<u>DETAINED AND DOPESICK</u>: THE RIGHT TO MEDICATION-ASSISTED TREATMENT FOR INCARCERATED INDIVIDUALS WITH OPIOID USE DISORDER

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August 19, 2020

Opioid withdrawal is a grueling physical ordeal. Fortunately, the effects of withdrawal—physical suffering, mental distress, and mortality—can be mitigated by proper medical care. In most jails and prisons, however, individuals with opioid use disorder are denied access to proper medical care for their disease and are forced to endure involuntary withdrawal. The refusal to provide adequate medical care for the serious health condition of opioid use disorder is unnecessary, unlawful, and deadly. This article is the first to argue that correctional facilities have an affirmative obligation to provide medication-assisted treatment to all incarcerated individuals with opioid use disorder, regardless of whether the patient was using legal prescriptions or illicit substances prior to incarceration. Providing medication-assisted treatment will reduce suffering, save lives, and uphold the state's promise of human dignity to those whose liberty is restricted by incarceration. Further, this article argues that the Supreme Court should modify the legal standard for adequate medical care in correctional facilities so that courts need only consider the objective medical need of incarcerated individuals.

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Introduction

> *Well you start the hot and cold sweats. And with the diarrhea, stomach cramps and you throw up and you do that for like three days straight or four days straight. And then you be weak as I don't know what. And when I had the heart attack I was sleeping and it woke me up out of my sleep. And it just feels like a cinder-block hit me on my chest and I woke up in a sweat. Luckily the officer that was there knew what was going on and they rushed me to the hospital. And if they didn't I probably would have died.* –Incarcerated individual discussing opioid withdrawal.[1]

> *[D]enial of medical care is surely not part of the punishment which civilized nations may impose for crime.* –Justice Stevens, Estelle v. Gamble.[2]

Sarah was a long-time heroin user.[3] When a harm-reduction clinic opened in her hometown, Sarah was among the first to sign up for treatment. She showed up to her appointments on time and was a friendly, well-liked patient. Then Sarah was arrested for shoplifting. At the local jail, the police took Sarah's prescription Suboxone, a medication designed to curb cravings and the physical symptoms of withdrawal without the elation of an opioid high. Sarah was unable to make bail and, without her daily dose of Suboxone, soon began experiencing withdrawal. She experienced fevers and sweats, retched repeatedly, was unable to sleep, and suffered severe anxiety and depression. Officers watched as she moaned on the floor of her cell, in pools of his own vomit and urine, and refused to give even Tylenol for her pain. Her family made multiple calls to the jail and to Sarah's medical provider begging for help. The police left Sarah's prescription medication sitting in a drawer twenty feet from her cell.

Mark started drinking at 13, progressed to marijuana, drifted to Percocet, then began using heroin.[4]

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[1] Shannon Gwin Mitchell et al., *Incarceration and opioid withdrawal: The experiences of methadone patients and out-of-treatment heroin users*, 41 J PSYCHOACTIVE DRUGS 145–152 (2009).

[2] 429 U.S. 97, 104 (1976) (dissenting).

[3] Sarah's story was shared by her medical provider. Select details have been modified to ensure anonymity.

[4] Mark's story is adopted from an article published by The Marshall Project. *See* Beth Schwartzappel, *A Better Way to Treat*

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At 22, he passed out in a motel room in a position that cut off circulation to his leg. The leg was amputated, but while in the hospital he almost enjoyed the unrestricted access to morphine. He went in and out of rehab and jail for years. Mark's pattern of treatment and incarceration was tragically conventional until his most recent incarceration at the Rhode Island Department of Corrections. There, during a twelve month sentence for theft, Mark was part of a medication-assisted treatment program. Each day he took a dose of Suboxone. He said that the treatment made him "feel comfortable in my own skin." Instead of wondering when he would get out so that he could get high, like during his past periods of incarceration, he said that "within 48 hours I felt like my old self, before I was even taking drugs . . . this is the first time I've ever been here where I've been mentally and physically at peace."

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Sarah and Mark were treated differently by their correctional facilities—Sarah's experience produced pain, while Mark's experience created optimism. There should be no more stories like Sarah's. This article argues that all incarcerated individuals with opioid use disorder have a right to medication-assisted treatment (MAT), which is the most successful treatment method for their disease.[5] MAT is the use of medication (for example, Suboxone) in combination with counseling and behavior therapies.[6] In

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Addiction in Jail, THE MARSHALL PROJECT, March 2, 2017, https://www.themarshallproject.org/2017/03/01/a-better-way-to-treat-addiction-in-jail.

[5] *See* Nora D. Volkow & Eric M. Wargo, *Overdose Prevention Through Medical Treatment of Opioid Use Disorders*, 169 ANNALS OF INTERNAL MEDICINE 3, 190 (Aug. 7, 2018) https://doi.org/10.7326/M18-1397.

[6] Some patients and providers consider "medication-assisted treatment" stigmatizing language, and provide the alternative "medication for addiction treatment." This author is dedicated to stopping the stigma associated with addiction, but I use the traditional term "medication-assisted treatment" here because it is most prevalent in the academic literature. *See*, Grayken Center for Addiction, *I pledge to Stop the Stigma Associated with Addiction*, BOSTON MEDICAL CENTER, https://development.bmc.org/wp-content/uploads/2018/09/Grayken-Center-for-Addiction-at-Boston-Medical-Center-Words-Matter-Pledge.pdf; Center for Drug Evaluation and Research, *Information about Medication-Assisted Treatment (MAT)*, FDA (Feb. 14, 2019)

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this article, MAT primarily means access to specific prescription medications.

Roughly two million people in the United States are struggling with opioid use disorder, like Sarah and Mark.[7] Less than 20 percent are treated with effective medication.[8] Regrettably, a high proportion of individuals with opioid use disorder become involved in the criminal legal system where most are denied access to treatment.[9] Jails and prisons are at the front lines of the opioid crisis, and have a duty to provide medical treatment to individuals in their care.[10] As phrased by an attorney for the American Civil Liberties Union of Maine, "[w]e don't expect jails to solve the opioid crisis, but the least they can do is not make it worse."[11]

A strategic sequence of cases in the last two years has established that incarcerated individuals cannot be denied access to their prescription medication for addiction, just as for any other disease, because they have a constitutional and statutory right to adequate medical

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https://www.fda.gov/drugs/information-drug-class/information-about-medication-assisted-treatment-mat.

[7] *See* National Academies of Sciences, Engineering, and Medicine, *Medications for Opioid Use Disorder Save Lives*, THE NATIONAL ACADEMIES PRESS, 1 (2019) https://doi.org/10.17226/25310. (finding that the pervasive lack of treatment for OUD is a serious ethical violation by both health care providers and the criminal legal system).

[8] *See id.* at 8; Olga Khazan, *Why 80 Percent of Addicts Can't Get Treatment*, THE ATLANTIC (Oct. 13, 2015), https://www.theatlantic.com/health/archive/2015/10/why-80-percent-of-addicts-cant-get-treatment/410269/.

[9] *See id.* at 98–99; The Editorial Board, *Want to Reduce Opioid Deaths? Get People the Medications They Need*, THE NEW YORK TIMES, March 26, 2019, https://www.nytimes.com/2019/03/26/opinion/opioid-crisis-sacklers-purdue.html.

[10] *See* Eric Westervelt, *County Jails Struggle With A New Role As America's Prime Centers For Opioid Detox*, NPR.ORG, April 24, 2019, https://www.npr.org/2019/04/24/716398909/county-jails-struggle-with-a-new-role-as-americas-prime-centers-for-opioid-detox; Farmer v. Brennan, 511 U.S. 825, 832 (1994) (holding that the Eighth Amendment "imposes duties on [prison] officials, who must provide humane conditions of confinement; prison officials must ensure that inmates receive adequate food, clothing, shelter, and medical care.").

[11] *Federal Judge Rules Jail Must Allow Access to Medication-Assisted Treatment*, ACLU OF MAINE (March 28, 2019) https://www.aclumaine.org/en/press-releases/federal-judge-rules-jail-must-allow-access-medication-assisted-treatment.

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care.[12] This article goes further and argues that correctional facilities have an affirmative obligation to provide MAT for all individuals with opioid use disorder, regardless of whether they were using legal prescriptions or illicit drugs prior to incarceration. Providing MAT will save lives, reduce suffering, and uphold the promise of human dignity to those whose liberty is restricted by incarceration. Additionally, this article argues that the Supreme Court should change the legal standard for adequate medical care in jails and prisons. Currently, an incarcerated individual must show both that they have an objectively serious medical need and that a correctional officer displayed a subjective deliberate indifference in failing to meet that medical need.[13] The Court should dispose of the subjective indifference requirement and look only to the incarcerated person's objective medical need.

This article begins with background on the opioid crisis and the dire lack of adequate treatment in the criminal legal system. Part II then shows that incarcerated individuals with opioid use disorder have a constitutional and statutory right to medication-assisted treatment. Part III argues that the right to treatment goes beyond preventing denial of care and creates an affirmative obligation for correctional facilities to offer MAT to all individuals with opioid use disorder. This step is necessary, because it will save lives, and novel—this is the first argument for a legal right to MAT across all correctional systems, regardless of whether the incarcerated individual

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[12] *See* Pesce v. Coppinger, 355 F.Supp.3d 35, 39 (D. Mass. 2018); Smith v. Aroostook Cty., 376 F. Supp. 3d 146, 152 (D. Me.), *aff'd*, 922 F.3d 41 (1st Cir. 2019); Dipierro v. Hurwitz, Settlement Agreement, 2 (D. Mass. Jun. 7, 2019); Kortlever et al. v. Whatcom County, Settlement Agreement, 5–6 (April 29, 2019) https://www.aclu-wa.org/docs/settlement-agreement-1; Crews v. Sawyer, *Kansas and Missouri ACLU affiliates reach settlement with Bureau of Prisons; Leavenworth inmate will receive opioid medication tonight*, ACLU OF KANSAS (Kans., Sept. 11, 2019), https://www.aclukansas.org/en/press-releases/kansas-and-missouri-aclu-affiliates-reach-settlement-bureau-prisons-leavenworth; Godsey v. Sawyer, *ACLU-WA lawsuit settled: Federal prison system agrees to provide medication-assisted treatment for opioid use disorder*, ACLU OF WASHINGTON (Wash., Dec. 11, 2019) https://www.aclu.org/press-releases/aclu-wa-lawsuit-settled-federal-prison-system-agrees-provide-medication-assisted.

[13] *See* Estelle v. Gamble, 429 U.S. 97, 104 (1976).

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was previously using legal or illicit drugs.[14] Part III also argues that courts should consider only a patient's objective medical need when evaluating adequacy of medical treatment in jails and prisons. Part IV advocates for legislative changes, at both the federal and state level, that will satisfy the right to medical care while incarcerated without the need for adversarial litigation.

I. The Opioid Epidemic and Inadequate Treatment

a. The Disease, the Epidemic, and Withdrawal

Opioid addiction is a disease, known as opioid use disorder (OUD).[15] OUD damages the brain's dopamine system and creates a chemical cycle where the brain receives signals that it is necessary to continue the addictive activity in order to survive.[16] Like other chronic

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[14] *See, e.g.*, Rebecca Boucher, *The Case for Methadone Maintenance Treatment in Prisons*, 27 Vt. L. Rev. 453, 454 (2003) (focusing on scientific findings as of 2003 and Vermont case law to argue for new bases against the denial of methadone in prisons); Michael Linden et al., *Prisoners as Patients: The Opioid Epidemic, Medication-Assisted Treatment, and the Eighth Amendment*, 46 J LAW MED. ETHICS 252, 254 (2018) (focusing on MAT in prisons, only for individuals post-conviction); Corey S. Davis, Derek H. Carr, *The Law and Policy of Opioids For Pain Management, Addiction Treatment, and Overdose Reversal*, 14 Ind. Health L. Rev. 1, 2 (2017) (focusing on the regulation of medication); Nicholas P. Terry, *Structural Determinism Amplifying the Opioid Crisis: It's the Healthcare, Stupid!*, 11 Ne. U. L. Rev. 315, 318 (2019) (focusing on the healthcare system); Emily Mann, *Advocating For Access: How the Eighth Amendment and the Americans With Disabilities Act Open A Pathway For Opioid-Addicted Inmates to Receive Medication-Assisted Treatment*, 29 Annals Health L. Advance Directive 231, 234 (focusing on MAT in prisons); Evelyn Malavé, Note, *Prison Health Care After The Affordable Care Act: Envisioning An End To The Policy Of Neglect*, 89 N.Y.U. L. Rev. 700, 700 (focusing on healthcare after release).

[15] *See* American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (5th Ed. 2013), 541; *Module 5: Assessing and Addressing Opioid Use Disorder (OUD)*, Center for Disease Control and Prevention (accessed Oct. 26, 2018) https://www.cdc.gov/drugoverdose/training/oud/accessible/index.html.

[16] *See* J.C. Fellers, Management of Addiction Issues in Complex Pain, Am. College of Physicians (Oct. 2, 2016) https://www.acponline.org/system/files/documents/about_acp/chapters/me/management_of_addi ction_issues_in_complex_pain_j_fellers.pdf.

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relapsing conditions, such as diabetes, OUD "involves periods of exacerbation and remission, but the underlying vulnerability never disappears."[17]

Health experts have considered OUD a disease for decades. For example, in 1997 the National Institutes of Health declared that "[o]piate dependence is a brain-related medical disorder," not an issue of willpower, and that, "[a]ll persons dependent on opiates should have access to [MAT]."[18] Today, the Center for Disease Control (CDC) considers OUD a specific type of addiction, defined as a "problematic pattern of opioid use leading to clinically significant impairment or distress."[19] Patients with OUD are prone to overdose and death, creating the present opioid epidemic.[20]

The opioid epidemic is a crisis of mortality. 300,000 Americans have died from opioid overdose since 2000, at a current rate of 175 people each day.[21] According to the CDC, drug overdoses killed over 70,000 Americans in 2017.[22] This represents a 9.6% increase in the rate of drug overdose death from 2016.[23] To provide some relative perspective, that is more deaths per year than from gun homicides or motor vehicle accidents, more than were killed by AIDS at the peak of that epidemic, more deaths

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[17] *See* Marc A. Schuckit, *Treatment of Opioid-Use Disorders*, New England Journal of Medicine, 357 (Jul. 28, 2016).

[18] NIH Nat'l Consensus Dev. Panel on Effective Med. Treatment of Opiate Addiction, *Effective Medical Treatment of Opiate Addiction*, 280 JAMA 1936, 1936-38 (1998).

[19] *Module 5: Assessing and Addressing Opioid Use Disorder (OUD)*, Center for Disease Control and Prevention.

[20] *See* Beth Schwartzappel, *A Better Way to Treat Addiction in Jail*, MARSHALL PROJECT, Mar. 2, 2017, https://www.themarshallproject.org/2017/03/01/a-better-way-to-treat-addiction-in-jail (noting that formerly incarcerated individuals are 12 times more likely to die and 129 times more likely to die of an overdose than the general population).

[21] *See* "The Opioid Crisis," The White House, https://www.whitehouse.gov/opioids/ (accessed Nov. 27, 2018); Centers for Disease Control and Prevention, "Opioid Overdose: Understanding the Epidemic," https://www.cdc.gov/drugoverdose/epidemic (last visited Nov. 20, 2018) (explaining that "[o]n average, 115 Americans die every day from an opioid overdose").

[22] *See* Holly Hedegaard, M.D., Arialdi M. Miniño, M.P.H., and Margaret Warner, Ph.D., "Drug Overdose Deaths in the United States, 1999–2017," (Nov. 28, 2018), https://www.cdc.gov/nchs/products/databriefs/db329.htm.

[23] *See id.*

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than in the entire Vietnam war, and more fatalities than the wars in Afghanistan and Iraq combined.[24] Before the coronavirus pandemic, the CDC blamed a drop in American life expectancy on the steep increase in overdose deaths.[25] 2014 to 2017 marked the first time that life expectancy fall since World War II,[26] and during that time drug overdoses became the leading cause of death of Americans under 50.[27] Nationally, over two million Americans have an addiction to prescription or illicit opioids and on October 26, 2017, President Trump declared the opioid crisis a Public Health Emergency.[28]

The opioid epidemic is exacerbated by the proliferation of potent synthetic opioids.[29] A single trunk-sized shipment of fentanyl (a synthetic opioid 40 times more potent than heroin) contains enough poison to wipe out the entire population of New Jersey and New York City

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[24] *See* Josh Katz, *You Draw It: Just How Bad Is the Drug Overdose Epidemic?* N.Y. TIMES, Apr. 14, 2017, https://www.nytimes.com/interactive/2017/04/14/upshot/drug-overdose-epidemic-you-draw-it.html; "Vietnam War U.S. Military Fatal Casualty Statistics," National Archives, Aug. 15, 2016, https://www.archives.gov/research/military/vietnam-war/casualty-statistics; U.S. Dep't of Defense, *Casualty Status*, May 4, 2020, https://www.defense.gov/casualty.pdf.

[25] *See* Susan Scutti. *US Life Expectancy Drops in 2017 Due to Drug Overdoses, Suicides*, CNN, https://www.cnn.com/2018/11/29/health/life-expectancy-2017-cdc/index.html; Lopez, German. *Drug Overdose Deaths Were so Bad in 2017, They Reduced Overall Life Expectancy*, VOX, Nov. 29, 2018. https://www.vox.com/science-and-health/2018/11/29/18117906/opioid-epidemic-drug-overdose-deaths-2017-life-expectancy; Josh Katz, and Margot Sanger-Katz. *"The Numbers Are So Staggering." Overdose Deaths Set a Record Last Year*. N.Y. TIMES, Nov. 29, 2018, https://www.nytimes.com/interactive/2018/11/29/upshot/fentanyl-drug-overdose-deaths.html.

[26] *Id.*

[27] *See* Centers for Disease Control and Prevention, "Underlying Cause of Death, 1999-2017 Results," https://wonder.cdc.gov/controller/datarequest/D76;jsessionid=691162F2000B175BA5D8ED18C296F130?stage=results&action=sort&direction=MEASURE_DESCEND&measure=D76.M3 (accessed Dec. 10, 2018).

[28] *See* "The Opioid Crisis," The White House, https://www.whitehouse.gov/opioids/ (accessed November 27, 2018).

[29] *See* Julie K. O'Donnell et al., *Deaths Involving Fentanyl, Fentanyl Analogs, and U-47700 — 10 States, July-December 2016*, 66 MMWR MORB. MORTAL. WKLY. REP. 1197–1202 (2017).

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combined.[30] Only two milligrams of fentanyl can tranquilize a 2,000-pound elephant.[31] Carfentanil, another synthetic opioid, is 10,000 times more powerful than morphine.[32] Additionally, the proliferation of drugs with increasing potency is not limited to illicit markets. For example, the FDA recently approved a new pain killer, Dsuiva, that is stronger than fentanyl and 50 to 100 times more potent than morphine.[33]

To save lives, experts agree that resources should be funneled toward treatment.[34] When an individual with OUD desires care, and has the courage to ask for help, they often have nowhere to go. Treatment centers are chronically overbooked, medical clinics have long waiting lists, and emergency rooms or fire departments cannot offer long-term care.[35] Continued use may be driven by the

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[30] *See* Andrew Sullivan, *The Poison We Pick: Americans Invented Modern Life. Now We're Using Opioids to Escape It*, DAILY INTELLIGENCER, Feb. 20, 2018, http://nymag.com/daily/intelligencer/2018/02/americas-opioid-epidemic.html.

[31] *See id.*

[32] *See* Abby Goodnough, *This City's Overdose Deaths Have Plunged. Can Others Learn From It*?, N.Y. TIMES, Nov. 26, 2018, https://www.nytimes.com/2018/11/25/health/opioid-overdose-deaths-dayton.html.

[33] *See Powerful New Drug Dsuvia Worries Some amid Opioid Epidemic*, AJC, https://www.ajc.com/lifestyles/people-front-lines-epidemic-fear-powerful-new-drug-dsuvia/bBLIHdH7Xca5s1qrabxttL/amp.html (accessed November 28, 2018); Raeford Brown and Sidney Wolfe, *The FDA Made the Wrong Call on This Powerful, New Opioid*, WASHINGTON POST, Nov. 16, 2018, https://www.washingtonpost.com/opinions/the-fda-made-the-wrong-call-on-this-powerful-new-opioid/2018/11/16/39b212e2-e464-11e8-ab2c-b31dcd53ca6b_story.html.

[34] *See* Josh Katz, *How a Police Chief, a Governor and a Sociologist Would Spend $100 Billion to Solve the Opioid Crisis*, N.Y. TIMES, Feb. 14, 2018, https://www.nytimes.com/interactive/2018/02/14/upshot/opioid-crisis-solutions.html. According to a 2018 report from the Surgeon General, treatment remained unavailable to the bulk of people who need it, with only one in four people diagnosed with OUD receiving specialty treatment for illicit drug use. *See* U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Spotlight on Opioids. Washington, DC: HHS, September 2018. https://addiction.surgeongeneral.gov/.

[35] *See* Abby Goodnough, *This E.R. Treats Opioid Addiction on Demand. That's Very Rare*, THE NEW YORK TIMES, Aug. 18, 2018, https://www.nytimes.com/2018/08/18/health/opioid-addiction-

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fear of withdrawal, or dopesickness.[36] Individuals with OUD often reorient their entire lives to avoid becoming dopesick, losing jobs, property, and family in the process.[37]

Feeling dopesick is a grueling physical ordeal.[38] Initial symptoms in the first six to twelve hours include feeling hot and cold at the same time, goose bumps, perspiration, and stomach-turning anxiety.[39] The body is acting as an alarm system, signaling to the nervous system that the body is missing something that it depends on.[40] As the cravings progress, individuals start shaking, slurring their speech, and experiencing severe stomach cramps.[41] Muscle spasms can cause libs to thrash involuntarily, while vomiting and diarrhea keep individuals crawling to the bathroom, if they can make it and have access to one.[42] The physical symptoms are accompanied by depression, anxiety, and the knowledge that the torture would end with another fix.[43] "Outsiders," or those unfamiliar with opioid use, "often confuse withdrawal symptoms for the

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treatment.html; "Safe Station," Manchester Fire Department, https://www.manchesternh.gov/Departments/Fire/Safe-Station (accessed Dec. 10, 2019).

[36] *See* BETH MACY, DOPESICK: DEALERS, DOCTORS, AND THE DRUG COMPANY THAT ADDICTED AMERICA, 41 (2018).

[37] *See* PHILIPPE I. BOURGOIS, RIGHTEOUS DOPEFIEND, 20 (2009).

[38] *See* BETH MACY, DOPESICK: DEALERS, DOCTORS, AND THE DRUG COMPANY THAT ADDICTED AMERICA, 41, (2018); Smith v. Aroostook Cty., 376 F. Supp. 3d 146, 150 (D. Me.), *aff'd*, 922 F.3d 41 (1st Cir. 2019) ("[The plaintiff] describes her ensuing withdrawal as the worst pain she has ever endured and recalls experiencing suicidal thoughts for the first time in her life."); Pesce v. Coppinger, 355 F.Supp.3d 35, 41 (D. Mass. 2018) ("When Pesce reduced his methadone dosage from 120 mg per day to 20 mg per day, he became sick, suffered from insomnia and felt anxious, unmotivated, fatigued and depressed.").

[39] *See* Shannon Gwin Mitchell et al., *Incarceration and opioid withdrawal: The experiences of methadone patients and out-of-treatment heroin users*, 41 J PSYCHOACTIVE DRUGS 145–152 (2009).

[40] See *id.*; *Dope Sick: Breaking Down Opioid Withdrawal*, THE FIX, https://www.thefix.com/dope-sick-breaking-down-opioid-withdrawal (accessed October 26, 2018).

[41] *See* Jonathan Reiss, *Opioid Crisis: What People Don't Know About Heroin*, ROLLING STONE, May 18, 2018, https://www.rollingstone.com/culture/culture-features/opioid-crisis-what-people-dont-know-about-heroin-630430/.

[42] *See Dope Sick: Breaking Down Opioid Withdrawal*, THE FIX, https://www.thefix.com/dope-sick-breaking-down-opioid-withdrawal (accessed October 26, 2018).

[43] *See* Pesce v. Coppinger, 2018 WL 4492200, ¶ 33 (D.Mass., 2018) (trial pleading).

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effects of the drug, because the effects of withdrawal are far more noticeable than the euphoria the drug produces."[44] During withdrawal, dopesickness dominates lived experience 24-hours a day for six to twelve days because insomnia prevents any respite from sleep.[45]

b. Treatment and the Criminal Legal System

Fortunately, effective treatment for OUD is available. Medication-assisted treatment (MAT) uses prescription opioids—primarily methadone, buprenorphine, and naltrexone—to stop cravings and prevent the brain from experiencing an opioid high.[46] A patient with OUD should have access to all three medications so that medical providers "can select the treatment best suited to an individual's needs."[47] Some of these medications activate opioid receptors in the brain to stop cravings while others block receptors from accepting their illicit counterparts.[48] The medications "normalize brain chemistry, block the euphoric effects of alcohol and opioids, relieve physiological cravings, and normalize body functions without the negative effects of the abused drug."[49] MAT combines medication with counseling,

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[44] *See* Jonathan Reiss, *Opioid Crisis: What People Don't Know About Heroin*, ROLLING STONE, May 18, 2018, https://www.rollingstone.com/culture/culture-features/opioid-crisis-what-people-dont-know-about-heroin-630430.

[45] *See Dope Sick: Breaking Down Opioid Withdrawal*, THE FIX, https://www.thefix.com/dope-sick-breaking-down-opioid-withdrawal (accessed October 26, 2018).

[46] *See* Corey Davis and Derek Carr, *The Law and Policy Of Opioids For Pain Management, Addiction Treatment, And Overdose Reversal*, 14 IND. HEALTH L. REV. 1 (2017). For a full list of FDA-approved MAT medications, see Center for Drug Evaluation and Research, *Information about Medication-Assisted Treatment (MAT)*, FDA (Feb. 14, 2019) https://www.fda.gov/drugs/information-drug-class/information-about-medication-assisted-treatment-mat.

[47] Center for Drug Evaluation and Research, *Information about Medication-Assisted Treatment (MAT)*, FDA (Feb. 14, 2019) https://www.fda.gov/drugs/information-drug-class/information-about-medication-assisted-treatment-mat.

[48] *See* Corey Davis and Derek Carr, *The Law and Policy Of Opioids For Pain Management, Addiction Treatment, And Overdose Reversal*, 14 IND. HEALTH L. REV. 1, 13–14 (2017).

[49] Medication and Counseling Treatment, SAMSHA, https://www.samhsa.gov/medication-assisted-treatment/treatment.

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behavioral therapy, and other interventions to treat substance use disorder.[50]

Experts recognize MAT as the gold standard of care for treating OUD. MAT decreases opioid use, decreases opioid-related overdose deaths, reduces criminal activity, and diminishes infectious disease transmission.[51] According to the California Society of Addiction Medicine, MAT is 60-90 percent effective at preventing relapse, as opposed to 5-10 percent for abstinence-based recovery.[52] Furthermore, MAT maintenance for pregnant women is an accepted best practice to avoid the medical risks of withdrawal for the fetus.[53] MAT has been provided to pregnant women in correctional settings for many years and has been widely researched.[54]

Without access to MAT, individuals with OUD may turn to illegally obtained prescription drugs or to illicit drugs like heroin and fentanyl to satisfy cravings and avoid becoming dopesick.[55] Use of illicit drugs leads to

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[50] *See* Pesce v. Coppinger, 355 F.Supp.3d 35, 40 (D. Mass. 2018).

[51] *See* U.S. Dep't of Health and Human Services (HHS), Office of the Surgeon General, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*, 1-1 (November 2016) https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf.

[52] *See Methadone Treatment Issues*, California Society of Addiction Medicine, https://www.csam-asam.org/methadone-treatment-issues (accessed Oct. 26, 2018). *See also* Amato, L, et al., *Psychosocial Combined with Agonist Maintenance Treatments Versus Agonist Maintenance Treatments Alone for Treatment of Opioid Dependence*, Cochrane Database Syst Rev., 10 (2011); American Society of Addiction Medicine, *Advancing Access to Addiction Medications: Implications for Opioid Addiction Treatment*, 13-15 (2013), https://www.asam.org/docs/default-source/advocacy/aaam_implications-for-opioid-addiction-treatment_final.

[53] *See* Substance Abuse and Mental Health Services Administration (SAMSA), *A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders*, HHS Publication No. (SMA) 16-4978, at 1 (2016) https://ncsacw.samhsa.gov/files/Collaborative_Approach_508.pdf.

[54] *See* National Sheriff's Association, Jail-Based Medication Assisted Treatment at 14 (Oct. 2018), https://www.sheriffs.org/publications/Jail-Based-MAT-PPG.pdf.

[55] *See* Julie K. O'Donnell et al., *Deaths Involving Fentanyl, Fentanyl Analogs, and U-47700 — 10 States, July-December 2016*, 66 MMWR MORB. MORTAL. WKLY. REP. 1197–1202 (2017).

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involvement with the criminal legal system and incarceration.[56]

Substance use disorder is prevalent and under-treated in correctional faculties. According to the National Center on Addiction and Substance Abuse, 65 percent of all incarcerated people in the U.S. meet medical criteria for substance abuse addiction, but only 11 percent receive any treatment at all.[57] This figure includes all treatment of any type; however, the rate of treatment using MAT for people with OUD is far lower. When individuals with OUD are incarcerated, they are typically forced to go through

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[56] *See Incarceration, Substance Abuse, and Addiction*, The Center for Prisoner Health and Human Rights, https://www.prisonerhealth.org/educational-resources/factsheets-2/incarceration-substance-abuse-and-addiction/ ("Approximately half of prison and jail inmates meet DSM-IV criteria for substance abuse or dependence, and significant percentages of state and federal prisoners committed the act they are incarcerated for while under the influence of drugs."); *Effective Medical Treatment of Opiate Addiction. National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction*, JAMA 280, no. 22, 1936–43 at 1939 (Dec. 9, 1998) (finding that more than 95% of people addicted to heroin reported committing crimes ranging from homicide to theft during an 11-year at-risk interval). Unfortunately, the criminalization of drugs is a twentieth century phenomenon: "In the nineteenth century you would walk into your local apothecary and purchase opium, cocaine, or marijuana . . . Many veterans of the Union army got hooked on morphine after taking it for injuries they got fighting the Civil War." PAUL BUTLER, LET'S GET FREE 43 (2009). At the time, the resulting addiction problem—affecting between two and five percent of the adult population—was addressed with civil, not criminal, regulation. *Id.* For example, in 1906, Congress passed The Pure Food and Drug Act which restricted certain medicines to sale by prescription and required labeling for habit-forming medicine. The public education provided by this *non-criminal* drug law "dramatically reduced addiction rates." *Id.* at 44.

[57] *See National Center on Addiction and Substance Abuse (2010)* https://www.centeronaddiction.org/newsroom/press-releases/2010-behind-bars-II. *See also*, National Sheriffs' Association and National Commission on Correctional Health Care, *Jail-Based Medication-Assisted Treatment* (2018) https://www.sheriffs.org/publications/Jail-Based-MAT-PPG.pdf (finding that more than half of the U.S. jail population struggles with drug use and dependence); Press Release, *Senator Markey Leads Bipartisan Call for Assessment of Drug Treatment Availability and Effectiveness in Correctional Facilities*, SENATOR ED MARKEY (May 30, 2018) https://www.markey.senate.gov/news/press-releases/senator-markey-leads-bipartisan-call-for-assessment-of-drug-treatment-availability-and-effectiveness-in-correctional-facilities (estimating that 40 percent of prisoners in the federal system have a substance use disorder).

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involuntary withdrawal instead of receiving proper medical care.[58] Supervised withdrawal is not a treatment for opioid use disorder.[59] In general, imprisonment for drug offenses is ineffective in curbing drug use,[60] increases recidivism,[61] exacerbates the health risks of drug use,[62] perpetuates stigma,[63] balloons costs,[64] and discriminates by race and social class.[65]

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[58] *See* Amy Nunn et al., *Methadone and buprenorphine prescribing and referral practices in US prison systems: results from a nationwide survey*, 105 DRUG ALCOHOL DEPEND 83, 83 (2009) ("Despite demonstrated social, medical, and economic benefits of providing ORT to inmates during incarceration and linkage to ORT upon release, many prison systems nationwide still do not offer pharmacological treatment for opiate addiction or referrals for ORT upon release.").

[59] Smith v. Aroostook Cty., 376 F. Supp. 3d 146, 152 (D. Me.), *aff'd*, 922 F.3d 41 (1st Cir. 2019). *See also* Pesce v. Coppinger, 355 F.Supp.3d 35, 41 (D. Mass. 2018) ("sudden, involuntary withdrawal of treatment will cause Pesce 'severe and needless suffering, jeopardize[s] his long-term recovery and is inconsistent with sound medical practice.'").

[60] *See* J. P. Caulkins et al., *Mandatory Minimum Drug Sentences: Throwing Away the Key or the Taxpayers' Money?* National Criminal Justice Reform Service (1997) http://www.ncjrs.gov/App/publications/abstract.aspx?ID=166127.

[61] *See* Cassia Spohn and David Holleran, *The Effect of Imprisonment on Recidivism Rates of Felony Offenders: A Focus on Drug Offenders*, 2 CRIMINOLOGY 40, 329 (2002) https://doi.org/10.1111/j.1745-9125.2002.tb00959.x.

[62] *See* R. Douglas Bruce and Rebecca A. Schleifer, *Ethical and Human Rights Imperatives to Ensure Medication-Assisted Treatment for Opioid Dependence in Prisons and Pre-Trial Detention*, 1 INTERNATIONAL JOURNAL OF DRUG POLICY 19, 17 (2008) https://doi.org/10.1016/j.drugpo.2007.11.019.

[63] *See* Michael Young, Jennifer Stuber, Jennifer Ahern, and Sandro Galea, *Interpersonal Discrimination and the Health of Illicit Drug Users,* 31 THE AMERICAN JOURNAL OF DRUG AND ALCOHOL ABUSE 3, 371 (2005) https://doi.org/10.1081/ADA-200056772.

[64] *See* E. A. Nadelmann, *Drug Prohibition in the United States: Costs, Consequences, and Alternatives*, 245 SCIENCE 4921, 939 (1989) https://doi.org/10.1126/science.2772647.

[65] *See* Shannon Mullen, Lisa Robyn Kruse, Andrew J. Goudsward, and Austin Bogues, *What will it take to end the inequity?*, ASBURY PARK PRESS, Dec. 5, 2019, https://www.app.com/in-depth/news/local/emergencies/2019/12/02/crack-vs-heroin-what-take-end-inequity/4302737002/; *Crack vs. Heroine Project: Racial Double Standard in Drug Laws Persists Today*, Equal Justice Initiative (2019), https://eji.org/news/racial-double-standard-in-drug-laws-persists-today/; Taylor N. Santoro & Jonathan D. Santoro, *Racial Bias in the US Opioid Epidemic: A Review of the History of Systemic Bias and Implications for Care*, 10 Cureus,

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The threat of overdose and death is higher upon release.[66] Studies show that abrupt withdrawal "can lead to post-release issues including failure to return to treatment, relapse, overdose, and death."[67] One study found that nearly 50 percent of deaths among recently released individuals were opioid related.[68]

MAT, however, can reduce post-release drug-related mortality by 80 to 85 percent.[69] In a recent case, a federal court wrote, "[g]iven the well-documented risk of death associated with opioid use disorder, appropriate treatment is crucial. People who are engaged in treatment are three

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https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6384031/. It is important to note, in particular, the racial disparities in the public response to the opioid epidemic compared to the crack cocaine epidemic. *See* Julie Netherland & Helena B. Hansen, *The War on Drugs That Wasn't: Wasted Whiteness, "Dirty Doctors," and Race in Media Coverage of Prescription Opioid Misuse*, 40 CULT MED PSYCHIATRY 664, 665 (2016).

[66] *See* Elizabeth L. C. Merrall et al., *Meta-analysis of drug-related deaths soon after release from prison*, 105 ADDICTION 1545–1554 (2010); Smith v. Aroostook Cty., 376 F. Supp. 3d 146, 150 (D. Me.), *aff'd*, 922 F.3d 41 (1st Cir. 2019) ("[T]he risk of overdose death is even higher among recently-incarcerated people and others who have just undergone a period of detoxification, because opioid tolerance decreases in the absence of use.").

[67] Smith v. Aroostook Cty., 376 F. Supp. 3d at 151 n.3.

[68] *See* Massachusetts Department of Public Health, *An Assessment of Fatal and Nonfatal Opioid Overdoses in Massachusetts (2011-2015)*, 50 (2017) https://www.mass.gov/files/documents/2017/08/31/ legislativereport-chapter-55-aug-2017.pdf. *See also*, Traci C. Green, et al., *Postincarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System*, 74 JAMA Psychiatry 4, 405 (April 2018) (observing "a large and clinically meaningful reduction in postincarceration deaths from overdose among inmates released from incarceration after implementation of a comprehensive MAT program" in the Rhode Island Department of Corrections).

[69] *See* John Marsden et al., *Does exposure to opioid substitution treatment in prison reduce the risk of death after release? A national prospective observational study in England*, 112 ADDICTION 1408, 1408 (2017) (finding that "prison-based opioid substitution therapy was associated with . . . an 85% reduction in fatal drug-related poisoning in the first month after release."); Smith v. Aroostook Cty., 376 F. Supp. 3d. at 150 (explaining that "[o]ne study of English correctional facilities found that treatment with buprenorphine or methadone was associated with an 80 to 85 percent reduction in post-release drug-related mortality" and that similar results were found in Australia).

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times less likely to die than those who remain untreated."[70] In a randomized, controlled study in Rhode Island, incarcerated individuals who were permitted to remain on MAT were seven times more likely to continue treatment after release than those who were forced to go through withdrawal.[71] In short, America's criminalization of a health crisis is ineffective and costly.

II. The Right to Medical Treatment While Incarcerated

a. Overview of the Right to Treatment

U.S. Courts have recognized a series of rights and protections guaranteed to individuals who are incarcerated and suffering from addiction.[72] The progression of cases shows that individuals with substance use disorder have a right to adequate medical care for their disease.

First, the Supreme Court held in 1962 that addiction is an illness and that it is unconstitutional to punish someone for having the illness of addition.[73] In *Robinson v. California*, a defendant appealed his conviction for the crime of being addicted to narcotics.[74] The Court held that addiction is an illness and that it was "cruel and unusual punishment" to make addiction a criminal offense.[75] The Court further noted that "[e]ven one day in prison would be a cruel and unusual punishment for the 'crime' of having a common cold."[76] In a subsequent case, Justice Fortas noted

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[70] Smith v. Aroostook Cty., 376 F. Supp. 3d 146, 152 (D. Me.), *aff'd*, 922 F.3d 41, 150 (1st Cir. 2019).

[71] *See id.* at 151 ("The evidence of MAT's benefits has become so compelling that it would no longer be possible to conduct the kind of randomized trial that was used in Rhode Island . . . researchers would not consider it ethically feasible to deny a group a medication that has such [a] proven track record at improving outcomes.") (internal quotations omitted).

[72] For an insightful analysis of health care in prisons and jails, see KENNETH FAIVER, HUMANE HEALTH CARE FOR PRISONERS - ETHICAL AND LEGAL CHALLENGES (2017).

[73] *See* Robinson v. California, 370 U.S. 660, 667 (1962) (recognizing that "narcotic addiction is an illness"); Linder v. United States, 268 U.S. 5, 18 (1925) (recognizing that persons addicted to narcotics "are diseased and proper subjects for (medical) treatment").

[74] *See* Robinson v. California, 370 U.S. 660, 660–61 (1962).

[75] *See id.* at 667.

[76] *Id.*

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in dissent that incarcerating individuals with addiction is punishment with no therapeutic or deterrent value.[77]

Second, the Court held in 1976 that incarcerated individuals have a right to adequate medical care.[78] In *Estelle v. Gamble*, a prisoner claimed that he had received inadequate medical care for a back injury. The Court held that the "deliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain'" in violation of the Eighth Amendment.[79] The Court provided examples of constitutional violations, including intentional denial of care, preventing access to care, or ignoring a physician's order and prescriptions.[80] The Court noted that denying medical care causes "pain and suffering which no one suggests would serve any penological purpose," and found that "[t]he infliction of such unnecessary suffering is inconsistent with contemporary standards of decency."[81] Due to the circumstances of confinement, "an inmate must rely on prison authorities to treat his medical needs."[82] Accordingly, the government must provide medical care for individuals that the state has decided to punish through incarceration.

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[77] *See* Powell v. State of Texas, 392 U.S. 514, 564 (1968) ("It is entirely clear that the jailing of chronic alcoholics is punishment. It is not defended as therapeutic, nor is there any basis for claiming that it is therapeutic (or indeed a deterrent).") (Justice Fortas, dissenting).

[78] *See* Estelle v. Gamble, 429 U.S. 97, 104 (1976); Newman v. Alabama, 349 F.Supp. 278, 285-86 (M.D. AL, 1972) ("[F]ailure of the Board of Corrections to provide sufficient medical facilities and staff to afford inmates basic elements of adequate medical care constitutes a willful and intentional violation of the rights of prisoners guaranteed under the Eighth and Fourteenth Amendments. Further, the intentional refusal by correctional officers to allow inmates access to medical personnel and to provide prescribed medicines and other treatment is cruel and unusual punishment in violation of the Constitution.").

[79] Estelle v. Gamble, 429 U.S. 97, 104 (1976) (internal citation omitted).

[80] *See id.* at 104.

[81] *See id.* at 103.

[82] *See id. See also*, Farmer v. Brennan, 511 U.S. 825, 832 (1994) (requiring that human confinement be accompanied by "adequate food, clothing, shelter, and medical care"); Spicer v Williamson, 132 S.E. 291, 293 (N.C. 1926) (holding that "[i]t is but just that the public be required to care for the prisoner, who cannot, by reason of the deprivation of his liberty, care for himself").

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Subsequently, in 1979, the Court held that pretrial detainees deserved an enhanced level of care relative to prisoners.[83] The Court permitted this discrepancy because the presumption of innocence prevents punishment prior to conviction, but conditions of incarceration may constitute punishment post-conviction.[84] In *Bell v. Wolfish*, the Court noted: "Due Process requires that a pretrial detainee not be punished. A sentenced inmate, on the other hand, may be punished, although that punishment may not be 'cruel and unusual' under the Eighth Amendment."[85] For the purpose of this article, a pretrial detainee is someone who is incarcerated but unable to pay bail or meet other conditions of pretrial release, while a prisoner is someone who has been convicted and is serving a criminal sentence.

However, despite the difference in level of care, both pretrial detainees and prisoners must show objective need and subjective indifference in order to prove a violation of their constitutional rights.[86] Under either the Due Process clause or the Eighth Amendment, people who are incarcerated and denied medical care must prove the objective element of the patient's serious medical need and the subjective element of correctional officer's intent to harm or deliberate indifference to suffering.[87] Within this two-pronged test, some courts have applied a lower standard to pretrial detainees, abiding by the rationale that the state may not impose punitive conditions before

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[83] *See* Bell v. Wolfish, 441 US 520, 535 n.16 (1979).

[84] *Id.*

[85] *See id.* at 535 n.16 ("The Court of Appeals properly relied on the Due Process Clause rather than the Eighth Amendment in considering the claims of pretrial detainees. Due process requires that a pretrial detainee not be punished. A sentenced inmate, on the other hand, may be punished, although that punishment may not be 'cruel and unusual' under the Eighth Amendment."). *See also* United States v. Lovett, 328 U.S. 303, 317-318 (1946) ("[T]he State does not acquire the power to punish with which the Eighth Amendment is concerned until after it has secured a formal adjudication of guilt in accordance with due process of law. Where the State seeks to impose punishment without such an adjudication, the pertinent constitutional guarantee is the Due Process Clause of the Fourteenth Amendment.").

[86] *See* part III. B. and part III. C, *infra*; Estelle v. Gamble, 429 U.S. at 104.

[87] Estelle v. Gamble, 429 U.S. at 104.

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conviction.[88] Some courts, however, have applied the same standard to both groups.[89]

Finally, in assessing constitutional violations for failure to provide medical care, most courts apply a "totality of circumstances" test that considers all conditions of confinement rather than the specific violation.[90] For example, in *Todaro v. Ward* the Second Circuit held, "while a single instance of medical care denied or delayed, viewed in isolation, may appear to be the product of mere negligence, repeated examples of such treatment bespeak a deliberate indifference by prison authorities to the agony engendered by haphazard and ill-conceived procedures."[91] Some courts, however, reject the totality of the circumstances test and focus solely on a specific medical need or condition of confinement.[92]

b. Treatment for Pretrial Detainees: The Due Process Clause

Claims challenging the conditions of confinement for pretrial detainees come under the Due Process clause of the Fifth and Fourteenth Amendments.[93] The Due Process

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[88] *See* Boswell v. County of Sherburne, 849 F.2d 1117 (8th Cir. 1988) (cert denied 488 US 1010).

[89] *See* Anderson v. Atlanta, 778 F.2d 678 (11th Cir. 1985); Johnson-Schmitt v. Robinson, 990 F.Supp.2d 331, 342 n3 (W.D.N.Y. 2013) ("Although a pre-trial detainee's challenge to the conditions of her confinement is properly reviewed under the due process clause of the Fourteenth Amendment, the standard for evaluating deliberate indifference to the health or safety of a person in custody is the same irrespective of whether the claim is brought under the Eighth or Fourteenth Amendment.").

[90] *See* McCord v. Maggio, 927 F.2d 844 (5th Cir. 1991); Albro v. Onondaga County, N.Y., 681 F.Supp. 991 (N.D.N.Y. 1998); Heitman v. Gabriel, 524 F.Supp. 622 (W.D. Miss. 1981).

[91] Todaro v. Ward, 565 F.2d 48, 52 (2d Cir. 1977). *See also*, Holt v. Sarver, 442 F.2d 304 (8th Cir. 1971) (also considering totality of circumstances).

[92] *See* Groseclose v. Dutton, 829 F.2d 581 (6th Cir. 1987).

[93] *See* Bell v. Wolfish, 441 US 520, 535 n.16 (1979) ("The Court of Appeals properly relied on the Due Process Clause rather than the Eighth Amendment in considering the claims of pretrial detainees. Due process requires that a pretrial detainee not be punished."); *see generally*, 24 AMJUR POF 3d 467 ("[T]he proper standard for analyzing conditions of confinement for pretrial detainees arises under the due process clause of the Fifth and Fourteenth Amendments. The inquiry is whether the pretrial detainees have been denied their liberty without due process."). However, some

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clause prohibits conditions of a pretrial detainee's confinement that are punitive in intent; conditions that are not rationally related to a legitimate purpose in maintaining safety, security, and efficiency; and conditions that are rationally related to safety, security, and efficiency, but are excessive in scope[94] or excessive in length.[95] To show a violation of their due process rights, detainees must prove that conditions of confinement are (1) subjectively punitive in intent, and (2) objectively beyond the legitimate state interests of safety, security, and efficiency.[96] This two part test is similar to the Eighth Amendment analysis, but with a lower bar for violation.[97]

The earliest MAT cases held that pretrial detainees should not have to suffer involuntary withdrawal before a finding of guilt. For example, in 1978 a pretrial detainee named Tyrone Norris was denied access to methadone treatment that had been prescribed prior to his incarceration.[98] Without his medication, the pain from withdrawal drove Mr. Norris to slash his left wrist.[99] The Third Circuit found that "the refusal to allow Norris to continue to receive methadone operates to deprive him of a liberty interest without due process of law."[100] The case,

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courts continue to apply the incorrect standard for a violation of the right to medical care. For example, in *Nauroth v. Southern Health Partners, Inc.* an Ohio district court applied an Eighth Amendment test to determine that jail's policy prohibiting Methadone treatment did not violate a pretrial detainees constitutional right to medical treatment. 2009 WL 3063404 (S.D. Ohio, Western Division, 2009). In this case, a pretrial detainee was being treated with Methadone, but the jail terminated his treatment immediately upon incarceration. The application of this heightened standard is a tragic misapplication of the law.

[94] *See* Bell v. Wolfish, 441 U.S. 520, 536–37 (1979); *see also*, Williams v. Community Solutions, Inc., 932 F. Supp. 2d 323, 331 (D. Conn. 2013) (holding that Fifth Amendment protections against cruel and unusual punishment typically apply to pretrial detainees and not to inmates); Oladokun v. Correctional Treatment Facility, 5 F.Supp.3d 7, 14–15 (D.C. 2013) (same).

[95] *See* Campbell v. McGruder, 580 F2d 521, 532 (D.C. Cir. 1978).

[96] *See* Bell v. Wolfish, 441 U.S. 520 (1979); Farmer v. Brennan, 511 U.S. 825, 837 (holding that section 1983 liability only attaches if an "official knows of and disregards an excessive risk to inmate health or safety").

[97] *See* Part II.c. Eighth Amendment, *infra*.

[98] *See* Norris v. Frame, 585 F.2d 1183, 1185 (3d Cir. 1978)

[99] *See id*. (noting that "Norris testified that the pain was sufficient to drive him to slash his left wrist").

[100] *Id.*

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Norris v. Frame, was decided under the framework that subjecting pretrial detainees to restrictions other than those inherent to "confinement itself" or "justified by compelling necessities of jail administration" violated the detainee's due process rights.[101]

Unfortunately, the Supreme Court restricted protections for pretrial detainees after *Norris*. In 1979, the Supreme Court in *Bell v. Wolfish* rejected the "compelling necessity" standard and limited due process protections for pretrial detainees to conditions that "amount to punishment of the detainee."[102] The Court held that the protections of the "presumption of innocence" applies to the state's burden of proof and to rules of evidence, but not to the conditions of confinement.[103]

Due to the restrictions that the Supreme Court created in *Bell*, it became more difficult for pretrial detainees to make successful claims against denial of medical care. For example, after *Bell*, pretrial detainees in a Pittsburgh jail claimed that the termination of methadone treatment on the sixth day of detention violated their constitutional rights.[104] The plaintiffs alleged due process violations because the jail's detoxification policy terminated treatment after six days of confinement for a detainee "who has been receiving methadone treatment from an authorized treatment center . . . prior to his incarceration."[105] In light of *Bell*, and only a year after *Norris*, the Third Circuit determined that the termination of medical treatment after six days did not violate the Due Process clause because the policy lacked a "punitive purpose."[106] *Inmates of Allegheny* demonstrates the

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[101] *Id.*; Rhem v. Malcolm, 507 F.2d 333, 336 (2d Cir. 1974).

[102] Bell v. Wolfish, 441 US 520, 535 (1979).

[103] Bell v. Wolfish, 441 US 520, 533 (1979) (holding that the presumption of innocence "has no application to a determination of the rights of a pretrial detainee during confinement before his trial has even begun").

[104] *See* Inmates of Allegheny County Jail v. Pierce, 612 F.2d 754, 756-57 (3d Cir. 1979).

[105] *Id.* at 758.

[106] *Id.* at 760-61. The plaintiffs succeeded on many counts including inadequate plumbing and lighting, extreme temperatures, inadequate supervision that permitted hoarding and vandalism of necessary supplies, confining detainees with mental instability in a "restraint room" where they were bound naked to a cot with a hold in the middle and a tub to collect bodily waste, extended solitary confinement without a mattress, toilet articles, or changes of clothing,

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limitations of constitutional protections for access to MAT that incarcerated plaintiffs faced in the late twentieth century.

Fortunately, at the turn of the millennium case law began to shift toward greater medical protection for pretrial detainees. In 1994, a pretrial detainee named James Messina sued correctional officers for denying access to his previously prescribed MAT.[107] In *Messina v. Mazzeo*, the federal district court denied the officers' motion for summary judgment because there was a reasonable likelihood that there was a "medical necessity" for the detainee to "receive methadone immediately," and therefore the prison doctor may have been "deliberately indifferent" to the detainee's serious medical need.[108] *Messina* represents a move toward recognizing OUD as serious medical need and denial of MAT as deliberately indifferent to that need.

Similarly, in *Alvarado v. Westchester County*, pretrial detainees alleged that they were uniformly denied methadone or other prescription medication over the course of nine months when it was apparent that their treatment with over-the-counter medications was not effective.[109] In 2014, the federal district court held that the detainees had successfully stated a claim that the denial of treatment for heroin withdrawal was deliberately indifferent to serious medical needs.[110] The case was later dismissed because the plaintiffs, who were proceeding pro se, failed to notify the court that their addresses had changed.[111]

As a final example of protections for pretrial detainees, a court in *Andrews v. County of Cayuga* found that a detainee's allegations that jail officials refused to give him legally prescribed medications were sufficient to state a claim for failure to provide adequate medical

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and isolation in an unfurnished, windowless cell without any clothes or blankets. *Id.* at 757.

[107] *See* Messina v. Mazzeo, 854 F.Supp. 116, 140 (E.D.N.Y. 1994).

[108] *Id.*

[109] *See* Alvarado v. Westchester County, 22 F.Supp.3d 208 (S.D.N.Y. 2014) (noting that one detainee was also falsely informed jail did not have methadone program).

[110] *See id.*

[111] *See id.*

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care.[112] The detainee was injured during a withdrawal-induced seizure.[113]

The standard for adequate medical care is rising; medical providers now must provide detailed treatment regimens in order for their care to meet constitutional minimum standards. For example, in *Ramos v. Patnaude* a pretrial detainee experiencing heroin withdrawal was placed on medical watch that called for observation on at least 25 occasions by nursing personnel.[114] He was examined by the facility's medical director, and—despite skepticism that the detainee's continuing complaints were genuine—twice given three-day drug treatment and twice taken to the Emergency Room.[115] The First Circuit held that this was not deliberate indifference to substantial risk of serious harm because the medical director followed "a pharmaceutical protocol he had applied in thousands of instances of drug withdrawal at the House of Correction," and because that protocol has had "overwhelming success over a period of 30 years."[116] *Ramos* in 2011 is similar to *Inmates of Allegheny* in 1979 because in both situations the jail offered only a brief period of medical treatment; however, *Ramos* is an important progression because of the higher expectations for the level of care.

These cases indicate that courts may be receptive to treating withdrawal as a preventable condition of a treatable disease. In short, the state has a duty to provide adequate medical treatment for pretrial detainees, and denial of MAT may violate the constitutional standard of care.

c. *Treatment for Prisoners: The Eighth Amendment*

As previously noted, prisoners are individuals who have been convicted and are serving a criminal sentence. Their claims must come under the Eighth Amendment and require a showing of a "deliberate indifference to serious medical needs" on behalf of jail or prison officials.[117] This

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[112] *See* Andrews v. County of Cayuga, 96 A.D.3d 1477 (4th Dep't 2012).

[113] *See id.*

[114] *See* Ramos v. Patnaude, 640 F.3d 485 (1st Cir. 2011).

[115] *See id.*

[116] *Id.*

[117] Estelle v. Gamble, 429 U.S. at 104.

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two-part test derives from the Eighth Amendment protection against cruel and unusual punishment and includes both a subjective and an objective prong. A prisoner must show (1) a deliberate indifference on the part of prison officials to address the prisoner's need, and (2) a depravation or medical need that is, objectively, significantly serious.[118] This test for prisoners is similar in form to the test for pretrial detainees under the due process clause but in application is more difficult for plaintiffs to meet; however, recent cases challenging inadequate medical care have succeeded under the Eighth Amendment standard.

Regarding the subjective awareness prong, a prisoner must show that prison officials knew of and disregarded a substantial risk.[119] In *Farmer v. Brennan*, the Supreme Court held, "the [prison] official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference."[120] Negligence in diagnosing or treating a medical condition is insufficient because "[m]edical malpractice does not become a constitutional violation merely because the victim is a prisoner."[121] Prisoners must go further and show that officials had a "culpable state of mind."[122]

Despite the limitations of the subjective test, prisoners can still get relief from future harm because "[a]n injunction cannot be denied to inmates who plainly prove an unsafe, life-threatening condition on the ground that

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[118] *See id. See also* Farmer v. Brennan, 511 U.S. 825, 837 (1994) (defining deliberate indifference).

[119] *See* Farmer v. Brennan, 511 U.S. 825, 837 (1994) ("We reject petitioner's invitation to adopt an objective test for deliberate indifference. We hold instead that a prison official cannot be found liable under the Eighth Amendment for denying an inmate humane conditions of confinement unless the official knows of and disregards an excessive risk to inmate health or safety.").

[120] Farmer v. Brennan, 511 U.S. at 837. *See also id.* at 826 ("[P]rison officials may not be held liable if they prove that they were unaware of even an obvious risk or if they responded reasonably to a known risk, even if the harm ultimately was not averted.").

[121] Estelle v. Gamble, 429 U.S. at 106 (applying the Eighth Amendment). *See also* Daniels v. Williams, 474 U.S. 327, 330-31 (1986) (noting that the same is true for pretrial detainees under the Fourteenth Amendment: "[M]ere lack of due care by a state official may "deprive" an individual of life, liberty, or property under the Fourteenth Amendment").

[122] Wilson v. Seiter, 501 U.S. 294, 296 (1991).

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nothing yet has happened to them."[123] Additionally, circuit courts have held that a persistent pattern of failing to provide adequate medical care may give rise to an inference of deliberate indifference, even when individual instances are mere negligence.[124] Similarly, infrequent access to care may show deliberate indifference.[125]

Regarding the objective seriousness prong, prison conditions violate the Eighth Amendment if they result in the unnecessary and wanton infliction of pain or are grossly disproportionate to the severity of the crime warranting imprisonment.[126] Conditions that are grossly disproportionate result in a serious deprivation of basic human needs or are totally without penological justification.[127] A serious medical need is "one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention."[128] Put simply, "the Eighth Amendment forbids not only deprivations of medical care that produce physical torture and lingering death, but also less serious denials which cause or perpetuate pain."[129] A significant risk of future harm may suffice as a serious medical need;[130] however, merely harsh conditions are "part of the penalty that criminal offenders pay for their offenses against society,"[131] unless they deprive the individual of the necessities of life.[132]

The standard for adequate medical care evolves over time because it derives from the Eighth Amendment. In *Trop v. Dulles*, the Supreme Court held that the Eighth

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[123] Helling v. McKinney, 509 U.S. 25, 25 (1993). *See also*, Farmer v. Brennan, 511 U.S. at 826-27 ("Use of a subjective test will not foreclose prospective injunctive relief, nor require a prisoner to suffer physical injury before obtaining prospective relief. The subjective test adopted today is consistent with the principle that "[o]ne does not have to await the consummation of threatened injury to obtain preventive relief.").

[124] *See* Todaro v. Ward, 565 F.2d 48 (2d Cir. 1977).

[125] *See* Wellman v. Faulkner, 715 F.2d 269 (7th Cir. 1983).

[126] *See* Rhodes v. Chapman, 452 U.S. 337, 346 (1981).

[127] *See* Rhodes, 452 U.S. at 346, 347.

[128] Gaudreault v. Municipality of Salem, Mass., 923 F.2d 203, 208 (1st Cir. 1990).

[129] Todaro v. Ward, 565 F.2d 48, 52 (2d Cir. 1977) ("It is clear from this principle that a constitutional claim is stated when prison officials intentionally deny access to medical care or interfere with prescribed treatment.").

[130] *See* Kosilek v. Spencer, 774 F.3d 63, 85 (1st Cir. 2014).

[131] Rhodes v. Chapman, 452 U.S. 337, 347 (1981).

[132] *See* Hutto v. Finney, 437 U.S. 678 (1978).

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Amendment "must draw its meaning from the evolving standards of decency that mark the progress of a maturing society."[133] Further, in *Rhodes v. Champman* the Court held that "[n]o static 'test' can exist by which courts determine whether conditions of confinement are cruel and unusual."[134]

Recently, Eighth Amendment law has developed in favor of prisoners with OUD. Four examples show that prisoners with OUD have colorable Eighth Amendment claims when they are denied MAT. First, in 2006 the Seventh Circuit precluded summary judgment over a disputed fact regarding denial of MAT. James Davis had a history of drug and alcohol addition, was in a methadone treatment program, and received his last dose the day he reported to Cook County Jail to serve a ten-day sentence for a traffic violation.[135] Mr. Davis made repeated requests for his methadone, never received medication, and died from a cerebral aneurism six days into his sentence.[136] In *Davis v. Carter*, the court precluded summary judgment for the defendants because there was a genuine issue of material fact as to whether the county had widespread practice of inordinate delay in providing methadone treatment to incarcerated individuals. The disputed fact was whether the county routinely delayed several days in providing medication to prisoners coming in with prior prescriptions for treatment.[137] In this case, a several days delay in treatment would constitute denial of care for a serious medical need.

Second, in the 2018 case *Pesce v. Coppinger*, the federal district court of Massachusetts issued injunctive relief requiring the Essex County House of Corrections to provide future-prisoner Geffrey Pesce with access to his physician-prescribed methadone treatment.[138] Mr. Pesce

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[133] Trop v Dulles, 356 U.S. 86, 100-01 (1958) ("The basic concept underlying the Eighth Amendment is nothing less than the dignity of man. While the State has the power to punish, the Amendment stands to assure that this power be exercised within the limits of civilized standards … The Amendment must draw its meaning from the evolving standards of decency that mark the progress of a maturing society.").

[134] Rhodes v. Champman, 452 U.S. 337 (1981).

[135] *See* Davis v. Carter, 452 F.3d 686, 688 (7th Cir. 2006).

[136] *See id.*

[137] *See id.* at 695.

[138] *See* Pesce v. Coppinger, 355 F.Supp.3d 35, 39 (D. Mass. 2018).

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had a long history of cycles of relapse and remission with OUD. Most recently, he had been in active recovery for two years and with the help of physician-prescribed MAT had not failed a drug test during that time. He worked as a mechanic, contributed financially to his family, and was able to spend time with his son. Unfortunately, in July 2018 Pesce's parents were unable to drive him to the methadone clinic to receive his normal dose of medication. To avoid withdrawal, Pesce drove himself to the clinic and was pulled over for speeding six miles over the speed limit. Pesce was driving on a suspended license and, as a consequence, was required to serve a sixty-day sentence for violating probation for a previous charge. The facility where Pesce was likely to serve his time required incarcerated individuals to undergo forced withdrawal under medical supervision.[139] This official policy had no consideration for an individual prisoner's specific medical history and directly contradicted Pesce's physician's recommendations.[140] The Court found that Pesce satisfied the objective prong of the Eighth Amendment test because his medical need was "either diagnosed by a physician as mandating treatment or is so obvious that a layperson would recognize the need for medical assistance."[141] The Court further found that Pesce satisfied the subjective prong because the facility's "course of treatment ignores and contradicts [Pasce's] physician's recommendations."[142] Because the facility's blanket policy "ignore[ed] treatment prescriptions given to [Pesce] by [his] doctors," the court held that Peace was "likely to succeed on the merits of his Eighth Amendment claim."[143]

Third, in 2019 the federal district court of Maine found that "withdrawal protocol is not a treatment for opioid use disorder" and required the prison to provide MAT.[144] In *Smith v. Aroostook County*, the court noted,

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[139] *Id.* at 37.

[140] *See id.* at 45–46.

[141] *Id.* at 47 (citing Gaudreault v. Mun. of Salem, Mass., 923 F.2d 203, 208 (1st Cir. 1990)).

[142] *Id.* (citing Alexander v. Weiner, 841 F. Supp. 2d 486, 493 (D. Mass. 2012) ("Allegations that prison officials denied or delayed recommended treatment by medical professionals may be sufficient to satisfy the deliberate indifference standard.")).

[143] *Id.* at 48.

[144] Smith v. Aroostook Cty., 376 F. Supp. 3d 146, 152 (D. Me.), *aff'd*, 922 F.3d 41 (1st Cir. 2019).

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"[t]he evidence presented in this action suggests that a scientific consensus is growing that refusing to provide individuals with their prescribed MAT is a medically, ethically, and constitutionally unsupportable denial of care."[145] The court explicitly refuted the ideal that withdrawal is a "necessary evil," instead finding that "withdrawal is a counterproductive, painful experience that is easily identified as an injury."[146] While the court resolved the case in favor of the prisoner under the Americans with Disabilities Act without reaching the Eighth Amendment claim, the opinion suggests that the prisoner would have been successful under the Eighth Amendment had the court reached that claim.[147]

Fourth, the Federal Bureau of Prisons (BOP) acknowledged their obligation to provide MAT three times in 2019.[148] In response to litigation, the BOP allowed three non-pregnant individuals to receive MAT while incarcerated.[149] Providing MAT to non-pregnant prisoners is against BOP policy, but the BOP made exceptions in the face of strong Eighth Amendment claims.[150]

These cases indicate that, despite the high bar to contest an Eighth Amendment violation, prisoners have colorable claims when they are denied treatment based on a blanket-policy that ignores the particularized characteristics of individual plaintiffs.

d. Treatment for Drug Addiction: The Americans with Disabilities Act

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[145] *Id.* at 161 n. 20.

[146] *Id.* at 161 n. 21.

[147] *See* part II.d., *infra.*

[148] *See* Dipierro v. Hurwitz, Settlement Agreement, 2 (Mass. June 7, 2019) https://www.aclum.org/sites/default/files/20190607_dipierro_settlement.pdf; Crews v. Sawyer, *Kansas and Missouri ACLU affiliates reach settlement with Bureau of Prisons; Leavenworth inmate will receive opioid medication tonight*, ACLU OF KANSAS (Kans., Sept. 11, 2019), https://www.aclukansas.org/en/press-releases/kansas-and-missouri-aclu-affiliates-reach-settlement-bureau-prisons-leavenworth; Godsey v. Sawyer, *ACLU-WA lawsuit settled: Federal prison system agrees to provide medication-assisted treatment for opioid use disorder*, ACLU OF WASHINGTON (Wash., Dec. 11, 2019) https://www.aclu.org/press-releases/aclu-wa-lawsuit-settled-federal-prison-system-agrees-provide-medication-assisted.

[149] *Id.*

[150] *Id.*

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The ADA protects against discrimination on the basis of a disability, which includes the denial of MAT based on a person's OUD diagnosis.[151] An individual can prevail on a disability discrimination claim if they show "(1) that he is a qualified individual with a disability; (2) that he was either excluded from participation in or denied the benefits of some public entity's services, programs, or activities or was otherwise discriminated against; and (3) that such exclusion, denial of benefits, or discrimination was by reason of the plaintiff's disability."[152] The ADA specifies that a person cannot be denied health or rehabilitative services if they have engaged in drug use, legal or illegal.[153]

First, a plaintiff can establish that they have a disability under the ADA by showing "(A) a physical or mental impairment that substantially limits one or more major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment."[154] The ADA dictates that the definition of disability "shall be construed in favor of broad coverage,"[155] and many courts have held that people with OUD are qualified individuals with a disability.[156] A particularly

[151] *See* 42 U.S.C. § 12102; 28 C.F.R. § 35.108(b)(2).

[152] Gray v. Cummings, 917 F.3d 1, 15 (1st Cir. 2019). *See also* Parker v. Universidad de P.R., 225 F.3d 1, 5 (1st Cir. 2000); Thompson v. Davis, 295 F.3d 890, 895 (9th Cir. 2001). This section on the ADA, and the citations within it, come largely from the excellent work by the Legal Action Center. Specifically, their report *Legality of Denying Access to Medication Assisted Treatment In the Criminal Justice System* (2011) https://lac.org/wp-content/uploads/2014/12/MAT_Report_FINAL_12-1-2011.pdf.

[153] *See* 42 U.S.C. § 12210(c).

[154] 42 U.S.C. § 12102(1).

[155] 42 U.S.C. § 12102(4)(A).

[156] An individual can show they are "qualified" if, "with or without reasonable modifications to rules, policies, or practices," they "meet[] the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by the public entity." *See* MX Group, Inc. v. City of Covington, 293 F.3d 326, 340–42 (6th Cir. 2002). Moreover, the U.S. Supreme Court held that a prisoner with a disability seeking access to a prison programs is a "qualified individual." Pennsylvania Dep't of Corrections v. Yesky, 524 U.S. 206, 210–11 (1999). It is worth noting that individuals challenging discrimination are not "qualified" if their participation in the program "poses a significant risk to the health or safety of others that cannot be ameliorated by means of a reasonable modification." *See* New Directions Treatment Serv. v. City of Reading, 490 F.3d 293, 305 (3d

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clear example is *MX Group, Inc. v. City of Covington*, where a MAT program charged the City of Covington with zoning discrimination based on the disability of its patients.[157] The court in *MX Group* held that drug addiction was a disability under all three prongs of the ADA's definition of disability and held that drug abuse is an impairment that substantially limited major life activities such as "functioning in everyday life."[158]

Second, prison health care is a "service, program or activity" that individuals with disabilities are excluded from or denied if they do not receive adequate medical care. The ADA applies specifically to prison medical services,[159] and medical benefits are denied if they do not exist or if the correctional facility does not provide adequate care. Incarcerated individuals are eligible for "whatever level of prison health care the correctional facility is required to provide pursuant to their governing laws, regulations, or policies."[160] If someone with a disability is qualified for a

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Cir. 2007) (citing Bay Area Addiction Research and Treatment, Inc. v. City of Antioch, 179 F.3d 725, 734 (9th Cir. 1999)). The assessment of "significant risk" must be "based on medical or other objective evidence," and not subjective speculation. *See* Bragdon v. Abbott, 524 U.S. 624, 626 (1998). However, there is no objective evidence that individuals in MAT pose a significant risk to correctional facilities. *See* Legal Action Center, *Legality of Denying Access to Medication Assisted Treatment In the Criminal Justice System*, 12 (2011) https://lac.org/wp-content/uploads/2014/12/MAT_Report_FINAL_12-1-2011.pdf.

[157] *See* MX Group, Inc. v. City of Covington, 293 F.3d 326, 336 (6th Cir. 2002)

[158] *Id.* at 338 (citing *Bragdon v. Abbott*, 524 U.S. 624, 632-333 (1998).

[159] *See* Pennsylvania Department of Corrections v. Yeskey, 524 U.S. 206, 210 (1999) (holding that the ADA applies to prisons and that a prisoner is a "qualified individual" for prison programs); Kiman v. N.H. Dep't of Corr., 451 F.3d 274, 287 (1st Cir. 2006) (holding that providing prescription medications—as one part of a prison's overall medical services—constitutes a service, program, or activity under the ADA); Pesce v. Coppinger, 2018 WL 6171881, 6 (D. Mass. 2018) ("As an initial matter, the medical care provided to Middleton's incarcerated population qualifies as a 'service' that disabled inmates must receive indiscriminately under the ADA.").

[160] Legal Action Center, *Legality of Denying Access to Medication Assisted Treatment In the Criminal Justice System*, 12 (2011) https://lac.org/wp-content/uploads/2014/12/MAT_Report_FINAL_12-1-2011.pdf (discussing how courts have rejected the argument that generalized fears about MAT create a significant risk).

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service, then they are denied the benefits when such services are not available.

Third, denial of access to proper medical care in prisons and jails is discrimination by reason of a person's disability. To prove discrimination because of a disability, a party must show disparate treatment, disparate impact, or failure to make a reasonable accommodation.[161] Disparate treatment claims argue "that the disability actually motivated the defendant's adverse conduct."[162] Disparate impact claims argue that a neutral policy disproportionately affects people with a disability.[163] Claims for failure to make reasonable accommodation argue that the correctional facility refused to affirmatively accommodate an incarcerated person's disability "where such accommodation was needed to provide 'meaningful access to a public service.'"[164] Incarcerated plaintiffs can show denial because of a disability if the correctional faciality has a policy against MAT or practices de facto denial of MAT. If a correctional facility has a blanket policy against provision of MAT, an incarcerated individual with OUD can show disparate treatment because those diagnosed with that specific disability are being denied medical care. If the facility denies MAT based on a policy against all controlled substances, the incarcerated individual with OUD can allege failure to make a reasonable accommodation because other correctional facilities are able to safety provide MAT.[165] If the facility has no explicit policy but refuses to administer MAT in practice, the individual can also claim of failure to make a reasonable accommodation. Correctional facilities could justify denial of MAT only if treatment threatened safety or "fundamentally alter[ed] the nature of services,

[161] *See* Tsombanidis v. W. Haven Fire Dep't, 352 F.3d 565, 573 (2d Cir. 2003) (overturned by statute).

[162] Nunes v. Mass. Dep't of Corr., 766 F.3d 136, 145–46 (1st Cir. 2014).

[163] *See* Tsombanidis v. W. Haven Fire Dep't, 352 F.3d 565, 573 (2d Cir. 2003)

[164] Nunes v. Mass. Dep't of Corr., 766 F.3d 136, 145–46 (1st Cir. 2014).

[165] *See* National Sheriffs' Association and National Commission on Correctional Health Care, *Jail-Based Medication-Assisted Treatment* (2018) https://www.sheriffs.org/publications/Jail-Based-MAT-PPG.pdf (detailing best practices for jail-based MAT and highlighting successful programs in California, Massachusetts, Kentucky, Washington, and Rhode Island).

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program, or activity."[166] However, MAT does not threaten safety and is easily administered, as the National Sheriffs' Association and National Commission on Correctional Health Care have recognized.[167]

Pesce v. Coppinger is an example of a successful ADA claim for denial of MAT. In *Pesce*, a federal district court in Massachusetts granted injunctive relief because a correctional facility's denial of MAT would likely violate the ADA.[168] The Court made two key findings. First, the Court found that "Medical decisions that rest on stereotypes about the disabled rather than an individualized inquiry into the patient's condition may be considered discriminatory."[169] Second, the Court acknowledged that the correctional facility "identified legitimate, but generalized, safety and security reasons for prohibiting the use of opioids."[170] But the Court found that the facility had "not articulated specific security concerns relevant to Pesce's proposed methadone intake."[171] This case shows that a correctional facility must make individualized medical and security assessments before denying medically necessary treatment. A blanket policy, like the one in Massachusetts, was arbitrary or capricious implying that "it was pretext for some discriminatory motive or discriminatory on its face."[172]

In a similar case, the federal district court of Maine granted injunctive relief because a correctional facility's denial of MAT would likely violate the ADA.[173] In *Smith v. Aroostook County*, the Court found that "forcing Ms. Smith

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[166] 28 C.F.R. § 35.130(b)(7).

[167] See National Sheriffs' Association and National Commission on Correctional Health Care, *Jail-Based Medication-Assisted Treatment* (2018) https://www.sheriffs.org/publications/Jail-Based-MAT-PPG.pdf.

[168] *See* Pesce v. Coppinger, 355 F.Supp.3d 35, 39 (D. Mass. 2018).

[169] *Id.* at 46 (internal citations omitted). The court first noted that that "disagreement with reasoned medical judgment is not sufficient to state a disability discrimination claim" (citing Kiman v. N.H. Dep't of Corr., 451 F.3d 274, 285 (1st Cir. 2006)).

[170] *Id.*

[171] *Id.* ("For example, Defendants have not explained why they cannot safely and securely administer prescription methadone in liquid form to Pesce under the supervision of medical staff, especially given that this is a common practice in institutions across the United States and in two facilities in Massachusetts.").

[172] *Id.* at 47 (internal citations omitted).

[173] *See* Smith v. Aroostook Cty., 376 F. Supp. 3d 146, 149 (D. Me.), *aff'd*, 922 F.3d 41 (1st Cir. 2019).

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to withdraw from her buprenorphine would cause her to suffer painful physical consequences and would increase her risk of relapse, overdose, and death."[174] Accordingly, refusal to allow MAT was both disparate treatment and denial of a reasonable accommodation in violation of the ADA.[175] The court held that the correctional facility's "out-of-hand, unjustified denial" of Smith's request to continue MAT while incarcerated was so unreasonable that it showed the correctional facility denied Smith's request because of her OUD diagnosis.[176] The First Circuit affirmed this ruling, holding that the jail must provide Smith with her medication while she was incarcerated.[177] According to one expert, "courts around the country will pay attention to this affirmation that denying inmates in jail medication-assisted treatment for opioid use disorder violates the ADA – and is illegal."[178]

In short, individuals with OUD have a disability, criminal justice organizations are subject to anti-discrimination laws, and individuals can show that they would be eligible for adequate medical treatment but for their stigmatized disability.

III. The Affirmative Obligation to Provide Treatment for OUD

a. The Enforceable Right to Treatment

The right to treatment for OUD has an encouraging trajectory. In the early 2000s, many courts held that forced withdrawal without medical supervision is deliberate indifference to a serious medical need, in violation of the

[174] *Id.* at 154.

[175] *Id.* at 160–61.

[176] *Id.* at 159–160 (citing Kiman v. N.H. Dep't of Corr., 451 F.3d 274, 286 (1st Cir. 2006) (finding that a correctional facility's withholding of prescribed medications was not "a medical 'judgment' subject to differing opinion[, but] an outright denial of medical services" that could constitute a violation of the ADA).

[177] Smith v. Aroostook Cty., 922 F.3d 41, 42 (1st Cir. 2019).

[178] Willis R. Arnold, *Setting Precedent, A Federal Court Rules Jail Must Give Inmate Addiction Treatment*, NPR (May 4, 2019) https://www.npr.org/sections/health-shots/2019/05/04/719805278/setting-precedent-a-federal-court-rules-jail-must-give-inmate-addiction-treatmen.

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Eighth and Fourteen amendments.[179] More recently, courts have noted that "withdrawal protocol is not a treatment for opioid use disorder" and held that denial of MAT violates the Eighth Amendment or the ADA.[180] In the future, courts should hold that prisons and jails have an affirmative obligation to provide MAT to individuals with OUD.

The cases and claims in Part II show that, at a minimum, it is unconstitutional to deny access to prescribed medical treatment. But denial of care is difficult to prove because it is difficult to get a medical care case heard on the merits. If a plaintiff with OUD is incarcerated, then it is nearly impossible for their legal claim to meet the stringent requirements of the Prison Litigation Reform Act (PLRA).[181] The PLRA was designed to decrease claims by incarcerated individuals and requires both an exhaustion of administrative remedies and a showing of physical injury for an incarcerated plaintiff to recover damages.[182] If a plaintiff with OUD is not yet incarcerated, then it is difficult to meet threshold question of ripeness and the stringent requirements of a temporary restraining order or a preliminary injunction.[183] Further, claims for denial of

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[179] *See* Monmouth Cnty., 834 F.2d at 347; Quatroy v. Jefferson Parish Sheriff's Office, 2009 WL 1380196, at *9 (E.D. La., May 14, 2009)); Foelker v. Outagamie Cnty., 394 F.3d 510, 513 (7th Cir. 2005); Sylvester v. City of Newark, 120 Fed. Appx. 419, 423 (3d Cir. 2005); Gonzales v. Cecil Cnty., Md., 221 F. Supp. 2d 611, 616 (D. Md. 2002); Anderson v. Benton Cnty., 2004 WL 2110690 (D. Or., Sept. 21, 2004); Quatroy v. Jefferson Parish Sheriff's Office, 2009 WL 1380196 (E.D. La., May 14, 2009); Messina v. Mazzeo, 854 F. Supp. 116 (E.D.N.Y. 1994); U.S. ex rel. Walker v. Fayette Cnty., 599 F.2d 573, 574 (3d Cir. 1979) (per curiam). As cited in Legal Action Center, *Legality of Denying Access to Medication Assisted Treatment In the Criminal Justice System*, 17–18 (2011) https://lac.org/wp-content/uploads/2014/12/MAT_Report_FINAL_12-1-2011.pdf.

[180] Smith v. Aroostook Cty., 376 F. Supp. 3d 146, 152 (D. Me.), *aff'd*, 922 F.3d 41 (1st Cir. 2019); Pesce v. Coppinger, 355 F.Supp.3d 35, 41 (D. Mass. 2018) ("sudden, involuntary withdrawal of treatment will cause Pesce 'severe and needless suffering, jeopardize[s] his long-term recovery and is inconsistent with sound medical practice.'").

[181] *See* 42 USC § 1997e.

[182] *Id.*

[183] *See, e.g.*, Pesce v. Coppinger, 355 F.Supp.3d 35, 43 (D. Mass. 2018) ("A claim is ripe only if the issues raised are fit for judicial decision at the time the suit is filed and the party bringing suit will suffer hardship if court consideration is withheld.") (internal citations omitted); Corp. Techs., Inc. v. Harnett, 731 F.3d 6, 9 (1st Cir. 2013) ("In determining whether to grant a preliminary injunction, the

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medical care must be brought as violations of constitutional rights under section 1983, and 1983 claims have very low success rates.[184]

Courts should not use procedural hurdles to avoid ruling on meritorious claims. Humans are suffering and dying[185]—if the criminal legal system is to be fair and respectful of human dignity, then courts should recognize that adequate medical care is denied any time a person with OUD is not offered the opportunity to initiate or continue MAT.

Courts can hold that the right to medical care goes further than preventing denial of care without changing constitutional or statutory interpretation. Correctional facilities have an obligation to offer MAT to all individuals with OUD within the existing constitutional and statutory framework. First, people who are incarcerated have a constitutional right to adequate medical care.[186] Incarcerated individuals can have their right violated by "prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed."[187] Second, adequate medical care includes MAT for individuals who will experience

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district court must consider: (i) the movant's likelihood of success on the merits of its claims; (ii) whether and to what extent the movant will suffer irreparable harm if the injunction is withheld; (iii) the balance of hardships as between the parties; and (iv) the effect, if any, that an injunction (or the withholding of one) may have on the public interest.").

[184] *See* 42 U.S.C. § 1983 ("Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory, subjects or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in any action at law, suit in equity, or other proper proceeding for redress.").

[185] *See* Legal Action Center, *Legality of Denying Access to Medication Assisted Treatment In the Criminal Justice System*, 7 (2011) https://lac.org/wp-content/uploads/2014/12/MAT_Report_FINAL_12-1-2011.pdf. ("The consequences of this denied access to MAT are that people relapse, experience the host of negative consequences associated with addiction including return to criminal activity, and get sick (and sometimes die) from withdrawal-related complications.").

[186] *See* Farmer v. Brennan, 511 U.S. 825, 832 (1994); Estelle v. Gamble, 429 U.S. 97, 104–05 (1976).

[187] Estelle v. Gamble, 429 U.S. 97, 104–05 (1976).

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withdrawal.[188] Therefore, instead of a mere right to sue after treatment is denied, courts should recognize that correctional facilities must offer MAT to individuals with OUD as part of their affirmative obligation to provide adequate medical care.

i. Implementing the Right to Treatment

For pretrial detainees, involuntary withdrawal is punishment before conviction in violation of the due process clause.[189] The affirmative obligation to provide adequate medical care to pretrial detainees means medical evaluation for OUD during booking at jail. If the individual is identified as high risk for OUD or is facing imminent withdrawal, they should be offered the opportunity to voluntarily begin MAT. Treatment should be offered regardless of whether the detainee was engaged in legal or illicit drug use prior to arrest and incarceration, and regardless of the crime for which the individual is being detained.

This protocol is not a novel concept—the Rikers Island jail, operated by the New York City Department of Corrections, has offered methadone treatment since 1987.[190] The program has served as a model for other jails across the country.[191] Similarly, a settlement in Whatcom County, Washington requires the county jail to offer MAT to all individuals with OUD.[192] In Whatcom County, MAT maintenance must be offered to individuals with OUD who were in treatment prior to incarceration, and MAT induction must be offered to individuals with OUD

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[188] *See supra* Part II.

[189] *See supra* Part II b.

[190] *See* Christine Vestal, *At Rikers Island, a Legacy of Medication-Assisted Opioid Treatment*, PEW, May 23, 2016, http://pew.org/27ISkFh.

[191] *Id.*

[192] *See* Kortlever et al. v. Whatcom County, Settlement Agreement, 5–6 (April 29, 2019) https://www.aclu-wa.org/docs/settlement-agreement-1; *Whatcom County Jail to provide medications necessary to treat opioid addiction in landmark settlement proposed in civil rights lawsuit*, American Civil Liberties Union (April 30, 2019) https://www.aclu.org/press-releases/whatcom-county-jail-provide-medications-necessary-treat-opioid-addiction-landmark ("[T]his is the first time that class-action litigation has resulted in a jail changing its policy to provide MAT to all individuals with a medical need for it.").

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"regardless of whether they were already taking MAT at their time of entry to the [jail]."[193] The settlement includes a commitment by the jail to help individuals transition to community care after release, similar to transition planning for behavior or medical health issues.[194]

Failure to provide MAT to vulnerable pretrial detainees is both subjectively punitive in intent and objectively beyond the legitimate state interests of safety, security, and efficiency.[195] Forced withdrawal is punitive because it is a grueling physical ordeal[196] and exceeds state penal interests because MAT presents no security threat.[197]

For prisoners, failure to treat opioid use disorder is deliberate indifference to a serious medical need in violation of the Eighth Amendment.[198] The affirmative obligation to provide adequate medical care to prisoners includes providing treatment for an ongoing condition. Prisoners with a history of opioid use should be offered the opportunity to continue, or voluntarily begin, a MAT program. Treatment must be offered regardless of whether the detainee was engaged in legal or illicit drug use prior to arrest and incarceration.

This protocol for prisoners, like pretrial detainees, is already being safely implemented. The Rhode Island Department of Corrections offers MAT in its state prison facility with remarkable success: 26 people released from the facility died from an overdose in 2016, before the MAT program began, and only 9 died from an overdose in the same period of 2017, after the facility began providing MAT.[199] Similarly, the Vermont Department of Corrections

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[193] *See* Kortlever et al. v. Whatcom County, Settlement Agreement, 5–6 (April 29, 2019) https://www.aclu-wa.org/docs/settlement-agreement-1

[194] *Id.*

[195] *See* Bell v. Wolfish, 441 US 520 (1979); Farmer v. Brennan, 511 U.S. 825.

[196] *See supra* Part I b.

[197] *See* National Sheriffs' Association and National Commission on Correctional Health Care, *Jail-Based Medication-Assisted Treatment* (2018) https://www.sheriffs.org/publications/Jail-Based-MAT-PPG.pdf.

[198] *See supra* Part II c.

[199] *See* Traci C. Green et al., *Postincarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System*, 75 JAMA PSYCHIATRY 405–407 (2018); Erick Trickey, *How the Smallest State is Defeating America's Biggest*

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provides MAT to nearly a third of prisoners.[200] The treatment continues "for as long as medically necessary."[201] Recently, the Rikers methadone program expanded to allow individuals to continue MAT post-conviction while serving sentences upstate at Elmira Correctional Facility, under the supervision of New York State Department of Corrections and Community Supervision.[202] Additionally, the Whatcom County settlement, discussed above, requires the county jail to provide MAT post-conviction.[203] Lastly, the Federal Bureau of Prisons (BOP) has also acknowledged their obligation to provide MAT.[204] Three times in the last year, the BOP has agreed to go against its policy of denying MAT to non-pregnant individuals in

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Addiction Crisis, POLITICO MAG., Aug. 25, 2018, https://politi.co/2wbuwha.

[200] *See* 28 V.S.A. § 801b, https://legislature.vermont.gov/Documents/2018/Docs/ACTS/ACT176/ACT176%20As%20Enacted.pdf; Mike Faher, *More than 500 Vermont inmates receiving addiction treatment*, VT DIGGER, Jan. 23 2019, https://vtdigger.org/2019/01/23/500-vermont-inmates-receiving-addiction-treatment/.

[201] 28 V.S.A. § 801b, https://legislature.vermont.gov/Documents/2018/Docs/ACTS/ACT176/ACT176%20As%20Enacted.pdf. *See also* Mike Faher, *More than 500 Vermont inmates receiving addiction treatment*, VT DIGGER, Jan. 23 2019, https://vtdigger.org/2019/01/23/500-vermont-inmates-receiving-addiction-treatment/.

[202] *See* Alison Knopf, *Methadone Now Allowed in Upstate NY Prison, If Inmates Come From Rikers OTP First*, ADDICTION TREATMENT FORUM, Aug. 7, 2019, https://atforum.com/2019/08/methadone-allowed-upstate-ny-prison-inmates-come-from-rikers-otp-first/.

[203] *See* Kortlever et al. v. Whatcom County, Settlement Agreement, 5–6 (April 29, 2019) https://www.aclu-wa.org/docs/settlement-agreement-1.

[204] *See* Dipierro v. Hurwitz, Settlement Agreement, 2 (Mass. June 7, 2019) https://www.aclum.org/sites/default/files/20190607_dipierro_settlement.pdf; Crews v. Sawyer, *Kansas and Missouri ACLU affiliates reach settlement with Bureau of Prisons; Leavenworth inmate will receive opioid medication tonight*, ACLU OF KANSAS (Kans., Sept. 11, 2019), https://www.aclukansas.org/en/press-releases/kansas-and-missouri-aclu-affiliates-reach-settlement-bureau-prisons-leavenworth; Godsey v. Sawyer, *ACLU-WA lawsuit settled: Federal prison system agrees to provide medication-assisted treatment for opioid use disorder*, ACLU OF WASHINGTON (Wash., Dec. 11, 2019) https://www.aclu.org/press-releases/aclu-wa-lawsuit-settled-federal-prison-system-agrees-provide-medication-assisted.

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response to litigation.[205] These federal settlements required provision of MAT to the named plaintiffs; the necessary next step is for the BOP to offer MAT to *all* individuals with OUD entering correctional facilities, not just those previously in MAT.

Failure to provide MAT to vulnerable prisoners shows deliberate indifference to a serious medical need.[206] Forced withdrawal creates physical symptoms that cannot be ignored by prison staff.[207] Forced withdrawal is also an unnecessary infliction of pain.[208] Further, the recent string of BOP settlements show that society's "evolving standards of decency" view forced withdrawal as cruel and unusual.[209] As the stigma of addiction lessons, our compassion for the afflicted grows.

For all incarcerated individuals, the failure to provide MAT violates the ADA.[210] Categorically denying MAT is discrimination because of a disability—individuals with OUD should have access to their medication just as incarcerated individuals with diabetes are allowed to take insulin. However, while "drug addiction" is a disability under the ADA,[211] it may be difficult for a plaintiff to succeed on a claim that they should be provided MAT to prevent withdrawal from an illicit opioid.[212] Discrimination claims under the ADA will be difficult to win if the correctional facility provides an "individualized assessment" and concludes that MAT is not required; this is why OUD should be offered to all individuals with OUD regardless of whether they were previously legally participating in MAT or using illicit substances.

ii. Arguments Against MAT

[205] *See id.*

[206] *See* Estelle v. Gamble, 429 U.S. at 104.

[207] *See supra* Part I b; Farmer v. Brennan, 511 U.S. 825, 837 (1994); Todaro v. Ward, 565 F.2d 48 (2d Cir. 1977); Wellman v. Faulkner, 715 F.2d 269 (7th Cir. 1983).

[208] *See* Rhodes v. Chapman, 452 U.S. 337, 346 (1981); Todaro v. Ward, 565 F.2d 48, 52 (2d Cir. 1977); Kosilek v. Spencer, 774 F.3d 63, 85 (1st Cir. 2014).

[209] Trop v Dulles, 356 U.S. 86, 100-01 (1958). *See also* Part II c.

[210] *See supra* part Part II d.

[211] 28 C.F.R. § 35.108(b)(2).

[212] *See* Jones v. City of Boston, 752 F.3d 38, 58 (1st Cir. 2014) (holding that "[i]ndividuals who are recovering from an addiction to drugs may be disabled in the meaning of the ADA" unless they are "currently using drugs, whether addicted or not.").

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Critics argue that correctional facilities should not provide MAT because of prohibitive cost, perception that MAT is trading one addiction for another, and fear of diversion of the drug to inappropriate uses.[213] These concerns are unfounded.

Cost, or "efficient administration of jails and prisons," does not obviate the affirmative obligation to provide adequate medical care. As noted by then-Judge Blackmun, "[h]umane considerations and constitutional requirements are not, in this day, to be measured or limited by dollar considerations."[214] While it is true that a prison regulation can impinge on constitutional rights if the regulation is "reasonably related to legitimate penological interests,"[215] lack of funding "cannot justify an unconstitutional lack of competent medical care or treatment of inmates."[216] Even if costs are considered, MAT is inexpensive—correctional facilities can offer MAT for less than a dollar per day per patient.[217] Furthermore, providing MAT in correctional facilities would reduce costs by reducing recidivism: "While MAT costs about $4,000 per person each year, incarceration in United States prisons has an average annual cost of $22,279."[218]

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[213] *See* National Academies of Sciences, Engineering, and Medicine, *Medications for Opioid Use Disorder Save Lives*, THE NATIONAL ACADEMIES PRESS, 1 (2019) https://doi.org/10.17226/25310.

[214] Jackson v. Bishop, 404 F. 2d 571, 580 (8th Cir. 1968).

[215] *See* Turner v. Safely, 482 U.S. 78, 89 (1987). To determine whether a relationship is reasonable, courts should consider several factors: whether there is valid, rational connection between prison regulation and a legitimate governmental interest; whether there are alternative means of exercising rights; whether accommodation of asserted rights will have significant "ripple effect" on fellow prisoners or prison staff; and whether there is a ready alternative. *Id.* at 89-90. None of these factors are monetary cost.

[216] Anderson v. City of Atlanta, 778 F. 2d 678, 688 n. 14 (11th Cir. 1985).

[217] *See* Ruth Potee M.D. Dec., *Pesce v. Coppinger*, No. 1:18-cv-11972-DJC, Dkt. No. 17 (Sept. 9, 2018).

[218] Colleen O'Donnell, M.S.W. & Marcia Trick, M.S., Nat'l Ass'n of State Alcohol and Drug Abuse Directors, Inc., *Methadone Maintenance Treatment and the Criminal Justice System* 4 (Apr. 2006) (citing Stephen Magura et al., *Buprenorphine and Methadone Maintenance in Jail and Post-Release: A Randomized Clinical Trial*, 99 DRUG AND ALCOHOL DEPENDENCE 1-3 at 222-230 (Jan. 2009)). As cited in Legal Action Center, *Legality of Denying Access to Medication Assisted Treatment In the Criminal Justice System*, 3 (2011)

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The perception that MAT is trading one addiction for another is sentiment based on stigma, not science. For example, in one case a court observed that "correctional staff often resist providing MAT because they equate MAT to giving addicts drugs rather than giving people treatment."[219] This apathetic attitude towards addiction led the court the hold that the correctional facility "lacked a baseline awareness of what opioid use disorder was despite serving a population that disproportionately dies of that condition."[220] As previously discussed, addiction is a disease and MAT is the most effective treatment for opioid addiction.[221]

Diversion of medications for alternative uses is not a barrier to safely implementing a MAT program in correctional facilities.[222] Multiple jails and prisons implement MAT safely, including facilities in Pennsylvania, Rhode Island, Connecticut, Vermont, and New York.[223] The National Sherriff's Association has recognized that there is little risk of diversion of MAT medications.[224] Jails themselves have described a variety of ways to provide MAT without risk of diversion.[225] For example, the First Circuit noted that a jail's "own submissions tout the variety of reasonable alternatives at their disposal for providing [MAT] . . . in a manner that alleviates any security concerns."[226] In contrast, studies have found that MAT makes correctional facilities safer by reducing in-custody deaths by overdose or suicide.[227]

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https://lac.org/wp-content/uploads/2014/12/MAT_Report_FINAL_12-1-2011.pdf.

[219] *Smith v. Aroostook Cty.*, 376 F. Supp. 3d 146, 160 (D. Me.), *aff'd*, 922 F.3d 41 (1st Cir. 2019).

[220] *Id.*

[221] *See supra* part I.

[222] *See generally*, Surgeon General's Report on Alcohol, Drugs, and Health (2016), at 4-22 ("Decades of research have shown that the benefits of MAT greatly outweigh the risks associated with diversion.").

[223] *See* Kathy Nickel, *Correctional MAT Programs – Facility Synopsis* (on file with author).

[224] *See* National Sheriff's Association, *Jail-Based Medication Assisted Treatment* at 14 (Oct. 2018), https://www.sheriffs.org/publications/Jail-Based-MAT-PPG.pdf.

[225] *See* Smith v. Aroostook Cty., 376 F. Supp. 3d 146, 159 (D. Me.), *aff'd*, 922 F.3d 41 (1st Cir. 2019).

[226] Smith v. Aroostook Cty., 922 F.3d 41, 42 (1st Cir. 2019).

[227] *See* Smith v. Aroostook Cty., 376 F. Supp. 3d 146, 150 (D. Me.), *aff'd*, 922 F.3d 41 (1st Cir. 2019) ("Participation in MAT during

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b. The Right to Treatment, Revised: Focus Only on Objective Medical Need

While courts can order correctional facilities to provide MAT under existing constitutional and statutory frameworks, they can also create new and more effective standards. Currently, the right to medical care in prison is based on *Estelle v. Gamble*, which requires subjectively deliberate indifference by prison officials and an objectively serious medical need.[228] Estelle was decided 8-1, with only Justice Stevens in dissent. Justice Stevens would have required an incarcerated patient to show only the objective denial of a serious medical need, because "whether the constitutional standard has been violated should turn on the character of the punishment rather than the motivation of the individual who inflicted it."[229] He wrote:

> "If a State elects to impose imprisonment as a punishment for crime, I believe it has an obligation to provide the persons in its custody with a health care system which meets minimal standards of adequacy. As a part of that basic obligation, the State and its agents have an affirmative duty to provide reasonable access to medical care, to provide competent, diligent medical personnel, and to ensure that prescribed care is in fact delivered. For denial of medical care is surely not part of the punishment which civilized nations may impose for crime."[230]

In the future, the Court should adopt Justice Steven's simple framework: an incarcerated individual's right to medical care is violated if they are not provided with adequate treatment. Failure to provide adequate medical care can be proven by an objective showing of a serious medical need that goes unmet, without any subjective showing of deliberate indifference.

Courts have the power to intervene and expand the right to healthcare in prisons and jails. For example, in

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incarceration has also been associated with a reduced likelihood of in-custody deaths by overdose or suicide and an overall 75 percent reduction in all-cause in-custody mortality.").

[228] *See* Estelle v. Gamble, 429 U.S. 97, 104 (1976)

[229] *Id.* at 116. (Justice Stevens, dissenting).

[230] *Id.* at 116 n.13.

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Brown v. Plata the Supreme Court upheld a district court order that required California to reduce its prison population to remedy inadequate medical care in violation of the Eight Amendment.[231] The Supreme Court recognized the importance of correctional healthcare, noting that "[j]ust as a prisoner may starve if not fed, he or she may suffer or die if not provided adequate medical care."[232] The Court went on to hold, "[a] prison that deprives prisoners of basic sustenance, including adequate medical care, is incompatible with the concept of human dignity and has no place in civilized society."[233] This explicit acknowledgement of human dignity affirms the role of MAT in adequate prison healthcare—there is no place for the preventable suffering of withdrawal. Courts who resist their obligation to protect individual rights simply because those rights belong to an incarcerated individual are failing in their role as judicial bodies. Constitutional violations are not permissible simply because they occur in prison.[234]

While awaiting federal court action, state courts should interpret their own state constitutional protections to mandate MAT in correctional healthcare. Constitutional law may be most protective of individual rights when states engage in their own interpretation of constitutional provisions, rather than acting in lockstep with their federal counterparts.[235] If state courts acknowledge that MAT is essential to adequate healthcare in jails and prisons, they will be leaders in the protection of individual rights and guardians of human dignity.

The state has a duty to provide care to those whose liberty it restricts through incarceration, and courts have acknowledged this duty in unequivocal terms.[236] In the words of Justice Souter, "having stripped [prisoners] of virtually every means of self-protection and foreclosed

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[231] *See* Brown v. Plata, 563 U.S. 493, 511 (2011).

[232] *Id.*

[233] *Id.*

[234] *Id.* ("Courts may not allow constitutional violations to continue simply because a remedy would involve intrusion into the realm of prison administration.")

[235] *See* JEFFREY S. SUTTON, 51 IMPERFECT SOLUTIONS: STATES AND THE MAKING OF AMERICAN CONSTITUTIONAL LAW, 16-20 (2018).

[236] *See* Battle v. Anderson, 376 F.Supp. 402, 424 (E.D. Oklahoma, 1974) (holding that "Inmates have a basic right to receive needed medical care while they are confined in prison," and citing cases from the Fourth, Tenth, Fifth, Second, and Eighth Circuits).

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their access to outside aid, the government and its officials are not free to let the state of nature take its course."[237] Similarly, as phrased by one court in 1974, "prison officials have an affirmative duty to make available to inmates a level of medical care which is reasonably designed to meet the routine and emergency health care needs of inmates."[238] This language clearly requires meeting objective medical needs and does not suggest a loophole of subjective intent.

A prisoner or pretrial detainee does not lose their constitutional rights when they are incarcerated.[239] People who are incarcerated are people, still deserving of their human dignity despite incarceration. When the state restricts an individual's liberty, it takes on an obligation to care for basic wellbeing. This is true regardless of the crime committed; denial of healthcare should not be part of our punishment apparatus.

IV. Coda: Solutions Without Suing

The best solutions to this crisis are cooperative, not antagonistic. Parts II and III discuss litigation, but the right to MAT while incarcerated is properly an issue for the legislative branch. Police departments and correctional facilities are on the front line of this epidemic and a meaningful solution requires collaboration. Legislative changes can fulfill the government's obligation to provide MAT in correctional facilities without the need for adversarial litigation.[240]

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[237] Farmer v. Brennan, 511 U.S. 825, 833 (1994).

[238] Battle v. Anderson, 376 F.Supp. 402, 424 (E.D. Oklahoma, 1974).

[239] *See* Wolff v. McDonnell, 418 U.S. 539, 555–56 (1974) (holding that prisoners are not wholly stripped of constitutional protections and that they entitled to certain minimal due process requirements consistent with the institutional environment); Procunier v. Martinez, 416 U.S. 396, 422–23 (1974) ("A prisoner does not shed such basic First Amendment rights at the prison gate. Rather, he retains all the rights of an ordinary citizen except those expressly, or by necessary implication, taken from him by law.") (Justice Marshall, concurring) (internal citation omitted). *But see* Bell v. Wolfish, 441 U.S. 520, 545 (1979) ("Simply because prison inmates retain certain constitutional rights does not mean that these rights are not subject to restrictions and limitations.").

[240] Americans across the political spectrum desire government aid to combat the opioid crisis. For example, one poll found that "among

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Some lawmakers are thankfully taking action to provide MAT to individuals with OUD; however, legislative action has infrequently included prisons and jails. Actions that designate funding for MAT in correctional facilities would help fulfill the state's obligation to provide medical care to the incarcerated.

a. Federal Solutions

Only one existing federal program directly provides substance abuse treatment to the incarcerated. The Residential Substance Abuse Treatment Program (RSAT) from the U.S. Department of Justice Bureau of Justice Assistance provides funds to assist governments in "the development and implementation of substance abuse treatment programs in state, local, and tribal correctional and detention facilities," and in community reintegration services after release.[241] Treatment must be evidence-based but the program does not specifically require MAT and requires participants to be housed in a separate facility.[242]

Congress must go further than existing legislation in order to satisfy the constitutional right to medical treatment while incarcerated. Because incarcerated individuals have a right to medical care and addiction is a disease, the government must provide MAT to prevent the debilitating symptoms of involuntary withdrawal while

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rural Americans who say their community will need outside help to solve its major problems, similar proportions of Trump voters (about 6 in 10) and Clinton voters (7 in 10) believe that federal, state or local government will 'play the greatest role.'" Danielle Kurtzlben, *Poll: Rural Americans Rattled By Opioid Epidemic; Many Want Government Help*, NPR, Oct. 17, 2018, 5:01 AM, https://www.npr.org/2018/10/17/656515170/poll-rural-americans-rattled-by-opioid-epidemic-many-want-government-help ("[T]he fact that the opioid drug abuse epidemic literally is either the same or even, for many people, more serious than economic issues is an extraordinary finding.")

[241] Bureau of Justice Assistance, *Residential Substance Abuse Treatment for State Prisoners (RSAT) Program*, https://www.bja.gov/ProgramDetails.aspx?Program_ID=79.

[242] *See id.* The 12-steps model, for example, is considered evidence-based. Many individuals have had success using the 12-step model, but the statics for those who successfully stopped opioid use after attempting the 12-step approach are discouragingly low. The success rate for treatment using MAT is much higher. *See* Part I, *supra*.

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incarcerated. Two recently proposed bills would create funding to provide this constitutionally mandated care.

First, the Community Re-Entry through Addiction Treatment to Enhance (CREATE) Opportunities Act would establish a grant program to be administered by the Department of Justice to create or expand MAT programs in jails and prisons.[243] The goals of the MAT programs are to reduce overdose upon release from jails or prisons and to prevent recidivism.[244] Grants, however, are not self-sustaining, and it is unreasonable to expect towns and counties to continue funding MAT programs in jails and prisons after the initial federal funding; hence, the next piece of proposed legislation.

Second, the Humane Correctional Healthcare Act (HCHA) would create a sustained funding source for MAT in the criminal legal system.[245] The HCHA would repeal the so-called Medicaid inmate exclusion, which strips health coverage from Medicaid enrollees who are involved in the criminal legal system. Eliminating Medicaid during incarceration increases healthcare costs for states and counties because care must be provided by the detention facility without federal aid from Medicaid expansion programs.[246] The Medicaid inmate exclusion was part of the original 1965 Medicaid Act.[247] In support of the HCHA, the bill says, "[w]ith a repeal of the Medicaid inmate

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[243] *See* Ann M. Kuster, *H.R.3496 - Community Re-Entry through Addiction Treatment to Enhance Opportunities Act of 2019*, 116th Congress (2019-2020), Jun. 26, 2016, https://www.congress.gov/bill/116th-congress/house-bill/3496/text.

[244] *See id.*

[245] *See* Ann M. Kuster, *H.R.4141 - Humane Correctional Health Care Act, 116th Congress*, Aug. 2, 2019, https://www.congress.gov/bill/116th-congress/house-bill/4141.

[246] *See* Ann M. Kuster, *H.R.4141 - Humane Correctional Health Care Act, 116th Congress*, Aug. 2, 2019, https://www.congress.gov/bill/116th-congress/house-bill/4141; Ann McLane Kuster, *Congresswoman Kuster, Senator Booker Introduce Legislation to End Outdated Policy that Prevents Incarcerated Individuals from Accessing Medicaid*, (2019), https://kuster.house.gov/media-center/press-releases/congresswoman-kuster-senator-booker-introduce-legislation-to-end.

[247] *See* Ann M. Kuster, *H.R.4141 - Humane Correctional Health Care Act, 116th Congress*, Aug. 2, 2019, https://www.congress.gov/bill/116th-congress/house-bill/4141; *Social Security Amendments of 1965*, Pub. L. 89-67, https://www.govinfo.gov/content/pkg/STATUTE-79/pdf/STATUTE-79-Pg286.pdf.

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exclusion, nearly all inmates would be eligible for the Medicaid program in States that expanded Medicaid through the Patient Protection and Affordable Care Act."[248] This proposed solution provides a sustained funding solution, and has hope to pass because President Trump has endorsed the goal of making addiction treatment available to the incarcerated.[249] In addition to supporting MAT, repealing the Medicaid Inmate Exclusion would provide a sustained mechanism to pay for mental health treatment and general health care for a large portion of the incarcerated population. Returning folks to the communities after treatment for complex illnesses such as OUD, mental illness, and communicable diseases, is a good public health policy because treatment leads to healthier communities and lower rates of recidivism.[250]

Despite this potential federal legislation, Congress is gridlocked and the federal effort to combat the opioid crisis is floundering.[251] Instead, state and local governments are leading the way on treatment for OUD.[252]

b. State and Local Solutions

Overall, governments should invest in community-based treatment and remove individuals with substance use disorder from the criminal legal system entirely;[253] however, until then, correctional facilities are a promising opportunity to initiate treatment.[254] If incarcerated

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[248] *Id.*

[249] *See id.*

[250] *See* Sam Quinones, *Addicts Need Help. Jails Could Have the Answer*, N.Y. TIMES, Jan. 20, 2018, https://www.nytimes.com/2017/06/16/opinion/sunday/opioid-epidemic-kentucky-jails.html.

[251] *See* Sheryl Gay Stolberg & Nicholas Fandos, *As Gridlock Deepens in Congress, Only Gloom Is Bipartisan*, N.Y. TIMES, January 27, 2018, https://www.nytimes.com/2018/01/27/us/politics/congress-dysfunction-conspiracies-trump.html.

[252] The Editorial Board, *States Show the Way on the Opioid Epidemic*, N.Y. TIMES, Aug. 25, 2018, https://www.nytimes.com/2018/08/24/opinion/opioid-epidemic-states.html.

[253] Letters, *We Can't Incarcerate Our Way to Recovery*, BOSTON GLOBE, Oct. 18, 2019, https://www.bostonglobe.com/opinion/letters/2019/10/18/can-incarcerate-our-way-recovery/8efuZKf4vMBdzTILy7UtpK/story.html.

[254] *See* Sam Quinones, *Addicts Need Help. Jails Could Have the Answer*, N.Y. TIMES, Jan. 20, 2018,

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individuals are willing participants, treatment in jails could take a huge bite out of recidivism and return healthier folks to their community.[255] No one should be jailed to receive treatment, but state and local correctional facilities are at the center of the opioid epidemic and could be a nexus to get patients the medication they need.[256] To that end, state and local governments are creating successful treatment models in prisons and jails.

Kentucky provides a promising example of jail-based MAT. Their substance-abuse treatment program can boast that 12 months after release 70 percent of former-residents were not incarcerated, 68 percent were employed at least part-time, 86 percent were housed, 76 percent said they spent most of their time with family, and half reported a significant decrease in illicit drug use.[257] Vermont is another auspicious example of providing MAT in county jails. The state legislature mandated provision of MAT in 2018, and in less than a year almost a third of the state's incarcerated population was in treatment.[258] Similarly, the Rhode Island legislature is a leader in treatment while incarcerated. Legislators approved $2 million to provide MAT in the state prison, which has led to a drastic decrease in deaths after release.[259] Part of Rhode Island's success is

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https://www.nytimes.com/2017/06/16/opinion/sunday/opioid-epidemic-kentucky-jails.html.

[255] *See* David Lebowitz, *Proper Subjects for Medical Treatment?*, 14 DEPAUL J. HEALTH CARE L. 271 (2012).

[256] Eric Westervelt, *County Jails Struggle With A New Role As America's Prime Centers For Opioid Detox*, NPR, April 24, 2019, https://www.npr.org/2019/04/24/716398909/county-jails-struggle-with-a-new-role-as-americas-prime-centers-for-opioid-detox; The Editorial Board, *Want to Reduce Opioid Deaths? Get People the Medications They Need*, N.Y. TIMES, March 26, 2019, https://www.nytimes.com/2019/03/26/opinion/opioid-crisis-sacklers-purdue.html.

[257] *See* Sam Quinones, *Addicts Need Help. Jails Could Have the Answer*, N.Y. TIMES, Jan. 20, 2018, https://www.nytimes.com/2017/06/16/opinion/sunday/opioid-epidemic-kentucky-jails.html.

[258] *See* 28 V.S.A. § 801b, https://legislature.vermont.gov/Documents/2018/Docs/ACTS/ACT176/ACT176%20As%20Enacted.pdf; Mike Faher, *More than 500 Vermont inmates receiving addiction treatment*, VT Digger, Jan. 23 2019, https://vtdigger.org/2019/01/23/500-vermont-inmates-receiving-addiction-treatment/.

[259] *See* Traci C. Green et al., *Postincarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System*, 75 JAMA PSYCHIATRY 405–407 (2018);

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that the program lets incarcerated individuals and their doctor choose which medication they will go on—60 percent choose methadone and 39 percent choose Suboxone, while only 1 percent choose Vivitrol (a drug that blocks an opioid high but does not help with withdrawal symptoms or cravings).[260]

More states can adopt similar MAT systems. For example, a bill is pending in New York state to establish a MAT program in state and county correctional facilities.[261] The program would offer intake treatment, provide MAT in correctional facilities for the duration of incarceration, and help individuals transition to community care upon release.[262] Similarly, New Hampshire will mandate the provision of MAT in jails beginning in July, 2021.[263]

State and local efforts to provide MAT in jails and prisons are succeeding at saving lives, reducing suffering, transitioning to community care, and meeting the constitutional obligation to provide medical care to the incarcerated. These efforts should be broadly replicated.

Conclusion

Failure to provide MAT in correctional facilities causes involuntary withdrawal without adequate medical care. This lack of treatment violates the due process clause, the Eight Amendment, and the Americans with Disabilities Act. Incarcerated individuals who are denied access to MAT are being deprived of their constitutional right to adequate medical care. To meet that right, and to stave off potential lawsuits, governments at the national, state, and local level should provide access to, and funding

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Erick Trickey, *How the Smallest State is Defeating America's Biggest Addiction Crisis*, POLITICO MAG., Aug. 25, 2018, https://politi.co/2wbuwha.

[260] *See* Erick Trickey, *How the Smallest State is Defeating America's Biggest Addiction Crisis*, POLITICO MAG., Aug. 25, 2018, https://politi.co/2wbuwha.

[261] *See* Jamaal T. Bailey, NY State Senate Bill S2161B, Jan. 23, 2019 (2019-2020), https://www.nysenate.gov/legislation/bills/2019/s2161/amendment/b.

[262] *See id.*

[263] Staff Report, *New Law Mandates Medication Assisted Treatment in Jails*, UNION LEADER, Aug. 5, 2020, https://www.unionleader.com/news/health/new-law-mandates-medication-assisted-treatment-in-jails/article_bbb2728a-9a25-530e-bdf7-306de5f5b9b1.html.

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for, medication-assisted treatment for opioid withdrawal. In general, the state should stop criminalizing addiction; however, until then, people with opioid use disorder who are incarcerated must be provided MAT. Further, the Supreme Court should modify the legal standard for adequate medical care in correctional facilities so that courts need only consider the objective medical need of incarcerated individuals.

This article began by noting that the opioid epidemic is a crisis of pain and mortality. But it is also a moment of resiliency and hope. Because of MAT, many people with OUD are living more meaningful, more fulfilling lives—the nation should give that opportunity for hope to incarcerated individuals.

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