Appellate Division–Second Department Docket No. 2024-02852

New York Supreme Court

Appellate Division – Second Department

IN THE MATTER OF CHRISTIAN C. (ANONYMOUS).

NEW ALTERNATIVES FOR CHILDREN, INC.,
Petitioner-Respondent,
JORGE C. (ANONYMOUS),
Respondent-Appellant, and
KATHERINE R.,
Respondent.

BRIEF OF *AMICI CURIAE* NEW YORK CIVIL LIBERTIES UNION, AMERICAN CIVIL LIBERTIES UNION & FOUR MEDICAL AND PUBLIC HEALTH EXPERTS ON SUBSTANCE USE DISORDER IN SUPPORT OF RESPONDENT-APPELLANT JORGE C.

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Queens County Family Court Index No. B-10938-2021

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PRELIMINARY STATEMENT

This case raises important questions about whether a Family Court has the power to condition a father's parental rights on lowering or stopping his use of methadone in the absence of medical justification for doing so. Medications for opioid use disorder ("MOUD"), like methadone, are the standard of care and the most effective treatment for opioid use disorder ("OUD"), a chronic, treatable disease of the brain. It would be unimaginable, and plainly illegal, for a court to terminate an individual's parental rights because they use a high dose of insulin to treat diabetes. Yet, because of the stigma facing individuals who use methadone, Respondent-Appellant Jorge C.'s (hereinafter "Jorge") parental rights were terminated in large part for precisely that reason: because of his disability and the medication he uses to treat it.

The Family Court discriminated against Jorge based on pernicious stereotypes about individuals who use methadone—a medication the World Health Organization lists as an essential medication. In doing so, the Family Court impermissibly ignored the Americans with Disabilities Act's ("ADA") prohibition on discrimination against people in recovery from a substance use disorder, like Jorge. A court may not make adverse decisions against a parent based on his participation in a methadone program. Yet, here, the Family Court improperly made adverse inferences about Jorge's ability to care for his child because of the dose of methadone his medical

provider placed him on. It repeatedly made inaccurate statements about the length and dosage of Jorge's methadone treatment despite the lack of record evidence and medical consensus supporting those assertions. Reversal of the Family Court's order is essential to ensure liberty and equality for parents with substance use disorder and parents receiving MOUD treatment in this and similar cases (*cf. Beeken v Fredenburg*, 145 AD3d 1394, 1397 [3d Dept 2016] [reversing Family Court's order because its findings on propriety of MOUD based on "many years of experience in Drug Court" were not supported by a sound and substantial basis in the record]). This appeal raises important questions of law and will serve to correct the substantial injustice to Jorge, whose parental rights were improperly terminated.

The ACLU, NYCLU, and four experts in addiction medicine ("*Amici*") submit this amicus brief to provide evidence-based research supporting the scientific and medical consensus that MOUD, including methadone, is the standard of care for OUD and is the appropriate medication for parents with OUD, and to combat the stigma surrounding methadone treatment. *Amici* also write to provide background on the purpose and scope of federal disability law and to show that the Family Court improperly discriminated against Jorge in its termination of his parental rights.

Accordingly, *Amici* urge this Court to reverse the Family Court's order terminating Jorge's parental rights.

INTEREST OF AMICI CURIAE

The American Civil Liberties Union is a nationwide, nonprofit, nonpartisan organization with nearly two million members and supporters dedicated to the principles of liberty and equality embodied in the Constitution and America's civil rights laws. The ACLU fights tirelessly in all 50 states, Puerto Rico, and Washington, D.C. for the principle that every individual's rights must be protected equally under the law, regardless of race, religion, gender, sexual orientation, gender identity or expression, disability, national origin, or record of arrest or conviction. The ACLU's Disability Rights Program envisions a society in which discrimination against people with disabilities no longer exists, and in which people understand that disability is a normal part of life. The New York Civil Liberties Union is the state affiliate of the national ACLU, with approximately 85,000 members and supporters in New York. Both the ACLU and the NYCLU work toward a society in which discrimination against people with disabilities, including substance use disorder, no longer exists, and in which people with disabilities are valued, integrated members of the community, with equal opportunity to parent, receive effective medical care, and participate in our justice system. Defending the right of New York parents to be free from discrimination based on their use of legal medications like methadone and their disability are matters of substantial interest to the ACLU, the NYCLU, and their members. Towards this end, the ACLU and the NYCLU frequently litigate on behalf of individuals with disabilities, including people who use MOUD like methadone

(*see e.g. P.G. v Jefferson County*, No. 5:21-CV-00388 [ND NY] [ACLU and NYCLU challenge to denial of MOUD in county jail]; *M.C. v Jefferson County*, No. 6:22-CV-190 [ND NY] [NYCLU class action challenge to inadequate medical care for OUD in county jail]). The ACLU and NYCLU have also appeared as *amici* in several cases involving discrimination against parents in the family regulation system (*see e.g. Matter of Lacee L.*, 32 NY3d 219 [2018]; *In re Child of Barni A.*, 2024 ME 16, as *rev* [Mar. 7, 2024]; *Matter of Sapphire W.*, No. 2023-10606 [NY App Div, 2d Dept] [pending]; *Matter of Ke Yong Z.*, No. 2024-813 [Ct App] [pending]). Accordingly, the ACLU and the NYCLU are well positioned to assist the Court in this matter.

Jonathan Giftos, MD is a Clinical Associate Professor of Medicine at NYU. He is board-certified in addiction medicine, and previously served as the Assistant Commissioner for the Bureau of Alcohol & Drug Use: Prevention, Care and Treatment at the NYC Department of Health and Mental Hygiene. Prior to that, he oversaw prevention, harm reduction and treatment services for incarcerated patients at Rikers Island in NYC and in the NYC shelter system. He is currently the Chief Quality Officer and Chief of Ambulatory Care at NYC Health + Hospitals/Woodhull in Brooklyn.

Dr. Ross MacDonald, MD is the Chief Medical Officer of NYC Health + Hospitals/Woodhull and Clinical Associate Professor of Medicine at NYU

Grossman School of Medicine. Dr. MacDonald previously served as Chief Medical Officer/Senior Assistant Vice President for the Division of Correctional Health Services for NYC Health + Hospitals, where he directed the provision of medical, mental health, substance use and discharge planning care for the 30,000 patients incarcerated annually in the NYC jail system and served as Medical Director for the jail-based opioid treatment program. Dr. MacDonald has published extensive peer-reviewed research on the topic of medications for opioid use disorder and served as an expert related to proper use of medications for opioid use disorder in carceral settings.

Brendan Saloner, PhD is the Donald G. Millar Distinguished Professor of Alcohol and Addiction Studies at Brown University School of Public Health. Dr. Saloner is a nationally recognized leader on issues related to access to OUD treatment. He has published more than two hundred peer-reviewed articles in leading journals and has received funding grants from the National Institute on Drug Abuse and major foundations. Dr. Saloner has been involved in the creation of major consensus reports on opioid policy and has testified in the U.S. Senate related to access to substance use treatment.

Carolyn Sufrin, MD, PhD, is a physician and researcher at Johns Hopkins School of Medicine, where she is an associate professor. Dr. Sufrin has conducted research on and has clinical experience in management of pregnant and parenting

individuals with OUD. She has received several research grants from the National Institute on Drug Abuse, conducted a national survey of nearly one thousand U.S. jails regarding to MOUD, and has published over one hundred peer-reviewed articles in leading medical and public health journals.

BRIEF STATEMENT OF FACTS

This appeal arises out of Queens County Family Court proceedings finding that Jorge permanently neglected his child and terminating Jorge's parental rights. Like many other parents, Jorge has a chronic disease, which he manages with medication directed by a medical provider. Despite having no medical training or expertise, the Family Court spent years repeatedly making incorrect assertions—based on its lay perception—that Jorge's methadone dose was inappropriate, and that the goal of methadone maintenance treatment is to wean people off of methadone. For example, in a permanency hearing order on July 15, 2020, the Family Court wrote that "[t]he Father is on 180 mg. of methadone and has been for years. Unclear why he is on such a high dose of methadone when the goal is to wean people off methadone" (Pet'r's Ex. 5).[1] At a permanency hearing on April 9, 2021, the Family Court again restated its mistaken belief that methadone is only appropriate when used temporarily, noting that no one has "adequately explain[ed] to me why the gentleman is on 180 milligrams of methadone. . . [P]arents go to a methadone

[1] *Amici* adopt the citation format used in Respondent-Appellant Jorge C's opening brief.

program so that they start . . . high, and the process is to actually wean them off the methadone, okay? That has not happened in this case. And nobody has adequately explained that to me" (Pet'r's Ex. 7 at 19). The Family Court went on to ask: "[W]hat steps are being taken to actually get him off of methadone" (Pet'r's Ex. 7 at 22-23).

Relying on its years presiding over drug treatment court instead of any medical expertise, the Family Court stated it was "educated every day about . . . treatment plans for . . . opioid addiction" (4T29). At fact-finding on March 24, 2023, the Family Court admitted two permanency hearing orders and a permanency hearing transcript for the truth of the court's own statements that the goal of Jorge's methadone maintenance program was to wean him off of methadone and for the truth of the fact that Jorge nodded off at some of his virtual visits via video call (2T29, 2T34-37).[2]

Under this enormous pressure from the Family Court to either reduce his methadone dose for no medical reason, or risk forever losing his parental rights, Jorge convinced his provider to reduce his dose in September 2021. In October 2021, he urged his provider to cut it even further (Pet'r's Ex. 8D at 122, 130). The results of this coerced withdrawal were painful: he felt "dizzy and drowsy," he vomited, and he felt discomfort when waking up (Pet'r's Ex. 8D at 130, 147). Indeed, this period

[2] *Amici* do not discuss the evidentiary error in admitting these statements, but rather point to this to further establish the Family Court's persistence in focusing on Jorge's use of methadone (*see* Appellant's Br. at 50-53).

of coerced withdrawal was the only documented time that Jorge experienced side effects directly connected to methadone (*id*).

In its order terminating Jorge's parental rights, after years of pressuring Jorge to reduce his methadone dose and offering repeated statements from the bench about Jorge's methadone, the Family Court faulted Jorge for insufficiently educating the court about methadone himself, by not "bring[ing] a doctor to court to explain how methadone works." (4T31). Throughout these proceedings, the Family Court never asked the child welfare agency that Jorge's child was placed with to bring a doctor to court to explain methadone, despite methadone treatment being a "major component" of Jorge's service plan (2T35–36).

ARGUMENT

I. MOUD, like Methadone, is the Standard of Care to Treat Opioid Use Disorder, But People Who Use Methadone Continue to Face Pernicious Discrimination.

OUD is a treatable, chronic disease affecting the brain, characterized by compulsive use of opioids despite negative consequences.[3] Patients with OUD "present with a compulsion or craving to consume opioids, prioritizing the use of opioids at the expense of other activities or responsibilities."[4] People with OUD

[3] American Psychiatric Association, *Desk Reference to the Diagnostic Criteria from DSM-5* (2016).

[4] Katherine Herlinger & Anne Lingford-Hughes, *Opioid Use Disorder and the Brain: A Clinical Perspective,* 117 Addiction 495 (2021), available at https://onlinelibrary.wiley.com/doi/10.1111/add.15636 (https://perma.cc/8G79-6VHW).

often experience acute and painful withdrawal symptoms when they stop using opioids.[5] Thus, for those with OUD, the urge to use opioids is not due to a lack of willpower, but rather is a symptom of a disease. OUD can lead to fatal consequences—over 81,000 people in the United States died of an overdose involving opioids in 2023 alone.[6]

There is effective treatment available for OUD. MOUD, such as methadone, in combination with appropriate behavioral health supports is the standard of care for OUD and the most effective treatment for OUD.[7] Methadone is an evidence-based, FDA-approved treatment for OUD. It is a long-acting opioid agonist, meaning that it activates the opioid receptors in the brain to limit cravings for opioids and

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[5] *Id.*

[6] *U.S. Overdose Deaths Decrease in 2023, First Time Since 2018*, Centers for Disease Control and Prevention, Natl. Ctr. for Health Statistics (May 15, 2024), https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2024/20240515.htm (https://perma.cc/WH56-ETH6).

[7] *See* American Society of Addiction Medicine, *National Practice Guideline for the Treatment of Opioid Use Disorder 2020 Focused Update* at 30 (2020), https://downloads.asam.org/sitefinity-production-blobs/docs/default-source/guidelines/npg-jam-supplement.pdf?sfvrsn=a00a52c2_4 (https://perma.cc/9RAK-MHHC); Sarah Wakeman, et al., *Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder*, 3(2) JAMA Netw Open (Feb. 5, 2020), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2760032 (https://perma.cc/Q76G-A63H).

prevent opioid withdrawal symptoms.[8] A therapeutic dose of methadone allows people with OUD to fully function and live their everyday lives.[9]

The appropriate length and dosage for MOUD treatment is individual to each patient. In clinical practice it has long been known that appropriate methadone doses vary widely based on individual factors, including genetics, which impact the way the body breaks down methadone. Laboratory studies have demonstrated that a standard blood concentration of methadone for treatment may require a range of dosing from 55mg daily to several hundred milligrams daily.[10] This range is also consistent with clinical practice where dosing in excess of 200 mg is not unusual. It is not possible to judge a dose of methadone within this range to be too high, as it may have the same impact in a given patient as a much lower dose in a different patient, because of each patient's unique characteristics.

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[8] National Academies of Sciences, Engineering, and Medicine, *Medications for Opioid Use Disorder Save Lives* at 34-35 (2019), available at https://nap.nationalacademies.org/catalog/25310/medications-for-opioid-use-disorder-save-lives (https://perma.cc/62SK-CULA).

[9] *Id.* at 35; Substance Abuse and Mental Health Services Administration, *Medications for Opioid Use Disorder, Treatment Improvement Protocol (TIP) Series 63*, Publication No. PEP21-02-01-002 at 3–17 (2019), https://library.samhsa.gov/sites/default/files/pep21-02-01-002.pdf (https://perma.cc/ACK3-RCV6) ("[M]ethadone reduces opioid craving and withdrawal and blunts or blocks the effects of illicit opioids.").

[10] Chin B. Eap et. al, *Plasma Concentrations of the Enantiomers of Methadone and Therapeutic Response in Methadone Maintenance Treatment* 61 Drug Alcohol Depend. 47 (2000), available at https://www.sciencedirect.com/science/article/pii/S0376871600001216?via%3Dihub (https://perma.cc/6RHV-D6S3).

Higher methadone dosages are increasingly necessary given the nature of the drug supply in the United States today. Fentanyl, which is 50 to 100 times more potent than morphine, has flooded the drug supply and resulted in a huge spike in overdose deaths in recent years.[11] According to the American Society of Addiction Medicine ("ASAM"), the medical society for professionals who specialize in addiction medicine, higher methadone doses are increasingly common because "blockade of opioid effects is becoming increasingly more difficult due to the increased availability of high potency opioids including fentanyl and other synthetic opioids."[12] Therefore, "[h]igher doses are more effective than lower doses," and result in better treatment retention.[13]

Long-term use of methadone, too, is typical and effective. Indeed, the safest option for treating OUD is to make methadone available "for an indefinite period of time," based on a patient's individual clinical needs, not a predetermined schedule.[14]

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[11] National Institute on Drug Abuse, *Fentanyl DrugFacts* (last updated June 2021), https://nida.nih.gov/publications/drugfacts/fentanyl (https://perma.cc/4ERK-3PA8); Joseph Friedman & Chelsea Shover, *Charting the Fourth Wave: Geographic, Temporal, Race/Ethnicity and Demographic Trends in Polysubstance Fentanyl Overdose Deaths in the United States, 2010-2021*, 118(12) Addiction 2477 (2023), https://onlinelibrary.wiley.com/doi/10.1111/add.16318 (https://perma.cc/BV9E-3G2R).

[12] *National Practice Guideline for the Treatment of Opioid Use Disorder 2020 Focused Update* at 37.

[13] *Medications for Opioid Use Disorder, Treatment Improvement Protocol (TIP) Series 63*, at 3-35; Yih-Ing Hser et al., *Treatment Retention Among Patients Randomized to Buprenorphine/Naloxone Compared to Methadone in a Multi-Site Trial*, 109 Addiction 79 (Oct. 9, 2013), available at https://pubmed.ncbi.nlm.nih.gov/23961726/ (https://perma.cc/2LX3-4NNQ).

[14] *Medications for Opioid Use Disorder Save Lives* at 38.

This is especially important because "patients who discontinue OUD medication generally return to illicit opioid use."[15] Weaning patients with OUD off of methadone is not, in and of itself, a goal of methadone treatment.[16] ASAM warns practitioners to "not encourage patients to discontinue medication based on a pre-determined duration of treatment."[17] Rather, "there is no recommended time limit for treatment with methadone"[18] and "[l]onger lengths of stay in methadone treatment are associated with superior treatment outcomes."[19]

Coerced withdrawal from methadone can be deadly. Medications like methadone reduce the risk of a fatal overdose by 50 percent.[20] Opioid withdrawal symptoms can lead to cravings for opioids to relieve the pain the patient

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[15] *Medications for Opioid Use Disorder, Treatment Improvement Protocol (TIP) Series 63* at 1-8.

[16] ASAM states that there are four goals of methadone treatment: "1. Suppress opioid withdrawal; 2. Block the effects of illicit opioids; 3. Reduce opioid craving and stop or reduce the use of illicit opioids; 4. Promote and facilitate patient engagement in recovery-oriented activities including psychosocial interventions." Ceasing the use of methadone itself is not a recognized treatment goal. *National Practice Guideline for the Treatment of Opioid Use Disorder 2020 Focused Update* at 36.

[17] *Id.* at 38.

[18] *Id.*

[19] *Medications for Opioid Use Disorder, Treatment Improvement Protocol (TIP) Series 63* at 3-33.

[20] *Medication for Opioid Use Disorder Save Lives* at 39.

experiences.[21] And if a person relapses after forced withdrawal, the consequences of relapse are especially likely to be fatal.[22]

Over 50 years of research demonstrates that methadone not only saves lives but also changes lives for the better.[23] Indeed, methadone's benefits are so well established that the World Health Organization has listed methadone on its model list of essential medicines.[24] Methadone has been shown to reduce mortality by approximately fifty percent among people with OUD, to improve quality of life, and to reduce rates of HIV transmission and Hepatitis C infection.[25] Crucially, for families involved in the family regulation system, a parent's participation in MOUD

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[21] Donald Wesson & Walter Ling, *The Clinical Opiate Withdrawal Scale (COWS)*, 35 J Psychoactives Drugs 253, 259 (2003), available at https://www.tandfonline.com/doi/abs/10.1080/02791072.2003.10400007 (https://perma.cc/UH4P-B92F).

[22] *Cf.* Josiah D Rich et al., *Methadone Continuation Versus Forced Withdrawal on Incarceration in a Combined US Prison and Jail: A Randomized, Open-Label Trial*, 386 Lancet 350 (July 25, 2015), available at https://www.hidta.org/wp-content/uploads/2021/11/Methadone-continuation-versus-forced-withdrawal-on-incarceration-in-a-combined-US-prison-and-jail-a-randomised-open-label-trial.pdf (https://perma.cc/2M99-NMPR); Charting the Fourth Wave at 2479.

[23] Vincent Dole & Marie Nyswander, *A Medical Treatment for Diacetylmorphine (Heroin) Addiction*, 193 JAMA 646 (Aug. 23, 1965), available at https://jamanetwork.com/journals/jama/article-abstract/656315.

[24] World Health Organization, *Opioid Agonist Pharmacotherapy Used for the Treatment of Opioid Dependence (Maintenance)*, https://www.who.int/data/gho/indicator-metadata-registry/imr-details/2718 (https://perma.cc/L2G6-QP24) (last accessed Feb. 4, 2025).

[25] *Medications for Opioid Use Disorder Save Lives* at 39.

treatment has been shown to improve their chance of retaining custody of their children.[26, 27]

Despite the overwhelming medical and scientific consensus that methadone saves and improves lives, methadone remains a highly stigmatized medication.[28] Methadone maintenance treatment for OUD was first established in the 1970s, around the time that President Nixon declared the War on Drugs.[29] Methadone's uniquely burdensome regulatory structure has endured since then. Methadone for OUD may only be dispensed at federally-regulated opioid treatment programs, more commonly known as methadone clinics,[30] while methadone prescribed for conditions other than OUD (like methadone for pain) can be prescribed and

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[26] Martin Hall, et al., *Medication-Assisted Treatment Improves Child Permanency Outcomes for Opioid-Using Families in the Child Welfare System*, 71 J Substance Abuse Treatment 63 (Dec. 2016), available at https://pubmed.ncbi.nlm.nih.gov/27776680/ (https://perma.cc/FFM2-V27X).

[27] While not directly relevant here, the federal government also encourages MOUD during pregnancy and post-partum where medically appropriate. Substance Abuse and Mental Health Services Administration, *A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders*, HHS Publication No. 16-4978 (2016), available at chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://library.samhsa.gov/sites/default/files/sma16-4978.pdf (https://perma.cc/3CCU-ZEKX).

[28] Julia Woo et al., *'Don't Judge a Book by Its Cover': A Qualitative Study of Methadone Patients' Experiences of Stigma*, 11 Substance Abuse: Research and Treatment (2017), available at https://journals.sagepub.com/doi/10.1177/1178221816685087 (https://perma.cc/GMP7-ZS2H).

[29] Nazish Dholakia, *Fifty Years Ago Today, President Nixon Declared the War on Drugs*, Vera Institute for Justice (June 17, 2021), https://www.vera.org/news/fifty-years-ago-today-president-nixon-declared-the-war-on-drugs (https://perma.cc/N732-7TXR) (last accessed May 9, 2025).

[30] Pub L 93-281, 88 US Stat 124 (93rd Cong, May 14, 1974) (Narcotic Addict Treatment Act of 1974).

dispensed like other prescription medications.[31] Further, federal regulations require new methadone patients with OUD to frequently come to methadone clinics in-person to receive their medicine.[32] Being required to frequently go to the clinic, often standing in long lines of other patients, and being publicly marked as someone with OUD, is a highly stigmatizing experience.[33, 34] Additionally, this regulatory framework limits methadone largely to more dense urban communities, which are disproportionately communities of color.[35] Buprenorphine, another FDA-approved MOUD, can be prescribed by any practitioner with an appropriate DEA license and

[31] 21 USC § 812; 21 CFR § 1301.13(e)(1); 21 CFR § 1306.07(a).

[32] 89 Fed Reg 7549 (2024), codified at 42 CFR. § 8.12(i).

[33] Paul Joudrey et al., *Methadone for Opioid Use Disorder--Decades of Effectiveness but Still Miles Away in the US*, 77 JAMA Psychiatry 1105 (2020), available at http://pubmed.ncbi.nlm.nih.gov/32667643/ (https://perma.cc/CRW6-Q78Y); *'Don't Judge a Book by Its Cover': A Qualitative Study of Methadone Patients' Experiences of Stigma*, *supra* n.28.

[34] There have been policy efforts to make methadone more easily accessible. Recently proposed bipartisan federal legislation would allow addiction medicine doctors to prescribe methadone and for pharmacies to dispense methadone to patients. Modernizing Opioid Treatment Access Act, S644 (2023). Additionally, a new final rule published in February 2024 allowed for OTPs to provide more take-home doses for patients, among other changes. 89 Fed Reg 7549.

[35] *See Methadone for Opioid Use Disorder--Decades of Effectiveness but Still Miles Away in the US*, *supra* n.33.

dispensed in a retail pharmacy.[36] Buprenorphine is disproportionately available to white people and people who have private insurance.[37]

This rigid regulatory framework, the clustering of methadone programs in communities of color, and the general bias and stigma against people with OUD, have combined to create a cultural suspicion of both methadone itself and the people who use it. Although this suspicion is unfounded in science and data, individuals who use MOUD are routinely denied access to the benefits of programs to which they would otherwise be entitled.[38] Given this context, it is especially critical that family courts refrain from further entrenching bias and stigma against people with OUD who use methadone.

II. The Family Court Order Terminating Jorge's Parental Rights Largely Due to Stereotypes About His Disability and the Medication He Used to Treat It Had No Substantial Basis in Law or Fact.

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[36] Substance Abuse and Mental Health Services Administration, *Waiver Elimination (MAT Act)*, https://www.samhsa.gov/substance-use/treatment/statutes-regulations-guidelines/mat-act# (https://perma.cc/LY72-LCFF) (last updated Nov. 6, 2024); Dima Qato, et al., *Federal and State Pharmacy Regulations and Dispensing Barriers to Buprenorphine Access at Retail Pharmacies in the US*, 3 JAMA Health Forum (2022), https://jamanetwork.com/journals/jama-health-forum/fullarticle/2795746 (https://perma.cc/J88W-V9AR) (last accessed May 9, 2025).

[37] Pooja Lagisetty, et al., *Buprenorphine Treatment Divide by Race/Ethnicity and Payment*, 76 JAMA Psychiatry 979 (May 9, 2019), available at https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2732871#:~:text=This%20study%20demonstrates%20that%20buprenorphine,insurance%20or%20use%20self%2Dpay (https://perma.cc/8TUQ-UHD3).

[38] *See e.g.* United States Department of Justice, *The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery* (April 5, 2022), https://archive.ada.gov/opioid_guidance.pdf (https://perma.cc/Y9ML-LPUC) (providing examples of individuals with OUD being illegally discriminated against in health care, carceral, zoning, and employment settings).

For years, the Family Court discriminated against Jorge because he took a lifesaving medication to treat his disability. Time and again, the Family Court—with no medical training and without the benefit of a medical expert—opined on the proper dose of Jorge's medication and the length of his treatment plan. This discrimination forced Jorge to make an impossible choice: either forego methadone and risk relapse, overdose, and possibly even death, or risk permanently losing his parental rights. If Jorge's chronic disease was diabetes or hypertension, it would be unimaginable for a court to order Jorge to either lower or eliminate his dose of insulin or diuretics, or risk losing his child. But the Family Court's conduct in Jorge's case and its order terminating his parental rights was no different: it discriminated against Jorge because of his disability.

As the Court of Appeals has confirmed, the "Family Court should not blind itself to the ADA's requirements" (*Matter of Lacee L.*, 32 NY3d at 231). Disparate treatment in violation of the ADA therefore cannot be the valid basis of a Family Court order. Here, the Family Court's order lacked any substantial basis in law or fact because it discriminated against Jorge based on his disability. Accordingly, the Family Court's permanent neglect finding should be reversed.

A. The Family Court's Order Did Not Have a Substantial Basis in Fact or Law Because It Discriminated Based on Disability.

Like many other loving parents, Jorge has a disability: OUD. A disability, for purposes of the ADA, is "a physical or mental impairment that substantially limits

one or more major life activities" (42 USC § 12102[1][A]). Major life activities are broadly defined, and include concentrating, thinking, and caring for oneself, as well as "major bodily function[s]," including brain function (*id.* § 12102[1], [2]). A disability that is in remission is still a disability "if it would substantially limit a major life activity when active" (*id.* § 12102[4][D]). Drug addiction, such as OUD, is an impairment (28 CFR 35.108[b][2]; *Reg'l Econ. Cmty. Action Program, Inc. v City of Middletown*, 294 F3d 35, 46 [2d Cir 2002] [recognizing substance use disorder as an impairment]). The record demonstrates that Jorge's OUD, when not treated with methadone, substantially limits major life activities, including his brain function and his ability to care for himself, and thus is a disability (*see* Pet'r's Ex. 8D at 130, 147).

Throughout the permanent neglect proceedings and in its order, the Family Court singled out Jorge for disparate treatment because it determined—based on no individualized review or relevant facts specific to Jorge—that Jorge's methadone dose was too high and that he had been on his medication for too long (*see Hamilton v Westchester County*, 3 F4th 86, 91 [2d Cir 2021] [explaining that discrimination can be shown through several methods, including disparate treatment [intentional discrimination] and failure to make a reasonable accommodation]).

Disparate treatment need not result from animus (*see Alexander v Choate*, 469 US 287, 296 [1985] ["[Disability discrimination] is primarily the result of apathetic

attitudes rather than affirmative animus."]). Rather discrimination often stems from "thoughtlessness" or "benign neglect" (*Martinez v Cuomo*, 459 F Supp 3d 517, 522 [SD NY 2020], citing *Alexander*, 469 US at 295). Reliance on stereotypes and generalizations, rather than individualized assessment based on objective evidence, is a prime example of disability discrimination (*see PGA Tour, Inc. v Martin*, 532 US 661, 690 [2001] [explaining that an individualized inquiry is among the ADA's most "basic requirement[s]"]; 28 CFR part 35, Appendix B ["public entities are required to ensure that their actions are based on facts applicable to individuals and not on presumptions as to what a class of individuals with disabilities can or cannot do."]). The same is true in the family regulation system.[39] When evaluating disabled parents' capacity to care for their children, public entities must conduct an individualized assessment consistent with objective evidence and may not rely on generalizations or stereotypes (*see* U.S. Department of Justice, Civil Rights Division, *Rights of Parents with Disabilities*).[40]

Courts have routinely found that differential treatment based on someone's use of methadone and other MOUDs can amount to disability discrimination. For example, courts have found that denials of MOUD to incarcerated people can

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[39] *Amici* use the term "family regulation" to refer to the system traditionally known as "child welfare."

[40] *Available at* https://www.ada.gov/topics/parental-rights/ (https://perma.cc/D353-EMR4).

amount to disability discrimination (*see e.g. M.C. v Jefferson County*, 65 NDLR P 82 [ND NY May 16, 2022]*; Smith v Aroostook County*, 376 F Supp 3d 146, 159-160 [D Me 2019], *affd*, 922 F3d 41 [1st Cir 2019]), and have found disparate treatment in challenges to strict zoning regulations burdening methadone clinics (*see e.g. New Directions Treatment Servs. v City of Reading*, 490 F3d 293, 304 [3d Cir 2007] [holding that a law limiting methadone clinics was facially discriminatory]; *MX Grp., Inc. v City of Covington*, 293 F3d 326, 345 [6th Cir 2002] [same]; *Bay Area Addiction Research & Treatment, Inc. v City of Antioch*, 179 F3d 725, 735 [9th Cir 1999] [same]). Likewise, The United States Department of Justice has issued guidance affirming that people who are in drug treatment programs are protected by the ADA (U.S. Department of Justice, *The Americans with Disabilities Act and the Opioid Crisis: Combatting Discrimination Against People in Treatment or Recovery*).[41] And the United States Department of Health and Human Services has investigated and reached settlements where entities in the family regulation system discriminated based on use of methadone and other MOUDs (*see e.g. Voluntary Resolution Agreement Between the U.S. Department of Health and Human Services Office for Civil Rights (OCR) and the Pennsylvania Department of Human Services*,

[41] *See supra,* n.38.

OCR Transaction Number 20-359940 [Apr. 6, 2023];[42] *Voluntary Resolution Agreement Between the U.S. Department of Health and Human Services Office for Civil Rights (OCR) and the West Virginia Department of Health and Human Resources Bureau for Children and Families*, OCR Transaction Number 18-306552 [Apr. 22, 2020]).[43]

Here, the Family Court repeatedly relied on stereotypes and generalizations about Jorge, rather than individualized, objective evidence to reach its conclusion in the termination proceeding. Citing its years presiding over drug treatment court, where the Family Court claims that it was "educated every day about . . . treatment plans for . . . opioid addiction" (4T29), the Family Court relied on incorrect generalizations about methadone in reaching its conclusion. The Family Court incorrectly asserted that the purpose of methadone "is to actually wean them off" (Pet'r's Ex. 7 at 19), when there is medical consensus that the safest option is to allow for indefinite use of methadone based on a patient's clinical needs. The Family Court further misapprehended that 180mg was an inappropriately high dose (Pet'r's Ex. 7 at 19, 22–23), when the medical consensus is that, especially in the age of

[42] *Available at* https://www.hhs.gov/civil-rights/for-providers/compliance-enforcement/agreements/vra-pennsylvania-department-human-services/index.html (https://perma.cc/84H5-N753).

[43] *Available at* https://www.hhs.gov/civil-rights/for-providers/compliance-enforcement/agreements/vra-pennsylvania-department-human-services/index.html (https://perma.cc/A64N-HVBF).

powerful synthetic fentanyl, higher doses are more effective than lower doses (*see supra* at 11-12). Finally, the Family Court faulted Jorge for not bringing in an expert to educate the court on "how methadone works," (4T31) and never asked the child welfare agency to bring in an expert of its own to put competent evidence before the court about methadone for OUD. In making these misstatements, the Family Court failed to undertake an individualized analysis of Jorge's needs rooted in reliable evidence, rather than stereotypes and generalizations.

This was not the first time that a New York Family Court has made this error. In *Beeken v Fredenburg*, the Third Department found that the "Family Court's findings—gleaned from its 'many years of experience in "Drug Court"'—as to the implications of the mother's treatment with [MOUD] . . . are not supported by a sound and substantial basis in the record . . . and the court erred in *sua sponte* taking judicial notice of certain facts after the conclusion of the fact-finding hearing . . . an error that we do not deem to be harmless" (145 AD3d at 1397). Likewise, here, the Family Court relied on its experience in drug treatment court, rather than the overwhelming scientific evidence supporting Jorge's continued use of methadone.

While someone who is a "direct threat" to the health and wellbeing of themselves or others is not protected by the ADA, the direct threat analysis may not be based on "prejudiced attitudes or the ignorance of others." Rather, it must be based on objective evidence and an "individualized assessment . . . rely[ing] on

current medical knowledge or on the best available objective evidence" (28 CFR 35.139[b]). These guardrails are especially critical here because "few aspects of a handicap give rise to the same level of public fear and misapprehension, [] as the challenges facing recovering drug addicts" (*Bay Area Addiction Research & Treatment, Inc.*, 179 F3d at 736). A direct threat analysis must also take into account whether there are reasonable modifications that would mitigate the threat (28 CFR 35.139[b]).

Here, the Family Court did not rely on the "best available evidence," nor on objective medical information or an individualized assessment of Jorge. Instead, the Family Court relied on its time presiding over drug treatment court about the appropriate dose and length of treatment with methadone (*see* 4T29). The Family Court even lamented that Jorge, despite not carrying the burden in the case, did not bring a doctor to the court to explain his methadone dose (*see* 4T31). If the Family Court had questions about the propriety of his treatment regimen, it was more than able to order the agency to present competent evidence on the subject.

To the extent the Family Court or the agency believed Jorge's drowsiness was a side effect of his MOUD and found such drowsiness to be a barrier to reunification, the agency failed to make any accommodations or modifications to address the drowsiness. The agency could have discussed solutions to the drowsiness with Jorge and his doctors, or provided Jorge with tools to ensure that his son was otherwise

supervised if he needed to rest following his MOUD treatments. Jorge is not the only loving parent to sometimes feel drowsy. Indeed, he is one of many parents who take medicines that can cause drowsiness as a side effect. These parents do not, and should not, lose their parental rights on this basis. Nor should Jorge.

B. Petitioner-Respondent's Arguments Reinforce Stereotypes About People with OUD.

Petitioner-Respondent's arguments reinforce the very stereotypes and generalizations that give rise to the ADA violation. While on appeal Petitioner-Respondent minimizes the role that methadone played in the termination proceeding, at fact finding in the Family Court, Petitioner-Respondent asserted that the "crux of this case . . . that he failed to comply with, was [] weaning off of methadone" (2T35-36). In its brief in this Court, Petitioner-Respondent faults Jorge for not engaging in relapse prevention services, reasoning that "his fear of relapsing if he came off of methadone . . . could have been addressed and ameliorated" by engaging in these services (Pet-Resp. Br. at 51, n.16). But the science is to the contrary: terminating methadone itself *causes* relapse.[44] Petitioner-Respondent also alleges that Jorge "minimized the effect . . . his own methadone usage was having" and compares the Family Court forcing Jorge to lower his methadone dosage to requiring "anger management for a parent that is having outbursts" (Pet-Resp. Br. at 54). But the

[44] *Medication for Opioid Use Disorder Save Lives* at 40.

science and the evidence in this case shows that Jorge himself was stable on methadone (*see* 3T67) and that methadone improves many aspects of patients' lives, including their ability to parent.[45]

C. Denying Jorge Access to MOUD is Contrary to New York Public Policy.

In the face of an unprecedented overdose epidemic, New York state has passed laws and enacted policies which strongly encourage people with OUD to use MOUD (*see* Criminal Procedure Law § 216.05; A6255B [2015] [sponsor's memo] [the Legislature found that "it is evident that prohibiting the use of methadone and buprenorphine therapy treatments, or requiring its use serve merely as a 'bridge to abstinence' is contrary to established best practices, and hinders the recovery process"]; Correction Law § 626 [requiring MOUD to be available to incarcerated people in correctional facilities]; State Finance Law § 99-jj(3)(d) [listing medication-assisted treatment as one of the purposes for the state's drug treatment public education fund]). Parents—indeed anyone—who has the courage to get the help that they need for their substance use disorder should be applauded, not punished.

The Family Court's ill-informed and discriminatory course of conduct put Jorge in an impossible position: either get off of your life-saving methadone or risk having all of your rights as a parent stripped from you. It goes without saying that

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[45] *Medication-Assisted Treatment Improves Child Permanency Outcomes for Opioid-Using Families in the Child Welfare System*, *supra* n.26.

separating a parent and a child has profound negative consequences for the whole family.[46] When Jorge, at the behest of the Family Court, started to taper his methadone dosage, he experienced painful withdrawal symptoms (*see* Pet'r's Ex. 8D at 130, 147). Forced withdrawal leads to dramatically higher rates of relapse, overdose, and death (*see supra* at 13).[47] If the Family Court's conduct is approved, it will threaten the sobriety and the lives of other parents who use medication to treat their OUD, and it will have a chilling effect on parents who want to receive lifesaving treatment for their OUD.

Demanding that parents with any other disability forego effective medication in order to retain their right to parent is unimaginable. Second guessing, without evidence, complex dosage and treatment decisions made by medical professionals about any other disability, too, is incomprehensible. But the Family Court did just that here, in violation of laws prohibiting disability discrimination. The Family Court's inappropriate meddling in Jorge's medical care was dangerous and illegal. Instead of jumping to conclusions not rooted in science, courts should rely on

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[46] *See generally* Shanta Trivedi, *The Harm of Child Removal*, 43 N.Y.U. Rev. L. & Soc. Change 523, 527-552 (2019), available at https://socialchangenyu.com/wp-content/uploads/2019/07/Shanta-Trivedi_RLSC_43.3.pdf (https://perma.cc/S564-22BS); American Bar Association, Children's Rights Litigation Committee, *Trauma Caused by Separation of Children from Parents* (2019), https://www.americanbar.org/content/dam/aba/publications/litigation_committees/childrights/child-separation-memo/parent-child-separation-trauma-memo.pdf (https://perma.cc/C573-H7PE).

[47] *See also Medication for Opioid Use Disorder Save Lives* at 39.

medical experts and follow evidence-based criteria to reach its conclusions (*see generally Daubert v Merrell Dow Pharmaceuticals*, 509 US 579 [1993]). Consistent with New York public policy, family courts should incentivize treatment, not discourage it and force parents who need help into the shadows.

CONCLUSION

For the aforementioned reasons, this Court should reverse the Family Court's permanent neglect finding and dismiss the petition.

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New York, NY

Respectfully submitted,

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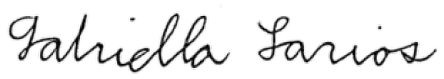

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**application for pro hac vice admission forthcoming*