LEGAL ACTION CENTER

SAMPLE LETTER ADVOCATING TO
STAY ON MEDICATION-ASSISTED TREATMENT
[Created by the Legal Action Center, 8.23.16]

INTRODUCTORY NOTE

- This letter is a template to use when courts or other criminal justice agencies require people to stop using FDA-approved medications such as methadone, buprenorphine-naloxone (Suboxone), or injectable naltrexone (Vivitrol) to treat opioid addiction, against physician advice.
- This letter is intended to be sent by a lawyer or other advocate. But people who do not have an advocate can use it themselves. Just be sure to change it accordingly.
- Consider adding to the letter a reference to the individual's treatment providers and other evidence in support of continued MAT. For additional advocacy ideas, read *Advocating for Your Recovery When Ordered Off Addiction Medication,* available at http://lac.org/resources/substance-use-resources/medication-assisted-treatment-resources/.
- **This letter should not be sent "as is."** A Word version is on the Legal Action Center's website at http://lac.org/resources/substance-use-resources/medication-assisted-treatment-resources/. Individual information must be inserted, and information in the brackets should be removed. You should also be sure to delete the heading ("Sample Letter" at the top of the page and this "introductory note."
- Remember to keep copies of everything you send to, and receive from, the court or criminal justice agency.

REMEMBER: do not include this cover sheet with your letter.

SAMPLE LETTER

[Date]

[Your name]
[Your address]

[Name of person you are writing to]
[Address of person you are writing to]

Re: [insert case name/number]

Dear [name]:

[Insert explanation of who is writing and what is at issue, e.g., a court has ordered someone to taper off of methadone, buprenorphine or injectable naltrexone within a specified time period, and what you are seeking.]

Requiring [insert name of individual being forced off MAT] to taper off [his/her] addiction medication runs counter to evidence-based practices and, accordingly, undermines [name]'s recovery and abstention from illicit drugs. It also could violate federal anti-discrimination laws. As set forth below, methadone, buprenorphine and injectable naltrexone are well-studied and highly effective treatments for opioid addiction, and they have the approval of all major public health authorities in the United States. Involuntary cessation of these prescribed medications for opioid addiction would significantly increase the risk of relapse, overdose, and even death.

I. Medication-Assisted Treatment Is Effective Treatment

Medication-assisted treatment ("MAT") is the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders, including opioid addiction. MAT combines counseling and behavioral therapies with FDA-approved medications, such as methadone, buprenorphine, or injectable naltrexone, to provide a whole-patient approach to recovery. MAT operates to normalize brain chemistry that has been disrupted by opioid addiction.

Because "drug abuse changes the way the brain works . . . drug abuse treatment must address these brain changes."[1] But unlike short-acting opioids such as heroin and prescription painkillers, which produce a euphoric "high," long acting MAT medications

[1] NATIONAL INSTITUTE OF DRUG ABUSE (NIDA), TOPICS IN BRIEF, MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION (Apr. 2012), *available at* http://www.drugabuse.gov/sites/default/files/tib_mat_opioid.pdf.

like methadone and buprenorphine block these euphoric effects while simultaneously relieving the cravings that often induce relapse.[2]

Methadone maintenance

Methadone maintenance treatment is the most highly studied form of addiction treatment. Its efficacy has been established for decades:

- In 1997, the U.S. Department of Health and Human Services' National Institutes of Health Consensus ("NIH") Panel found that "[o]f various treatments available, methadone maintenance treatment, combined with attention to medical, psychiatric and socio-economic issues, as well as drug counseling, has *the highest probability of being effective.*"[3]

- The Centers for Disease Control and Prevention ("CDC") called methadone maintenance treatment "the most effective treatment for opiate addiction" in 2002.[4]

- NIH declared in 1997 that "the safety and efficacy of narcotic agonist (methadone) maintenance treatment has been unequivocally established. . . . [Methadone maintenance treatment] is effective in reducing illicit opiate drug use, in reducing crime, in enhancing social productivity, and in reducing the spread of viral diseases such as AIDS and hepatitis." In addition, NIH found that "every study showed that death rates were lower in opiate-dependent persons maintained on methadone compared with those who were not."[5]

- The National Institute on Drug Abuse ("NIDA") has said that methadone and other forms of MAT "help patients disengage from drug seeking and related criminal behavior and become more receptive to behavioral treatments."[6]

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[2] *See, e.g.*, U.S. DEP'T OF HEALTH & HUMAN SVCS., NAT'L INST. OF HEALTH, NAT'L INST. ON DRUG ABUSE, PRINCIPLES OF DRUG ADDICTION TREATMENT, NIH PUB. NO. 12-4180, 26-27 (3rd Ed., Dec. 2012), *available at* http://www.drugabuse.gov/sites/default/files/podat_1.pdf.; and U.S. DEP'T OF HEALTH & HUMAN SVCS., SUBSTANCE ABUSE AND MENTAL HEALTH SVCS. ADMIN., ARE YOU IN RECOVERY FROM ALCOHOL OR DRUG PROBLEMS? KNOW YOUR RIGHTS – RIGHTS FOR INDIVIDUALS ON MEDICATION-ASSISTED TREATMENT (2009), 4, *available at* http://www.samhsa.gov/sites/default/files/partnersforrecovery/docs/Know_Your_Rights_Brochure_0110.pdf.

[3] NATIONAL INSTITUTES OF HEALTH, NIH CONSENSUS STATEMENT: EFFECTIVE MEDICAL TREATMENT OF OPIATE ADDICTION (1997), 15-17, *available at* http://consensus.nih.gov/1997/1998TreatOpiateAddiction108PDF.pdf (emphasis added).

[4] U.S. DEP'T OF HEALTH & HUMAN SVCS, CENTERS FOR DISEASE CONTROL, METHADONE MAINTENANCE TREATMENT (Feb. 2002), *available at* http://www.nhts.net/media/Methadone%20Maintenance%20Treatment%20(20).pdf

[5] National Institutes of Health, *NIH Consensus Statement: Effective Medical Treatment of Opiate Addiction* (1997), p. 4, 7, available at http://consensus.nih.gov/1997/1998TreatOpiateAddiction108PDF.pdf.

[6] NATIONAL INSTITUTES OF HEALTH, NIH CONSENSUS STATEMENT: EFFECTIVE MEDICAL TREATMENT OF OPIATE ADDICTION (1997), 4-7, *available at* http://consensus.nih.gov/1997/1998TreatOpiateAddiction108PDF.pdf

- When compared with non-pharmacological approaches, methadone maintenance treatment is more effective in retaining patients in treatment and suppressing illicit opioid use, thus enabling patients to enter recovery.[7]

Buprenorphine

Similarly, since 1995, numerous studies have demonstrated the safety and efficacy of buprenorphine in treating opioid addiction.[8]

- The National Institute of Drug Abuse ("NIDA") found that, like methadone, buprenorphine has "been shown to help normalize brain function" for individuals addicted to heroin.[9]

- A July 2014 Informational Bulletin from the Directors of the Center for Medicaid and CHIP Services, the Centers for Disease Control and Prevention ("CDC"), the Substance Abuse and Mental Health Services Administration, and the National Institute of Health ("NIH") stated that buprenorphine "reduces or eliminates opioid withdrawal symptoms, including drug cravings, without producing the euphoria or dangerous side effects of heroin and other opioids."[10]

- Studies have shown that buprenorphine is safe and highly efficacious;[11] decreases hospital admissions, morbidity, and mortality;[12] reduces illicit opioid use;[13] increases treatment retention;[14] and is much more effective when used in ongoing maintenance treatment than when patients are tapered off the medication.[15]

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[7] Catherine A. Fullerton et al., *Medication-Assisted Treatment With Methadone: Assessing the Evidence*, *Psychiatric Services* in Advance, (Nov. 18, 2013), *available at* http://idhdp.com/mediaimport/43721/appi.ps.201300235.pdf.

[8] *See, e.g.*, Cindy Parks Thomas et al., *Medication-Assisted Treatment with Buprenorphine: Assessing the Evidence*, PSYCHIATRIC SERVICES IN ADVANCE, (Nov. 18, 2013).

[9] NIDA, U.S. DEP'T OF HEALTH & HUMAN SVCS, *Principles of Drug Abuse Treatment for Criminal Justice Populations,* (September 2006), 5 NAT'L INST. OF HEALTH, NIH PUB. NO. 06-5316.

[10] CMS, SAMHSA, CDC & NIH, INFORMATIONAL BULLETIN—MEDICATION ASSISTED TREATMENT FOR SUBSTANCE USE DISORDERS (Jul. 11, 2014) 3.

[11] Johan Kakko et al., *1-Year Retention & Social Function After Buprenorphine-Assisted Relapse Prevention Treatment for Heroin Dependence in Sweden: a randomized, placebo-controlled trial*, LANCET, VOL. 361 (Feb. 22, 2003).

[12] Sofie Mauger, Ronald Fraser, & Kathryn Grill, *Utilizing buprenorphine-naloxone to treat illicit and prescription-opioid dependence*, NEUROPSYCHIATRIC DISEASE & TREATMENT 2014:10 587-598, 588 (2014).

[13] Roger D. Weiss et al., *Adjunctive Counseling During Brief and Extended Buprenorphine-Naloxone Treatment for Prescription Opioid Dependence*, ARCH. GEN. PSYCHIATRY (Dec. 2011), 9, *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3470422/.

[14] Cindy Parks Thomas et al., *Medication-Assisted Treatment with Buprenorphine: Assessing the Evidence," Psychiatric Services in Advance*, (Nov. 18, 2013), 7.

David A. Fiellin et al., *Primary Care-Based Buprenorphine Taper vs Maintenance Therapy for Prescription Opioid Dependence*, JAMA INTERN. MED. (Oct. 20, 2014).

Injectable naltrexone

Studies have also demonstrated the efffectivness of injectable naltrexone.

- One study showed that its use in a New York City jail decreased illicit opioid use by more than 50 percent following release.[16]

- Another study showed that individuals under probation and parole supervision who received injectable naltrexone had abstinence rate three times higher than those getting psychosocial treatment only.[17]

In short, scientific research has established that MAT increases patient retention in drug treatment and decreases illicit drug use. Studies also have shown that MAT decreases infectious disease transmission, criminal activity, and overdose.[18]

II. Common Misconceptions about MAT

Despite the overwhelming evidence of MAT's benefits, there are many negative perceptions of addiction medication that often are inconsistent with scientific evidence. Following are common misconceptions and the corresponding evidence about MAT:

- ***Common Misconception***: *MAT "substitutes one addiction for another."*

  Evidence Shows: Though methadone and buprenorphine are opioid-based, they are fundamentally different from short-acting opioids such as heroin and prescription painkillers. The latter go right to the brain and narcotize the individual, causing sedation and the euphoria known as a "high." In contrast, methadone and buprenorphine, when properly prescribed, reduce drug cravings and prevent relapse without causing a "high."[19] They help patients disengage from drug seeking and related criminal behavior and become more receptive to behavioral treatments.[20] Injectable naltrexone is not opioid based and does not produce physical dependence.

- ***Common Misconception***: *Addiction medications are a "crutch." They prevent people from learning coping skills and entering "true recovery."*

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[16] Joshua D. Lee et al., *Opioid treatment at release from jail using extended-release naltrexone,* ADDITION (2015), *available at* http://onlinelibrary.wiley.com/doi/10.1111/add.12894/epdf.
[17] Chrits-Christoph, P., et al., Extended-Release Naltrexone for Alcohol and Opioid Problems in Missouri Parolees and Probationers, *Journal of Substance Abuse Treatment* (2015), http://dx.doi.org/10.1016/j.jsat.2015.03.003.
[18] NIDA TOPICS IN BRIEF, MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION, (April 2012) *available at* http://www.drugabuse.gov/sites/default/files/tib_mat_opioid.pdf.
[19] NIDA TOPICS IN BRIEF, MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION, (April 2012) *available at* http://www.drugabuse.gov/sites/default/files/tib_mat_opioid.pdf.
[20] *See, e.g.*, U.S. DEP'T OF HEALTH & HUMAN SVCS., NAT'L INST. OF HEALTH, NAT'L INST. ON DRUG ABUSE, *Principles of Drug Addiction Treatment*, NIH PUB. NO. 12-4180 (3rd Ed., Dec. 2012), 26-27, *available at* http://www.drugabuse.gov/sites/default/files/podat_1.pdf.

Evidence Shows: True recovery does not mean abstinence from MAT – the abstinence from MAT understanding of recovery is scientifically inaccurate. MAT combines medications *with* behavioral and counseling therapies. The medication normalizes brain chemistry so individuals can focus on counseling and participate in behavioral interventions necessary to enter and sustain recovery.[21]

- ***Common Misconception***: *MAT should not be long term.*

  Evidence Shows: There is no one-size-fits-all duration for MAT. The U.S. Substance Abuse and Mental Health Services Administration ("SAMHSA") recommends a "phased approach," beginning with stabilization (withdrawal management, assessment, medication induction, and psychosocial counseling), and moving to a middle phase that emphasizes medication maintenance and deeper work in counseling. The third phase is "ongoing rehabilitation," when the patient and provider can choose to taper off medication or pursue longer term maintenance, depending on the patient's needs.[22] For some patients, MAT could be indefinite.[23] NIDA describes addiction medications as an "essential component of an *ongoing* treatment plan" to enable individuals to "take control of their health and their lives."[24] For methadone maintenance, NIDA states that "12 months of treatment is the minimum."[25]

- ***Common Misconception***: *Requiring people to taper off MAT is beneficial because it leads to "true recovery."*

  Evidence Shows: Requiring people to stop taking their addiction medications is counter-productive and increases the risk of relapse.[26] Furthermore, because tolerance to opioids fades rapidly, one episode of opioid misuse after detoxification can result in life-

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[21] NIDA, *Drug Facts: Treatment Approaches for Drug Addiction*, Revised Sept. 2009, *available at* http://www.drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction.

[22] OFFICE OF NATIONAL DRUG CONTROL POLICY, MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION, (Sept. 2012), 3, *available at* http://www.whitehouse.gov/sites/default/files/ondcp/recovery/medication_assisted_treatment_9-21-20121.pdf.

[23] U.S. DEPT OF HEALTH & HUMAN SVCS, SUBSTANCE ABUSE & MENTAL HEALTH ADMIN., MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION IN OPIOID TREATMENT PROGRAMS, TREATMENT IMPROVEMENT PROTOCOL (TIP) 43 (2005), *available at* http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214. *See also* David Mee-Lee, ed., *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions* (Oct. 14, 2013), e-page 293, noting that "the notion that the duration of treatment varies … is a foundational principle of the ASAM criteria."

[24] NIDA TOPICS IN BRIEF, MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION (April 2012).

[25] U.S. DEP'T OF HEALTH & HUMAN SVCS, CENTERS FOR DISEASE CONTROL, METHADONE MAINTENANCE TREATMENT, (Feb. 2002), *available at* http://www.cdc.gov/idu/facts/methadonefin.pdf, citing NIDA, PRINCIPLES OF DRUG ADDICTION TREATMENT: A RESEARCH BASED GUIDE (1999), *available at* http://www.drugabuse.gov/sites/default/files/podat_1.pdf.

[26] OFFICE OF NATIONAL DRUG CONTROL POLICY, MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION, (Sept. 2012) *available at* http://www.whitehouse.gov/sites/default/files/ondcp/recovery/medication_assisted_treatment_9-21-20121.pdf (citing Day, E., & Strang, J. (2010). *Outpatient versus inpatient opioid detoxification: a randomized controlled trial* [Electronic Version]. J.OF SUBSTANCE ABUSE TREATMENT. 40 (1), 46-66).

threatening or deadly overdose.[27] Indeed, a 28-year old New Yorker, Robert Lepolszki, died from a heroin overdose in 2014 after a judge ordered him to stop his successful methadone maintenance treatment.[28]

- ***Common Misconception***: *Courts are in a better position than doctors to decide appropriate drug treatment.*

  Evidence Shows: Deciding the appropriate treatment for a person with opioid addiction is a matter of physician discretion, taking into consideration the relevant medical standards and the characteristics of the individual patient. Just as Probation Officers would not decide that a person should treat her diabetes through exercise and diet alone, and instruct her to stop taking insulin, Probation Officers are also not trained to make medical decisions with respect to various forms of medically-accepted addiction treatment.

III. Broad-Brushed Denial of MAT Violates Anti-Discrimination Laws

Title II of the Americans with Disabilities Act ("ADA") prohibits local and state governments, including courts and probation departments, from discriminating on the basis of disability.[29] The ADA requires probation departments to treat individuals with disabilities objectively and fairly, and to make decisions on the basis of medical evidence rather than assumptions about disabilities and the people who have them.

[*Insert name of individual being forced to end MAT*] is an "individual with a disability" under the ADA. The law is well settled that people with opioid addiction, including those who receive treatment with medications such as methadone, buprenorphine, or naltrexone, are individuals with a "disability" under the ADA. They have a current impairment (drug addiction) that substantially limits a major life activity (including, but not limited to, major bodily functions such as neurological and brain function, as well as activities such as caring for one's self, learning, and working), a record of such an impairment, and/or are regarded as having such an impairment.[30] Accordingly, courts and probation departments may not

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[27] OFFICE OF NATIONAL DRUG CONTROL POLICY, MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION, (Sept. 2012), *available at* http://www.whitehouse.gov/sites/default/files/ondcp/recovery/medication_assisted_treatment_9-21-20121.pdf.

[28] *See* Ann Givens & Chris Glorioso, *I-Team: Father Faults Judge for Son's Heroin Overdose*, NBC New York, (Aug. 29, 2014), http://www.nbcnewyork.com/news/local/Methadone-Judge-Rule-Father-Blame-Lepolszki-Son-Overdose-Heroin-Addict-Ruling-I-Team-Investigation-273213211.html.

[29] Courts that receive federal funding also are subject to the anti-discrimination provisions of the Rehabilitation Act of 1973. The ADA and Rehabilitation Act are analyzed interchangeably. *See, e.g.*, *Lincoln Cercpac v. Health and Hospitals Corp.*, 147 F.3d 165, 167 (2d Cir. 1998).

[30] *See* 42 U.S.C. § 12102(1) and 28 C.F.R. § 35.104. and cases applying the ADA's protections to individuals with opioid addiction: *MX Group, Inc. v. City of Covington*, 293 F.3d 326, 336 (6th Cir. 2002) (noting that it is well established that drug addiction constitutes an "impairment" under the ADA and that drug addiction necessarily substantially limited the major life activities of "employability, parenting, and functioning in everyday life."; *Start, Inc. v. Baltimore Cnty., Md.*, 295 F. Supp. 2d 569, 576-77 (D. Md. 2003) (reasonable to assume that individuals in MAT are "limited in their ability to work, raise children, care for themselves, and

treat opioid-addicted individuals who receive (or need) MAT differently than other individuals because of their disability. Decisions about individuals with opioid addiction must be made in an even-handed, non-discriminatory manner and must not be based on animus, fear, or stereotypes of people with opioid addiction.

As outlined above, MAT is a scientifically proven form of treatment uniformly endorsed by leading medical and public health authorities, including NIH, NIDA, CDC, and SAMHSA. The benefits associated with its use, as well as the costs associated with its prohibition and with forced taper, are clearly established. Any policy or practice forcing people on probation to change their addiction medication or to stop taking their addiction medication, in contravention of their doctor's recommendation, runs counter to this objective scientific evidence and increases the chance of relapse and recidivism. Such policies and practices, therefore, can violate the ADA.

For more information about why denial of access to MAT can violate anti-discrimination laws, please read Legal Action Center's report, *Legality of Denying Access to Medication Assisted Treatment*, available at http://lac.org/wp-content/uploads/2014/12/MAT_Report_FINAL_12-1-2011.pdf. For more information about MAT generally, please see the resources cited in the footnotes.

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Please consider the information provided herein and end any policy or practice that requires individuals to end their medication-assisted treatment. Such policies and practices deprive individuals of their federally-protected rights, and increase the risk that those individuals will relapse, recidivate, overdose, and even die.

Respectfully submitted,

[your name]
[your title (if relevant)]

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function in everyday life" and have a record of such an impairment); *Bay Area v. City of Antioch*, 2000 WL 33716782, at *6 -7 (N.D. Cal. Mar. 16, 2000) (individuals receiving MAT are still often substantially limited in their ability to work and raise a family and have a "record" of disability of untreated heroin addiction; also are regarded as disabled). Since the passage of the ADA Amendments Act of 2008, the ADA's applicability to opioid addicted individuals is even clearer.