How Medication-Assisted Treatment Is Becoming the Standard of Care

Absalom Tilley, MD, CCHP
Deputy Chief Medical Officer
Turn Key Health Clinics, LLC

Alexandra G. Ah Loy, JD
Partner, Sweet Law Firm

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Disclosure and Disclaimer

Dr. Absalom Tilley: I have the following relevant financial relationship(s) with a commercial interest: I am employed by Turn Key Health Clinics, LLC, which contracts with county agencies for the provision of health care services in correctional facilities.

Alexandra Ah Loy: I have the following relevant financial relationship(s) with a commercial interest: I represent correctional healthcare companies in their medical malpractice and civil rights litigation.

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Educational Objectives

Objective 1: Review the basics of medication-assisted treatment

Objective 2: Describe the benefits and burdens of providing MAT

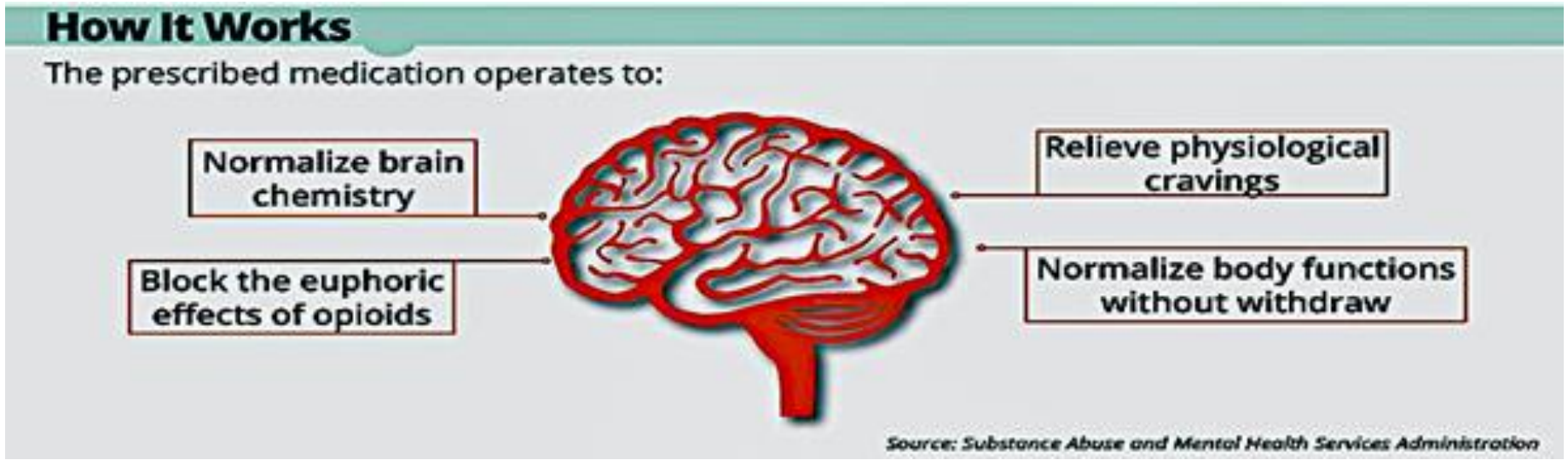
Objective 3: Examine the legal liability of failing to implement MAT programs

What is Medication-Assisted Treatment (MAT)?

- **Medication-Assisted Treatment (MAT)**: use of medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders.

- **Opiate Use Disorder (OUD):** OUD is defined as a problematic pattern of opiate use that leads to serious impairment or distress.

Medication-Assisted Treatment (MAT)



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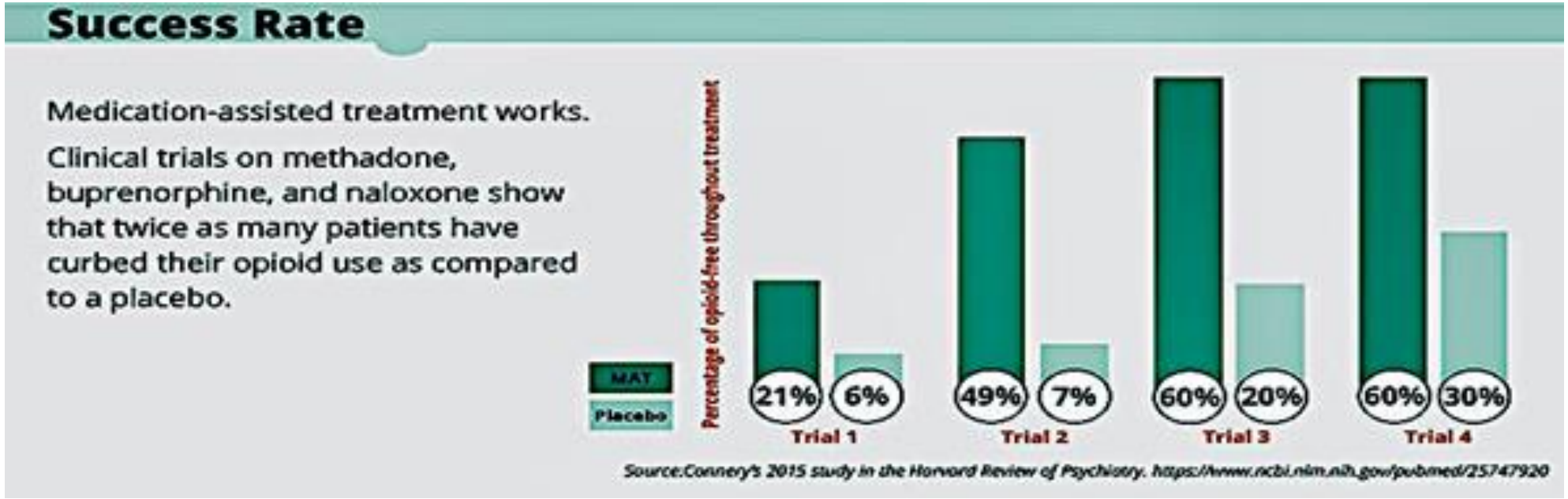
Medication-Assisted Treatment (MAT)

Medications Used

	Methadone	Buprenorphine	Naltrexone
Brand Names	Dolophine, Methadose	Subutex, Suboxone, Zubsolv	Depade, ReVia, Vivitrol
Used	Taken orally once per day; methadone can only be administered in a licensed opioid treatment program and patients need to visit the clinic daily for their medication	Taken orally usually once per day; buprenrophine and naltexone can be administered by a physician in the office	Taken orally or by injection
Effects	Reduces opioid cravings and withdrawal symptoms.	Reduces opioid cravings and withdrawal symptoms.	Not addictive or sedating and does not make patient physically dependent. Patient needs to be clean for seven days before administering.

Source: New England Journal of Medicine. https://www.nejm.org/doi/full/10.1056/NEJMp1402780

Medication-Assisted Treatment (MAT)



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THE OPIOID EPIDEMIC BY THE NUMBERS

130+
People died every day from opioid-related drug overdoses[3]
(estimated)

10.3 m
People misused prescription opioids in 2018[1]

47,600
People died from overdosing on opioids[2]

2.0 million
People had an opioid use disorder in 2018[1]

808,000
People used heroin in 2018[1]

81,000
People used heroin for the first time[1]

2 million
People misused prescription opioids for the first time[1]

15,349
Deaths attributed to overdosing on heroin (in 12-month period ending February 2019)[2]

32,656
Deaths attributed to overdosing on synthetic opioids other than methadone (in 12-month period ending February 2019)[2]

SOURCES

1. 2019 National Survey on Drug Use and Health. Mortality in the United States, 2018
2. NCHS Data Brief No. 329. November 2018
3. NCHS. National Vital Statistics System. Estimates for 2018 and 2019 are based on provisional data.

HHS.GOV/OPIOIDS

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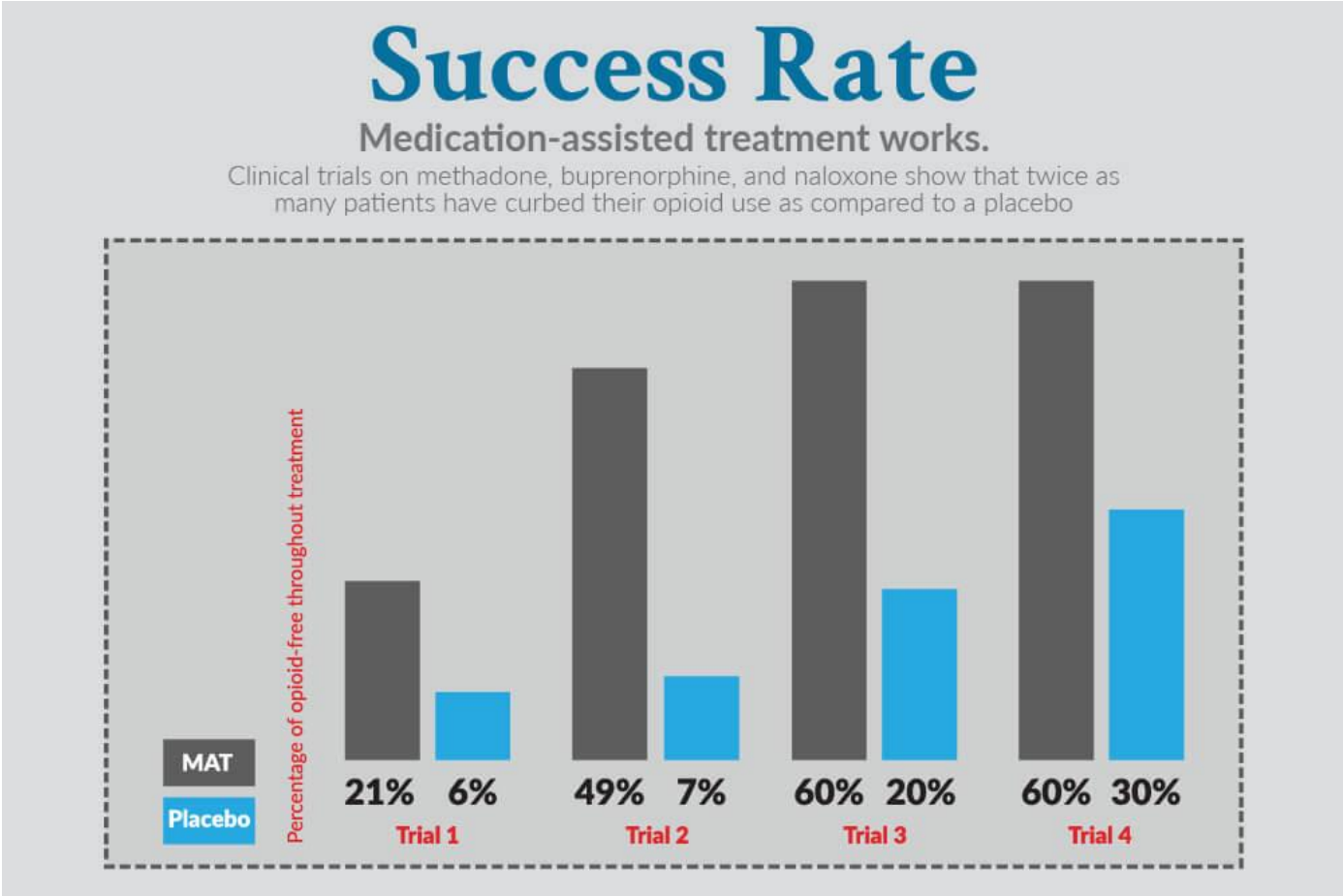
What is the goal of MAT?



- **Decreasing community crime rates**
  - More than one-fourth of people with OUD in the United States pass through prisons and jails every year.
- **Decrease recidivism**
  - The implementation of MAT in correctional facilities decreases the probability of reincarceration by increasing a “patient's adherence to treatment and reducing illicit opioid use.”

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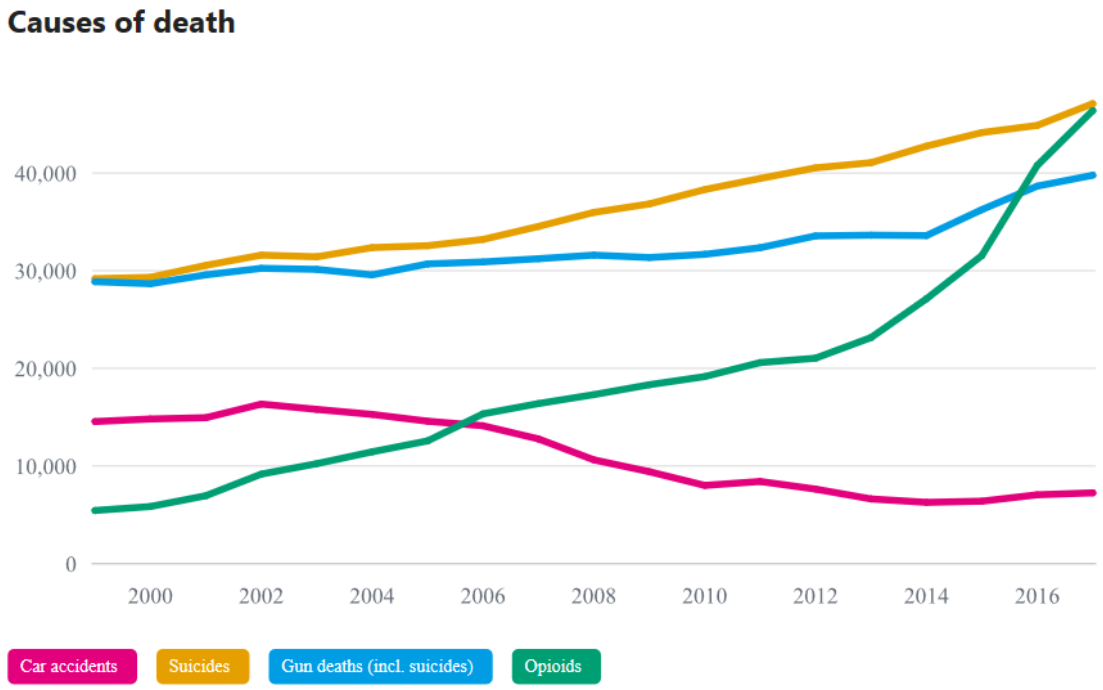
What is the goal of MAT?



- **Decrease financial burden**
  - Costs US economy an estimated $78 billion per year.
  - In 2017, 2.1 million people reported using heroin or abusing painkillers.
  - ***Opioids are now responsible for more deaths than cars or guns and are about equal to suicides in the US.***
- **More patients with fewer relapses**
- **More patients in stable recovery**
  - Nationwide 130 deaths per day from OUD

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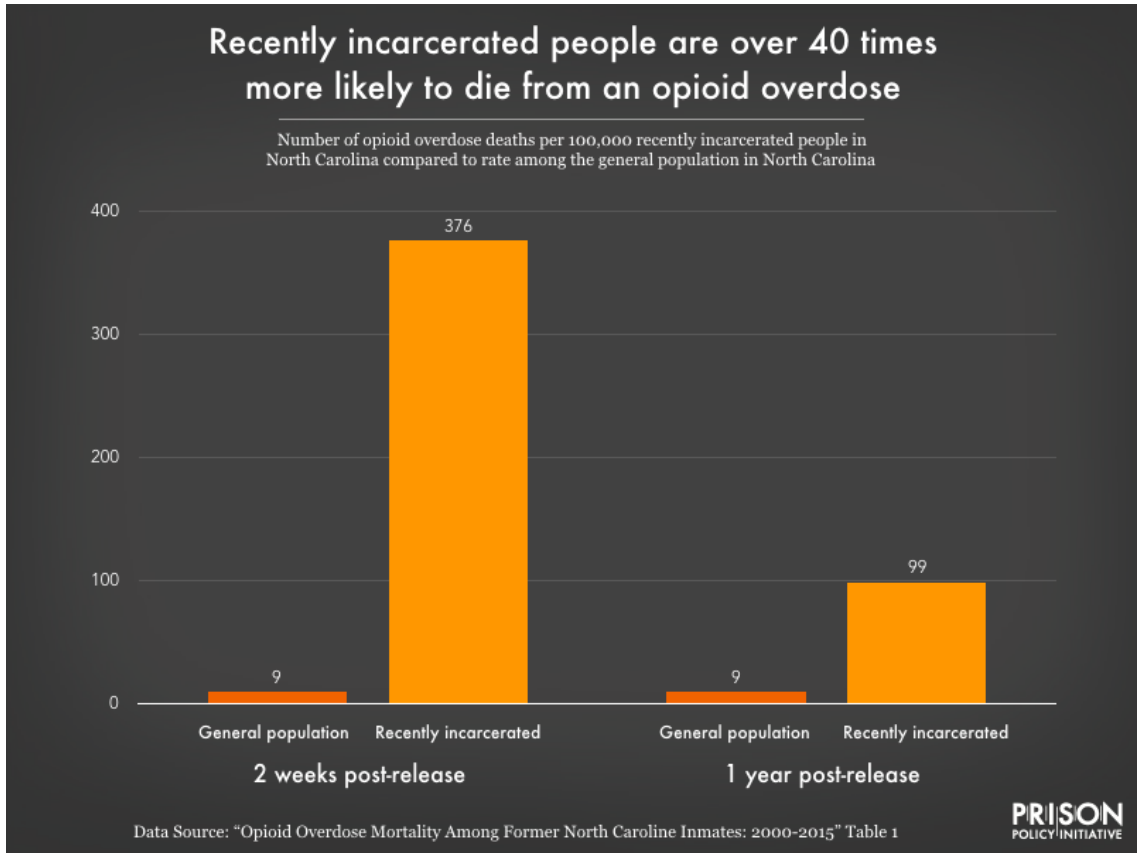
What is the goal of MAT?



- **Fewer deaths by overdose**
  - Overdose is the leading cause of death for individuals recently released from prison.
    - This is because, after a period of forced abstinence without adequate medical treatment, an incarcerated individual who returns to the community will have a significantly lower tolerance to substances and be susceptible to other factors affecting overdose risk.

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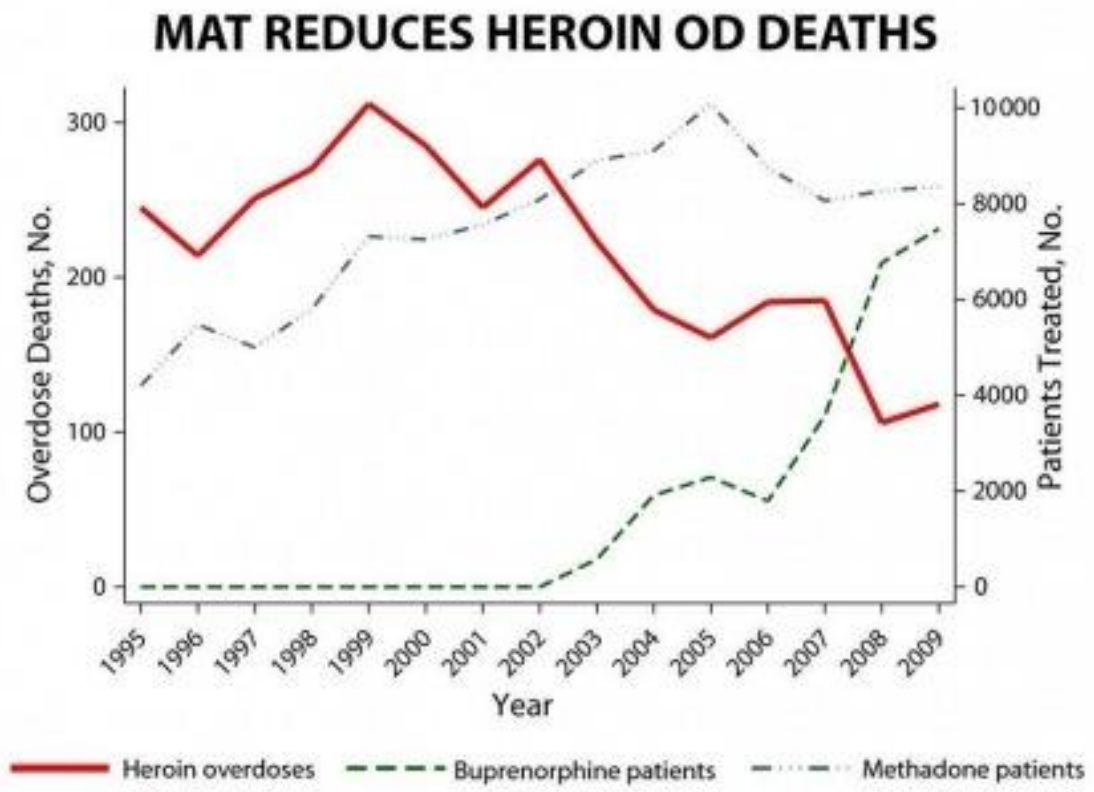
What is the goal of MAT?



- **Fewer deaths by overdose**
  - MAT is correlated with a reduced risk of mortality in the weeks following release, and incarcerated patients who continue their previously prescribed MAT throughout incarceration have better outcomes than those who are forced to discontinue MAT during incarceration.
  - One study found that individuals receiving MAT in prison were 85% less likely to die of drug poisoning in first month after release

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Professional Associations are advocating for MAT

- Substance Abuse and Mental Health Services Administration (SAMHSA) in their "Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings" states:

  "There is overwhelming evidence that MAT is an effective intervention for addressing OUDs in criminal justice and non-criminal justice populations."

SAMHSA
Substance Abuse and Mental Health Services Administration

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Professional Associations are advocating for MAT

SAMHSA cites dozens of studies that have proven that MAT:

- Enhances **treatment engagement** during and after discharge from custody.
- Decreases **relapse rates**
- Is associated with reduced **criminal recidivism**
- Is associated with lower **overdose deaths and health risk behaviors**

SAMHSA
Substance Abuse and Mental Health Services Administration

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Professional Associations are advocating for MAT

"**The American Society of Addiction Medicine National practice guideline for the use of medications in the treatment of addiction involving opioid use** establishes a national benchmark for treatment.

Providers in correctional settings should follow these guidelines when treating people with substance use disorders. Effective treatment of those with substance use disorders is key to halting the national epidemic of drug abuse, particularly opioid use disorder, and interrupting the costly cycle of recidivism resulting form this underlying disorder."

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NCCHC Position Statement

- "The National Commission on Correctional Health Care advocates the following principles for care of adults and adolescents with substance use disorders in correctional facilities; these principles reinforce and expand on principles in NCCHC's Standards for Health Services."

- Several points are of primary medial focus in this position statement:
  - Screening, evaluation, and care coordination upon entry
  - Continuation or initiation of MAT while incarcerated
  - Monitoring and withdrawal according to national medical standards (if needed)
  - Prerelease initiation of treatment and care coordination
  - Linkage of medication treatment programs with nonpharmacological treatment options

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Professional Associations are advocating for MAT

Joint Public Policy Statement on the Treatment of OUD for Justice Involved Individuals by the American Correctional Association (ACA) and the American Society of Addiction Medicine (ASAM):

"The **ACA** supports the use of evidence-based practices for the treatment of OUDs. **ACA** and the **ASAM** have developed recommendations specific to the needs of correctional policy makers and healthcare professionals. These recommendations will enable correctional administrators and others, such as community corrections, to provide evidence-based care to those in their custody or under their supervision that have OUDs."

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Professional Associations are advocating for MAT

ASAM Board of Directors 2015 Summary of Recommendations:

- Pharmacotherapy for the continued treatment of OUDs, or the initiation of pharmacotherapy, has been shown to be effective and is recommended for prisoners and parolees regardless of the length of their sentenced term.
- Individuals with OUD who are withing the criminal justice system should be treated with some type of pharmacotherapy in addition to psychosocial treatment.
- Opioid agonists (methadone and buprenorphine) and antagonists (naltrexone) may be considered for treatment. There is insufficient evidence to recommend any one treatment as superior to another for prisoners or parolees.
- Pharmacotherapy should be initiated a minimum for 30 days before release from incarceration.

Professional Associations are advocating for MAT

The National Academies of Sciences, Engineering, and Medicine:

- "For people with OUD involvement in the criminal justice system, a lack of access to medication-based treatment leads to a greater risk of returning to use and overdose after they are released from incarceration."

The National Academies of SCIENCES ENGINEERING MEDICINE

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Logistics of Implementing MAT

- **MAT can be expensive to implement**
  - Especially in states that did not expand Medicaid.
  - While all states reimburse prisons for some form of MAT medication, including some forms of buprenorphine and naloxone, only forty-two states reimburse for the use of methadone and even fewer states reimburse for implanted or extended release buprenorphine.
- **Many states impose limits on the quantity of MAT medications** given to patients and require that patients receiving MAT medications also undergo **psychosocial treatment**.

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Logistics of Implementing MAT

- ALL INCARCERATED INDIVIDUALS ARE SCREENED IN BOOKING FOR DRUG AND ALCOHOL DEPENDENCE
- ANY PATIENT THAT MAY GO THROUGH WITHDRAWAL SYMPTOMS ARE PLACED ON DETOX CHECKS
- DETOX CHECKS ARE A SCORING SYMPTOM, THOSE PATIENTS THAT HAVE DETOX SCORES THAT ARE HIGH ENOUGH ARE PLACED ON MEDICATIONS TO TREAT THEIR SYMPTOMS.
- NOT EVERY PATIENT ON DETOX CHECKS WILL END UP ON MEDICATIONS.

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MAT Medications

SUBUTEX (BUPRENORPHINE)

- GIVEN TO PREGNANT INMATES WHO HAVE OPIATE DEPENDANCE TO PREVENT WITHDRAWAL SYMPTOMS THAT MAY CAUSE FETAL DISTRESS OR DEMISE.
- Methadone and buprenorphine reduce or eliminate withdrawal symptoms

VIVITROL (NALTREXONE)

- LONG ACTING SHOT THAT LAST FOR ONE MONTH. IT BLOCKS OPIATE RECEPTORS IN THE BRAIN AND CAUSES WITHDRAWAL SYMPTOMS IF A PATIENT ON THIS MEDICATION USES OPIATES.
- Vivitrol, an injectable form of naltrexone, prevents the euphoric effect of opioids.

SUBOXONE (BUPRENORPHINE/NALTREXONE)

- PREVENTS WITHDRAWAL SYMPTOMS AND LEVELS OUT SYMPTOMS. IT BLOCKS OPIATE RECEPTORS IN THE BRAIN AND CAUSES WITHDRAWAL SYMPTOMS IF A PATIENT ON THIS MEDICATION USES OPIATES.

General MAT Treatment Options

Discuss treatment options available to patients:

- No Agonist/Antagonist treatment with(out) adjuvant detoxification Medication Set
- Suboxone Detoxification Taper
- Adjuvant Detoxification Medications then Maintenance LANTX (Vivitrol)
- Suboxone Taper then Maintenance LANTX
- Suboxone Maintenance Treatment
- Methadone/Subutex for pregnant females

Suboxone administration (Diversion prevention)

- Medication is administered QD between 1300-1500 (originally at 2100)
- Two Crushed Buprenorphine/Naloxone 8/2mg tablets are placed SL by the Charge Nurse
- Patients remain constantly observed by a Med Aide and Detention Officer during clinic
- Patients remain sitting on their hands for 3-5 minutes for medication absorption
- After elapsed time, patients vigorously swish and swallow any remaining medication
- Charge RN performs thorough oral cavity search with light to verify absence of remaining medication

Suboxone Continuation Prescription

1. Important for Ongoing Treatment in Community
2. Provides Patient Demographics
3. Important for Potential Future Follow-up
4. Important for Metrics/CQI
5. Prescription can be Provided up to TWO WEEKS

Long-Acting Naltrexone (LANtx-Vivitrol)

- Patient and providers must understand Overdose Risk Potential
- Requires screening labs: HCG and CMP
- Generally, patient will have 3 test doses of oral Naltrexone
  - 1st dose administered day 1 and patient observed 15 mins for signs of allergy
  - 2nd and 3rd doses on corresponding days can be administered at Med Pass
- Must emphasize to patients the need for ongoing treatment after release
- LANtx injection given intramuscularly in gluteal region only
- Also approved for use in patients with Alcohol Use Disorder.

OUD in Pregnancy

- ACOG Committee Opinion – Number 711, August 2017 (Reaffirmed 2019) written in conjunction with:
  - The Society of Maternal-Fetal Medicine
  - The American Society of Addiction Medicine
- OUD in Pregnancy Trends
  - 2007 – 22.8% of pregnant women, on Medicaid, in 46 states filled an opioid Rx
  - 2000-2009 – Antepartum maternal opioid use increased nearly 5-Fold
  - 1999-2013 –
    - Sharp increase in Neonatal Abstinence Syndrome (NAS)
    - From 1.5 cases per 1000 births to 6.0 per 1000 births
    - Average cost of $1.5B in annual hospital charges
  - 2015-2016 – VA and MD Departments of Health conducted maternal mortality reviews and identified SUD as a MAJOR risk factor for pregnancy-associated deaths

OUD in Pregnancy

- Effects of Opioid Use on Pregnancy and Pregnancy Outcomes
  - Chronic untreated OUD in Pregnancy is associated with:
    - Lack of Prenatal Care
    - Increased Risk of Fetal Growth Restriction
    - Abruptio Placentae
    - Fetal Demise
    - Preterm Labor
    - Meconium Aspiration

  - Social and Public Health Consequences of Untreated OUD during Pregnancy:
    - Increased High Risk Sexual Activities
    - Increased Criminal Activities
    - Increased exposure to:
      - STIs
      - Violence
      - Legal Consequences
      - Loss of Child Custody
      - Criminal Proceedings
      - Incarceration

OUD in Pregnancy

- Pregnant Women with OUD often suffer from Psychiatric Dual-Diagnosis
  - Between 30-40% of Pregnant Women enrolled in a SUD treatment program screen positive for Moderate to Severe Depression.
  - Increased Risk of Polysubstance Abuse
  - Increased Risk of Compromised Nutrition
  - Increased Risk of Disrupted Support Systems
  - Increased Need for and Cost of Social Service Needs

OUD in Pregnancy

- Opioid Agonist/Partial Agonist Pharmacotherapy is the Standard of Care of OUD in Pregnancy
  - Prevents Opioid Withdrawal Symptoms
  - Prevents Complications of nonmedical opioid use → Reduced Relapse Risk
  - Improved adherence to prenatal care and OUD Programs
  - Reduces the risks of Obstetric complications
  - NAS is expected and treatable

MAT for the Pregnant Patient with OUD

Methadone

- Dosage likely needs increased adjustment in 3rd Trimester
- May require multiple doses per day due to increased metabolism
- Can be prescribed ONLY by OB/Gyn for NAS or Addictionologists at licensed OTPs
- Inadequate dosing increases:
  - Fetal Stress
  - Maternal Drug Cravings
  - Incidence of Relapse
  - Incidence of OUD Treatment D/C

Buprenorphine

- Reduced likelihood of Overdose
- Fewer Drug Interactions (QT Prolongation)
- Decreased need for dosage adjustments
- Less severe NAS
- Rare reports of hepatic dysfunction
- Increased risk of precipitated withdrawal
- Increased risk of diversion when used as outpatient
- Methadone patients should not be transitioned

Medically Supervised Withdrawal (Detox)

- **NOT RECOMMENDED**
- High Relapse Rates Reported from 59% to over 90%
- Relapse Poses Risk of Communicable Disease Exposure
- Overdose Due to Loss of Tolerance
- Obstetric Complications
- Lack of Prenatal Care

Litigation Trends Related to MAT

Deliberate Indifference: Judicially-Created Law Arising from the Constitution

Estelle v. Gamble

- Landmark U.S. Supreme Court Case (1977)

Overview:

- Created a **constitutional** basis for a civil rights claim against jails/prisons for failure to provide adequate medical care
- State prisoner filed a pro se complaint against various prison officials under civil rights statute for failure to provide adequate medical care. The Supreme Court held that while deliberate indifference to prisoner's serious illness or injury constitutes cruel and unusual punishment in violation of Eighth Amendment, prisoner's pro se complaint showing that he had been seen and treated by medical personnel on 17 occasions within three-month period was insufficient to state a cause of action against physician both in his capacity as treating physician and as medical director of the corrections department, but case would be remanded to consider whether a cause of action was stated against other prison officials.

Estelle v. Gamble

- Landmark U.S. Supreme Court Case (1977)

Key Points:

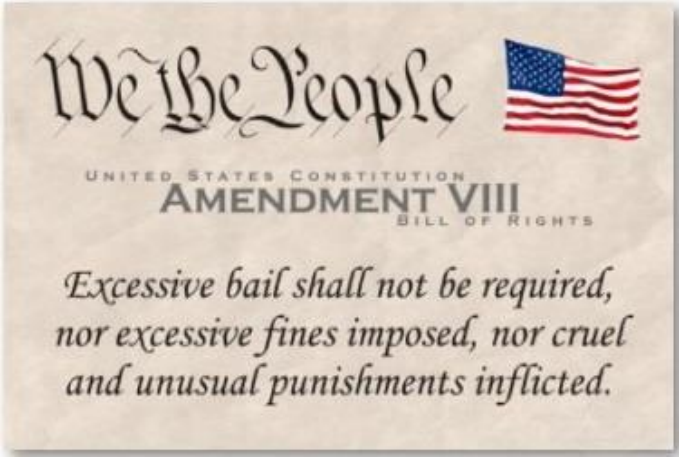
- Deliberate indifference to prisoner's serious illness or injury constitutes **cruel and unusual punishment** in violation of Eighth Amendment
- Indifference can be manifested by jail medical staff in their response to prisoner's needs, by intentionally denying or delaying access to medical care, or intentionally interfering with treatment once prescribed

Estelle v. Gamble

- "These elementary principles **establish the government's obligation to provide medical care for those whom it is punishing by incarceration**. An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical "torture or a lingering death," In re Kemmler, supra, the evils of most immediate concern to the drafters of the Amendment. In less serious cases, **denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose**. Cf. Gregg v. Georgia, supra, at 173, 96 S.Ct. at 2924-25 (joint opinion). The infliction of such unnecessary suffering is inconsistent with **contemporary standards of decency** as manifested in modern legislation codifying the common-law view that "(i)t is but just that the public be required to care for the prisoner, who cannot by reason of the deprivation of his liberty, care for himself."

- **We therefore conclude that deliberate indifference to serious medical needs of prisoners constitutes the "unnecessary and wanton infliction of pain,"** Gregg v. Georgia, supra, at 173, 96 S.Ct. at 2925 (joint opinion), proscribed by the Eighth Amendment. This is true whether the indifference is manifested by prison doctors in their response to the prisoner's needs[10] or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed. Regardless of how evidenced, deliberate indifference to a prisoner's serious illness or injury states a cause of action under s 1983."

- The Supreme Court set a **constitutional standard** for medical care in jails
- Estelle guaranteed inmates:
  - ✓ The right to access to medical care
  - ✓ The right to care that is ordered
  - ✓ The right to professional medical judgment



Deliberate Indifference

Overview of U.S Supreme Court
& Nationwide Federal Law

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Farmer v. Brennan

- SCOTUS Opinion
- "Prison officials have a duty under the Eighth Amendment to provide humane conditions of confinement. They must ensure that inmates receive adequate food, clothing, shelter, and medical care."

Wilson v. Seiter

- SCOTUS Opinion
- There is "no significant distinction between claims alleging inadequate medical care and those alleging inadequate conditions of confinement."
- "Whether one characterizes the treatment received by [the prisoner] as inhumane conditions of confinement, failure to attend to his medical needs, or a combination of both, it is appropriate to apply the 'deliberate indifference' standard articulated in *Estelle.*"

Estelle v. Gamble

"[E]very claim by a prisoner that he has not received adequate medical treatment" does not state "a violation of the Eighth Amendment."

"[I]n the medical context, an inadvertent failure to provide adequate medical care cannot be said to constitute '**an unnecessary and wanton infliction of pain' or to be 'repugnant to the conscience of mankind**.'" …

As such, a complaint alleging that negligence in diagnosing or treating a medical condition does not become a valid constitutional claim of medical mistreatment under the Eighth Amendment simply because the victim is a prisoner.

"In order to state a cognizable claim, a prisoner must allege acts or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs. **It is only such indifference that can offend 'evolving standards of decency' in violation of the Eighth Amendment."**

Legal Trends

Substance Abuse/Detoxification

Original Law (10+ years ago)

- Just as an Example: Boyett v. Cty. of Washington, 282 F. App'x 667, 674 (10th Cir. 2008)
  - *b. Failure to provide the medicine and care prescribed by Boyett's treating physicians prior to incarceration*
  - Plaintiffs contend the decision by Washington County officials to take away Boyett's prescription Methadone when he entered the facility violated his rights.[3] Boyett's doctor had prescribed the Methadone to treat his alcohol withdrawal symptoms, but because Methadone is a narcotic, he was not allowed to keep it in the jail. To replace the Methadone, Physician's Assistant Steele prescribed 0.1 mg of Clonidine to be taken twice daily. Steele's prescription of substitute medication for Boyett does not demonstrate deliberate indifference. *See Callahan v. Poppell,* 471 F.3d 1155, 1160 (10th Cir.2006) ("[A] prison doctor remains free to exercise his or her independent professional judgment and an inmate is not entitled to any particular course of treatment." (quoting *Dulany v. Carnahan,* 132 F.3d 1234, 1240 (8th Cir.1997))); *Perkins v. Kansas Dep't of Corrs.,* 165 F.3d 803, 811 (10th Cir.1999) ("[A] prisoner who merely disagrees with a diagnosis or a prescribed course of treatment does not state a constitutional violation.").

Methadone

Pesce v. Coppinger, 355 F. Supp. 3d 35 (D. Mass. 2018)

- Background:
  - Plaintiff who was facing impending incarceration after violating the terms of his probation brought § 1983 action against correctional facility officials, alleging that their policy of denying methadone treatment to incarcerated population at correctional facility violated his rights under the Americans with Disabilities Act (ADA) and the Eighth Amendment. Plaintiff moved for preliminary injunction requiring officials to provide him with access to his physician-prescribed methadone treatment upon his incarceration.

Methadone

Pesce v. Coppinger, 355 F. Supp. 3d 35 (D. Mass. 2018)

- Background:
  - Plaintiff Geoffrey Pesce ("Pesce") is a resident of Ipswich, Massachusetts who had been in active recovery from opioid addiction for two years with the help of a methadone treatment program prescribed by his doctor.
  - Pesce brought this lawsuit alleging that Defendants' policy of denying inmates access to methadone for the treatment of opioid use disorder violates the Americans with Disabilities Act ("ADA") and the Eighth Amendment pursuant to 42 U.S.C. § 1983.
  - Pesce sought injunctive relief requiring that Defendants provide Pesce with access to his physician-prescribed methadone treatment (this was all prior to him actually be incarcerated).
  - The court ALLOWED his motion for preliminary injunction.

Methadone

Pesce v. Coppinger, 355 F. Supp. 3d 35 (D. Mass. 2018)

- The parties do not dispute that Pesce, who suffers from opioid use disorder, is a “qualified individual[ ] with disabilities” under the ADA. D. 13 at 15; D. 41 at 13. Here, Pesce asserts that Defendants' refusal to administer methadone (as prescribed) deprives him of the benefit of health care programs, and that such conduct constitutes discrimination on the basis of his disability.
- As an initial matter, the medical care provided to Middleton's incarcerated population qualifies as a “service” that disabled inmates must receive indiscriminately under the ADA.
- Pesce asserts that he should have access to methadone because it is the only medication that has been effective in treating his disorder. Pesce's physician, Dr. Yuasa, strongly recommends that he continue methadone treatment while incarcerated. Dr. Yuasa also explained that Pesce risks severe physical and mental illness, relapse into opioid addiction and death if he is denied access to methadone and subjected to Defendants' treatment program.

Methadone

Pesce v. Coppinger, 355 F. Supp. 3d 35 (D. Mass. 2018)

- Defendants, in lieu of conducting an individualized assessment of Pesce's medical needs or his physician's recommendation, would require Pesce to participate in a treatment program that bares strong resemblance to the methods that failed Pesce for five years, **including detoxification**and administration of **Vivitrol.**
- Not only would Defendants' treatment program contradict Pesce's physician's recommendations and place Pesce at a higher risk of relapse upon his release from Middleton, but it would also make him physically ill for several days while he undergoes forced withdrawal.

Methadone

Pesce v. Coppinger, 355 F. Supp. 3d 35 (D. Mass. 2018)

Defendants have identified legitimate, but generalized, safety and security reasons for prohibiting the use of opioids in their facilities.

- "Concerns over prison security may be legitimate non-discriminatory grounds for limiting access to a jail program");
- The Court recognizes that Defendants' primary objective is to enforce policies that promote public safety

Defendants, however, have not articulated specific security concerns relevant to Pesce's proposed methadone intake.

- The denial of petitioner's access to a program was not a violation of the ADA given petitioner's record of violence in jail.
- For example, Defendants have not explained why they cannot safely and securely administer prescription methadone in liquid form to Pesce under the supervision of medical staff, especially given that this is a common practice in institutions across the United States and in two facilities in Massachusetts.

Without more, Defendants' concerns about inmates "cheeking" medications, *i.e.*, hoarding legally prescribed and administered medicine for use or transfer to other inmates, see D. 41 at 8, are not applicable to Pesce or the liquid methadone prescription at issue here.

Methadone

Pesce v. Coppinger, 355 F. Supp. 3d 35 (D. Mass. 2018)

- Pesce contends that Defendants' refusal to continue his prescribed Pesce's particular medical history and pre-methadone treatment constitutes deliberate indifference to his medical condition.
- Defendants have implemented a **blanket policy prohibiting the use of methadone treatment** at Middleton. They have stood by the policy without any indication that they would consider scribed treatment in considering whether departure from such policy might be warranted.
- Defendants' current policy ensures Pesce will be denied methadone treatment **despite his physician's recommendations and contrary to the opinions of health care professionals** familiar with Pesce's history of unsuccessful attempts at recovery prior to being treated with methadone.
- Because Pesce has alleged that Defendants' policy "ignore[s] treatment prescriptions given to Plaintiff by [his] doctors," the Court concludes that, on the present record, Pesce is likely to succeed on the merits of his Eighth Amendment claim. Alexander, 841 F.Supp.2d at 493 (holding that plaintiff, who alleged that prison officials repeatedly ignored her physician's recommendations, stated sufficient facts to establish an Eighth Amendment violation).

Methadone

Foster v. Maloney, 785 F. App'x 810, 812 (11th Cir. 2019)

- **Background:** Inmate Whitney Foster was detained at Madison County Jail. She alleged that while jailed there, she did not receive adequate treatment for various health issues stemming from methadone withdrawal. She filed a lawsuit claiming this was in deliberate indifference to her medical needs, suing Advanced Correctional Healthcare, its doctor, and nurses at the jail (as well as detention staff)
  - Foster was arrested and booked at the Madison County Jail on April 4, 2014. Prior to her arrest, Foster had been taking 80 milligrams of methadone per day, administered by a methadone clinic. Morrison and the correctional officers—along with members of the medical staff at the jail—were aware Foster had been taking methadone prior to her booking.
  - Within a week of her incarceration, Foster began showing visible signs of methadone withdrawal, as well as elevated blood pressure. These symptoms grew more severe each day, but the defendants "did nothing to help her." Instead, the nurses and correctional officers accused her of "faking" as she slurred her speech, bit her tongue, and exhibited limited control of her body. Foster was seen in the clinic on April 18, 2014, given ibuprofen, and put on a blood-pressure "watch" for three days.

Methadone

Foster v. Maloney, 785 F. App'x 810, 812 (11th Cir. 2019)

- Starting on April 21, 2014, Foster's condition became "desperate," and she continued to deteriorate until she was sent to the Huntsville Hospital emergency room on April 23, 2014. Specifically, on April 21, Foster began having strokes and seizures as a result of her untreated high blood pressure. At one point, an inmate in the cell with Foster called for medical assistance because she was "shaking and sweating," and Foster was temporarily moved to a medical cell, where she was observed to be lethargic and slurring her words. Rather than provide her with comfort or adequate medical care, the correctional officers and nurses on duty "harassed and ridiculed" Foster and "watched [her] deteriorate."
- By the next day, April 22, Foster could no longer sign her name to forms, dial a phone, or remember her "charge code" for making phone calls. Another inmate used her own charge code and helped Foster call her mother, and Foster told her mother with slurred speech that she was "gonna die." During commissary, the correctional officers on duty left Foster to "lay on the ground" until another inmate asked them to send for a nurse. Some of the correctional officers later had to physically put Foster in the shower because she had urinated on herself. Throughout the day, the officers on duty "saw [Foster] shaking, sweating, and knew she was having strokes." Again, the officers and nurses on duty "harassed and ridiculed" Foster rather than provide her with comfort or adequate medical care.

Methadone

Foster v. Maloney, 785 F. App'x 810, 812 (11th Cir. 2019)

- Later that night, another inmate requested emergency assistance for Foster, and when Officers Spicer and Beasley arrived, they found Foster in her bunk "twitching" and complaining that she hurt all over. They helped her into a wheelchair and took her to triage, where a nurse instructed them to take her to a medical cell for observation. While being assessed, Foster twice slid out of the wheelchair and had to be helped back up by the officers and nurse.
- By the next morning, April 23, Foster's condition had become even more desperate. The correctional officers on duty again observed Foster shaking, sweating, and exhibiting symptoms of strokes and seizures. When a nurse came to check on Foster, she was found "lying on the floor with her upper body under the bed." When the nurse was unable to get Foster off the floor, she called a doctor, who ordered that Foster be sent to the Huntsville Hospital emergency room for treatment "due to signs of a stroke." When Foster arrived at the hospital, she "looked like she had been beaten," and was blind and partially paralyzed.
- Foster remained hospitalized for three weeks and was diagnosed with Posterior Reversible Encephalopathy Syndrome, which she alleged is no longer fully reversible. Foster has some use of her arms and legs, but the repeated strokes and seizures caused permanent neurological deficits and cortical blindness.

Methadone

Foster v. Maloney, 785 F. App'x 810, 812 (11th Cir. 2019)

- The court ruled these allegations were enough to state a claim for deliberate indifference:
  - Foster's complaint plausibly alleges a claim for deliberate indifference to serious medical needs. Foster's supervisory claim against Morrison includes allegations that Morrison and others **implemented "deliberately-indifferent customs or policies" by establishing an "explicit or implicit agreement, plan, and policy of delaying or denying necessary medical treatment to avoid liability for inmate medical bills."**
  - Officers were trained to defer to ACH personnel even in the case of a medical emergency and disciplined for contacting outside emergency personnel. Morrison knew "ACH had a practice of delaying or denying referrals of inmates for outside medical care ... that put cost control over inmate health and safety." Foster alleged Morrison and others were "on notice that their plan was harmful to the health of detainees and jailees" from complaints, deaths, and other lawsuits. Further, Morrison and others did not take steps to investigate the circumstances of the deaths of six Madison County Jail inmates over the course of four years.

Methadone

Young v. Peoria Cty., Illinois, No. 1:16-CV-01367-JBM, 2017 WL 6418888, at *1 (C.D. Ill. Dec. 15, 2017)

- **Background**:
  - On October 12, 2014, the decedent, Tylor Young, committed suicide in his jail cell at Peoria County Jail. His family sued the sheriff and detention staff, as well as Correctional Healthcare Companies ("CHC"), Correct Care Solutions, LLC ("CCS"), and Nurse Olivia Radcliff–Tish
  - On October 6, 2014, Young was booked into the Jail on a charge of failure to appear. Prior to and at the time of his arrest, Young was struggling with heroin addiction, asthma, depression, anxiety, and other mental health issues. Upon arrival at the Jail on October 6, 2014, Young was examined and evaluated. Young was identified as suffering from heroin abuse, opioid withdrawal, asthma, mental health problems, and he was deemed a suicide risk and a medical alert as a pre-trial detainee. At that time, Young was participating in a Narcotic Treatment Program ("NTP") and taking methadone daily as part of his treatment. Young was exhibiting severe symptoms of opioid withdrawal including nausea, vomiting, and sweats.

Methadone

Young v. Peoria Cty., Illinois, No. 1:16-CV-01367-JBM, 2017 WL 6418888, at *1 (C.D. Ill. Dec. 15, 2017)

- **Background**:
  - Notwithstanding Young's evaluation at booking, he was placed into the Jail's general population, in a section called the “F–Pod.” The “F–Pod” did not have suicide-proof cells and did not allow for adequate supervision of “at-risk” inmates like Young. After booking and through his stay at the Jail, Young was denied access to or was not given methadone despite exhibiting withdrawal symptoms and severe mental distress.
  - On October 10, 2014, the Medical Defendants discharged Young from observation despite knowing that he was not receiving methadone treatment for his opioid addiction, and having observed that Young was exhibiting withdrawal symptoms, verbal and non-verbal behaviors and other characteristics associated with mental illness and distress including anxiety, appetite change, and refusal to communicate or cooperate with Defendants.
  - That same day, Young placed a recorded phone call to his grandparents during which he expressed his intent to kill himself if they did not bond him out of Jail. =

Methadone

Young v. Peoria Cty., Illinois, No. 1:16-CV-01367-JBM, 2017 WL 6418888, at *1 (C.D. Ill. Dec. 15, 2017)

- Background:
  - Officers at the Jail are required to make cell checks on all inmates at least every fifteen minutes. On October 12, 2014, Officer Michel was assigned to work on “F–Pod's” first shift. He completed an inmate check at 10:15 A.M. At approximately 10:29 A.M., Officer Michel took his lunch break; he did not perform another inmate check before taking his lunch break. Officer Smith was also on duty and in the guard station that covered “F–Pod.”
  - Officer Smith did not perform an inmate check while Officer Michel at was lunch. When Officer Michel returned from lunch, Officer Smith went to perform an inmate check at 11:05 A.M. At that time, Young was found to have committed suicide by hanging in his cell.

Methadone

Young v. Peoria Cty., Illinois, No. 1:16-CV-01367-JBM, 2017 WL 6418888, at *1 (C.D. Ill. Dec. 15, 2017)

- Plaintiff alleges that nurse Radcliff–Tish was responsible for providing, and did provide, mental and physical evaluations to Young while he was incarcerated from October 6 to October 12, 2014 (personal involvement).
- Plaintiff states that nurse Radcliff–Tish knew that Young was a "repeat" offender, that he had been on "suicide watch" during previous incarcerations, that he was at a higher risk for suicide and for exhibiting opioid withdrawal symptoms, that he was a heroin addict and was being treated for addiction with methadone daily, and that she witnessed him exhibiting signs of mental distress and severe withdrawal symptoms between October 6 and October 10 (subjective knowledge of the significant likelihood that Young may harm himself)
- Plaintiff further claims that nurse Radcliff–Tish denied Young methadone treatment and discharged him from care on October 10 with no further instruction, despite her knowledge that he was previously on suicide watch and despite Young exhibiting signs of withdrawal symptoms, mental distress, verbal and non-verbal behaviors, anxiety, appetite change, and refusal to cooperate or communicate with defendants between October 6 and October 9, thereby exhibiting deliberate indifference to his medical needs (deliberate indifference)

While the Court makes no prediction about the ultimate merit of Plaintiff's claim against nurse Radcliff–Tish, the Court finds that "it is one that deserves at least the development that summary judgment would permit."

Methadone

Young v. Peoria Cty., Illinois, No. 1:16-CV-01367-JBM, 2017 WL 6418888, at *1 (C.D. Ill. Dec. 15, 2017)

RULING

- *See Dixon*, 819 F.3d at 350 (7th Cir. 2016)(allegations that doctor knew about prisoner's chest tumor yet offered him only non-prescription pain medication, and discharged him from the jail's hospital were enough to state deliberate indifference claim); *Thomas*, 604 F.3d at 301–02 (finding deliberate indifference based on prison officials ignoring an inmate's visible symptoms of serious illness); *McIntosh v. Wexford Health Sources, Inc.*, 17–103, 2017 WL 1067782, *5 (S.D. Ill. Mar. 21, 2017) (plaintiff stated deliberate indifference claim in jail suicide case where he alleged that defendant was aware that plaintiff had been deemed a suicide risk in the past). At this stage of the litigation, Plaintiff's second amended complaint plausibly alleges a deliberate indifference claim against nurse Radcliff–Tish.

Plaintiff's second amended complaint purports to bring a deliberate indifference claim against CHC and CCS in their individual capacities, as well.

Suboxone

Alvarado v. Westchester Cty., 22 F. Supp. 3d 208 (S.D.N.Y. 2014)

- **Background**:
  - Several pro se inmates filed a lawsuit alleging deliberate indifference against CCS and Westchester County Jail
  - Before being taken into custody, each was addicted to heroin. At booking, they informed intake medical staff that they were "regular heroin users who had begun to experience withdrawal symptoms"
    - For example, one plaintiff told medical personnel he used 5-10 bags of heroin daily and "displayed needle marks on his arms as verification of drug abuse"
    - Three other plaintiffs informed medical staff they had been "participating in a Methadone Clinic" before their incarceration
  - Shortly after booking, these inmates began reporting withdrawal symptoms (vomiting, nausea, fatigue, diarrhea, insomnia, loss of appetite, anxiety, shakes, aching bones, etc.)

Suboxone

Alvarado v. Westchester Cty., 22 F. Supp. 3d 208 (S.D.N.Y. 2014)

- Background:
  - The plaintiffs requested treatment with Methadone or Suboxone
  - Their requests were uniformly denied
  - They were detoxed & treated for their withdrawal symptoms (Tylenol, Maalox, etc.)
- The plaintiffs brought a Section 1983 action, alleging the medical defendants were deliberately indifferent to their serious medical needs
  - They specifically alleged that the medical defendants' refusal to dispense methadone or Suboxone violated County policy and evinced deliberate indifference to their serious medical needs

Suboxone

Alvarado v. Westchester Cty., 22 F. Supp. 3d 208 (S.D.N.Y. 2014)

The Court ruled that the plaintiffs had stated a claim for deliberate indifference

Here, plaintiffs plausibly allege the Defendants' deliberate indifference.

After learning Heady was using heroin, WCJ medical personnel allegedly told him—apparently contrary to fact—"let's get one thing clear[:] we do not have a Methadone program here at [WCJ] so don't ask." Heady was given ibuprofen and sent back to his housing unit. Throughout the week, Heady allegedly continued to seek "medical attention" at "sick call," complaining he was suffering from "insomnia" and could not eat but was consistently denied treatment with methadone or Suboxone.

WCJ medical personnel allegedly told Susa he "would not receive any medication for withdrawal symptoms" and denied him treatment of any kind, forcing him to withdraw from heroin "cold turkey."

And after medical personnel allegedly ignored Fraiser's complaints that the over-the-counter medications he had been given were "not effective," Fraiser alleges he could neither eat without vomiting nor sleep through the night for approximately two-and-one-half months.

These allegations, among others, plausibly allege the Correct Care Defendants' deliberate indifference to plaintiffs' serious medical needs. *See Messina v. Mazzeo,* 854 F.Supp. at 140 (pretrial detainee pleaded deliberate indifference of prison doctor who told him "I don't care what you do. You can stand on your head, tear the place apart, you're not getting methadone").

Moreover, plaintiffs' allegations they were uniformly denied methadone or Suboxone over the course of nine months when it was apparent their treatment with over-the-counter medications was "not effective"—together with Heady's allegation he was falsely informed WCJ "[did] not have a Methadone program" at all—plausibly allege such deliberate indifference was so widespread as to amount to a pattern of misconduct by the [Medical] Defendants.

Suboxone

Brawner v. Scott Cty., Tennessee, 14 F.4th 585 (6th Cir. 2021)

In this case, the inmate was on active CD Rx's when booked into the jail (specifically: suboxone, clonazepam, and gabapentin) and made the jail aware of those Rx's at intake; however, those Rx's were not continued. The inmate showed withdrawal-type symptoms and ended up having significant seizures, leading to alleged permanent injury. I would also note that her seizures were being treated within the jail with Dilantin.

The court ruled that a reasonable jury could infer that the nurse "failed to take the necessary steps to ensure that Brawner received her medications **or suitable substitutes**."

The court also stated: Based on this evidence and **considering that suboxone is a well-known opioid-withdrawal medication**, "a jury could reasonably find that [Brawner] had a serious need for medical care that was 'so obvious that even a layperson would easily recognize the necessity for a doctor's attention.' " Blackmore v. Kalamazoo County, 390 F.3d 890, 899 (6th Cir. 2004) (quoting Gaudreault v. Municipality of Salem, 923 F.2d 203, 208 (1st Cir. 1990)).

Suboxone

Brawner v. Scott Cty., Tennessee, 14 F.4th 585 (6th Cir. 2021)

- Now, to the meat and potatoes -- the issue of county liability/policy and custom claim under *Monell ...* (Remember that, while this case involved a jail policy, correctional healthcare companies can be held liable under the same policy & custom standard as jails.)
- Two county policies were identified at issue as being the moving force behind the constitutional violation:

1. The jail had a fourteen-day policy that inmates did not have to undergo a medical examination until they had been in jail for 14 days.
2. **The jail had a policy that did not allow controlled-substances in the jail**.

Suboxone

Brawner v. Scott Cty., Tennessee, 14 F.4th 585 (6th Cir. 2021)

- It's this latter policy that the Sixth Circuit took issue. In the *Brawner* case, the jail had a "blanket ban on controlled substances." With regard to this second policy, the court ruled:
  - In short, **because it is undisputed that the jail had a ban on controlled substances,** and there was testimony that the abrupt discontinuation of Brawner's prescriptions caused her seizures, **Brawner presented sufficient evidence to identify the problematic policy, connect it to the County, and show that the policy caused her injuries**. Morgan, 903 F.3d at 566; see also Ford v. County of Grand Traverse, 535 F.3d 483, 498 (6th Cir. 2008) (finding sufficient evidence of causation where a doctor's testimony that Dilantin would have prevented the plaintiff's seizures “provided a basis for finding that Ford would not have suffered a seizure had she been given Dilantin within a few hours of her arrival at the jail”).

Shift in culture…

- *The Journal of Law, Medicine & Ethics,* 46 (2018): 252-267.

Prisoners as Patients: The Opioid Epidemic, Medication-Assisted Treatment, and the Eighth Amendment

Michael Linden, Sam Marullo, Curtis Bone, Declan T. Barry, and Kristen Bell

NCCHC NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE

Prisoners as Patients: The Opioid Epidemic, Medication-Assisted Treatment, and the Eighth Amendment

Michael Linden, Sam Marullo, Curtis Bone, Declan T. Barry, and Kristen Bell

The United States still has the highest rate of incarceration of any nation in the world, despite a modest decline over the last decade.[1] During that same decade, an opioid crisis was brewing, and has now captured the nation's attention. In 2016, an estimated 42,000 people died from opioid overdoses, 28 percent more than the year prior.[2] This epidemic is particularly acute in American prisons and jails, where more than half the population meets the criteria for drug abuse or dependence.[3] Drug use in correctional institutions leads to a series of negative consequences during and after incarceration — not only deadly overdoses, but also the transmission of dangerous diseases like hepatitis C and HIV through injection drug use, and other long-term health consequences like pulmonary and heart infections.[4]

It is clear that opioid use disorder — "a problematic pattern of opioid use leading to clinically significant impairment or distress"[5] — puts the lives and well-being of incarcerated people at risk. Yet in the face of such great need, only a small percentage of incarcerated people with opioid addictions have access to what leading medical organizations take to be the standard of care: medication-assisted treatment (MAT).[6] MAT typically uses medications that are opioid agonists, such as methadone and buprenorphine-naloxone. Methadone and buprenorphine are long-acting medications that offer a slow release of dopamine and help patients refrain from illicit opioid use without the physical and psychological consequences of withdrawal or the euphoric effects of short-acting opioids.[7] Both allow patients to pursue normal activities of daily living without debilitating drug cravings.[8]

Despite 50 years of evidence demonstrating the effectiveness of MAT, "of the nation's 5100 jails and prisons, fewer than 30... offer opioid users the most proven method of recovery: administering methadone or buprenorphine."[9] Even in facilities that purport to

This article argues that correctional institutions violate the Eighth Amendment when they refuse to establish MAT programs and prevent doctors from exercising medical judgment to properly treat incarcerated people with OUD.

Evolving standards

The current consensus of the medical community — both clinical and academic — is that MAT is the standard of care for treating OUD. A broad range of mainstream organizations — the World Health Organization (WHO),[161] the National Institute on Drug Abuse,[162] the Substance Abuse and Mental Health Services Administration,[163] the Center for Disease Control,[164] the American Medical Association (AMA),[165] and even the American Academy of Pediatrics[166] — all recommend MAT. The WHO goes further and explicitly recommends MAT during incarceration,[167] as does the American Psychiatric Association.[168]

Evolving standards

In 2016, Rhode Island became the first state in the nation to implement a comprehensive MAT program for its entire prison system	Other states, including Connecticut and Vermont, are currently experimenting with programs of their own
• A year and a half later, initial results showed an almost four-fold increase in the number of patients receiving MAT & a 61% decrease in overdose deaths among people released from incarceration within the past year	

Evolving standards

In 2016, the Surgeon General of the United States released a 400-page report on addiction, discussing MAT extensively.

In 2017, the President's Commission on Combating Drug Addiction and the Opioid Crisis called for offering MAT in jails and prisons in its final report.

The National Association of Drug Court Professionals have issued statements in support of MAT.

The Hazelden Betty Ford Foundation, one of the largest drug treatment providers in the U.S., has opted to provide MAT instead of focusing on 12-step programs.

The Federal Bureau of Prisons has also launched MAT field trials in prisons

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