July 31, 2023

The Americans with Disabilities Act

Protecting Civil Rights for People with Substance Use Disorders

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Introduction

Now entering its third decade, the overdose crisis claims more than 100,000 lives per year in the U.S., [1] with 106,699 fatal drug-involved overdoses in 2021. [2] Of those deaths, 75% (80,411) were opioid-related, a near four-fold increase of opioid-related deaths since 2010 (21,089). [3] Deep-seated misconceptions about addiction have contributed to these significant increases. However, evidence-based harm reduction tools, including medications for opioid use disorder (MOUD), like methadone and buprenorphine (Suboxone), are available to confront this crisis. [4] But despite MOUD cutting the risk of opioid overdose fatality by approximately 50%, [5] access remains elusive for far too many people. The problem is especially acute for incarcerated persons, of whom 65% have a diagnosable SUD, but merely 5% with opioid use disorder (OUD) have access to medication treatment. [6]

In 2017, then-President Donald Trump declared the opioid crisis a national emergency. [7] His Commission on Combating Drug Addiction and the Opioid Crisis called for expanded MOUD access in jails and prisons, emphasizing that providing OUD treatment to incarcerated people is "correlated with reduced risk of mortality in the weeks following release" and "reduce[s] future public safety and public health costs." [8] Since then, more governmental agencies have shifted their narrative to recognize the need for treatment, rather than criminalization, of people with addiction.

In an effort to reduce overdose deaths, the U.S. Department of Justice (DOJ) recently issued guidance that emphasizes the role of the Americans with Disabilities Act (ADA) in protecting treatment access for people living with addiction, a qualifying disability. [9] The DOJ has demonstrated its commitment to expanding treatment access, including MOUD access, through

multiple enforcement actions and settlements. [10] Nevertheless, many individuals with OUD continue to be denied MOUD or are otherwise discriminated against due to their substance use disorder (SUD) diagnosis, which makes private action urgently necessary. This paper will inform readers about SUD and MOUD, explore the DOJ's related ADA enforcement actions within carceral and other settings, and offer guidance for private litigants to do the same.

Opioid Use Disorder is a Medical Condition for Which MOUD is the Standard of Care

Addiction and substance use disorders are chronic medical conditions. Specifically for people with OUD, MOUD provides an opportunity for recovery. As such, MOUD has become the medical and legal standard of care for people who seek treatment for their OUD. Despite this designation, pervasive stigma limits uptake of these life-saving medications.

Addiction is a Medical Condition

Addiction is a diagnosable medical condition, which often requires treatment, opposed to merely will power, to improve. The American Society of Addiction Medicine defines it as follows:

> Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors... Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death. [11]

Despite a clear medical consensus about addiction as an illness and what remedies exist to treat it, not enough people with OUD have access to treatment for several reasons. One major reason is a lack of understanding and comfort with the evidence-based treatments available.

Medication for Opioid Use Disorder is the Standard of Care

There are three Food and Drug Administration (FDA)-approved medications for OUD: methadone, buprenorphine (including brand names Subutex and Suboxone), and naltrexone (brand name Vivitrol). [12] Methadone and buprenorphine are an opioid agonist and a partial agonist, respectively. They help diminish the effects of physical dependence on opioids, such as withdrawal symptoms and cravings, by activating the same opioid receptors in the brain targeted by prescription or illicit opioids, without producing euphoria. [13] Treatment with methadone or buprenorphine is associated with greater retention in SUD care, lower rates of other opioid use, improved social functioning, decreased injection drug use, reduced HIV and hepatitis C risk and transmission, better quality of life, and less criminality. [14] For example, after Rhode Island implemented MOUD treatment in its carceral facilities, (1) 82.4% of individuals interviewed in the MOUD program continued drug treatment after release, [15] (2) post-release deaths for participants declined by 60%, and (3) statewide overdose deaths fell by over 12% in just the first year of operation. [16] By contrast, studies demonstrating similar efficacy of naltrexone for OUD treatment do not exist. [17] Naltrexone treats OUD by blocking opioid receptors and thereby preventing any opioid from producing rewarding effects such as euphoria or pain relief, but it does not alleviate withdrawal symptoms, which hinders its adherence. [18]

Given the well-established effectiveness of methadone and buprenorphine for OUD, the medical and legal standard of care is unburdened access to long-term methadone and buprenorphine for all patients meeting clinical criteria. Government agencies and professional organizations at the forefront of this crisis have all endorsed the critical need for MOUD, specifically methadone and buprenorphine, in addressing opioid addiction. [19] Law enforcement agencies, including The American Correctional Association, [20] the National Sheriffs' Association, [21] the Bureau of Prisons (BOP), [22] and the DOJ, [23] have also expressed support. In 2021, the federal BOP issued its "Opioid Use Disorder: Diagnosis, Evaluation, and Treatment Clinical Guidance," which directed its correctional facilities to screen and assess people for OUD "throughout their incarceration" and provide MOUD to those who need it. [24] The American Correctional Association, which creates national standards and accredits prisons across the country, states

MOUD access in jails and prisons is a priority, "has a sizeable impact on overdose deaths, recidivism, and opioid use post incarceration," and "represents the best practice for OUD treatment persons inside and outside correctional settings." [25]

Deviation from the standard of care, namely restricted access to MOUD, presents a serious threat to health. Forced withdrawal from MOUD, often occurring upon incarceration, is particularly dangerous. MOUD withdrawal symptoms include severe pain, anxiety, nausea, tremors, vomiting, diarrhea, insomnia, muscle spasms, headaches, delirium, hallucinations, and suicidal ideation. [26] They can start as early as eight hours following the last dose of medication and can last for months or even years after a complete withdrawal from opioids. [27] Rapid, involuntary withdrawal and forced abstinence can push patients from regulated and safe treatment avenues to illicit markets, while simultaneously decreasing opioid tolerance and engagement with healthcare. [28] As a result, many people experience overdoses after release from institutional settings. One study found that within two weeks of release from incarceration, releasees were 129 times more likely to die from an overdose compared to people in the community. [29] Another study found that for opioid dependent inmates, those provided MOUD were 93% less likely to die from preventable death (overdose) within the first four weeks of incarceration compared to those not provided MOUD, and 87% less likely to die from preventable death across all prison time. [30] Another study found that forced withdrawal from methadone during incarceration reduced likelihood of methadone re-engagement post incarceration. [31]

Stigma and Other Barriers Impede Access to MOUD

Despite its proven effectiveness, MOUD remains subject to regulatory, logistical, and social barriers that limit its availability. Only one out of four people with OUD received MOUD in 2019 at large. [32] Uptake is far lower for those who are incarcerated. [33]

Unlike most other medications for chronic conditions, MOUD has heightened restrictions. Obstructive regulatory requirements are most evident in the provision of methadone. Many patients can only access methadone through in-person, daily appointments at licensed opioid treatment facilities and can only receive a limited number of doses. [34] This often requires patients to modify work and child care schedules to accommodate limited program hours and locations and frequently subjects them to long travel distances to reach a provider. [35] Further, many treatment providers have onerous rules and exclusion criteria that eject patients for

relatively minor issues, such as being late. For buprenorphine, providers no longer need an X-waiver [36] to prescribe buprenorphine in office-based settings; however, they must complete an eight-hour training, which may deter already overstretched prescribers rather than expand access. [37] These regulatory structures inaccurately distinguish MOUD as risky and exacerbate stigma against MOUD, and by extension, people with OUD. [38]

Common stigmatizing narratives position drug use as a moral failing rather than an illness [39] and MOUD as merely a substitute of one addiction for another, which is a fundamental misunderstanding of addiction and the pharmacologic effect of MOUD. [40] Equating MOUD use to addiction is akin to equating a diabetic person's dependence on insulin to addiction—it does not hold factual value. Stigma pervades the medical community as well. Some providers consider MOUD to be a crutch and suggest patients should wean off it as soon as possible, [41] contrary to evidence that long-term maintenance is often best practice. Other critics, especially jails and prisons, cite diversion of MOUD (in which a patient is coerced into providing their medication to another person) as a concern that prevents treatment adoption. [42] However, diversion is uncommon; [43] when it does occur, it is typically to fulfill an unmet treatment need. [44]

Individuals internalize the cumulative interpersonal and institutional stigma, which hampers treatment uptake and engagement. [45] Internalized stigma contributes to lower quality of life and higher stress for people who use drugs. [46] Additionally, people with SUD frequently cite stigma as a reason for avoiding SUD treatment all together. [47] Institutional restrictions on MOUD, particularly in jails in prisons, further calcify negative attitudes that exist among people with OUD and contribute to low MOUD uptake following release. [48]

Although these barriers represent significant obstacles to uptake and engagement of MOUD, recent efforts by the DOJ and private parties illuminate an avenue for combating the multileveled stigma in correctional and healthcare settings.

Protections Within the ADA Can Break Down these Barriers

Amid growing enforcement efforts, the DOJ published guidance entitled "The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or

Recovery." [49] This guidance demonstrates how the ADA prohibits discrimination against people with addiction, including those who use MOUD.

Addiction is a Disability

The ADA defines disability as (1) a physical or mental impairment that substantially limits one or more major life activities, including major bodily functions; (2) a record of such an impairment; or (3) being regarded as having such an impairment. [50] Drug addiction substantially limits one or more of major life activities and as such, is considered a physical or mental impairment under the ADA. [51]

Policies or Practices That Restrict Access to MOUD Discriminate Against People with OUD

Under Title II of the ADA, "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." [52] This protects people from discrimination by government entities, such as jails, prisons, and courts. [53] Title III of the ADA protects the right to purchase goods and services and guarantees people with disabilities the equal enjoyment of places of public accommodation. [54] As many people with disabilities closely rely on treatment, including medications, courts have equated discrimination against medications used for the treatment of disabilities with discrimination against people with disabilities. [55] Thus, a place of public accommodation (a hospital or skilled nursing facility, for example) or a public entity with a policy or practice that restricts use of MOUD does discriminate against people with disabilities in violation of the ADA.

Ongoing Drug Use Does Not Diminish the Right to Healthcare

There is an exception to the ADA protections. If an individual is currently using illicit substances, ADA protections for addiction do not apply. [56] However, there is an exception to that exception:

> A public entity shall not deny health services, or services provided in connection with drug rehabilitation, to an individual on the basis of that individual's current illegal use of drugs, if the individual is otherwise entitled to such services. [57]

This exception to the exception protects access to MOUD and other healthcare for individuals using illicit drugs in settings where they are entitled to such healthcare, like in jail, prison, and many other healthcare settings. [58] The DOJ's recent enforcement action has operationalized this guidance. However, several private plaintiffs paved this path.

Several Notable Cases and Settlements Have Enforced These Protections

The two seminal court decisions establishing the ADA as a means for MOUD protection are *Pesce* v. *Coppinger* [59] and *Smith* v. *Aroostook County.* [60] In *Pesce*, the plaintiff won a motion for preliminary injunction to enjoin a jail from denying his MOUD upon his forthcoming incarceration. [61] The Court noted that prison staff's generalized security concerns about distributing methadone were based on stereotypes of people with OUD. [62] As a provider of medical care, jails and prisons that restrict medication access based on administrative, rather than medical reasons, without making an individualized assessment, provide disparate treatment based on disability, in violation of the ADA. [63] In *Smith*, the Court cited *Pesce* and found for the plaintiff on similar grounds, rejecting the prison staff's stigmatizing concerns about substituting addictions and increasing the risk of diversion. [64] Subsequent cases furthered this progress through class actions against counties for policies and practices that deny MOUD access, ultimately forcing change within those county jails. [65]

The DOJ picked up the momentum that *Pesce* and *Smith* created through several notable actions. U.S. Attorneys' Offices in many states have written demand letters, brought complaints, and negotiated settlements against healthcare providers, jails, sheriff's departments, skilled nursing facilities, and other public accommodations. Below are just a few examples of the Department's work:

- In February of 2022, in *USA v. the Unified Judicial System of Pennsylvania*, the three U.S. Attorney's Offices in Pennsylvania and the Disability Rights Section (DRS) of the Civil Rights Division of the DOJ filed suit against the Pennsylvania court system for violating Title II of the ADA by prohibiting or limiting the use of lawfully prescribed MOUD to people under court supervision. [66] DRS also issued a letter of findings, demanding that the court change its practice by revising relevant policies, appropriately training relevant personnel, and paying compensatory damages to aggrieved individuals. [67]

- On March 17, 2022, the DRS entered into a settlement agreement with Ready to Work, a Colorado-based employment, residential, and social services program for individuals experiencing homelessness, resolving allegations that the program denied admission to an individual because she takes medication for OUD. [68] The agreement ensures that people with OUD will "not face discriminatory barriers when seeking access to housing, jobs and social services, which are critical to support recovery and combat the epidemic of opioid addiction." [69]

- On March 24, 2022, the U.S. Attorney's Office for Massachusetts reached a settlement with the Massachusetts Trial Court resolving a complaint that the trial court discriminated against drug court participants using MOUD by pressuring participants to stop taking their lawfully prescribed MOUD, violating Title II of the ADA. [70] The settlement mandates that the trial court implement policy in which only licensed prescribers or opioid treatment programs will make decisions regarding a participant's treatment plan, excluding the drug court personnel from interference in these medical decisions. This was one of the Massachusetts Office's fourteen settlement agreements since May 2018 resolving allegations of ADA violations related to OUD treatment. [71]

- On March 25, 2022, the DRS issued a letter finding that the Indiana State Board of Nursing violated Title II of the ADA by denying a nurse the opportunity to participate in a substance use disorder rehabilitation program because she takes MOUD. [72] The program is required for the individual to reinstate her nursing license. The letter provided a list of remedial actions the nursing board should take to comply with the ADA. [73]

- In April 2022, the U.S. Attorney's Office for Massachusetts announced that it entered into agreements with state and county correctional facilities to maintain all forms of MOUD for people in custody who were using the prescriptions prior to incarceration, as required by the ADA. [74]

- In September 2022, the U.S. Attorney's Office for Massachusetts sent a letter to all skilled nursing facilities in Massachusetts warning them that refusing to provide care for persons with OUD violates the ADA and that the Office will aggressively enforce these protections. [75] Since 2018, the U.S. Attorney's Office of Massachusetts has entered into 10 settlement agreements with entities covering 51 skilled nursing facilities that refused to admit people on MOUD. [76]

Conclusions and Recommendations

Although thousands of lives have been lost due to the overdose crisis, MOUD presents a critical, evidence-based tool that reduces the risk of fatal opioid overdose. However, institutional and interpersonal stigma and other barriers impede MOUD access for many people with OUD, particularly those accessing care within carceral settings. Recent actions by the DOJ and private parties provide one pathway to overcoming these barriers by employing the ADA and combating discriminatory healthcare decision-making.

Attorneys can leverage these recent developments to improve MOUD access for their clients. For clients on MOUD with impending incarcerations, *Pesce v. Coppinger* and *Smith v. Aroostook County* provide useful examples of procuring an ADA preliminary injunction before surrender. For clients who are already incarcerated, per the Prison Litigation Reform Act (PLRA), they must exhaust the administrative remedy grievance process before being able to file a lawsuit in federal court. (77) The grievance process varies between facilities and can be lengthy. Attorneys should advise clients to tackle this process as soon as they are denied their MOUD. For clients who have OUD and have exhausted the administrative grievance process, attorneys can use the ADA to achieve injunctive relief and recover damages for the pain and suffering experienced during forced withdrawal.

For non-carceral settings, where individuals are denied services, healthcare, or other enjoyment of public accommodations because of their status as a person with SUD or their prescription MOUD, attorneys should consider individual and class actions in line with the Massachusetts U.S. Attorney's Office's efforts against skilled nursing facilities. (78) In the absence of capacity to bring a lawsuit in carceral or non-carceral settings, individuals should consider reporting ADA violations to the DOJ. (79) There are other legal avenues to achieve MOUD access, which should be used in conjunction with the ADA where appropriate, such as the Eighth and Fourteenth Amendments, Rehabilitation Act, and state human and disability rights laws. (80) Attorneys should take advantage of these additional protections.

Endnotes

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