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August 25, 2022

Via Email: greg.vrato@prisons.phila.gov
Commissioner Blanche Carney and Chief of Medical Operations Bruce Herdman
c/o Greg Vrato
Chief of Staff
Philadelphia Department of Prisons
7901 State Rd.
Philadelphia, PA 19136

RE: PDP's policy regarding Medication for Opioid Use Disorder

Dear Commissioner Carney and Dr. Herdman:

On behalf of the Pennsylvania Institutional Law Project (PILP), we are writing regarding serious concerns about access to medical care for people with opioid use disorder in the Philadelphia Department of Prisons (PDP). Specifically, PILP urges PDP to address two issues: (1) the frequent practice of denying individuals Medication for Opioid Use Disorder (MOUD) after allegations of diversion, and (2) relying on a uniform dosage of 8 mg of Suboxone per day, rather than providing an individualized assessment to determine the appropriate dose, for those who are starting medication in jail.

Alleged Diversion

On the issue of alleged diversion of MOUD, we have spoken with almost 20 individuals over the past several months who have had their MOUD discontinued after being accused of diversion. PDP documents confirm that this problem is widespread. While the individual experiences may vary, they share important details reflecting the same problem. For all of these people, PDP recognized that they have Opioid Use Disorder (OUD), initiated treatment according to the standard of care with MOUD, but then, after either a nurse or security staff member accused them of seeking to divert their medication, their MOUD was discontinued without recourse.

Responses to grievances and sick call slips, when responded to at all, indicate that there is no process to appeal or challenge the allegation of diversion or the cessation of MOUD, often causing suffering for the incarcerated patient. Despite PDP policy that the patient must be seen by a provider for a "second chance evaluation," most of these individuals did not see a doctor after

being taken off their medication, and none received a "second chance." No disciplinary action was taken against any of these individuals.

Some of these examples where individuals were denied MOUD were prompted by something as simple as a slight movement. Others began with an argument between the incarcerated person and security staff. On some occasions, a direct accusation of diversion was made. Some people were searched only for the search to turn up empty, yet the person was still accused of diversion. Other times, the incarcerated person requested that they be searched to no avail. In some cases, the individual received their medication as usual, with no indication of any problem, and were only informed of the accusation of diversion after they were denied MOUD and submitted sick calls and grievances to determine what had happened. In some cases, other security or medical staff corroborated the incarcerated person's account that they had not diverted. Some individuals were weaned off of their medication or received comfort medication, but others received nothing at all. All of these individuals were permanently removed from their MOUD.

First, as a baseline matter, due process should be provided to these individuals. More importantly, termination of medical treatment is unacceptable regardless of whether diversion occurred or not. Broad consensus in the medical and scientific communities, as well as the National Commission on Correctional Health Care (NCCHC) and the National Sheriffs' Association, is that MOUD is necessary to effectively treat OUD. The NCCHC and the National Sheriffs' Association have noted many benefits to providing MOUD in a carceral setting, including "stemming the cycle of arrest, incarceration, and release associated with substance use disorders (SUDs)," "contributing to the maintenance of a safe and secure facility for inmates and staff," "reducing costs," among other benefits.[1] Scientific evidence shows that MOUD, in particular agonist MOUD, reduces illicit drug use, overdose deaths, and crime.[2]

The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), a division of the federal Department of Health and Human Services, has concluded that "just as it is inadvisable to deny people with diabetes the medication they need to help manage their illness, it is also not sound medical practice to deny people with OUD access to FDA-approved medications

[1] The National Sheriff's Association and National Commission on Correctional Healthcare, *Jail-Based Medication-Assisted Treatment Promising Practices, Guidelines, and Resources for the Field* (Oct. 2018), https://www.sheriffs.org/publications/Jail-Based-MAT-PPG.pdf.

[2] *See* Sarah E. Wakeman, et al., *Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder*, JAMA Network Open (2020), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2760032; Nat'l Inst. on Drug Abuse ("NIDA"), Nat'l Inst. of Health, *Medications to Treat Opioid Use Disorder Research Report*, (Dec. 2021), https://nida.nih.gov/publications/research-reports/medications-to-treat-opioid-addiction/how-opioid-use-disorder-treated-in-criminal-justice-system.

for their illness."[3] SAMHSA also advises medical providers that "[m]isuse or diversion doesn't mean automatic discharge from the practice."[4]

Abrupt discontinuation of MOUD also puts individuals at high risk of overdose and death upon their release. Research demonstrates that having medication discontinued while incarcerated makes people less likely to return to treatment upon release.[5] Individuals also face significantly increased risk of death due to a decreased tolerance for opioids. One study found that in the two weeks following release, people who had been incarcerated in state prisons were 129 times more likely to die from an overdose compared to the general public.[6]

While concern regarding diversion of MOUD is commonly referenced by correctional institutions as a reason for limiting access to incarcerated individuals, research demonstrates that reduced availability of MOUD actually leads to an increase in diversion, a fact recognized by correctional leaders, including the National Sheriff's Association and National Commission on Correctional Healthcare.[7]

The vast majority of people who use agonist MOUD without a prescription do so to control the otherwise debilitating symptoms of their OUD, not to get high.[8] Research also demonstrates that as buprenorphine becomes more available legally, the less likely people are to seek it out illegally, suggesting that the best way to prevent an illicit buprenorphine market in a carceral setting is to provide more people the medication they need.[9] Ironically, as PDP removes more people from their medication, it only increases the overall likelihood of diversion. Further, where accusations of diversion are supported by evidence, there are other means of providing this medication which make it less susceptible to diversion.

PILP appreciates that PDP offers a robust MOUD program, including induction for individuals who were not in treatment prior to their incarceration. However, PDP's MOUD program suffers from a major flaw by allowing non-medical staff to remove people from their medication with impunity.

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[3] SAMHSA, Medications for Opioid Use Disorder for Healthcare and Addiction Professionals, Patients, and Families, Treatment Improvement Protocol Tip 63, at ES-2 (2020), https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP21-02-01-003.pdf.

[4] SAMHSA, Buprenorphine Quick Start Guide, https://www.samhsa.gov/sites/default/files/quick-start-guide.pdf.

[5] American Society of Addiction Medicine, *Public Policy Statement on Treatment of Opioid Use Disorder in Correctional Settings,* (2020), https://www.asam.org/docs/default-source/public-policy-statements/2020-statement-on-treatment-of-oud-in-correctional-settings.pdf

[6] Ingrid A. Binswanger et al., *Release from prison-a high risk of death for former inmates*, 157 New Engl. J. Med. 157 (2007).

[7] The National Sheriff's Association and National Commission on Correctional Healthcare, *supra* at 1.

[8] NIDA, *supra* at 2.

[9] Zev Schuman-Olivier, et al., *Self-treatment: Illicit buprenorphine use by opioid-dependent treatment seekers*, 39 Journal of Substance Abuse Treatment 41 (2010), https://pubmed.ncbi.nlm.nih.gov/20434868/.

Dosing of Suboxone

PILP's understanding is that individuals who are already receiving MOUD prior to their incarceration continue to receive their prescribed dose through a partnership with Northeast Treatment Centers. For others with opioid use disorder, they may be initiated on MOUD. We appreciate that the Philadelphia Department of Prisons will start people on a MOUD; however, individuals who begin taking MOUD at PDP are given a standardized dose of 8mg of Suboxone per day. This standardized dose is not sufficient to control everyone's symptoms, and is not best medical practice.

"To be effective, buprenorphine must be given at a sufficiently high dose (generally, 16 mg per day or more)."[10] Experts, including those from the National Sheriffs Association and NCCHC, explain that dosing is an individualized decision tailored to each person's circumstances.[11] Guidelines from SAMHSA indicate that when starting a patient on Suboxone, they should be given an initial dose of 2 to 4 mg, with this dose increased 2-4 mg at a time until their symptoms are controlled.[12] Therefore, by definition, when dosing is not an individualized decision, some people's symptoms will not be controlled.

As with removing people from their medication, this failure to adequately treat OUD may contribute to an illicit Suboxone market because some people will require a higher dose of medication to treat their symptoms. It also may contribute to some individuals attempting to save a portion of their medication because they know that their dose will not control their symptoms for the entire day.

Again, PILP appreciates that PDP provides induction of Suboxone, but unfortunately it does so in a manner that makes the program ineffective for many.

PDP's Legal Obligation to Treat OUD

As you are aware, while these individuals are in your custody, it is your duty to provide them with adequate medical care. It is well-settled law that the Fourteenth and Eighth Amendments to the United States Constitution impose a duty on jailers to ensure the safety and well-being of those whom they imprison.[13] This duty requires you to provide MOUD to those in custody diagnosed with opioid use disorder. "Where knowledge of the need for medical care is accompanied by the intentional refusal to provide that care," the Constitution is violated.[14]

Further, the denial of MOUD implicates PDP's obligations under the Americans with Disabilities Act ("ADA") and Rehabilitation Act ("RA"). The DOC is subject to Title II of the

[10] NIDA, *supra* at 2.
[11] The National Sheriff's Association and National Commission on Correctional Healthcare, *supra* at 1.
[12] SAMHSA, *supra* at 4.
[13] *Estelle v. Gamble*, 429 U.S. 97, 106 (1976).
[14] *Spruill v. Gillis*, 372 F.3d 218, 235 (3d Cir. 2004).

ADA and Section 504 of the RA,[15] which prohibit covered entities from precluding an individual with a disability from participating in a program, service or activity because of their disability and require them to provide "reasonable accommodations" to individuals with disabilities.[16] Individuals with OUD are unquestionably individuals with a disability for the purposes of the ADA and RA and are entitled to their broad protections. Removing people from their medication or providing them with an inadequate dose, thus violates the ADA and RA. Here, a reasonable accommodation includes the provision of buprenorphine in a manner in which it will be effective.

Several federal courts have now required facilities to provide this treatment and have found that the failure to do so likely violates the ADA and Constitution.[17] The United States Department of Justice has also recognized the importance of access to MOUD, stating its position that failure to provide MOUD can be an ADA violation, and engaging in significant enforcement actions on this issue.[18]

We therefore implore you to immediately change PDP's practices with respect to these two issues. Accusations of diversion are accompanied by no evidence, but even if they were, denial of necessary medical treatment is never an appropriate punishment and only increases the likelihood of diversion more generally. Similarly, failure to provide an adequate dose of MOUD means that PDP is failing to treat OUD, which also contributes to diversion. We also urge you to rectify past harm by providing a second chance to those removed from their medication for an accusation of diversion and re-evaluating the dosage of everyone who did not originally receive an individualized assessment.

Please respond in writing by Friday, September 9, 2022. In your response, please explain in detail how you will address the concerns we have raised here, including whether and PDP will change its policies to provide appropriate treatment for OUD.

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[15] *See Pa. Dep't of Corr. v. Yeskey*, 524 U.S. 206, 210 (1998); *Geness v. Cox*, 902 F.3d 344, 361 (3d Cir. 2018); 29 U.S. § 794(b)(1)(A).

[16] *See* 42 U.S.C. § 12132; 29 U.S.C. § 794; *Furgess v. Pa. Dep't of Corr.*, 933 F.3d 285, 287 (3d. Cir. 2019).

[17] *P.G. v. Jefferson Cty.*, No. 21-388, 2021 U.S. Dist. LEXIS 170593 (N.D.N.Y. Sept. 7, 2021); *Smith v. Aroostook Cty.*, 376 F. Supp. 146, 160-62 (D. Me 2019) (granting motion for preliminary injunction under the ADA when jail refused to provide plaintiff with buprenorphine "without regard to her medical needs and without any true justification"); *Pesce v. Coppinger*, 355 F. Supp. 3d 35, 47-48 (D. Mass. 2018) (granting motion for preliminary injunction because a blanket policy denying prescribed methadone treatment was likely to violate both the ADA and Eighth Amendment). See also *Strickland v. Delaware Cty.*, No. 21-4141, 2022 U.S. Dist. LEXIS 71347 (E.D. Pa. April 19, 2022) (motion to dismiss Fourteenth Amendment and ADA claims denied where Plaintiff alleged that he "asked for medically accepted treatment and was denied pursuant to an official policy").

[18] *See* U.S. Department of Justice, Civil Rights Division, *The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery* (April 5, 2022), https://www.ada.gov/opioid_guidance.pdf; *USA v. Unified Judicial System of Pennsylvania*, No. 22-709 (E.D. Pa.) (Goldberg, J.).

If you do not agree to take immediate steps to remedy this situation, or if we do not receive a response by the appointed time, we may seek relief in federal court. If you would like to discuss this further you can reach Sarah Bleiberg Bellos at sbellos@pailp.org or by phone at 215-925-2966.

Thank you for your attention to this matter.

Sincerely,

Sarah B Bellos

Sarah Bleiberg Bellos
Attorney

Su Ming Yeh
Executive Director

Cc: Anne Taylor (via e-mail)
Craig Straw (via e-mail)