Health Care and the ADA-Inclusion of Persons with Disabilities
Pacific ADA Center
Thursday, June 22, 2023 1:15-3:00 P.M. CT

>> PAM WILLIAMSON: Good afternoon or good morning, everyone. Welcome to the ADA healthcare and inclusion of persons with disabilities webinar series. I'm Pam Williamson and assistant director of the Southeast ADA Center. I'm joined by Oce Harrison, director of the New England ADA Center, and we'll be your moderators for today's webinar. This series of webinars is brought to you by the Pacific ADA Center on behalf of the ADA National Network. The ADA National Network is made up of ten regional centers federally funded to provide training, technical assistance and other information as needed on the Americans with Disabilities Act. You can reach your regional ADA Center by calling 1-800-949-4232. Next slide, please. Realtime captioning is provided for this webinar. The caption screen can be accessed by choosing the CC closed caption icon in the meeting control bar. To toggle the meeting control bar permanently on press the alt key once and the alt key a second time. As always in our sessions only the speakers will have audio. Next slide, please. If you do not have sound capabilities on your computer or prefer to listen by phone, you may dial 1-669-900-2128 or 1-646-558-8656. The webinar ID is 837-2204-3591. Please note this is not a toll-free number. As a reminder, the webinar is being recorded and can be accessed on at the website. And it will be available next week.

Next slide, please. You may type and submit questions in the chat area box or press alt-H and enter text in the chat area. If listening by phone and not logged into the webinar, you may ask questions by emailing them to adatech@ADAPacific.org.

This series is intended to share issues and promising practices in healthcare accessibility for people with disabilities. The series topics covers physical accessibility effective communication and reasonable modification of policy issues under the Americans with Disabilities Act of 1990, also known as the ADA upcoming sessions are available at www.ADAPresentations.org under the Schedule tab and follow to healthcare. These webinars occur every month on the fourth Thursday of the month at 2:30 p.m. Eastern time, 1:30 p.m. Central time, 12:30 p.m. Mountain time, and 11:30 a.m. Pacific time. By being here you are on the list to receive notices for this series. The notices go out two weeks before the webinar and open the webinar to registration. You may follow along on the webinar platform with the slides. If you are not using the webinar platform, you may download a copy of today's PowerPoint presentation at the healthcare schedule webpage at www.ADAPresentations.org. At the conclusion of today's presentation, there will be an opportunity for everyone to ask questions, and you may submit your questions using the chat area within the webinar platform. The speakers and I will address them at the end of the session. So feel free to submit them as they come to your mind during the presentation.

Next slide, please.

If you experience any technical difficulties during the webinar, please send a private chat message to the host by typing in the chat window. Type your comment and in the text box and enter. You may also use the keyboard alt-H to access the chat box via keyboard keys, or you may email adatech@ADAPacific.org or call 510-831-6714, and that's voice or relay. Oce, at this time I would like to turn it to you to introduce our topic for today and also our speaker.

>> OCE HARRISON: Thank you, Pam. Today's ADA National Network learning session is titled "Healthcare and the Civil Rights in the Opioid Crisis: DOJ On Utilizing the ADA and Other Civil Rights Laws." Opioid crisis has been an ongoing major issue in the United States. The treatment of those with opioid use disorder in both health systems and the criminal justice system has also raised civil rights concerns. Today's discussion will focus on the Department of Justice and how it has been using the Americans with Disabilities Act and other federal civil rights statutes to address the opioid crisis. Today's speaker is Greg Dorchak. Greg is an assistant U.S. attorney in the Civil Rights Unit at the U.S. attorneys office in Massachusetts where he has worked since 2015. Greg's office has entered into numerous settlement agreements and letters of resolution to ensure ADA compliance arising from opioid use disorder mistreatment in healthcare and in the justice system. These agreements spark many others across the country. Last year Greg co-authored a journal article with David Syncman of the U.S. attorney's office in Louisiana. The title of the article is "Using the Americans with Disabilities Act to Reduce Overdose Deaths." The article provides evidence that when people have access to the doctor-prescribed medications to treat their addiction overdose deaths go down. I'll put the link into this article in the chat. Greg also teaches disability rights at Boston University's school of law. He received his JD from northeastern University and Ph.D. from the University of Massachusetts Amherst. As a professional, a colleague, and a collaborator, Greg is a person that many of us can count on. He is readily available to staff at the New England ADA Center to people with addiction and recovery and their families and to addiction professionals. It is my good fortune to introduce you to Greg Dorchak, and your good timing to meet him. Greg.

>> GREG DORCHAK: Thank you, Oce. And thank you so much for the kind words. And thank you, everybody, today for joining me here. I actually didn't plan on wearing the same outfit that I have in the photo here, so that's a lovely coincidence. You can tell it's me, although more beard, I believe, and more gray, sadly. But if you go to the next slide, what I want to do today is talk about the ADA, how we use it to address the opioid crisis in the Department of Justice and how our work can be replicated elsewhere. It can be replicated by advocates in the community, and it's important for folks to know, just to understand that there is a strong role for disability rights in the opioid crisis. Next slide, please.

So we want to talk about three different learning objectives. First I'm going to kind of give the overview of the opioid crisis and its relationship to both the criminal justice systems and health systems, where I'm going to talk about how routinely people with opioid use disorder are denied access to medication and that ends up perpetuating the opioid crisis. A lot of times people focus when talking a the opioid crisis on supply,

thinking about this economically, the supply of drugs. But if you also think about opioid use disorder as a disability, a treatable disability, you recognize that there's also the demand component. And too often understanding that people have opioid use disorder and that addiction lasts, whether or not there is a supply of drugs or not, that reducing the supply of drugs doesn't necessarily treat the disability. So I want to talk about that relationship, and give an overview of the use disorder and how it is tied into the criminal justice system and the health system. Then I'm going to talk about how the ADA and also other federal civil rights statutes -- here I'm thinking of the Fair Housing Act and Section 504 protect individuals with OUD or Opioid Use Disorder, ensuring access to their medication that treats the addiction. And then finally I'm going to close out today by talking about the Department of Justice, and specifically how we tie that together. How we have used the ADA the Fair Housing Act in Section 504 to address ensuring access to healthcare for people with Opioid Use Disorder. As always, I'm happy to take questions as we go along, as well as at the end. I'm going to provide copies of guidance that the Department of Justice has released on the relationship between the ADA and Opioid Use Disorder, just so you have that ready. I just have to remember when we get to the end, I have the link ready to go and I'll drop that in the chat so that everybody has that available. But to give it a start... could you go to the next slide, please?

So let's give an overview of the problem. And the problem is the criminal justice system and health systems routinely deny persons with Opioid Use Disorder access to their medications, and that perpetuates the opioid crisis. So diving in... next slide, please.

We have an overview of the opioid crisis. We hear a lot about it in the news and media. It's always on the front page it seems, at least here in Massachusetts, which has been hit particularly hard by the opioid crisis, but according to the CDC, 109,000 and 680 individuals died from opioid overdoses in the United States in 2022. And this was the highest number ever recorded. In Massachusetts, the numbers were just released for 2022 showing that 2,300 individuals died of opioid overdoses in 2022. That was the highest number on record for Massachusetts. Now, when we're talking about those numbers, there is a different kind of stratification of who is hit, the vulnerable populations that are necessarily impacted by the opioid crisis. And at the key to this is the criminal justice involved individuals. Specifically newly returned prisoners, who are 120 times more likely to die of an opioid overdose from the rest of the population. I'm happy to provide links to all of the statistics that I give throughout. Please reach out to me. My email address will be found at the end. The article that Oce mentioned that I wrote last year with David Syncman also cites these numbers, but the real factor is the criminal justice involved individuals are by far leaps and bounds the most impacted by the opioid crisis. And if you go to the next slide...

First I want to talk about what Opioid Use Disorder is. I'm going to use the acronym OUD throughout. You might hear me use an acronym called SUV, which is substance use disorder. OUD is a subset of SUD. Substance use disorder is the name of the DSM-5 gives to a whole broad range of use disorders, whether or not it's alcohol use disorder, opioid use disorder, cocaine use disorder, by common vernacular we refer to

these as addiction or forms of addiction, but OUD is going to be kind of the focus that I have here today. But some of the information about protections will fall and address other use disorders as well. If we think about opioid use disorder -- I apologize for the beeping. It should stop now.

The DSM-5 gives a number of characteristics for what Opioid Use Disorder is. You can think of it as a chronic brain disease. So chronic disease. It's going to be something that somebody has chronically treated for the rest of their life. It is a chronic brain disease where a person has cravings for opioids and is compelled to chronically use opioids despite negative consequences. Those negative consequences might be impacts on personal relationships, might be impacts on the ability to obtain housing and maintain a job and so on. The need for increased use of opioids to achieve a high or a euphoria, and the body physically going through withdrawal when not using opioids. Now, it's important to know there is a large fear factor when we talk about opioids and the crisis in the media. But it's important to know not everybody who uses opioids develops opioid use disorder. In fact, only about 24%, a rather small number of people who use opioids develop Opioid Use Disorder. So somebody might need opioids for pain management. That person, if they're using eight as prescribed, and consistent with the doctor's orders, does not exhibit these other symptoms would be not indicating or not having an opening use disorder. Similarly, somebody who might have a surgery or might have an experience at a dentist office, who provide opioids. Just because a person uses opioids doesn't mean that they are automatically going to or even likely to develop an opioid use disorder. It demonstrates that some people's bodies develop the use disorder over time. It might be a number of psychosocial aspect that make them predetermined to develop the use disorder. It might be things -- part of their body physiology that make them more likely to develop an opioid use disorder. But the important thing is that some people can and do use opioids without developing this and some people do not. If you can go to the next slide.

So it's important to know where I'm going here that I give you a little bit of the scientific background about how opioids work in the body and how opioid use disorder itself works, as well as about how the medications are used to treat opioid use disorder. And to start all that off, I want to start by talking about what is called the mu receptor. The mu receptor is a part of the body's brain. It is part of the brain that controls the body's pleasure system. So this is a part of the brain that is triggered by opioids, but it's also triggered by other bodily processes. So if you ever have heard of the body developing its own natural endorphins, whether or not it's after eating food, whether or not it's after exercise, etc., various activities that we engage with on the day to day trigger the mu receptor. But so too do opioids. Opioids trigger the mu receptor, and that's the state of feeling that some people will experience when triggered in a particular way will experience a euphoria or a high. But it's important to think of the mu receptor. And if you are going to make an analogy, I want you to think of the mu receptor as a cup. It's a vessel. And when the mu receptor is being triggered think of ourselves as pouring water into that cup. So that's the mu receptor. So next slide, please.

So knowing what the mu receptor is, I want to point out opioid use disorder, we hear all the statistics about people dying regularly, but Opioid Use Disorder is a highly, highly treatable disease, and there are three medications that are used to treat it.

So keeping the mu receptor and keeping the cup analogy in mind, if you could go to the next slide.

The first medication I want to talk about is one called buprenorphine. I can't say that word often, but I might refer to it as bupe, which is what many doctors in the medical field will refer to it as well, if they don't want to find themselves stumbling over buprenorphine over and over again. This comes by the name-brand suboxone. You might hear of suboxone. When you think of suboxone, you think of buprenorphine. Buprenorphine is the medical name, much like, you know, Ibuprofen could be Motrin, I think, Motrin being the name-brand, ibuprofen being the drug name. Buprenorphine is the drug name, suboxone is the name-brand. Now, buprenorphine works by activating the mu receptor. So you think of it as filling that cup. But in filling the cup, it has a ceiling effect. So it can only fill if cup so much before a certain point it doesn't fill the cup anymore. So let's think of it as filling the cup about halfway, and not to trigger the mu receptor, but more -- the more that you fill in after that, I just doesn't do anything. It overflows, it spills out, and you can only fill it halfway. So the way that buprenorphine works is by triggering the same receptor in the brain that opioids would work, but doing it only to a certain point so that it's triggered -- somebody is not receiving -- not experiencing the euphoria. The person who is using -- a person with opioid use disorder who is using buprenorphine is not getting high. Buprenorphine controls cravings. It controls withdrawals. So it's very effective in controlling some of the main things that come with an Opioid Use Disorder, and you can also go to a pharmacy to fill the prescription for buprenorphine. You can go to CVS, you can go to Walmart. So the other key factor is that ceiling effect that I talked about, it actually prevents other opioids from working. So it does not trigger the mu receptor, but it helps to prevent other opioids from also triggering the mu receptor, because of the way that it binds to the mu receptor. So if somebody were to use heroin while using buprenorphine, the heroin wouldn't have as much of an effect as it would if the person didn't have buprenorphine in the system. And therefore the person would be protected from an overdose. I'm not saying it would be a certainty, that it would guarantee they wouldn't have an overdose, but it would cause a high protection against having an overdose with that in the system. So that's medication one, buprenorphine. Similar medication, if you can go to the next slide, is medication number 2, which is methadone. Methadone is only the generic. Methadone is a highly regulated medication that has been around for decades. It's been around since the '70s, the '60s, and people receive methadone at a methadone clinic. Now, a methadone also fills the mu receptor, the cup pouring into the mu receptor. It also activates and triggers the mu receptor, but it does so not with the ceiling effect that you get from buprenorphine. It does so with a highly calibrated dose. So somebody who takes and uses methadone, goes to the clinic. The clinic works on finding the right dose and measuring to find the right dose that does not create the euphoria for the person, does not ideally give them side effects, such as drowsiness and so on, but does enough to activate the mu receptor to control withdrawals, to

control cravings, and with that the person is able to obtain, you know, a job, go through their normal everyday business without having those cravings and withdrawals that they are experiencing. Now, because it's highly regulated you can't just go to a CVS or pharmacy to pick it up in the United States. There are some countries where that regulatory scheme isn't in effect, in Australia, Portugal, for example. You can go to a pharmacy not in the United States. You have to go to the methadone clinic and you have to go there every day for the dosing. Now, the difference between the two, just so you have it as kind of in the background, somebody who has a longer opioid use disorder, much more chronic huge opioid use disorder is probably going to be treated with the methadone, because it is -- it had more effect for the long-term ore-the person who has used heroin, fentanyl, etc., for longer terms. So that's the difference between why somebody might have methadone as opposed to buprenorphine, but buprenorphine does have all the advantages that you don't need to go to the clinic daily. It's much more part of your daily lifer, you pick it up at the pharmacy, and much less stigmatized because of that. So those are the first two medications. And if you can click on the next slide...

So these two medications that I talked about, buprenorphine and methadone, they come in the same class or category of medication called an opioid agonist. Now, they're called an agonist because they activate the mu receptor. And I'm going to contrast that with medication 3, if you can click on the next slide. Medication 3 is called naltrexone or Vivitrol. Vivitrol being the name-brand for the shot that you receive every 28 days. But Vivitrol works, naltrexone works by blocking the mu receptor from working. It cuts it off. So you're thinking of that cup. Rather than activating it and finding that right calibrated dose to stimulate and control cravings, what this is doing is putting a cap on the top. So you go to pour in and nothing can get in to the mu receptor. Nothing can get into that cup. However, it doesn't control the cravings. Now, some people might have a placebo effect where they are feeling that they experienced less desire to go use opioids, but the long-term control is this does not control somebody's cravings. The other aspect about naltrexone is it prevents the body's own opioid endorphins from working in the same way. So there are some down sides. I want to make a huge asterisk in the caveat that I'm not condoning the use of one medication over another. In fact, on the contrary, what I'm doing is pointing out these are three very different medications, and the right medication, as we know from disability rights, everybody's treatment is different, and it requires an individualized assessment, because somebody's body might work different. Somebody's social aspects might work different in such a way that everybody needs their own clinical evaluation to decide what medication is right for them. One other aspect is on the naltrexone you have to get a shot every 28 days in order to maintain that cap over the mu receptor and everybody's body metabolizes that differently. So maybe 26 days for me and maybe 30 days for somebody else. And what is happening or one of the things that could happen is somebody who then uses an opioid after that 20 days -- 28 days, because the cravings might still be there. There may be some down sides in the fact that they're using a dosage that they thought their body could tolerate because it's what their body tolerated, but in fact the 28 days of not using opioids, their body has reduced the ability to process

that dosage. And it can create some danger. In that respect, and there are a number of studies showing that. If you can go to the next slide.

So the third category of medication, the naltrexone, it's what is called an opioid antagonist. So it's a contrast from the opioid agonist. It's an opioid antagonist. It is called an opioid antagonist because it antagonizes, it blocks the mu receptor from working. So that's the overview of the three different medications, thinking of that cup, thinking of methadone and buprenorphine as activating, filling the cup, and thinking of naltrexone as blocking the cup. If you can go to the next slide. Now, studies show that opioid agonists reduce overdose death by more than 50%. Opioid agonists reduce overdose death by more than 50%. There are a number of studies out there, but they are highly effective at reducing overdose death. Next slide.
Here is the problem. Only one in three people have -- with opioid use disorder have access to these medications. We just talked about the entire start -- about the large volumes of individuals in the country that die of opioid overdose every year. One in -- I believe it's 1 in 20 people at least in Massachusetts. It's about 5% of people in Massachusetts have an opioid use disorder. A large number -- and I don't want to say that extrapolates across the country, but large number of people have opioid use disorder and yet so few people have access to these lifesaving medications. And one of the reasons why... go to the next slide, please. One of the reasons why is stigma. So stigma for Opioid Use Disorder and stigma for the treatments are one of the main inhibitors to people actually receiving the standard of care for Opioid Use Disorder. So first of all, there is a non-medical understanding of addiction that is even prevalent in the recovery community that might focus on somebody needing to go cold turkey or not necessarily in true recovery unless they're off those medications. So this theory or this feeling if we're stigmatizing the medication, stigmatizing the treatment, as the medication for Opioid Use Disorder, that's an acronym you're going to hear me say, M-O-U-D, medication for Opioid Use Disorder, as replacing one drug for another. So you will say -- you will hear somebody say, oh, they've just replaced their heroin with their buprenorphine or with their suboxone, when it's really infusing the idea of addiction, where somebody is engaging in behavior that is compulsive that is attempting to reach a high with dependence on a prescribed medication. Somebody might -- if we're thinking of other chronic diseases, somebody might be dependent on insulin to treat their diabetes. Just because they use the insulin every day does not make them addicted to insulin. It means they're dependent on insulin to treat their diabetes. So that distinction between the medication used to treat the Opioid Use Disorder as something that they are dependent on versus the addiction, versus the compulsive behavior not at the direction of a doctor, not under a clinical setting. And so that confusion creates a lot of stigma for methadone, for buprenorphine mostly. There's not as much stigma for Vivitrol. Vivitrol or naltrexone doesn't necessarily carry that same stigma. Much of the reason is because it's not an opioid agonist. It doesn't trigger or activate the mu receptor. So therefore people see it as different than the opioid agonist, at least in the way that the stigma plays out. If you can go to the next slide. In this, it comes with doctors. Doctors who are not addiction specialists who understand that addiction is disease, but they prefer not to treat people with addiction. This is something that happens in cases where I have brought, because doctors decide you

know, we don't want to provide -- it's not even they don't want to provide addiction treatment to people with addiction. They don't want to provide their normal treatment, whether or not it's their surgeons, whether or not they were in a long-term care facility and so on. There is an aversion to providing normal healthcare treatment to people with addiction. There is a study that showed cask surgeons, for example, might not want to -- and the study by Dr. Simeon Kimball and Dr. Elise Racell out of Boston, the study shows that doctors don't want to provide stents to people with a history of addiction because they're just going to have to provide another stent down the road because the person keeps using again. And this is a life-saving treatment that sometimes requires this kind of acute intervention. And those statements, they're just going to use again, you know, you make the comparison to somebody who has high cholesterol. I have high blood pressure. I am going to have a cheeseburger, and I am going to revert to some of the behavior that may have caused my hypertension. Somebody with high cholesterol is going to revert to some behavior that may cause their high cholesterol, and yet those people who revert to that behavior are not being stigmatized or punished for reverting to that behavior. So making those comparisons to other chronic diseases can sometimes reveal where this stigma and these beliefs and statements like this, how they can be discriminatory and have discriminatory effects.

Next slide, please.

Finally, one of the major places the stigma exists is in the criminal justice system. I talked about one in three people having access to Opioid Use Disorder medication despite many more requiring this medication, despite the lifesaving potential of this medication, this goes to jails and prisons. In the United States, 80% of jails and prisons provide no form of medication for Opioid Use Disorder. They provide cold turkey. They might say that perhaps we will give somebody a shot of Vivitrol on the way out as we release them into the community, but they're not providing the treatment within the jail or prison as if they would to any other chronic disease that goes through their jail or prison.

Similarly, judges, probation officers and parole officers who have the stigmatized view of buprenorphine, who might see people illicitly using buprenorphine on the street, and they might say that those people are just being sneaky and they're just getting high. So therefore I'm going to order them off of their buprenorphine. It is common for people to illicitly use buprenorphine, but the vast majority of those people are, in fact -- 85% of people, according to 2018 study by Cicero, 85% of those individuals use the illicit buprenorphine for clinically appropriate reasons. They are treating their Opioid Use Disorder, because they can get a strip of suboxone on the street and they just don't want to use heroin today. They don't want to experience the cravings and withdrawals, so they're going to begin treatment sometimes illicitly, not under the care of a doctor. Those people actually, when they do find a doctor, do well in treatment, but the point of the matter is, some of that has led to the stigmatized view of the medication for Opioid Use Disorder, and as a result, 80% of jails and prisons, no MOUD, no form of medication for Opioid Use Disorder at all. And you can go to the next slide.

So you saw there how there is this very key tool that we have to intervene in this very acute health crisis. You know, Opioid Use Disorder, very acute, chronic disease, highly treatable. 50% -- 50-80% of people with Opioid Use Disorder could be prevented from an overdose death if they were treated with one of the forms of medication. And yet only one in three people don't have access -- or have access to the medication. So now I want to talk about how federal civil rights statutes protect individuals with Opioid Use Disorder and ensures access to medications used to treat their addiction. Next slide, please. So I'm going to presume that many people, given the nature of the ongoing series, most people here are familiar with the ADA. So I don't want to give the broad impact of what the Americans with Disabilities Act is. I think we can all be assured that, just as a reminder, a disability protected by the Americans with Disabilities Act is a physical or mental impairment that affects one or more major life functions. And when the ADA was drafted in 1991, it was very clear that it addressed addiction. So, in fact, here is a copy of the regulations, and I grayed out all the non-important words, just to point out that physical or mental impairment includes drug addiction and alcoholism. So it's very clear when the drafters drafted the ADA, Fair Housing Act similarly, Section 504 similarly. When it was drafted, addiction was covered. If you can go to the next slide.

So when barriers are treatment, inherently linked to disability. As I will discuss, there are a number of facilities that might say, we will take people with Opioid Use Disorder into our facility. But we will not take people on medication for Opioid Use Disorder in our facility. There are a number of long-term care facilities in Massachusetts, and there still are, that would just not accept patients if they were prescribed buprenorphine or if they were on methadone treatment. They just refused to allow those people. They might accept patients who had Opioid Use Disorder, but they're just saying, we don't want people on those medications in our facility. That would be akin to saying we accept people with mobility impairments here, but we will not accept somebody with a walker in our facility, who needs a walker to enable their mobility with their mobility impairment. Treatment is inherently linked to disability. So when barriers are created to treatment, those barriers are tied to disability. Next slide, please.

Talking about title 2 or state and local governments that have to provide indiscriminate services. Medical care is provided to justice involved individuals as a service that disabled inmates must receive indiscriminately under the ADA. So a jail or prison, I just talked about how 80% of jails or prisons refuse to provide medications for Opioid Use Disorder in their general prison. That means 80% of jails and prisons are violating the ADA, because they're not providing their services indiscriminately. They are making administrative decisions. These are not medical decisions to not provide this medication. It's not an individualized assessment by a doctor. It's just categorically a superintendent saying, we're not going to provide those medications here.

Similarly, medical decisions that rest on stereotypes about the disabled rather than an individualized inquiry into a patient's condition, they may also be considered discriminatory under the ADA, and this impacts the people with opioid use disorder as I'll give some examples coming up.

And finally, withholding a medication used to treat addiction without an individualized inquiry into the patient's condition may be considered discriminatory.

So, again, what we're getting down to is things that impair or prohibit or cut off access to somebody's medication, used to treat that Opioid Use Disorder, if it's not based on medical decision, it's not built upon stereotypes, that could be discriminatory under the ADA. It could be discriminatory under the Fair Housing Act, if we're talking about access to somebody's housing in a halfway house or recovery home. These would all be violations of the ADA, the Fair Housing Act or Section 504. Next slide, please.

So now I'm going to give examples of what that means when we're looking at the ADA Fair Housing Act and how the department has begun applying this and what we have done so far. If you can go to the next slide.

So since 2018, DOJ has entered into more than 25 settlements to resolve discrimination involving Opioid Use Disorder. If you think about that, I mentioned that addiction was covered since the inception of the ADA in 1991. There have been a smattering of cases that have involved maybe land use in the building of recovery homes or treatment centers and whether or not cities and towns would put up zoning roadblocks. Some people are familiar with those kinds of cases that DOJ has brought. But until 2018, this notion of medication for Opioid Use Disorder -- access to it being protected under the ADA have gone unrecognized. It was something that the department frankly was unaware of and did not recognize that this was happening. And it did not recognize the role that it had played in the opioid crisis altogether. Since then DOJ has really reversed course and gone to address this and really has been aggressive, especially in the last few years, has been aggressive in resolving cases in this area.

So if you can go to the next slide.

So in addition to the guidance that DOJ has released, which I see in the chat at 2:49 p.m. you can see it in chat there, there is a link to the guidance. The guidance is lovely. It's been vetted and we've gone over it quite a bit. It gives examples and Q&A. I highly recommend people going through that, perusing it and sharing it. But I want to talk about three main areas DOJ has entered into, agreements, but also has brought lawsuits. And the first is in trial courts and probation. So the United States entered into an agreement with the Massachusetts Trial Court System that was entered into I believe just last year. And this was a result of some judges and probation officers ordering people off of their buprenorphine as a condition of being in Drug Court, there were Drug Courts that say we only allow Vivitrol in our drug court, and this is something that while it was entered in Massachusetts, this is an issue that has been going on nationwide, where drug courts -- judges essentially are making the order from the bench. If you think about it, it's essentially practicing medicine from the bench, the judge is practicing medicine without a clinical opinion present. And we found this to be a violation under the ADA. Similarly, colleagues of mine in the Justice Department filed a lawsuit against

the state of Pennsylvania for Pennsylvania's practice of many of its courts were on a court-by-court basis ordering people off of their buprenorphine as just a matter of policy. And this is where it is being done as a matter of policy, as an administrative issue. Now, if you know anything about the Justice Department, the fact that the DOJ has filed a lawsuit there is not insignificant. It's much more difficult to file a criminal case and send somebody to jail than it is to file a civil rights lawsuit in the Department of Justice. The number of approvals that need to be gone into have to go all the way up to the assistant attorney general for civil rights to give every approval, and that's just what happened here. So that litigation is ongoing. But there is also the settlement agreements that my office entered into in Massachusetts. And this is an issue that is going on throughout the country. Next is corrections. This is the issue that I mentioned earlier, where 80% of jails and prisons in the United States are not providing this medication. And this is an area that the DOJ is bringing and going after and addressing very, very aggressively right now. As of right now, all Massachusetts prisons and jails are providing the medication, but that wasn't the case in 2018 when we began doing this work.

So there's been a large shift. I believe all of New England is now providing all medications for Opioid Use Disorder. New York, Alaska. It's happening state-by-state, and it's happening very quickly. There are other assistant U.S. attorneys who are working on cases on this, and this is one area that we're working to address very aggressively, because we see the level of intervention that this can have. If many justice-involved individuals are having a substance use disorder and it's estimated that as many as between one and four and one and five -- or one in four -- it's estimated between 25 and 50% all justice-involved individuals have an Opioid Use Disorder. So if somebody is going through the correctional system and touching into the correctional system and yet that correctional system is not providing treatment, it's not providing diagnostic treatment, so it's not inducing people in medication, not maintaining people that are already on the medication as going through, this is a high area of intervention that can impact the crisis.

Which is what the article that I wrote about really addresses -- this is one at of the major ways that we can intervene in the opioid crisis to have a big impact with a relatively low lift, if you think about the grand scheme of things. And then in Massachusetts, what was happening is the parole board was ordering and mandating that people go on Vivitrol as a condition of parole. And then they changed their ways, but they mandated that people go on to a specific form of treatment. So it was mandating that people on methadone stay on methadone. Mandating that people on buprenorphine stay on buprenorphine. That may sound like an improvement, and in many ways it was an improvement, but still a violation of the ADA. And the reason is because that was interfering with the community doctor's decision making. So let's say that you were on buprenorphine and it's not working for you, and the doctor says, we need to switch you to methadone, if that would happen, the parole officer would come and bring the person back to jail. Because they are violating the parole by not being on the mandated medication.

So what we require that the parole office do here in Massachusetts, the parole board had to -- they can mandate that somebody seek care of a doctor and follow instructions of a doctor, and do everything clinically appropriate, not bake into the conditions of parole precisely what that treatment would be.

So those are the things that have been done in the criminal justice setting, and that my colleagues in the Department of Justice are aggressively doing right now. But also there is the healthcare system that is not in the criminal justice system, and if you can go over to the next slide, please. There are two main areas where this is occurring or has been occurring. the first is long-term care facilities. So somebody might ask, you know, why is somebody with Opioid Use Disorder needing care in a nursing home? And it's a very concrete reason. So somebody who has Opioid Use Disorder may have used injectable drugs. So they might have used heroin with a needle. They might have used fentanyl with a needle. And with that they might have developed a secondary infection. Endocarditis comes to mind as major one. Hepatitis C is another one, HIV is another one. And some of the secondary infections require six-week courses of antibiotic treatment that you can't -- sure, you could get it in a hospital, but you don't need that hospital level of care. You need something like a nursing home. And so it's very common for people with Opioid Use Disorder to be -- to require care in long-term care settings. However, the vast majority of long-term care facilities are just routinely denying care to people with Opioid Use Disorder or with a history of substance use disorder. They say, we're not going to accept these patients. We don't want to deal with this population. And so they are turning them away, essentially denying care because of their disability, because of their addiction. This violates the ADA. There was one -- there was one report that statin used -- if nobody is familiar with Stat News, it is a journalism publication that really focuses on the healthcare industry, and looking at this phenomenon, it interviewed folks in Ohio, for example, and the takeaway from that is 0% of long-term care facilities in Ohio would accept a patient with the history of addiction. I'm not saying that is what is happening in Ohio right now, but this was, I believe, a 2018 news article. In Massachusetts at the time, again, vast majority of long-term care facilities were just routinely not accepting patients with Opioid Use Disorder. We entered into our first settlement agreement with a facility called Charwell House. And this is available on adanet.gov in the enforcement section. I'm going to pull up a link to the enforcement section as we're going through. And it looks like that is... in the enforcement section, which you can find here, sending it to the archived version of ADA.gov, because looks like the new version doesn't have all the links for the old cases. But if you go through there and if you can pull up for opioids, you will find a number -- at this point I think we've entered into 11 agreements with skilled nursing facilities and long-term care facilities. One of the reasons is we entered into our first agreement with a facility called Charwell House, and what the addiction community found and the healthcare industry found is that it actually had no effect on whether the practices of other facilities -- other facilities were still routinely discriminating, and in the federal prosecutor mode, we often think of deterrent as one of the reasons to bring cases. We wanted to deter other people from engaging in similar conduct. But there was no deterrent effect. In fact, there was a study, an eye opening study again by Dr. Simeon Kimball from the Boston Medical Center that showed that before the settlement

agreement and after the settlement agreement, folks from Boston Medical Center were being denied access to long-term care facilities at the same range.

So we opened a large number of additional cases after that to really put it on the map to facilities. So this is something that they have to change the practices, and the message was received.

Since then I now regularly am giving talks to the Massachusetts Senior Care Alliance, which is the trade organization for long-term care facilities to provide guidance on how to comply with the ADA in this area. Next Tuesday I'm giving a talk for the Department of Public Health here in Massachusetts that is providing training to long-term care facilities.

So it takes work, but these practices do change. And so now long-term care facilities are much more likely to provide care to people with Opioid Use Disorder, and what they have found is, you know, there was this fear that the sky would fall upon providing care to these facilities, to individuals with this use disorder in their facilities. And the sky very much did not fall. People in long-term care facilities... people in long-term care facilities routinely have a number of complex medical issues, psychological issues that they might be dealing with, and the population with addiction did not provide any necessarily new challenges, just different challenges to providing care. And they were able to provide this kind of treatment.

Similarly, surgeons were not providing, and still are not providing care and treatment to people with use disorder. We resolved a complaint with Mass General Hospital. That, again, is in the settlement agreements in the ADA.gov link that you will find there. There was somebody who required an organ transplant, a lung organ transplant. And actually there is a news article about this particular case, again, Stat News, but this person required a lung transplant and the transplant surgeons at Mass General Hospital said, we can't provide the surgery to somebody who is taking buprenorphine for the use disorder, and it was based not necessarily on any scientific diagnostic reason. In fact, the folks from Mass General Hospital's own addiction treatment care were willing to provide consultation. And this is an important case, because what happened here. In thinking of this on the ADA perspective and the legal theory of how the law works, it's important to note this case. Mass General Hospital, the lung transplant specialist routinely consulted with specialists in other areas of medicine.

If you think of that, somebody who requires a lung transplant probably has other chronic conditions that are going to cause complexities. And so when the complexities come up, they might consult with a pulmonologist or a cardiologist. They are going to consult with those specialists for the other condition. Here the other condition was addiction. And they did not consult with the specialist in addiction to look into whether or not their concerns with providing the surgery were, in fact, something that could be resolved. And it was that deviation from their standard course of practice, where their standard course of practice is consult when we don't know what to do. They didn't consult here. That was the violation. And that particular case, the person ended up receiving the lung

transplant, but they had to go out of state to do so. In fact, if you're not familiar with organ transplants when that happens, quite often you will need a support person that is living with you, and you will need to be living near the facility that is going to provide the transplant. So that when the organ comes in you can have the transplant -- you can be ready for the transplant at moment's notice. And often you might not be able to travel after that transplant. And in this case, the person's mother had to sell her home and move states away in order for the person to receive their organ transplant.

And so we were able to get compensatory damages to the tune of $250,000 for that denial. Again, all of that is on the enforcement section of ADA.gov. But that is an example of an organ transplant. We similarly handled cases involving orthopedic surgeons who have not performed full joint replacements to people and MOUD just because they presented some... you know, they might see them as needy according to, you know -- in this particular case. But you can see that stigma really playing a role.

If you can go to the next slide.

So that is what the DOJ has been doing. We have been aggressively enforcing cases. As I said, there's been 25 settlements since 2018, which is a large portion of DOJ's settlements since 2018. So we have aggressively been working there. I am happy to field questions, but also I am putting my email address on the screen. It's Gregory.Dorchak@USDOJ.gov . And even though I'm based in Massachusetts, I'm happy to field questions from anywhere, and I'm also happy to connect folks with my counterparts anywhere to really talk through these issues as you encounter them, as you see them.

>> PAM WILLIAMSON: Greg, we thank you so much for providing this excellent overview of the opioid crisis and how the ADA is being used to combat it. I even learned a lot of new stuff today, even though I follow this on a regular basis.

At this time Greg is ready for questions and you can submit your questions via the chat window. And we will read those out for the captioner and the rest of the audience.

And while we are waiting -- as we're waiting for questions, what if folks were -- if folks were interested in -- you said you would connect them with your counterparts. If they were interested in, you know, pursuing information about this or putting trainings out in their own areas, what would you encourage them to do?

>> GREG DORCHAK: I would reach out to me. I can submit -- I can put them in touch with my counterpart who can give trainings as well as me who can give trainings. We can figure out who is the best person whether it's not from the disability rights section and DOJ, another assistant U.S. attorney, as a way of background, I mentioned there were 25 settlement agreements. I believe I had 17 of those 25 settlement agreements. It's an area... it's an area that I have really focused on here in Massachusetts. And because of that development of expertise, I have been giving brown bags to my counterparts for the past year, and we generally give 507 to 60 assistant U.S. attorneys

as well as trial attorneys in the disability rights section talking about issues every month. So there is a large -- even though I have been bringing most of those settled cases, there is now a large bench to draw from of people who have become more familiar with it and that are more than happy to give presentations. I know counterparts in Kentucky have brought a number of cases of late and developed a significant amount of expertise, same in Seattle. This is really an expertise that is being drawn all across the country, New Jersey, and so on. So don't hesitate. There are plenty of people who would be more than not just willing but excited to discuss.

>> PAM WILLIAMSON: Great. So we appreciate that. Well, we have had several questions come in now, and the first one is: Are the jails or prisons using medical doctors in those facilities to overcome the decisions of the community treatment providers by saying that they have different medical opinions?

>> GREG DORCHAK: That's a great question. And what we're seeing in practice is no, that is not what is occurring. What is really happening is we're seeing that this is a policy decision, and these are policy administratively implemented decisions. There was a... there are some cases where some facilities are saying that medically speaking we will provide buprenorphine or methadone to pregnant women because a fetus could actually be put in jeopardy if somebody who is pregnant is taken off of their MOUD. But then the jail or prison would take away access to the medication upon the person giving birth and delivery. So, no, we haven't seen those issues. At least in terms of the facilities where it's just been an administrative denial. What has happened is in some facilities that have then -- you know, as a result of settlement or court order become providing the medication, there might be some secondary issues that have come along where doctors, you know, might still be resorting to some of those stereotypes about how to treat somebody with addiction. And I'll give you a perfect example, that the community -- in if community somebody needs typically 16 to 24 milligrams of buprenorphine. That's a clinical dose in the community. It might come lower than that. There were some doctors that might say, well, what we want to do is start you fresh, so we're going to bring you down to 2 milligrams and we're making our medical judgment that 2 milligrams is a good dosage to start you at. We might increase you from there.

While they're couching that in medical terms and that's coming from a medical doctor, that's not based in any medicine. That's not based ode-there's no medical study that demonstrates that that is medically appropriate. Here we rely on some of the medical cases under the law, such as Brandon v. Abbott, for people who are really familiar with the Supreme Court cases under the ADA that say, you know, when it comes to those medical decisions, what we really want to do is not look at what any individual doctor feels comfortable with, but what the medical community says is a direct threat. If the medical community is saying, that's not what you are supposed to be doing, then that's not going to fly in terms of being legally allowed. But those issues have always been ironed out, because we really see, as we have been implementing these settlement agreements, there's just that educational need that needs to be done. And nobody has really been steadfast. I think everybody just recognizes there's an educational

component. So when you're seeing the 80% of jails and prisons, it's just a complete administrative ban.

>> PAM WILLIAMSON: Thank you. So we've got another question here. What would be some major public policies to push forward to reduce harming communities which are affected by the addiction crisis?

>> GREG DORCHAK: So here in my role, I can't necessarily advocate for policies. I think that is something that the DOJ is really precluded from doing, but I would say, you know, one of the takeaways from my presentation is anything that ensures access to the medication for Opioid Use Disorder is probably going to be beneficial. And also from a policy perspective, you can see that many of these large-scale public entities, their policies are not in compliance with the ADA. So? You can align those policy decisions with ensuring that they are compliant with the ADA... so perfect example is should the jails and prisons of X jurisdiction provide the medication as a matter of policy. Well, the law -- the ADA says that ensure access to those medications is required. So ensuring that public policies align with the requirements of the law is probably a good place to start, and just given the volume of entities that we see that are just not in compliance is a matter.

>> PAM WILLIAMSON: Thank you. We have another question. Is the law different for those who are still actively using instead of those that are in active recovery? And can medical practitioners refuse to treat?

>> GREG DORCHAK: And this is a great question. And I'm glad you asked both sets of those questions, or asked it in two different ways, because the answer is actually going to be different for those two.

So the first question: Is the law different for those who are still actively using instead of those in active recovery? And the answer to that question is yes. There is a current illegal use exception for the ADA. And that means that somebody who is illegally using substances... so let's say the person is illegally using cocaine, the person is illegally using heroin, is that person covered by the ADA? No. That person is not covered by the ADA. But don't stop listening. Because question 2: Can medical practitioners refuse to treat? So while I just had that big carve-out, that people who are illegally using substances are not protected by the ADA, there is a huge carve-out to that carve-out, and that says, in the ADA, it says that healthcare facilities, healthcare entities cannot deny health services to people just because they are illegally using substances. So it's this exception to this exception. And while people are treated differently under the ADA if they are illegally using, think of that more in an employment setting. Think of that more in the housing setting. Don't think of that in terms of providing healthcare or access to healthcare. Because there the carve-out -- there's that second carve-out that healthcare services can't be denied to somebody just because they are illegally using.

Now, does this mean that a doctor is required to provide all healthcare services? It just means that the person needs to be clinically analyzed. If somebody is going through

active withdrawals because of their illegal use or because of their illicit use, it very well might be that they need that different level of care than what that doctor can offer. But if somebody is, let's say, using marijuana illegally, I know that marijuana in different states is still illegal. Just because somebody is illegally using marijuana or may have illegally used opioids yesterday but is not going through active withdrawals and is not likely to be going through withdrawals doesn't mean that the doctor can deny them healthcare. It just means it can be a clinically made decision over whether or not that denial is clinically appropriate and not all denials are.

>> PAM WILLIAMSON: Thank you so much for that excellent answer.

All right, as a reminder to everyone, if you have questions, please put them in the chat area and we will be reading them aloud. We do have another question.

Who is usually flagging the ADA treatment or access issues? Is it families, attorneys, inmate, advocates? And what is the fastest route to address ADA issues in prisons and jails?

>> GREG DORCHAK: On first question, my experience is that social workers have actually been the largest referral point for this issue. Maybe it's because I give my talking to social workers more than anybody, but I found they have been some of the most likely to see these issues. Social workers generally work on the ground, with the unhoused population, they work with people who are going through the criminal justice system. They work in hospitals. They work in all of these -- they work in shelters and all these different settings where people with addiction are going to touch upon. Somebody who is dealing with their addiction isn't often thinking first thing, I need to contact the federal prosecutor to help me out. In fact, they don't want to talk to a federal prosecutor until they know generally what it is that they do. So social workers, doctors, addiction specialists, that's been a greatest source of referrals. What is the fastest route to address ADA issues in prisons and jails? You can file a complaint at ADA.gov. I know if there are a number of advocacy groups local who are working on these issues as well. The ACLU has filed lawsuits in Massachusetts, Maine, New York, Kansas, New Jersey. They have filed lawsuits all over the place. And so that is one way to address this issue and they always have been successful. Prisoner legal services are places that can advocate. Local public defenders, if they know about these issues. What I am finding more and more often is that judges are withholding sentencing until they can ensure that a particular prison or jail is going to provide the access to the medication. And so even though we're not necessarily seeing it on the civil side, that's on the criminal side, one of the fasters ways to ensure something is happening is make it so that it's interfering with the priority and the sentencing of a particular case. And so that has had an effect as well.

So there is a multitude of avenues, but you can always file complaints at ADA.gov on this issue. And there's a number of local sources I would imagine in your area, if anywhere as active as the areas I have been familiar with.

>> PAM WILLIAMSON: Great. We have one more question here. This deals with the resources and data that you were sharing during your presentation. Folks would really like to get access to that, so I would like to suggest that maybe we can get that and put it with the archives, so that folks can get to that information easily. Would that work?

>> GREG DORCHAK: That does work. And I am going to find... if I can pull up my article, my article is... I think there's like 120 footnotes. And those footnotes are going to have all of the things I have cited today. If I can find that here.

>> OCE HARRISON: Are you talking about using the ADA to reduce overdose? I did put that in the chat.

>> PAM WILLIAMSON: And I'm putting it in again for folks.

>> GREG DORCHAK: Perfect. So that's going to have the vast majority of statistics from what I have cited. I have been doing this quite a bit now, and so developed a large background of information. So if I gave information that is not cited in here, which the majority of it is, and you want to know a source for it, please email me and I can provide you to something I might have just said offhand that I can provide you an actual citation for.

>> PAM WILLIAMSON: Fantastic. And we will include using the ADA to reduce overdose deaths as part of the resources when we have the archive available.

>> OCE HARRISON: I also put in there the ADA addiction and recovery fact sheet series produced by the ADA National Network as well for folks.

>> PAM WILLIAMSON: Fantastic! At this time we do not have any more questions, so we're going to head out for our wrap-up for the day. Greg, I want to thank you again for all of this excellent information you have shared with us today. It's so very important and something that many of us have interest in. And, you know, if you do have additional questions for our speakers and didn't get a chance to ask your question or wanted to -- want to talk to someone one-on-one, please contact your regional ADA Center at 1-800-949-4232. And you will receive an email with a link to today's session with an online evaluation. Please complete the evaluation for today's program, because we do value your input.

We want to thank Greg again for sharing his time and knowledge with us. I want to thank Oce for making the connection, and being with me as a co-moderator today. And just as a reminder, today's session will be archived, and it's recorded, and it will be available for viewing next week at ADApresentations.org /archive.php. Thank you again for attending today's session, and wishing you a great rest of the day!

>> GREG DORCHAK: Thank you so much!

>> OCE HARRISON: Thank you very much, Greg, and thank you everyone in the audience for participating today. Thanks, Pam!