INTRODUCTION

In 2017, drug overdoses became the leading cause of accidental death in the United States, with opioids driving this epidemic.[1] Over the last two decades, there have been nearly half a million deaths attributable to opioids;[2] half of these deaths occurred in the last three years, and one quarter in 2017 alone.[3] Prescription opioids may have initiated the problem,[4] but the recent advent of synthetic opioids—estimated to be 50 to 10,000 times more potent than morphine[5]—has spiraled the epidemic into a crisis much deadlier than anyone could have anticipated.

The criminalization of drug addiction and the ongoing opioid crisis are inextricably intertwined. Since the advent of the infamous "War on Drugs" campaign in 1971, the number of people incarcerated for drug offenses in the United States has skyrocketed.[6] According to the United States Bureau of Justice Statistics (BJS), there are

[1] Multiple Cause of Death 1999–2017 on CDC Wide-ranging Online Data for Epidemiologic Research (CDC WONDER). Atlanta, GA: CDC, National Center for Health Statistics. 2018, *available at* <https://www.cdc.gov/drugoverdose/pdf/PDO_WONDER_Guide_MCOD_Dataset-a.pdf>.
[2] *Ibid.*
[3] *Ibid.*
[4] N. Dasgupta et al., "Opioid Crisis: No Easy Fix to Its Social and Economic Determinants," American Journal of Public Health (AJPH), *AJPH Perspectives*, February 2018, *available at* <https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2017.304187>.
[5] *See* Kathleen McLaughlin, "*Underground labs in China are devising potent new opiates faster than authorities can respond*," March 29, 2017, *available at* <https://www.sciencemag.org/news/2017/03/underground-labs-china-are-devising-potent-new-opiates-faster-authorities-can-respond>.
[6] C. Petty, 20/20 Bipartisan Justice Center, *The War on Drugs & Mass Incarceration*, 2018, *available at* <http://www.2020club.org/Mass-Incarceration>.

nearly 2.3 million adults currently detained in federal or state correctional facilities[7]—the highest number of any nation in the world,[8] and sixty-five percent of these individuals meet the criteria for substance abuse or dependence.[9] Today, there are more people behind bars for a drug offense than the number of people who were in prison or jail for any crime in 1980.[10]

The opioid epidemic evolved in three distinct waves. The first wave of deaths began in the 1990s following a sharp increase in the prescribing of opioid analgesics.[11] As legislative efforts to reduce opioid prescribing took effect in the early-to-mid 2000s, prescription opioid use declined, and heroin emerged as a more potent, cost-effective alternative.[12] The rapid rise in heroin-related deaths became apparent in 2010, marking the second wave of the opioid epidemic.[13] The emergence of illicitly-manufactured fentanyl (IMF) sparked the third and deadliest wave of the epidemic in 2013.[14] Overdose deaths involving IMF rose by 540% between 2015 and 2016.[15] In 2017, the death toll reached 49,068, a record high that surpassed mortality rates due to breast cancer and gun

[7] Bureau of Justice Statistics, "Total Correctional Population," January 2017, *available at* <https://www.bjs.gov/index.cfm?tid=11&ty=tp>.
[8] D. Cann, "5 facts behind America's high incarceration rate," CNN, July 10, 2018, *available at* <https://www.cnn.com/2018/06/28/us/mass-incarceration-five-key-facts/index.html>.
[9] J. Bronson et al., Bureau of Justice Statistics, *Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates*, NCJ 250546 (June 2017).
[10] *Ibid.*
[11] Dasgupta, *supra* note 4.
[12] *See* Lindsy Liu et. al, "History of the Opioid Epidemic How Did We Get Here?" June 2018, *available at* <https://www.poison.org/articles/opioid-epidemic-history-and-prescribing-patterns-182>.
[13] *Ibid.*
[14] Dasgupta *supra* note 4.
[15] T. Green et al., "Detecting Fentanyl, Saving Lives," Johns Hopkins Bloomberg School of Public Health, 2017, *available at* <https://americanhealth.jhu.edu/fentanyl>.

violence.[16] In October of 2017, the U.S. Department of Health and Human Services issued a statement declaring the opioid crisis a national public health emergency.[17]

The opioid epidemic is particularly acute in correctional facilities.[18] Opioid overdoses are the leading cause of premature mortality among recently incarcerated persons, accounting for one-quarter of all deaths among this population.[19] In North Carolina, opioid overdoses accounted for fifty percent of all deaths among recently incarcerated populations in 2015.[20] The high mortality rates among prisoners with Opioid Use Disorder (OUD) is a direct result of the institutional practice of forcing drug abstinence on inmates.[21] Forced abstinence precipitates physical withdrawal, which often leads to severe and overwhelming cravings, while simultaneously reducing one's tolerance for opioids.[22] The body's reduced tolerance, combined with the high relapse rates and potential exposure to highly toxic and deadly synthetic opioids, makes opioid

[16] F. Pirani, the Atlanta Journal-Constitution, "Opioids now kill more Americans than guns or breast cancer, CDC says," December 21, 2017, *available at* <https://www.ajc.com/news/health-med-fit-science/opioids-now-kill-more-americans-than-guns-breast-cancer-cdc-says/DUx1KS33P4sbyzgj9T9rrN>.
[17] L. Kaplan, "Opioids: A Public Health Emergency," *The Nurse Practitioner,* April 19, 2018, *available at* <https://journals.lww.com/tnpj/Citation/2018/04000/Opioids__A_public_health_emergency.2.aspx>.
[18] I.A. Binswanger et al., "Release from Prison—A High Risk of Death For Former Inmates," New England Journal of Medicine, 2007; 356:157-165., *available at* <https://www.nejm.org/doi/full/10.1056/NEJMsa064115>.
[19] M. Troilo, Prison Policy Initiative, "*We know how to prevent opioid overdose deaths for people leaving prison. So why are prisons doing nothing*?" December 7, 2018, *available at*: <https://www.prisonpolicy.org/blog/2018/12/07/opioids/>.
[20] *Id.*
[21] *See* Binswanger, *supra* 16.
[22] *Id.*

addicts particularly susceptible to suffering a fatal overdose in the first two weeks following incarceration.[23]

An extremely effective method for treating OUD is medication-assisted treatment (MAT),[24] which medical literature describes as the gold standard of treatment.[25] MAT combines FDA-approved medications with counseling and behavioral therapies to provide a more holistic approach to the treatment of OUD.[26] Studies involving the use of MAT in correctional settings have yielded up to seventy-five percent reductions in post-release overdoses,[27] along with sharp reductions in relapse and recidivism.[28] Despite the evident short and long-term benefits to the individual prisoner, less than one percent of U.S. correctional facilities currently offer these medications to incarcerated opioid addicts.[29]

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[23] *See supra* 19; *see also* National Institute on Drug Abuse, "Treating Opioid Addiction in Criminal Justice Settings," December 14, 2017, *available at* <https://www.drugabuse.gov/treating-opioid-addiction-in-criminal-justice-settings>.
[24] U.S. Food and Drug Administration, "*Information about Medication-Assisted Treatment (MAT),*" February 13, 219, *available at* <https://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm600092.htm>.
[25] M. Mittal et al. "History of medication-assisted treatment and its association with initiating others into injection drug use in San Diego, CA." *Substance abuse treatment, prevention*, and policy vol. 12,1 42. 3 Oct. 2017, doi:10.1186/s13011-017-0126-1.
[26] Substance Abuse and Mental Health Services Administration (SAMHSA), "Medication-Assisted Treatment," *available at* <https://www.integration.samhsa.gov/clinical-practice/mat/mat-overview>.
[27] L. Degenhardt, et al., "The impact of opioid substitution therapy on mortality post-release from prison: retrospective data linkage study," *Addiction*, 2014 Aug;109(8):1306-17. doi: 10.1111/add.12536., *available at* <https://www.ncbi.nlm.nih.gov/pubmed/24612249>.
[28] *Ibid*.; A. Joseph, "A novel approach to opioid addiction: access to treatment for all inmates," STAT, August 3, 2017, *available at* <https://www.statnews.com/2017/08/03/opioid-treatment-prisons/>.
[29] T. Williams, "Opioid Users are Filling Jails. Why Don't We Treat Them?" *New York Times*, August 4, 2017, *available at* <https://www.nytimes.com/2017/08/04/us/heroin-addiction-jails-methadone-suboxone-treatment.html>.

This paper questions the constitutionality of denying prisoners with OUD access to MAT. In particular, it argues that denying prisoners with OUD access to MAT amounts to deliberate indifference to a serious medical need, and rises to the level of cruel and unusual punishment under the Eighth Amendment. Part I of this paper examines the elements of cruel and unusual punishment under the Eighth Amendment as it pertains to claims involving inadequate medical care within correctional facilities. Part II establishes that OUD is a serious medical condition for which treatment with MAT is necessary, and denying prisoners with OUD access to MAT constitutes deliberate indifference of a serious medical need under the principles outlined in Part I. Part III examines the current correctional MAT programs that are in place and proposes a statutory change that would mandate correctional facilities to make MAT accessible to incarcerated opioid addicts.

I. REQUIREMENTS FOR AN EIGHTH AMENDMENT CLAIM ARISING OUT OF INADEQUATE MEDICAL CARE

The Eighth Amendment to the United States Constitution prohibits the infliction of "cruel and unusual punishment."[30] *Estelle v. Gamble* was a landmark case in which the Supreme Court first applied the Eighth Amendment to matters involving the medical care of prisoners.[31] *Estelle* stands for the proposition that the Eighth Amendment requires that correctional facilities provide prisoners a system of ready access to adequate medical

[30] US Const. amend. VIII.
[31] *Estelle v. Gamble*, 429 U.S. 97, 103 (1976).

care.[32] The Court reasoned that the government "has an obligation to provide medical care for those whom it is punishes by incarceration" because "[a]n inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met."[33]

In *Estelle,* the Court outlined the standard of what a prisoner must plead in order to prevail on a constitutional claim involving inadequate medical care under 42 U.S.C. § 1983.[34] In particular, the Court held that a prisoner must allege conduct by prison officials evincing a "deliberate indifference" to an objectively "serious medical need."[35] To obtain relief, the prisoner must show that the medical need was objectively serious, and that prison officials had subjective knowledge of the seriousness of the need and recklessly disregarded the attendant risk of harm.[36] Both elements must be met in order to prevail on an Eighth Amendment challenge to adequacy of medical care.[37]

A. *What Qualifies as a "Serious Medical Need"*

In *Estelle*, the Court held that the Eighth Amendment may be violated by depriving an inmate with a "serious medical need" access to medical treatment.[38] The court did not offer a bright line rule for what constitutes a "serious medical need," except

[32] *Ibid.*
[33] *Id.* at 103.
[34] *See Porter v. Nussle,* 534 U.S. 516 (2002) (explaining that 42 U.S.C. § 1983 is the federal statute that allows prisoners to sue the government for civil rights violations and that prisoners need not exhaust administrative remedies prior to filing a claim).
[35] *Estelle*, 429 U.S. at 104.
[36] *Farmer v. Brennan,* 511 U.S. 825, 836 (1994).
[37] *Ibid.*
[38] *Estelle*, 429 U.S. at 103-04.

to say that failure to treat it would "result in further significant injury" or cause "unnecessary and wanton infliction of pain."[39] In *Hill v. Dekalb Regional Youth Detention Center*, the Eleventh Circuit defined a "serious medical need" as "one that has been diagnosed by a physician as mandating treatment," or where failure to treat would cause further injury or chronic pain to the prisoner.[40] The majority of federal circuits have adopted the *Hill* definition of "serious medical need;"[41] some have also set-forth their own factor-based analyses in determining what type of condition rises to the level of "sufficiently serious" medical need.[42]

The Second Circuit set forth a three-factor test in *Chance v. Armstrong* for resolving whether a medical need was sufficiently serious to engender a constitutional claim: (1) whether a reasonable doctor or patient would perceive the medical need to be "important and worthy of comment;" (2) whether the condition significantly affected activities of daily living; and (3) the existence of chronic and substantial pain.[43] In this case, the plaintiff's unresolved dental condition, which caused him "great pain, difficulty eating, and deterioration of the health of his other teeth," was held to be sufficiently serious to meet the *Estelle* standard.[44]

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[39] *Id*. at 104.
[40] *Hill v. Dekalb Reg'l Youth Det. Ctr*., 40 F.3d 1176, 1187 (11th Cir. 1994); see also *McGuckin v. Smith*, 974 F.2d at 1059-60 (1992).
[41] *Id.*; *Gaudreault v. Municipality of Salem, Massachusetts,* 923 F.2d 203 (1st Cir. 1990); *Sheldon v. Pezley*, 49 F.3d 1312, 1316 (8th Cir.1995); *Gutierrez v. Peters*, 111 F.3d 1364 (7th Cir. 1997).
[42] *McGuckin*, 974 F.2d at 1050; *Chance v. Armstrong*, 143 F.3d 69, 702 (2nd Cir. 1998); *Brock v. Wright,*315 F.3d 158, 162 (2nd Cir. 2003).
[43] *Chance v. Armstrong*, 143 F.3d 698, 702 (2nd Cir. 1998).
[44] *Id*. at 702.

In *Brock v. Wright*, the Second Circuit added a fourth factor to the three-part inquiry outlined in *Chance*: the consequences of forgoing treatment and likelihood of a favorable outcome with treatment.[45] Here, the plaintiff suffered a serious knife wound to his face after being slashed with a razor, which progressed into a disfiguring keloid scar that left him unable to move his mouth.[46] The prison physician referred the plaintiff to a dermatologist for steroid injections—an order that prison officials refused to abide by.[47] The Second Circuit reversed the lower court's ruling that keloid formation was not a sufficiently serious need, explaining that it was not up the court to pass judgment on "the quality of evidence . . . regarding the keloid's effect on the plaintiff's condition or severity of his disfigurement,[48]" and that "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."[49]

Chance and *Brock* exemplify the level of deference given by courts to the judgment of medical personnel as it relates to the seriousness of a medical need.[50] In *Bowring v. Godwin*, the Fourth Circuit similarly held that it was improper for the district court to discount the observations of competent medical personnel when it granted the defendants' motion for summary judgment.[51] The Second Circuit reiterated this principle in *Smith v. Carpenter*, explaining that, because the severity of medical need depends on

[45] *Brock v. Wright,* 315 F.3d 158, 162 (2nd Cir. 2003)
[46] *Id.* at 158, 160.
[47] *Id.* at 162.
[48] *Id.* at 164.
[49] *Id.* at 163; *see also Todaro v. Ward*, 565 F.2d 48, 52 (2d Cir. 1977).
[50] *Bowring v. Godwin* 551 F.2d 44, 48 (4th Cir. 1977).
[51] *Id*. at 46

the facts surrounding each individual prisoner, courts should defer to the judgement of prison medical staff in determining whether medical need is sufficiently serious as a matter of law.[52]

Serious medical needs are not necessarily limited to a physical condition or even present suffering.[53] In *Helling v. McKinney*, the Court held that that deliberate indifference to a serious medical need could be based upon a possible future harm to health.[54] The court in that case held that involuntary exposure to second-hand smoke amounted to deliberate indifference.[55] According to the court's opinion, as long as the risk of harm is obvious and known to cause injury or illness, and the risk could be abated with reasonable effort, then this constituted deliberate indifference to a serious medical need.[56] Many federal circuits have since allowed claims premised on adverse medical events occurring after the inmate's release.[57]

In summary, the majority of federal circuits have adopted the definition of a serious medical need as being "one that has been diagnosed by a physician as mandating treatment," or where failure to treat "would cause further injury or chronic pain to the prisoner."[58] Many circuits have also adopted factor-based tests to help delineate the

[52] *Smith v. Carpenter*, 316 F.3d 178 (2d Cir. 2003).
[53] *Helling v. McKinney,* 509 U.S. 25, 27-28 (1993); *McKinney v. Anderson,* 924 F.2d 1500 (9th Cir. 1991).
[54] *Helling,* 509 U.S. at 28-30.
[55] *Id.* at 31-33.
[56] *Id.* at 36.
[57] *Id.* at 33, 36; see also *Wakefield v. Thompson*, 777 F.3d 1160 (9th Cir. 1999) (explaining that the government's duty of care to the prisoner extends beyond the period of incarceration until they are able to secure medical care on their own behalf); see also *Atkinson v. Taylor*, 316 F.3d 257 (3rd Cir. 2003) (reiterating that prison officials violate the Eighth Amendment when they expose prisoners to levels of environmental tobacco smoke that pose a risk of harm to the prisoners' future health).
[58] *Hill*, 40 F.3d at 1176, 1187; see also *McGuckin v. Smith*, 974 F.2d at 1059-60 (1992).

seriousness of a medical need: (1) whether a reasonable doctor or patient would perceive the medical need to be "important and worthy of comment;" (2) whether the condition significantly affected activities of daily living; and (3) the existence of chronic and substantial pain.[59] Courts also consider the consequences of foregoing treatment and the likelihood that the treatment would yield a favorable outcome.[60]

B. ***The Deliberate Indifference Standard***

The *Estelle* Court held that "deliberate indifference" towards a prisoner's serious medical need violates the Eighth Amendment's prohibition against cruel and unusual punishment.[61] To qualify as "deliberate indifference," the correctional staff's action must "disregard a substantial risk of harm" that results in the "unnecessary and wanton infliction of pain."[62] The deliberate indifference standard is akin to criminal recklessness in that it requires a showing that the prison official knew of a substantial risk of harm and consciously disregarded that risk.[63]

Proof of knowledge of a substantial risk of harm does not require prison officials to be aware of a risk from a specific source.[64] Proof may be proven by direct evidence, such as medical records, sick call requests, or formal grievances, or it may be inferred

[59] *Chance*, 143 F.3d at 698.
[60] *Brock,* 315 F.3d at 162.
[61] *Estelle*, 429 U.S. at 97.
[62] *Farmer v. Brennan*, 511 U.S. 825, 836-37 (1994); see also *Redman v. RadioShack Corp.*, 769 F.3d 622 (7th Cir. 2014) (defining criminal recklessness as "knowledge of a serious risk to another person, coupled with failure to avert the risk though it could easily have been averted").
[63] *Farmer,* 511 U.S. at 839-40.
[64] *Id*. at 837.

from circumstantial evidence showing that the risk of harm was obvious.[65] In *Farmer v. Brennan*, the Court held that prison official cannot "escape liability if the evidence showed that he merely refused to verify underlying facts that he strongly suspected to be true, or declined to confirm inferences of risk that he strongly suspected to exist."[66]

In *Madrid v. Gomez,* a district court found the Pelican Bay Prison to be constitutionally deficient because prison officials had "an abundant knowledge of inadequacies" in the prison healthcare system and failed to remedy them, thereby "practically ensuring that inmates would endure unnecessary pain, suffering, debilitating disease, and death.[67] In *Coleman v. Wilson* that the mental health care system in California state prisons was "grossly deficient," and that incarcerated prisoners faced "an objectively intolerable risk of harm" as a result of these deficiencies, which were so patently obvious as to make the "prison officials' claims of ignorance unbelievable."[68]

In *McElligott v. Foley*, the Eleventh Circuit outlined the following criteria for deliberate indifference claims: (1) subjective knowledge of a risk of serious harm; (2) disregard of that risk; and (3) by conduct that is "more than mere negligence."[69] Conduct that is "more than mere negligence" may manifest in a number of ways, including knowledge of a serious medical need and refusal to provide care,[70] delaying treatment for

[65] *Id.* at 844.
[66] *Id*. at 843.
[67] *Madrid v. Gomez*, 889 F. Supp. 1146, 1210 (N.D. Cal. 1995).
[68] *Coleman v. Wilson*, 912 F. Supp. 1282, 1316-19 (E.D. Cal. 1995).
[69] *McElligott v. Foley*, 182 F.3d 1248, 1255 (11th Cir. 1999); *Brown v. Johnson*, 387 F.3d 1344, 1351 (11th Cir. 2004).
[70] *Estelle*, 429 U.S. at 105.

non-medical reasons,[71] refusal to carry out medical orders,[72] or care that is "so cursory that it amounts to no treatment at all."[73] Though disagreement between medical staff and prisoner over what constitutes proper treatment does not establish deliberate indifference, [74] a physician may be deliberately indifferent if "he or she consciously chooses an easier and less efficacious treatment plan."[75]

Systemic challenges to prison medical care systems are also governed by the deliberate indifference standard.[76] It is well-established that prisons must provide a system of ready access to adequate medical care.[77] An adequate system of medical care requires "[s]ervices at a level reasonably commensurate with modern medical science and of a quality acceptable within prudent professional standards,"[78] and at "a level of health services reasonably designed to meet routine and emergency medical, dental and psychological or psychiatric care."[79] Accordingly, inadequate staffing,[80] lack of basic

[71] *Murphy v. Walker*, 51 F.3d 714, 719 (7th Cir. 1995) (holding that a two-month delay in treatment for a head injury amounted to deliberate indifference); *Natale v. Camden County Correctional Facility*, 318 F.3d 575 (3rd Cir. 2003) (finding deliberate indifference where prison officials waited 21 hours to provide insulin to a diabetic prisoner).
[72] *Brock,* 315 F.3d at 158; see also *Koehl v. Dalsheim*, 85 F.3d 86, 88 (2nd Cir. 1996) (finding deliberate indifference when prison officials refused to provide eyeglasses that were prescribed); *Erickson v. Holloway*, 77 F.3d 1078, 1080 (8th Cir. 1996) (holding that failure to comply with emergency room aftercare instructions amounted to deliberate indifference).
[73] *McElligott,* 182 F.3d at 1248.
[74] *Stewart v. Murphy*, 174 F.3d 530, 535 (5th Cir. 1999).
[75] *Williams v. Vincent*, 508 F.2d 541, 544 (2d Cir. 1974); see also *Waldrop v. Evans*, 871 F.2d 1030, 1035 (11th Cir. 1989) (reaffirming position that "choice of an easier but less efficacious course of treatment can constitute deliberate indifference").
[76] *Hutto v. Finney*, 437 U.S. 678 (1978).
[77] *Estelle*, 429 U.S. at 105.
[78] *United States v. DeCologero*, 821 F.2d 39, 43 (1st Cir. 1987); See also *Fernandez v. United State*s, 941 F.2d 1488, 1493-94 (11th Cir. 1991) (citing to *DeCologero*).
[79] *Ramos v. Lamm*, 639 F.2d 559, 574 (10th Cir. 1980); *Hoptwowit v. Ray*, 682 F.2d 1237 (9th Cir. 1982) (reaffirming that a prison's medical care system is constitutionally deficient when it fails to comply with medical standards set forth by the AMA).
[80] *Id.* at 1252.

psychiatric or mental health services,[81] deficiencies in equipment, space, or medical record systems,[82] prison overcrowding,[83] and failure to comply by basic medical standards set forth by the American Medical Association (AMA)[84] are just a few of the many reasons for which prisons have been deemed to be constitutionally deficient.

C. *Summary of Deliberate Indifference to a Serious Medical Need*

The Eighth Amendment prohibits cruel and unusual punishment, which may be evidenced through reckless disregard for a serious medical need.[85] To give rise to a colorable constitutional claim for inadequate medical care, both the objective "serious medical need" and subjective "deliberate indifference" standards must be met.[86] Courts are likely to find a "serious medical need" if a condition "has been diagnosed by a physician as mandating treatment" and failure to treat a prisoner's condition results in further significant injury or the unnecessary and wanton infliction of pain.[87] A prison or prison official demonstrates "deliberate indifference" to a serious medical need if they are aware of a substantial risk of harm and disregard that risk by conduct that exceeds negligence.[88]

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[81] *Id.* at 1253.
[82] *Ibid*.
[83] *Lareau v. Manson,* 651 F.2d 96, 98 (2nd Cir. 1981) (explaining that overcrowding of prisons can be a basis for an Eighth Amendment violation when it increases violence or dilutes the provision constitutionally required services).
[84] *Hoptwowit*, 682 F.2d at 1237.
[85] *Estelle*, 429 U.S. at 104.
[86] *Id*.
[87] *Farmer*, 511 U.S. at 842; *Clement v. Gomez*, 298 F.3d 898, 904 (9th Cir. 2002).
[88] *Farmer*, 511 U.S. at 843.

II. FAILURE TO TREAT OUD WITH MAT IN CORRECTIONAL FACILITIES AMOUNTS TO CRUEL AND UNUSUAL PUNISHMENT

This paper argues that prison officials display deliberate indifference to the serious medical needs of prisoners by refusing to make MAT accessible to prisoners with OUD. OUD rises to the level of "serious medical need" because it is a diagnosed diseased that mandates treatment with MAT, failure to treat OUD results in unnecessary pain and suffering, and even death. This conduct exceeds negligence; it displays reckless disregard for the health and safety of inmates with OUD and represents a substantial departure from accepted medical standards. Thus, correctional facilities violate the Eighth Amendment when denying prisoners with OUD access to MAT.

A. *OUD is a Serious Medical Need*

OUD has clear guidance for diagnosis as both a brain disease and mental illness. The American Society of Addiction Medicine (ASAM) defines addiction as a chronic disease that changes both the structure and function of the brain.[89] Like other chronic diseases, addiction has a genetic component, involves cycles of relapse and remission, and failure to treat it can cause progression of the disease and premature death.[90] OUD is also

[89]American Society of Addiction Medicine, "Public Policy Statement: Definition of Addiction," 2011, *ASAM, available at* <http://www.asam.org/advocacy/find-a-policy-statement/viewpolicy-statement/public-policy-statements/2011/12/15/thedefinition-of-addiction>.
[90] *Id*.

classified as a mental illness with a clear definition under the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).[91]

OUD's classification as a brain disease and mental illness makes it a serious medical need under established legal standards. Specifically, OUD is a diagnosed condition that mandates medical treatment, thereby meeting the definition of a "serious medical need" outlined in *Hill*. OUD also rises to the level of "sufficiently serious" when analyzed under the Second Circuit's four-factor inquiry set forth in *Brock*: OUD is reasonably considered to be an important condition, significantly affects daily activities, causes chronic and substantial pain, and has significant consequences for foregoing treatment.

1. OUD is a Diagnosed Condition that Mandates Treatment with MAT

The DSM-5 defines OUD as a "problematic pattern of opioid use leading to clinically significant impairment or distress."[92] A DSM-5 diagnosis for OUD requires two or more of the following: (1) cravings for opioids; (2) escalating opioid use; (3) loss of control or inability to abstain from opioid use; (4) continued use, despite apparent negative consequence; (5) recurrent opioid use in physically hazardous situations (i.e. sharing needles); (6) neglecting major life roles; and (7) tolerance and physical withdrawal.[93] The clear diagnostic guidelines provided by the DSM-5 for OUD renders it a diagnosable condition as required by the *Hill* definition of "serious medical need."

[91] American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (Arlington, VA: American Psychiatric Association Publishing, 2013).
[92] *See* ASAM *supra* 72.
[93] *Id*.

Once diagnosed, OUD also mandates medical treatment.[94] The recommended treatment for OUD is known as "medication-assisted treatment" (MAT).[95] MAT combines the use of FDA-approved medications and counseling to provide a "whole person" approach to the treatment of OUD.[96] When compared to abstinence-based models for treating OUD, MAT is vastly superior in terms of efficacy, long-term treatment retention, and safety profile.[97]

There are three FDA-approved medications commonly used as part of MAT to treat OUD: buprenorphine, naltrexone, and methadone.[98] These medications significantly reduce the risk of overdose fatalities by blocking the effects of other opioids and heightening tolerance to opioids.[99] Even without the therapy component, buprenorphine and methadone are still viewed as being highly efficacious on their own in treating OUD.[100] In fact, the World Health Organization (WHO) lists buprenorphine and methadone as "essential medicines" considered to be the "most effective and safe to meet the most

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[94] Center for Substance Abuse Treatment, *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*, Treatment Improvement Protocol Series 23 (Revised 2012).

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[96] *Id*.

[97] Robert P. Schwartz et al., "Opioid Agonist Treatments and Heroin Overdose Deaths in Baltimore, Maryland, 1995-2009," American Journal of Public Health 103, no. 5 (2013): 917–22, available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3670653>.

[98] Substance Abuse and Mental Health Services Administration, "*Medication-Assisted Treatment (MAT)*" February 7th, 2018, available at <https://www.samhsa.gov/medication-assisted-treatment>.

[99] *See* Binswanger, *supra* 17.

[100] O. Khazan, "America's Health-Care System, is Making the Opioid Crisis Worse." *The Atlantic*, November 20, 2018, available at< https://www.theatlantic.com/health/archive/2018/11/why-heroin-and-fentanyl-addicts-cant-get-treatment/576118/>.

important needs in a health system."[101] Thus, OUD also meets the second prong of *Hill,* as it is a diagnosable medical condition that mandates medical treatment.

2. The Consequences of Denying Access to MAT are Significant

The importance of OUD as a condition, its effect on the addict's daily life, the physical pain it causes and the significant of the consequences for foregoing treatment are best exemplified by examining the effects of withdrawal from opioids. The symptoms of opioid withdrawal syndrome (OWS) can include nausea, vomiting, cold sweats, restlessness, body aches, depression, anxiety, aggression, insomnia, and even seizures.[102] Brown University professor Josiah D. Rich, director and co-founder of the Center for Prisoner Health and Human Rights at the Miriam Hospital in Rhode Island, describes the horrors that opioid addicts experience when forced to withdraw cold-turkey:

> "Almost everybody who is withdrawing from opioids feels like they're dying. It is a horrible, horrible feeling. Imagine the worst flu you ever had, and then imagine the worst stomach bug you ever had, with nausea and vomiting and diarrhea. Add those two things together and multiply it by

[101] World Health Organization, "*WHO Model Lists of Essential Medicine*," 2017, available at: <https://www.who.int/medicines/publications/essentialmedicines/EML_2017_ExecutiveSummary.pdf?ua=1>.
[102] A. Lautiere, "Opioid Withdrawal Timelines, Symptoms and Treatment," *American Addiction Centers*, March 28, 2019, available at: <https://americanaddictioncenters.org/withdrawal-timelines-treatments/opiate>.

> between 100 and 1,000, and that's starting to get at what it feels like."[103]

Symptoms of opioid withdrawals can be alleviated with medications like methadone and buprenorphine.[104] These medications work by attaching to opioid receptors in the brain, thereby "tricking" the body into thinking the person is taking opioids.[105] This has the dual effect of alleviating painful withdrawal symptoms and reducing cravings, while simultaneously heightening tolerance for opioids.[106] This, in turn, significantly decreases the likelihood of relapse and overdose upon release.[107]

The data surrounding the use of MAT to treat prisoners with OUD is overwhelming and unequivocal, yielding up to seventy-five percent reductions in overdose fatalities upon release from a correctional facility.[108] Initiating treatment with MAT in correctional facilities also promotes long-term retention in treatment, and reduces relapse and recidivism rates by up to sixty percent.[109] Moreover, MAT and its

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[103] V. Kim, "Family To Sue After Father-Of-Four Dies From Withdrawal In Prison," *The Fix*, January 10, 2018, *available at* <https://www.thefix.com/family-sue-after-father-four-dies-withdrawal-prison>.
[104] *Lautiere*, supra 88
[105] Gateway Foundation, "Medication-Assisted Treatment Program," 2018, *available at* <https://www.gatewayfoundation.org/addiction-treatment-programs/medication-assisted-treatment-program/>.
[106] Lautiere, supra 88
[107] *Id.*
[108] R. Chandler et al., "Treating Drug Abuse and Addiction in the Criminal Justice System: Improving Public Health and Safety," *JAMA*, January 2019, *available at* <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2681083/>.
[109] T. Green et al., "Postincarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System," *JAMA Psychiatry*, April 2018, *available at* <https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2671411>.

corresponding medications has been shown to increase social functioning, and decrease collateral harms associated with illicit drug use, such as HIV and Hepatitis C.[110]

OUD clearly constitutes a "serious medical need" that entitles prisoners to treatment with MAT. OUD is recognized as a chronic brain disorder that is progressive and fatal, and the perceived need for treatment is great, particularly considering the high mortality rates among prisoners with untreated OUD.[111] The high risk of death associated with untreated OUD would clearly be "sufficiently serious" to qualify as a medical need. Treatment with MAT halts the disease progression, prevents unnecessary pain and suffering associated with OWS, and most importantly, reduces the risk of overdose fatalities.[112] The prognosis of OUD after treatment with MAT is favorable, and the consequences of foregoing treatment are severe. Based on these factors, OUD rises to the level of "serious medical need," and failure to provide treatment constitutes deliberate indifference of this need.

B. ***Failure to Treat OUD with MAT Constitutes Deliberate Indifference***

According to well-established federal case law, prison officials display deliberate indifference towards a serious medical need of a prisoner when they disregard a serious risk of harm of which they are aware through conduct that is beyond mere negligence.[113] This can be established in a number of ways, including refusal to provide care in light of

[110] *Id*.
[111] *See* Binswanger, *supra* 17.
[112] *See* Chandler, *supra* 91.
[113] *Farmer*, 511 U.S. at 837.

the risk of harm, delaying or refusing treatment for nonmedical needs, or even a decision to take an easier, but less efficacious form of treatment.[114]

In light of the current, ongoing opioid crisis, the dangers of untreated OUD are well-documented. The opioid crisis is particularly acute in correctional facilities, where nearly one-third of opioid addicts will end up at any given year[115]. Despite the high volume of prisoners with OUD and the well-established efficacy of MAT, opioid addicts rarely receive treatment while incarcerated.[116] Though there are many risks associated with untreated OUD in correctional facilities, this section will focus on the two most severe, concretes risks: death and disease.

Experts in the field of addiction medicine have deemed incarceration to be the most "lethal point" of an opioid addiction.[117] Incarceration usually leads to prolonged periods of abstinence and, though drug use ceases during these periods, the addiction itself does not. The body's reduction in tolerance, combined with possible exposure to synthetic opioids upon relapse, significantly heightens the prisoner's risk of overdose upon release.[118] A Washington State study found that the risk of premature mortality among recently incarcerated opioid addicts is 129 times greater than that of the general population.[119]

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[114] *See* Waldorp, *supra* note 62.
[115] A. Fox et al., "Release from incarceration, relapse to opioid use and the potential for buprenorphine maintenance treatment: a qualitative study of the perceptions of former inmates with opioid use disorder," *Addiction Science*, January 16, 2015, *available at*: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4410477/>.
[116] *See* New York Times, *supra* 22.
[117] D. Wohl et al., "HIV and Incarceration: Dual Epidemics." *AIDS Read,* May 2006, *available at* <https://www.ncbi.nlm.nih.gov/pubmed/16764066>.
[118] *See* Binswanger, *supra* 17.
[119] *Id.*

Another serious risk among prisoners with OUD who do not receive treatment is possible contraction of communicable diseases.[120] Hepatitis C is communicable disease that is primarily contracted through shared needle use, a fairly common practice among incarcerated opioid addicts.[121] One study found that the rate of hepatitis C among incarcerated opioid addicts was seventeen times higher than for non-incarcerated addicts.[122] New infections of hepatitis C have tripled as a direct result of the ongoing opioid epidemic.[123] Research has also shown direct evidence of ongoing hepatitis C transmission among incarcerated opioid addicts.[124] This is largely the true for HIV as well, the prevalence of which is three times higher in incarcerated opioid addicts.[125]

The attendant risks of untreated OUD in correctional settings are obvious and severe. There is no greater risk than a risk to one's life or health and, prison officials knowingly and consciously disregard that risk by denying prisoners access to MAT. Proof of knowledge of the risk need not be shown; proof can come from the "very fact that the risk is obvious."[126] Given the acute nature of the opioid epidemic in correctional settings, where nearly sixty-five percent of all prisoners meet the criteria for substance

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[120] A.L. Beckman et al., "New Hepatitis C Drugs are Very Costly and Unavailable to Many State Prisoners," *Health Affairs* 35 (2016): 1893-1901.
[121] *Id.*
[122] *Id.*
[123] S. Scutti, "New Hepatitis C Infections Triple Due to Opioid Epidemic," CNN, May 11, 2017, *available at* <https://www.cnn.com/2017/05/11/health/hepatitis-c-rates-cdc-study/index.html>.
[124] L. Clemens-Cope et al., "Medicaid Coverage of Effective Treatments for OUD," Urban Institute, June 2017, *available at* < https://www.urban.org/research/publication/medicaid-coverage-effective-treatment-opioid-use-disorder >
[125] K. Dolan et al., "People who Inject Drugs in Prison: HIV Prevalence, Transmission, and Prevention," *International Journal of Drug Police* 26 (2015): 512-515.
[126] Farmer, 511 U.S. at 842.

abuse,[127] and where drug overdoses are the leading cause of death among recently incarcerated populations,[128] this burden is fairly easy to establish.

Deliberate indifference is more obvious if prisoners have access to medical providers who cannot provide the standard of care. The decision of whether or not to offer MAT typically comes from prison administrators, as opposed to doctors relying on medical judgment.[129] A survey of prison administrators nationwide found that opposition for institutional MAT programs is based on cost or preference for abstinence-based treatment.[130] Cost is not a valid defense to constitutional violations, even when legislative underfunding makes it impossible to pay.[131] A Florida district court recently issued a preliminary injunction against a state prison for failure to treat thousands of prisoners with hepatitis C, in spite of the $37,000 cost of treatment per prisoner.[132] In any event, the cost of establishing MAT programs is not an obstacle to treatment; a daily dose of methadone and buprenorphine cost as little as $0.40 and $3, respectively,[133] a tiny fraction of the average $91 per day it costs to detain someone.[134]

The Seventh Circuit definition of deliberate indifference involves a decision that is "such a substantial departure from accepted professional judgment, practice, or

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[127] Bronson, *supra* 16; NIDA *supra* 18.
[128] Troilo, *supra* 17,
[129] A. Nunn et al., "Methadone and Buprenorphine Prescribing and Referral Practices in US Prison Systems," *Drug and Alcohol Dependence*, 105 (2009): 83-85.
[130] *Id.*
[131] *Hoffer v. Jones*, 207 US Dist. LEXIS 194544 at *6.
[132] *Id.*
[133] *See* New York Times, *supra* 22.
[134] E. Mills, "The Price of Prisons," *Vera Institute of Justice*, 2015, *available at* <https://www.vera.org/publications/price-of-prisons-2015-state-spending-trends/price-of-prisons-2015-state-spending-trends/price-of-prisons-2015-state-spending-trends-prison-spending>.

standards, as to demonstrate that the person responsible did not base their decision on medical judgment."[135] Refusal to treat OUD with MAT represents a substantial departure from accepted professional judgement, as the medical and addiction treatment communities regard MAT as a first-line treatment for OUD. Even if the decision to refuse MAT was premised on medical judgment, it might still rise to the level of deliberate indifference. It is well-established that MAT is vastly superior to abstinence-based treatments, and courts have held deliberate indifference can be shown through the decision to provide a less efficacious form of treatment.[136] Moreover, abstinence-based treatments require some form of counseling or behavioral treatment in order to be effective, which correctional facilities rarely provide.[137] Thus, forced abstinence is not a viable approach to OUD; it effectively amounts to nothing at all.

III. THE GOVERNMENT HAS AN OBLIGTION TO MEET THE MEDICAL NEEDS OF PERSONS THAT IT INCARCERATES

In *Estelle*, the Supreme Court outlined the state's broad obligations to provide services to the prisoner because they cannot otherwise care for themselves.[138] The Ninth Circuit clarified in *Hoptowit* that "access to medical staff has no meaning if the staff is not competent to deal with the prisoners' problems," and that, if it cannot treat the

[135] *Williams*, 508 F.2d at 541; *see supra* note 16.
[136] E. Sarlin, "Long-Term Follow-Up of Medication-Assisted Treatment for Addiction to Pain Relievers Yields "Cause for Optimism,' November 30, 2015, *NIDA, available* at <https://www.drugabuse.gov/news-events/nida-notes/2015/11/long-term-follow-up-medication-assisted-treatment-addiction-to-pain-relievers-yields-cause-optimism>.
[137] D. James et al., Bureau of Justice Statistics, *Mental Health Problems of Prison and Jail Inmates*, NCJ 213600 (September 2006).
[138] *Estelle*, 429 U.S. at 97, 103.

medical needs of prisoners, it "must refer prisoners to others that can."[139] Lack of access to basic medical and psychiatric care, or failure to comply with basic standards of care set forth by the American Medical Society, renders a facility constitutionally deficient.[140]

In order to rectify these blatant constitutional deficiencies, there must be federal legislation mandating that correctional facilities set up programs to dispense medications like buprenorphine and methadone to prisoners with OUD. MAT expansion requires institutional support, and most correctional facilities are slow to get behind this treatment modality because of reasons that are entirely unrelated to medical judgment. Most courts would agree that, if a correctional facility disallowed physicians from treating chronic conditions like HIV, hypertension, diabetes, or cancer with the requisite standard of care, this would almost always entitle the prisoner to relief and likely result in injunctions or fines. OUD should be no different.

In 2016, the Rhode Island Department of Corrections launched a statewide program uniformly expanding access to MAT to incarcerated opioid addicts.[141] The statewide program, which is the first of its kind, offers all three MAT medications to inmates with OUD throughout the duration of their incarceration.[142] Within the first twelve months of implementation, the program yielded a 61% reduction in post-incarceration fatalities, along with sharp reductions in recidivism.[143] Whereas the

[139] *Id.* at 103; *Hoptwowit*, 682 F.2d at 1237-38.
[140] *Hoptwowit*, 682 F.2d at 1237.
[141] T. Green et al., "Postincarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System," *JAMA Psychiatry* 2018;75(4):405-407., available at <https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2671411>.
[142] *Ibid.*
[143] *Id.* at 405-06.

nationwide overdose death toll grew by a 12% between 2016 and 2017,[144] Rhode Island's declined by 12% during that period.[145] Despite the demonstrated efficacy of offering MAT to incarcerated opioid addicts, only 30 of the nation's 5,100 jails and prisons have followed suit.[146]

Mandatory MAT programs in correctional facilities would serve several purposes. First and foremost, it would put the decision of whether or not to treat a prisoner with MAT back in the hands of the patients and their doctors, as opposed to prison administrators who have no medical training and are not fit to make treatment decision. This is particularly important considering OUD is a condition in which the provision of treatment is the difference between life and death. Meta-analyses have shown long-term benefits to MAT access in correctional facilities, both to the individual prisoner and public health and safety as a whole.[147] Institutional MAT programs result in significant reductions in post-release overdose fatalities, relapse and recidivism.[148] Facilities that offer MAT have also seen communal reductions in rates of HIV and hepatitis C.[149] Thus,

[144] L. Scholl et al., "*Drug and Opioid-Involved Overdose Deaths — United States, 2013–2017*" CDC Morbidity and Mortality Weekly Report (MMWR), January 4, 2019 / 67(5152);1419–1427, available at <https://www.cdc.gov/mmwr/volumes/67/wr/mm675152e1.htm>.
[145] Green *supra* 140.
[146] T. Williams, "Opioid Users are Filling Jails. Why Don't We Treat Them?" *New York Times*, August 4, 2017, *available at* <https://www.nytimes.com/2017/08/04/us/heroin-addiction-jails-methadone-suboxone-treatment.html>.
[147] E.L.C. Merrall et al., "Meta-Analysis of Drug-Related Overdose Deaths Soon After Release from Prison," Addiction 105 (2010): 1549, *available at* <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2955973/>.
[148] *Ibid.*
[149] K. Dolan et al., "People who Inject Drugs in Prison: HIV Prevalence, Transmission, and Prevention," *International Journal of Drug Police* 26 (2015): 512-515.

mandatory MAT programs in correctional facilities would simultaneously tackle many of the numerous harms associated with untreated OUD.

Another favorable solution would be to decriminalize drug addiction altogether. In *Robinson v. California,* the Supreme Court has held that the status of being an addict is not a crime in it of itself;[150] however, in light of our current drug laws, it is impossible to separate addiction from crime. For example, in most states, simple drug possession is a crime, and drug use necessitates drug possession. Portugal is an excellent example of the harm reduction that results from decriminalization. After decriminalizing possession of all illicit drugs in 2001, Portugal now has the second-lowest overdose rate per 100,000 citizens of any country in the world.[151] Portugal, which once had the highest drug-transmitted HIV infection rate, now has the lowest rates of new HIV transmission from intravenous drug use than any other country in the European Union.[152]

The bottom line is that the United States government has an obligation to provide prisoners access to medical care when it chooses to incarcerate someone. If the government insists on criminalizing addiction, thereby compounding the effects of the opioid crisis, correctional facilities should at the very least carry the burden of treating and contributing to the rehabilitation of incarcerated addicts.

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[150] *Robinson v. California*, 370 U.S. 660 (1962).
[151] N. Bajekal, "Want to Win the War on Drugs? Portugal Might Have the Answer," *TIME*, August 1, 2018, available at <http://time.com/longform/portugal-drug-use-decriminalization/>
[152] T. Newman, "Portugal's Dramatic Declines in Overdose Deaths, HIV Infections & Drug Arrests Draw Those Hit Hardest by U.S. Drug War to Investigate Further," *Drug Policy Alliance,* March 7, 2018, *available at* <http://www.drugpolicy.org/press-release/2018/03/us-delegation-heads-portugal-march-19-22-learn-countrys-groundbreaking-drug>.

CONCLUSION

There are many frustrating aspects of the opioid crisis, among them being that it continues to worsen despite the existence of safe and effective, yet woefully underutilized treatments. Medications like methadone and buprenorphine have been shown to drastically reduce the harms associated with OUD, including overdose fatalities and risk of contracting communicable diseases.[153] Experts are unanimous in that early intervention with MAT is key to saving lives and reducing the opioid-related death toll;[154] and our current system is inimical to this mission; incarceration not only delays this crucial intervention and treatment, it renders addicts more susceptible to overdosing upon release. Thus, when prisons refuse to provide treatment for OUD within their facilities, they exhibit deliberate indifference to a serious medical need. This deprivation of care amounts to cruel and unusual punishment as a matter of law, and entitles the prisoner to relief under 42 U.S.C. § 1983.

[153] *See* Dolan, *supra,* 109.
[154] *See* Troilo, *supra* 19; NIDA, *supra* 23.