RA to parole decisions); *Robinson v. Hofbauer*, No. 07 Civ. 134, 2008 WL 324217, at *1 (W.D. Mich. Feb. 2, 2008) (agreeing with *Thompson*); *Prater v. Caruso*, No. 05 Civ. 105, 2006 WL 2882350, at *3 (W.D. Mich. Oct. 5, 2006) (ADA and RA are applicable to state parole board decisions); *Ghashiyah v. Wis. Parole Comm’n*, No. 03 Civ. 839, 2006 WL 2690372, at *4 (E.D. Wis. Sept. 19, 2006) (parole board is subject to Title II of the ADA); *Webber v. Pa. Board of Prob. and Parole*, No. 03 Civ. 1600, 2006 WL 581197, at *3 (M.D. Pa. Mar. 8, 2006) (same); *People v. Brathwaite*, 11 Misc.3d 918, 922–24 (Crim. Ct. Kings Cnty. 2006) (applying Title II to a condition on a sentence of conditional discharge).

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48. *New Directions*, 490 F.3d at 305.

49. 28 C.F.R. § 35.130(b)(3)(ii) (2018). In addition, 28 C.F.R. § 35.130(b)(1)(ii) prohibits practices that afford qualified individuals with a disability opportunity to participate “that is not equal to that afforded others,” while 28 C.F.R. § 35.130(b)(1)(iii) prohibits the provision of qualified individuals with a disability with a benefit that is “not as effective in affording equal opportunity to obtain the same result ... as that provided to others.”

50. 28 C.F.R. § 35.130(b)(8) (2018).

51. 28 C.F.R. § 35.130(b)(7).

52. *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 281 (1990).

53. *Kulak v. City of New York*, 88 F.3d 63, 74 (2d Cir. 1996) (citing *Rivers v. Katz*, 67 N.Y.2d 492 (1986)).

54. *Cruzan*, 497 U.S. at 281.

55. *Washington v. Harper*, 494 U.S. 210, 221–22 (1990).

56. *Tenenbaum v. Williams*, 193 F.3d 581, 599 (2d Cir. 1999).

57. See, e.g., *CareToLive v. von Eschenbach*, 525 F. Supp. 2d 952, 963 (S.D. Ohio 2007) (“The Due Process Clause of the Fifth Amendment

... provides heightened protection against government interference with certain fundamental rights and liberty interests.”).

58. *Cruzan*, 497 U.S. at 279; see also *Rivers v. Katz*, 67 N.Y.2d 485, 496 (N.Y. 1986).

59. *Cruzan*, 497 U.S. at 280.

60. *Planned Parenthood of SE Pa.*, 505 U.S. 833, 852 (1992).

61. *Katz*, 67 N.Y.2d at 496.

62. *Matter of Storar*, 52 N.Y.2d 363, 378 (1981).

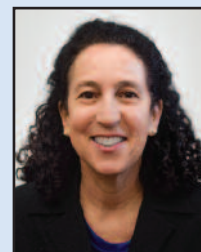
63. See N.Y. PENAL LAW § 65.10.1 (“The conditions of probation ... shall be such as the court ... deems reasonably necessary to ensure that the defendant will lead a law-abiding life. ...”); *id.* § 65.10.2(l) (appropriate probation conditions include “any other conditions reasonably related to [a defendant’s] rehabilitation”); *id.* § 65.10.5 (courts may impose probation conditions “determine[d] to be necessary or appropriate to ameliorate the conduct which gave rise to the offense. ...”).

64. The MAT Advocacy Toolkit is available at www.lac.org/MAT-Advocacy.

65. *Id.* ■

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