MEDICATION-ASSISTED TREATMENT: STATUTORY SCHEMES & CIVIL RIGHTS IMPLICATIONS

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I. INTRODUCTION: PRISONERS' FEAR OF LACK OF TREATMENT

After years of suffering from opioid[1] use disorder, Geoffrey Pesce was able to begin treating his addiction after enrolling a in a Medication-Assisted Treatment ("MAT") program.[2] On July 19, 2018, Pesce drove with a suspended driver's license to the clinic that administered methadone, as required by his recovery program; he was subsequently pulled over for going six miles per hour over the speed limit and arrested.[3] As a result of Massachusetts's policy of minimum sentencing, implemented in April 1996, Pesce knew that he would have to serve a minimum sentence of sixty days.[4] Prior to being sentenced, Pesce filed suit alleging that Middleton House of Correction, where Pesce was detained, would not administer his prescription methadone in accordance with its policy not to provide MAT for inmates suffering from opioid use disorder.[5] Pesce's case is just one of many recently litigated cases concerning prisoners' rights and MAT.

Pesce's history illustrates the drug crisis that has clogged court dockets for decades–an unsurprising consequence of President Richard Nixon's declaration of the "War on Drugs" in 1971.[6] Under the Nixon administration, the Special Action Office for Drug Abuse Prevention ("SAODAP")[7] and the Drug Enforcement Administration[8] were created,

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1 In the context of this Note, opioids refer to "a class of drugs that include the illegal drug heroin, synthetic opioids such as fentanyl, and pain relievers available legally by prescription, such as oxycodone (OxyContin) hydrocodone." (Vicodin), codeine, morphine, and many others. *Opioids*, NAT'L INST. ON DRUG ABUSE, https://www.drugabuse.gov/drug-topics/opioids (last visited Aug. 11, 2020).

2 Complaint at 2, Pesce v. Coppinger, 355 F. Supp. 3d 35 (D. Mass. 2018) (No. 18-11972-DJC).

3 *Id*. at 3.

4 *Learn about the Massachusetts Sentencing Guidelines*, https://www.mass.gov/info-details/learn-about-the-massachusetts-sentencing-guidelines, (Last visited Sept. 24 2019); *see also Advisory Sentencing Guidelines*, MASS. SENTENCING COMM'N at 63 (Nov. 2017).

5 Complaint at 3, *Pesce*, 355 F. Supp. 3d at 35 (No. 18-11972-DJC).

6 *A Brief History of the Drug War*, DRUG POL'Y ALLIANCE, http://www.drugpolicy.org/issues/brief-history-drug-war (last visited Sept. 18, 2019).

7 In a significant step towards standardizing treatment centers, SAODAP "produced treatment guidelines that standardized the service expectations of the federal system for the programs receiving federal support." Karst J. Besteman, *Federal Leadership in Building the Nat'l Drug Treatment System, in 2* TREATING DRUG PROBLEMS: COMMISSIONED PAPERS ON HISTORICAL, INSTITUTIONAL, & ECONOMIC CONTEXTS OF DRUG TREATMENT 74 (Dean R. Gerstein & Henrick J. Harwood eds., 1992)

8 *Brief History of the DEA*, JEMS, (Dec. 31, 2009), https://www.jems.com/2009/12/31/brief-history-dea/; The CSA categorizes drugs into five schedules, which allows legislation to cover multiple drugs by imposing penalties on the use and distribution of each category; *The Controlled Substance Act*, DEA, https://www.dea.gov/controlled-substances-act (last visited Jan. 25, 2020).

and Congress passed the Controlled Substance Act ("CSA").[9] These newly implemented programs created task forces that directly took on drug use in America, which led to an uptick in arrests.

In recent years, prisoners who were denied or anticipated being deprived of their prescription treatment program have brought suit against the counties where they were arrested and the correctional facilities where they anticipated being jailed. Part II of this Note discusses the effect the War on Drugs had on the current prison population and the current treatments available to prisoners who suffer from opioid use disorders. Part III of this Note will explore and compare multiple states' case law and their current statutory schemes. Part IV of this Note will then argue that the denial of MAT to prisoners potentially violates the Eighth Amendment to the U.S. Constitution and the Americans with Disabilities Act ("ADA").

II. THE WAR ON DRUGS AND PRISON CAPACITY

While the War on Drugs was announced under the Nixon administration, subsequent presidents made it their mission to continue the combat. In a joint address given by President Ronald Reagan and First Lady Nancy Reagan on September 15, 1982, the Commander-in-Chief and First Lady told America's youth to "just say no" to drugs.[10] This mission statement fueled the justice system's continued operation to incarcerate individuals found to have violated newly enacted laws concerning drug use.[11]

The War on Drugs' effects are still felt today. While the number of those incarcerated due to drug offenses prior to the declaration in 1980 was 40,900, the number rose to 443,200 in 2017.[12] Moreover, over half of the prison population today is composed of inmates that suffer from substance abuse addictions or opioid use disorders ("OUD").[13]

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[9] The CSA "established five schedules that classify controlled substances according to how dangerous they are, their potential for abuse and addiction, and whether they possess legitimate medical value." It remains the legal framework from which the DEA derived its authority. *The DEA Years*, DEA, available at https://www.dea.gov/sites/default/files/2018-07/1970-1975 p 30-39.pdf (last visited Aug. 11. 2020).

[10] Gerald M. Boyd, *Reagans Advocate 'Crusade' on Drugs*, (Sept. 15, 1986), https://www.nytimes.com/1986/09/15/us/reagans-advocate-crusade-on-drugs.html.

[11] Anti-Drug Abuse Act of 1986, H.R. 5484, 99th Cong. (1986) (creating minimum sentencing for drug-related offenses).

[12] THE SENTENCING PROJECT, TRENDS IN U.S. CORRECTIONS 3 (2020); On July 1, 1980, the United States population was 227.22 million and on July 1, 2017 the population was 325.15 million. Therefore, while the incarceration rate due to drug offenses in 1980 was one in 5,555, in 2017 the rate was one in 717. *US Population by Year*, https://www.multpl.com/united-states-population/table/by-year (last visited Jan. 25, 2020).

[13] *Online only: Report finds most U.S. inmates suffer from substance abuse or addiction*,

In 2010, the National Center on Addiction and Substance Abuse released a report on statistics concerning prison populations and addiction rates among those incarcerated.[14] Unsurprisingly, the report found that drugs and alcohol play a significant role in the crime associated with sentences.[15] Furthermore, the report noted that in 2006, 85 percent of the United States' 2,258,983 prisoners were "substance involved inmates."[16] In a more recent publication, the Department of Justice's Bureau of Justice Statistics reported on the 2012 correctional population. Out of the 6,937,600 individuals in the correctional population, including those on probation and under parole supervision, the most common criminal offense was drug law violations.[17] Within the report, the Department of Justice recommended numerous strategies that it believed would lead to the effective treatment of substance-abusing offenders.[18] One of these approaches recognized that "medications are an important part of treatment for many drug abusing offenders."[19] Medications that can ease the drug recovery process include Food and Drug Administration ("FDA") approved medications for the treatment of opioid dependence, such as buprenorphine, suboxone, and naloxone.[20]

A. Current Opioid Crisis

On October 26, 2017, President Donald Trump declared the opioid crisis as a public health emergency.[21] On September 5, 2019, in a continued race to prevent accidental overdoses, President Trump announced more than $1.8 billion in funding to continue to combat the opioid crisis.[22] The

THE NATION'S HEALTH (Apr. 2010), http://thenationshealth.aphapublications.org/content/40/3/E11.

[14] *Behind Bars II: Substance Abuse & America's Prison Population*, THE NAT'L CENTER ON ADDICTION & SUBSTANCE ABUSE RECOVERY AT COLUM. UNIVERSITY (Feb. 2010), https://www.centeronaddiction.org/addiction-research/reports/behind-bars-ii-substance-abuse-and-america's-prison-population.

[15] *Id.*

[16] *Id.*

[17] NAT'L INST. ON DRUG ABUSE, PRINCIPLES OF DRUG ABUSE TREATMENT FOR CRIMINAL JUSTICE POPULATIONS: A RESEARCH-BASED GUIDE 13 (2012), https://www.drugabuse.gov/sites/default/files/txcriminaljustice_0.pdf.

[18] *Behind Bars II: Substance Abuse & America's Prison Population*, *supra* note 14, at 98.

[19] *Id.* at 99.

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

[21] Julie Hirschfeld Davis, *Trump Declares Opioid Crisis a 'Health Emergency' but Requests no Funds*, N.Y. TIMES (Oct. 26 2017), https://www.nytimes.com/2017/10/26/us/politics/trump-opioid-crisis.html.

[22] *Trump Administration Announces $1.8 Billion in Funding to States to Continue Combating Opioid Crisis*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (Sept. 4, 2019),

initiative follows the recent escalation of drug overdose deaths in the United States. In 2015, there were 52,404 drug overdose deaths of which 63.1 percent involved an opioid.[23] That number rose by over 10,000 in one year, which led to 63,632 drug overdoses in the United States in 2016, of which 66.4 percent involved an opioid.[24] Opioid overdose has become so widespread that the country has implemented state-run naloxone administration programs to reverse the overdose.[25] Naloxone is "an opioid antagonist—meaning that it binds to opioid receptors and can reverse and block the effects of other opioids."[26] New York has dedicated a portion of its state-run website to inform the public of these naloxone administration trainings.[27]

1. Prison Approaches To Treating Those With Opioid Use Disorders

There are differing approaches used to help a prisoner overcome their opioid abuse disorder: the longstanding cold-turkey approach and the newly structured MAT. Individuals who do not have access to drug withdrawal programs and medications in prison are forced to quit cold-turkey, an approach that demands an abrupt discontinuation of the opioid, whereby a prisoner is not given access to a safe environment to undergo their withdrawal. This approach can be harmful to the individual and may result in side effects such as seizures, rapid heart rate, hallucinations, and tremors.[28] The abrupt withdrawal "without tapering off methadone over a period of weeks, is considered inhumane and has resulted in numerous deaths inside prisons and jails."[29]

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https://www.hhs.gov/about/news/2019/09/04/trump-administration-announces-1-8-billion-funding-states-combating-opioid.html.

[23] Puja Seth, et al. *Overdose Deaths Involving Opioids, Cocaine, & Psychostimulants – United States, 2015-2016*, CENTER FOR DISEASE CONTROL AND PREVENTION (Mar. 30, 2018), https://www.cdc.gov/mmwr/volumes/67/wr/mm6712a1.htm.

[24] *Id.*

[25] Eliza Wheeler, et. al, *Opioid Overdose Prevention Programs Providing Naloxone to Laypersons — United States, 2014*, CENTER FOR DISEASE CONTROL AND PREVENTION (June 19, 2015) https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6423a2.htm.

[26] *Opioid Overdose Reversal with Naloxone (Narcan, Evzio)*, NAT'L INSTITUTE ON DRUG ABUSE (Apr. 2018), https://www.drugabuse.gov/related-topics/opioid-overdose-reversal-naloxone-narcan-evzio.

[27] *Community Calendar of Opioid Overdose Trainings*, NY STATE DEPT. OF HEALTH https://www.health.ny.gov/diseases/aids/general/opioid_overdose_prevention/training_calendar.htm - nyc (last visited Sept. 24, 2019).

[28] *Dangers of Cold Turkey Detox*, FOUNDATION RECOVERY NETWORK https://www.dualdiagnosis.org/guide-drug-detox/cold-turkey/ (last Visited Sept. 24, 2019).

[29] Christine Vestal, *Opioid treatment at Rikers Island is a long-standing success, but few jails adopt it*, PBS (May 23, 2016 2:50 PM), https://www.pbs.org/newshour/nation/opioid-treatment-at-rikers-island-is-a-long-standing-success-but-few-jails-adopt-it.

MAT, on the other hand, focuses on a gradual withdrawal from the opioid, and combines counseling and behavioral therapies with the use of FDA-approved medications to treat OUD.[30] Currently, while there are three FDA-approved medications used to treat OUD (methadone, buprenorphine, and vivitrol), few correctional facilities take full advantage of the medications available.[31] Methadone and buprenorphine reduce or eliminate withdrawal symptoms, while vivitrol, an injectable form of naltrexone, prevents the euphoric effect of opioids.[32] The FDA first approved buprenorphine in October 2002 for the "treatment of opioid dependence in patients."[33] Buprenorphine is similar to an opioid in its ability to produce effects "such as euphoria and respiratory depression."[34] In November 2017, the FDA approved Sublocade, a monthly injectable buprenorphine.[35] This option increases the possibility that those with an OUD will adhere to their treatment plans and reduces the burden that taking a daily pill requires. There are three medications available to treat OUD, and yet, as of April 2018, "methadone, the oldest and most researched addiction medication, is available in only 22 of the nation's 3,300 local jails and even fewer of its prisons."[36]

III. STATUTORY SCHEME & COMPARISON OF STATE LAWS

States can be divided into three categories in relation to MAT treatment: (1) states that do not provide any MAT medications or treatment

[30] *Information about Medication-Assisted Treatment (MAT)*, *supra* note 20.

[31] *Id*.; *see also* Christine Vestal, *New Momentum for Addiction Treatment Behind Bars*, PEW, (Apr. 4, 2018), https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/04/04/new-momentum-for-addiction-treatment-behind-bars.

[32] *Principles of Drug Addiction Treatment: A Research Based Guide*, NAT'L INSTITUTE ON DRUG ABUSE, https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/pharmacotherapies (last updated Jan. 2018).

[33] Letter from Cynthia G. McCormick, Director, Center for Drug Evaluation and Research, to Alan N. Young, Director, Department of Health and Human Services (Oct. 8, 2002), available at https://www.accessdata.fda.gov/drugsatfda_docs/appletter/2002/20732,20733ltr.pdf.

[34] *Buprenorphine*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine (last visited Sept. 24, 2019).

[35] *FDA Approves First Once-Monthly Buprenorphine Injection, a Medication-Assisted Treatment Option for Opioid Use Disorder*, FDA, (NOV. 30, 2017), https://www.fda.gov/news-events/press-announcements/fda-approves-first-once-monthly-buprenorphine-injection-medication-assisted-treatment-option-opioid.

[36] Vestal, *supra* note 31; As of January 29, 2019, out "of the thousands of jails around the country, only about 30 provide methadone and buprenorphine to people incarcerated there." Beth Schwartzapfel, *When Going to Jail Means Giving up Meds that Saved your Life*, MARSHALL PROJECT, (Jan. 29, 2019), https://www.themarshallproject.org/2019/01/29/when-going-to-jail-means-giving-up-the-meds-that-saved-your-life - :~:text=Yet of the thousands of,prisons and jails with drug.

facilities;[37] (2) states that provide prisoners access to some MAT medications;[38] and (3) states that allow prisoners access to all MAT medications. Those that do not offer any medication are likely violating both the ADA and the Eighth Amendment,[39] while prisons that offer some MAT medications or other treatment options can argue that their treatment does not violate the ADA. The standard for an ADA violation is disparate treatment and prisons that do not offer MAT treatment can argue that there is no disparate treatment between prisoners who suffer from OUD and those who do not. Moreover, these prisons can argue that there was no deliberate indifference or request for a specific treatment, which are required elements to bring an Eighth Amendment claim.

While many states are shifting towards a MAT-centered approach to treat OUDs, Georgia stands out in its restriction of treatment centers.[40] In July 2016, Congress, with a vote of 92-2, passed a bill[41] aimed at strengthening the fight against the nation's opioid crisis.[42] Despite this, Georgia created a moratorium on new treatment facilities in its state.[43] This cap is in spite of the fact that more than 1,200 people died of an overdose in Georgia in 2014, just two years prior to the bill's passage.[44] The restraint limits Georgia's opioid treatment programs to just sixty-seven, a limitation that profoundly affects its neighboring states.[45] Since Georgia has more treatment facilities than any other southeastern state,[46] despite the current moratorium, many nearby residents rely on Georgia to access proper

[37] This includes Alabama, Georgia, Oklahoma, North Dakota, South Dakota, Nebraska, Idaho. *Id.*

[38] New York and Pennsylvania provide both Methadone and Vivitrol, Washington provides Methadone and Buprenorphine, and Massachusetts, Kentucky, Maine, and West Virginia provide Vivitrol. *Id.*

[39] *Supra* Part IV.

[40] Strasser Sheryl, *Despite National Efforts to Fight Addiction, States can Tailor – and Trim – Programs*, THE CONVERSATION (July 20, 2016, 6:09 AM), http://theconversation.com/despite-national-efforts-to-fight-addiction-states-can-tailor-and-trim-programs-61179.

[41] The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT), H.R. 6, 115th Cong. (2018). ." Emmarie Huetteman, *Senate Approves Bill to Combat Opioid Addiction Crisis*, N.Y. TIMES (July 13, 2016), https://www.nytimes.com/2016/07/14/us/politics/senate-opioid-addiction-bill.html?_r=0.

[42] *Id.* The bill "would strengthen prevention, treatment and recovery efforts, largely by empowering medical professionals and law enforcement officials with more tools to help drug addicts. It would also expand access to a drug that emergency medical workers could use to help reverse overdoses and improve treatment for the incarcerated." Huetteman, *Id.*

[43] *Despite Overdose Epidemic, Georgia Caps The Number Of Opioid Treatment Clinics*, NPR (June 15, 2016 4:33 AM), https://www.npr.org/sections/health-shots/2016/06/15/481523994/despite-overdose-epidemic-georgia-caps-the-number-of-opioid-treatment-clinics.

[44] *Id.*

[45] *Id.*

[46] "Tennessee has only 12, in contrast; Alabama has 24, and Mississippi has one." *Id.*

treatment.[47] Georgia's decision to not open new treatment facilities is two-fold: first, the moratorium bill stands to prevent medical directors from prescribing or giving out methadone in order to make a profit and, second, to stop the free-rider problem of people from neighboring states traveling to Georgia for treatment, thus limiting the treatment availability for Georgia's own citizens.[48] This moratorium limits the availability of treatment post-incarceration because those recovering from OUDs have fewer facilities to get treatment from. Even if prisoners are allowed to begin a MAT program while detained, the treatment will end after they are released because there are now limited facilities to seek MAT medications. Fortunately, relying on the FDA's determination that MAT is "more effective than either behavioral interventions or medication alone,"[49] many states are moving towards increasing the availability of MAT programs in their prisons.[50]

In 2018, New York was one of five states that offered both methadone and buprenorphine to its prison population.[51] While the New York Department of Corrections and Community Supervision created Comprehensive Alcohol and Substance Abuse Treatment Program in 1989, which directly supervises alcohol and substance abuse treatment of prisoners,[52] there is no comprehensive across-the-board MAT program

[47] *Id.*

[48] Tyler Jett, *Georgia bill to further regulate opioid clinics*, CHATTANOOGA TIMES FREE PRESS (Feb. 4, 2017), https://www.timesfreepress.com/news/local/story/2017/feb/04/georgibill-reins-opioid-clinics/411181/.

[49] *Medication-Assisted Treatment Improves Outcomes for Patients with Opioid Use Disorder*, PEW (Nov. 22, 2016), https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2016/11/medication-assisted-treatment-improves-outcomes-for-patients-with-opioid-use-disorder#:~:text=Medication%2Dassisted%20treatment%20(MAT),behavioral%20interventions%20or%20medication%20alone.

[50] The proposed legislation includes a grant program, a proposition that more medication and properly trained staff be available, and connecting newly released prisoners to MAT treatment to prevent overdose. Kaitiri Zuluaga, *New Legislation Introduced to Increase MAT Access in Correction Facilities*, NAT'L COUNCIL FOR BEHAVIORAL HEALTH (July 25, 2019), https://www.thenationalcouncil.org/capitol-connector/2019/07/new-legislation-introduced-to-increase-mat-access-in-correctional-facilities/.

[51] Vestal, *supra* note 31.

[52] Sarah K. Peterson, *The Comprehensive & Substance Abuse Treatment Program* 2016, THE HARRIMAN STATE CAMPUS, https://doccs.ny.gov/system/files/documents/2019/09/2017-CASAT-Report.pdf (last visited Oct. 7, 2019) (explaining that "the New York State Department of Corrections and Community Supervision (DOCCS) Comprehensive Alcohol and Substance Abuse Treatment (CASAT) program was created by the 1989 Prison Omnibus Legislation."). The program includes three phases, which provide care to patients who suffer from an alcohol or substance addiction both during the time they are incarcerated and after their release. *Substance Abuse Treatment Services*, DEP'T OF CORRECTIONS AND COMMUNITY SUPERVISION, http://www.doccs.ny.gov/ProgramServices/substanceabuse.html - asat (last visited Sept. 25, 2019).

instituted in New York state prisons.[53] Rikers Island Correctional Facility ("Rikers") stands apart from other state-run prisons as it has "run a model opioid treatment program since 1987."[54] The MAT program implemented at Rikers gives prisoners with OUD the opportunity to recover from their addictions by providing methadone and a staff that is solely dedicated to addiction treatment.[55] The chief medical officer for NYC Health + Hospitals/Correctional Health, Ross MacDonald, cites methadone as being the standard of care to treat OUDs outside of a correctional facility, and sees no reason why the standard would be lower in a jail setting.[56] While correctional system insiders know of the pervading opioid abuse occurring in prisons,[57] funding to implement MAT programs has predominantly been reserved for the general population.[58]

In 2018, West Virginia deviated from its former protocol of only administering vivitrol for re-entry following a prison sentence[59] and announced an addiction recovery pilot program that would serve sixty-four

[53] *Addressing Addiction & Preventing Overdose in NY: Providing Medication-Assisted Treatment (MAT) in Jails & Prisons*, KATAL CENTER FOR HEALTH, EQUITY, & JUSTICE, (March 05, 2019 1:21 P.M.), https://d3n8a8pro7vhmx.cloudfront.net/katal/pages/2043/attachments/original/1551809986/MAT_in_Jails_and_Prisons_-_NYS_Factsheet__2.28.2019.pdf?1551809986.

[54] Vestal, *supra* note 29.

[55] *Id.*

[56] *Id.*

[57] ("Some guards find themselves part of their respective prison's black market. Whether intimidated by inmates, swayed by sympathy, or because they've simply "gone bad" (due to the stress), correctional officers are becoming an unlikely method for drugs and illegal materials to get into prison.") *Correction Officers*, AMERICA ADDICTION CENTERS (Oct. 11, 2019), https://americanaddictioncenters.org/rehab-guide/corrections-officers..

[58] *Governor Cuomo Announces $5.25 Million In Funding To Facilitate & Expand Access To Medication Assisted Treatment In Primary Care Clinics And Hospital Emergency Departments*, NY STATE (May 16, 2019),

https://www.governor.ny.gov/news/governor-cuomo-announces-525-million-funding-facilitate-and-expand-access-medication-assisted (explaining that on May 16, 2019 New York governor Andrew Cuomo announced $5.25 million in funding to facilitate OUD through the MAT program, yet none of the money was allocated for state or locally run prisons).

[59] Vestal, *supra* note 31; Vivitrol is a "non-narcotic that blocks the euphoric effects of opioid/alcohol and reduces cravings." Prisoners who are offered vivitrol for re-entry are injected with the medication prior to release and have the option of obtaining the medication from a treating physician after release. Andrew Klein, *Residential Substance Abuse Treatment*, ADVOCATES FOR HUMAN POTENTIAL http://www.rsat-tta.com/Files/MAT-Reentry-Programming-Policy—-Providence-Ballro (last visited Sept. 25 2019). However, the cost of vivitrol can be too costly for those who were given a re-entry injection to opt for another administration every four weeks; without insurance, vivitrol can cost more than $1,000 a month. Kenneth Craig, *Monthly Vivitrol Treatment Helps Fight Heroin Addiction*, CBS (Jan. 19, 2016 12:33 PM), https://www.cbsnews.com/news/vivitrol-vaccine-helps-fight-heroin-addiction/.

inmates across three counties.[60] The motivation behind the newly implemented program was two-fold. First, "the number of drug offenders admitted into West Virginia Department of Correction's custody each year has more than tripled in the past seventeen years."[61] This increase in prisoners who were arrested on drug related charges created an increased need for programs to detoxify the inmates and to give them tools, which MAT provides, to prevent reincarceration. Second, the program was motivated in part by the 830 West Virginian residents who died from an opioid overdose in 2016, 158 of which had been in the criminal justice system within the last year of their lives.[62] The program is an improvement from the limited assistance that was previously provided to prisoners who suffer from OUDs; prior to the implementation of the pilot program, prisoners with a MAT prescription were forced to undergo withdrawal.[63]

Kentucky joins the group of states that are hesitant to allow the availability of all FDA-approved MAT medications in its prisons.[64] In October 2018, Steve Durham, an assistant director in a Louisville jail, stated that many of the Kentucky jails are reluctant to allow buprenorphine and methadone because "they have the potential for abuse."[65] However, Kentucky has also reconsidered its treatment plan for prisoners with OUD. In April 2018, Kentucky only offered vivitrol for those re-entering society post incarceration.[66] One year later, Kentucky founded the pilot program Supporting Others in Active Recovery (SOAR).[67] SOAR is an 88-bed, six-

[60] Taylor Stuck, *Addiction Treatment Program coming to Western Regional Jail*, HERALD DISPATCH (Jul. 26 2018), https://www.herald-dispatch.com/news/addiction-treatment-program-coming-to-western-regional-jail/article_010397a5-48c7-5878-839f-38057d4f9a01.html.

[61] "growing from about 200 inmates per year in 1998 to more than 800 in 2015." Maria M. Orsini & Douglas H. Spence, *Drug Offenders Incarcerated in West Virginia: Characteristics & Population Trends, 1998-2015*, OFFICE OF RESEARCH & STRATEGIC PLANNING (Jan. 2017), http://www.jrsa.org/member-spotlight/files/wv-drug-offenders-incarcerated-in-wv-1998-2015.pdf.

[62] Stuck, *supra* note 60.

[63] Vestal, *supra* note 31.

[64] Melanie Saltzman & Megan Thompson, *In Kentucky, jail is becoming an addict's last-resort rehab*, PBS (Oct. 8, 2017 5:59 PM), https://www.pbs.org/newshour/show/kentucky-jail-becoming-addicts-last-resort-rehab (explaining that "they have the potential to be used as contraband, they have the potential to become barter inside a detention facility.").

[65] *Id.*

[66] Vestal, *supra* note 31.

[67] Melissa Patrick, *Kentucky opens first sober-living unit in a medium-security prison anywhere, with plans to open others across the state*, KY. HEALTH NEWS, http://ci.uky.edu/kentuckyhealthnews/2019/07/11/kentucky-opens-first-sober-living-unit-in-a-medium-security-prison-anywhere-with-plans-to-open-others-across-the-state/ (July 11, 2019); SOAR "focuses on relapse prevention, education, and reentry skills based on the Therapeutic Community Model, a group-based, residential approach to treating substance abuse" *Department of Corrections Launces Aftercare Program for Inmates Recovering from Substance Use Disorder*, KY FORWARD, (Jul. 13,

month program, with the option to continue after six months, located within Northport Training Center, a medium security prison.[68] The program was made possible by a grant from the Kentucky Office of Drug Control Policy and focuses on giving patients individual plans to aid them in their treatment program.[69]

A. Massachusetts after Pesce v. Coppinger

In response to lawsuits regarding MAT availability, Massachusetts has altered its approach to MAT in prisons. In September 2018, three months before Mr. Pesce's sentencing, Mr. Pesce's attorney filed suit in the United States District Court of Massachusetts, seeking a preliminary injunction and temporary restraining order.[70] Pesce's attorney relied on the ADA and Eighth Amendment to argue that the defendants, the Sheriff of Essex County and the Superintendent of the Essex County House of Corrections,[71] should give Mr. Pesce access to his prescription treatment plan while he is detained at the Essex County House of Corrections.[72] The court granted Mr. Pesce's preliminary injunction.[73]

Following Mr. Pesce's case, Massachusetts passed a law that "requires the Department of Correction to offer buprenorphine and methadone at . . . MCI Framingham . . . South Middlesex Correctional Center; at MCI Cedar Junction . . . and at the Massachusetts Alcohol and Substance Abuse Center".[74] The new program, includes "medical and behavioral healthcare in jails, prisons, and inpatient and residential treatment facilities,"[75] was allocated $2.2 million for its first year and provides prisoners with buprenorphine.[76] This was a steep change from Massachusetts's 2018

2019), https://www.kyforward.com/department-of-corrections-launches-aftercare-program-for-inmates-recovering-from-substance-use-disorder/.

[68] Patrick, *supra* note 67.

[69] KY. DEP'T OF CORRECTIONS, *Kentucky Dep't of Corrections Launches New Aftercare Program for Inmates in Recovery*, https://corrections.ky.gov/About/Documents/Newsroom/2019/07-09-19 Aftercare Program.pdf (July 9, 2019).

[70] Pesce v. Coppinger, 355 F. Supp. 3d 35, 42 (D. Mass. 2018).

[71] *Id.* at 39.

[72] *Id.* at 39.

[73] *Id.* at 49; Rivera v. Fed. Bureau of Prisons, No. 17cv05103 (GBD) (DF), 2018 U.S. Dist. LEXIS 212231, at *23 n.7 (S.D.N.Y. Dec. 14, 2018) (distinguishing *Pesce* where the basis for the plaintiff's constitutional claim was the complete prohibition against the use of any methadone treatment).

[74] Felice J.Freyer, *Mass. Prisons Start Offering Medication to Treat Addiction*, Bos. GLOBE, (Apr. 2, 2019 6:29 PM), https://www.bostonglobe.com/metro/2019/04/02/mass-prisons-start-offering-medication-treat-addiction/o0Fslv3clpO9Ne0PUiO77N/story.html.

[75] *Medical & Behavioral Healthcare in Jails, Prisons,& Inpatient & Residential Treatment Facilities*, WELLPATH https://wellpathcare.com/services/ (last visited Oct. 7, 2019).

[76] Freyer, *supra* note 74.

policy to provide only vivitrol to prisoners with OUD.[77] Mr. Pesce's case is seminal in the line of cases brought by prisoners who suffer from OUD and can stand as precedent in future cases brought by those in comparable situations.[78]

Like Mr. Pesce, Brenda Smith brought suit in Maine, seeking access to her prescribed MAT program. In late 2017, Ms. Smith was sentenced to forty days in Aroostook County Jail.[79] Based on a previous seven-day sentence, three years earlier in the same prison, Ms. Smith knew that she would be denied her prescription buprenorphine, medication that she had been taking since 2014 as a result of her diagnosis of opioid use disorder in 2009.[80] Aroostook County Jail did any medication to treat OUD, "the only treatment that the Jail offers for opioid use disorder is substance abuse counseling."[81] One day prior to Ms. Smith's surrender date, her attorney, like Mr. Pesce's attorney, filed a motion for a temporary restraining order or a preliminary injunction.[82] In March 2019, the United State District Court for the District of Maine granted Ms. Smith's motion for a preliminary injunction, and ordered the Aroostook County Jail to provide Ms. Smith her prescription buprenorphine during her sentence at the County Jail.[83] Ms. Smith's case "is the first federal appeals court in the country to address the right to treatment for opioid addiction in jail."[84] Ms. Smith's case marked a turning point for how those with OUD will serve their time in prison. It stands as precedent in the state of Maine and as persuasive authority throughout the United States.

Pennsylvania has not been immune from the opioid crisis that has taken the lives of hundreds of thousands of people in the United States in the past twenty years.[85] Following a lawsuit filed by the family of Frederick Adami, who died in Bucks County Prison as a result of complications from opiate withdrawal, the Pennsylvania Department of

[77] Vestal, *supra* note 31.

[78] In a Marshall Project article, Beth Schwartzapfel argues that Pesce's case has put "sheriffs and correctional administrators around the country on notice [that many of them] are violating federal law." Schwartzapfel, *supra* note 36.

[79] Smith v. Aroostook Cty., 376 F. Supp. 3d 146, 153 (D. Me. 2019).

[80] *Id.* at 149–50.

[81] *Id.* at 152.

[82] *Id.* at 154. Smith's motion for a temporary restraining order was subsequently withdrawn. *Id*.

[83] *Id.* at 162.

[84] Smith v. Aroostook Cty. was affirmed on appeal from the district court; Willis Ryder Arnold, *Appeals Court Rules Aroostook County Jail Must Give Inmate Opioid Treatment Drug*, ME. PUBLIC (May 1, 2019 12:05 PM), https://www.mainepublic.org/post/appeals-court-rules-aroostook-county-jail-must-give-inmate-opioid-treatment-drug.

[85] *Overdose Death Rates*, NAT'L INSTITUTE ON DRUG ABUSE https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates (last updated Jan. 2019).

Corrections implemented a new scheme of treatment in its prison system that follows MAT protocols.[86] On April 1, 2019, the Pennsylvania DOC created a pilot program, which provides prisoners with OUD with monthly buprenorphine injections.[87]

Like many of its sister states, Washington faced a lawsuit regarding its approach of treating prisoners with OUDs.[88] In *Kortlever v. Whatcom County*, the American Civil Liberties Union (ACLU) sued Whatcom County Jail, a medium-sized local jail located in northern Washington, alleging an ADA violation based on the prison's refusal to offer all FDA-approved medications to prisoners with OUDs.[89] Whatcom County settled the claim, and, as part of the settlement, agreed to provide opiate-withdrawal medication as treatment for prisoners who suffer from OUD.[90] Moreover, the jail agreed to allow inmates with existing MAT prescriptions to continue their current treatment plan[91] and implemented a MAT program to give prisoners the option to begin a MAT treatment plan during their incarceration.[92] Interestingly enough, this new protocol is reminiscent of Washington's former drug rehabilitation practices in prison that was in place prior to the suit.[93]

Although Washington's Uniform Controlled Substance Act repealed much of Section 69 of the Washington Revised Code, decisions like *Kortlever* have increased the likelihood of prisoners gaining access to their prescribed MAT programs. While it is promising that states have started to implement MAT programs in their prisons, it is distressing that the only way to initiate these programs in states that do not currently offer them is through an actual or threat of a lawsuit.

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[86] Jo Ciavaglia, *Family Files Lawsuit in 2018 Death of Bucks County Inmate*, BUCKS COUNTY COURIER TIMES https://www.buckscountycouriertimes.com/news/20190521/family-files-lawsuit-in-2018-death-of-bucks-county-inmate (May 21, 2019 6:00 AM); *Medication Assisted Treatment*, COR https://www.cor.pa.gov/About Us/Initiatives/Pages/Medication-Assisted-Treatment.aspx (last visited Sept. 26, 2019).

[87] *Medication Assisted Treatment*, *supra* note 86.

[88] *Washington State Jail to give Addiction Meds after Lawsuit*, ASSOCIATED PRESS (Apr. 30, 2019 5:14 P.M.), https://q13fox.com/2019/04/30/washington-state-jail-to-give-addiction-meds-after-lawsuit/.

[89] Kortlever v. Whatcom Cty., No. 2:18-cv-00823, at *2 (W.D. Wash. filed July 25, 2019) (settlement agreement).

[90] *Id.* at *5.

[91] *Id.*

[92] *Supra*, note 88.

[93] *See* Michael H. Slutsky, *The Rights of Prisoners to Medical Care & the Implications for Drug-Dependent Prisoners & Pretrial Detainees*, UNIV. OF CHI. L. R., 705, 710 (1975); "[A]ny person who shall be confined or imprisoned in any state, county, or city prison in the state and who may be reasonably suspected by the health officer of being a narcotic addict shall be examined for and if found to be an habitual user of said drugs or any of them, shall be treated therefor at public expense." WASH. REV. CODE § 69.32.090 (1962).

Rhode Island was the first state to expand its MAT program to offer all three FDA-approved drugs to its state prisoners with OUDs,[94] and is currently the only state that allows all three FDA-approved medications for opioid withdrawal to be administered in its prisons.[95] After MAT was implemented in July 2016, the Rhode Island Department of Corrections experienced a reduction of 60.5 percent in post-incarceration overdose related deaths in two years.[96] Dr. Jennifer Clarke, the medical programs director for the corrections department in Rhode Island, shares the same view as Ross MacDonald, the medical director of the New York City's correctional health program, regarding the implementation of MAT in prisons: MAT Programs are the standard of care outside of correctional facilities, and it should be the standard of care within them as well.[97]

In sum, while some states, such as Georgia, are reluctant to institute MAT programs in prisons and have taken steps to create a barrier between those with an OUD and treatment, many states are reassessing their approaches to treating prisoners with OUDs.[98] West Virginia,[99] Kentucky,[100] and Washington[101] have all recently instituted recovery pilot programs for prisoners, and New York,[102] Massachusetts,[103] and Pennsylvania[104] require its prisons to offer buprenorphine to treat prisoners. Rhode Island, however, stands alone in its decision to allow prisoners to be treated with all three FDA-approved medications.[105] Overall, "only about 30 [jails around the country] provide methadone and buprenorphine."[106] Nevertheless, the recent strides made by many of these states generate hope that they will soon adopt the same protocol as Rhode Island.

IV. CIVIL RIGHTS ANALYSIS: WITHHOLDING MAT

[94] Andrew Joseph, *One State takes a Novel Approach to Addiction: Access to Treatment for all Inmates*, STAT https://www.statnews.com/2017/08/03/opioid-treatment-prisons/ (Aug. 3, 2017).

[95] Vestal, *supra* note 31.

[96] Traci C. Green, *Postincarceration Fatal Overdoses after Implementing Medications for Addiction Treatment in a Statewide Correctional System*, JAMA PSYCHIATRY, (Feb. 14, 2018), https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2671411.

[97] Joseph, *supra* note 94.

[98] *Supra*, note 31.

[99] Stuck, *supra* note 60.

[100] Patrick, *supra* note 67.

[101] *Kortlever* v. Whatcom County No. 2:18-cv-00823, at 6 (W.D. Wash. Filed July 25, 2019) (settlement agreement).

[102] Vestal, *supra* note 31.

[103] Freyer, *supra* note 74.

[104] Vestal, *supra* note 31.

[105] Joseph, *supra* note 94.

[106] Schwartzapfel, *supra* note 78.

VIOLATES THE ADA & EIGHTH AMENDMENT

A. The ADA

1. "Today, Congress opens the doors to all Americans with disabilities."[107]

On July 26, 1990, President George H.W. Bush signed the ADA, which, among other guarantees, protects American citizens recovering from drug addiction from discrimination in both the public and private sector.[108] The ADA's legislative purpose is widely known: to eliminate "discrimination against individuals with disabilities" and to ensure that the "federal government plays a central role in enforcing the standards established in the Act."[109] Prior to the enactment of the ADA, the Supreme Court of the United States was the decision maker in cases concerning the treatment programs for those with OUD. In 1925, the Court in *Linder v. United States* relied on the concept that a doctor does not frustrate his *bona fide* duty by prescribing a person with OUD narcotics for self-administration in order to combat his addiction.[110] In part, the Court determined that "the suffering of an addict caused by deprivation of his customary drug is as intense as any suffering caused by disease."[111]

In 1998, the Supreme Court in *Pennsylvania Department of Corrections v. Yeskey* held that prisoners may bring ADA claims against state prisons[112] because they fall under the definition of "public entity" subject to the ADA.[113] Moreover, because prisons are public entities, they are subject to liability incurred by their employees.[114] Thus, an argument in favor of prisoners under the ADA is that when a corrections officer or prison administrator fails to provide MAT, the prison itself is liable.

Under the ADA, disability is defined as a "physical or mental impairment that substantially limits one or more of the major life activities

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[107] Steven A. Holmes, *Rights Bill for Disabled is Sent to Bush*, N.Y. TIMES (July 14, 1990), https://www.nytimes.com/1990/07/14/us/rights-bill-for-disabled-is-sent-to-bush.html. (quoting a speech given by then Iowa Democratic Senator Tom Harkin in response to the Senate completing Congressional Action on what will become the ADA).

[108] 28 C.F.R. § 35.108 (2016); *The Americans with Disabilities Act & "Current" Illegal Drug Use*, THOMSON REUTERS, https://corporate.findlaw.com/litigation-disputes/the-americans-with-disabilities-act-and-current-illegal-drug.html (last visited Oct. 13 2019).

[109] 42 U.S.C. § 12101 (2008).

[110] Linder v. United States, 268 U.S. 5, 22 (1925).

[111] *Id.* at 5.

[112] Pa. Dep't of Corr. v. Yeskey, 524 U.S. 206, 208 (1998).

[113] 42 U.S.C.S. § 12131 (1990).

[114] Duvall v. Cty. of Kitsap, 260 F.3d 1124, 1141 (9th Cir. 2001) (holding that "when a plaintiff brings a direct suit under…Title II of the ADA against a municipality, the public entity is liable for the vicarious acts of its employees").

of such individual."[115] In order to succeed on an ADA claim, the standard is that a prisoner must have an impairment "that substantially limits one or more major life activities; a record of such an impairment; or being regarded as having such an impairment."[116] Opioid addiction falls under the definition of "impairment" as laid out in the ADA.[117] Thus, there are three elements an individual who suffers from an OUD must satisfy to meet the status of "disabled":[118] the individual can no longer be engaged in illegal drug use, the individual must have "successfully completed a supervised drug rehabilitation program, and the individual must have otherwise been rehabilitated successfully, or be actively participating in a supervised rehabilitation program."[119]

2. Proving an ADA Violation

In order to make out a prima facie case for an ADA violation, the plaintiff, a person with an OUD, needs to plead one of the three following prongs and provide sufficient facts to satisfy the elements: (1) An individual with OUD has an "impairment"[120] (2) OUD limits many of their major life activities; or (3) they have "problems fulfilling obligations at work, school or home,"[121] which fall under the definition of "major life activities" under the ADA.[122]

A "record of impairment" under the ADA[123] includes previous documentation that a prisoner with OUD has been successfully participating in a MAT program. Prisoners prescribed MAT have such documentation, as the treatment program is prescribed by a doctor and includes prescription narcotics. Moreover, a prisoner with OUD can be regarded as having such an impairment if "the individual is subjected to prohibited discrimination

[115] 28 CFR § 35.108(a)(1)(i).

[116] 42 U.S.C.S. § 12102 (2008).

[117] START, Inc. v. Balt. Cty., 295 F. Supp. 2d 569, 576 (D. Md. 2003) ("there is no question that opiate addiction may qualify as an "impairment" provided the addict is not currently using drugs").

[118] 42 U.S.C. § 12114(a)(1) (1990).

[119] *Id.*

[120] *START, Inc.*, 295 F. Supp. 2d at 576. A federal court in the district of Hawaii held that, at a minimum, a plaintiff may state that he is a "known drug addict," and that alone is enough to qualify one as possessing a disability under the ADA. Kula v. Malani, 539 F. Supp. 2d 1263, 1268 (D. Haw. 2008). In order to satisfy these elements, the plaintiff must also show that he or she is participating in a drug rehabilitation program. *Id.*

[121] *Opioid Use Disorder*, AMERICAN PSYCHIATRIC ASSOC., (Nov. 2018) https://www.psychiatry.org/patients-families/addiction/opioid-use-disorder/opioid-use-disorder.

[122] The ADA includes "caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working" as major life activities. 42 U.S.C.S. § 12102(2)(A).

[123] 42 U.S.C. § 12102(1)(B).

because of an actual or perceived physical or mental impairment, whether or not the impairment substantially limits or is perceived to substantially limit a major life activity."[124] A prisoner with OUD can also satisfy this last prong. In order to succeed under an ADA claim, an individual could argue that the "denial could constitute discrimination under any of the three bases: (1) disparate treatment, (2) disparate impact, (3) or failure to provide a reasonable accommodation."[125]

An individual with OUD can prove disparate impact by showing that they are being treated differently because of their disability. For example, the individual can argue that they are being forced to stop their MAT treatment in order to fulfill their requirement of serving their sentence, in comparison to a person who does not have to halt their own medical treatment, if they have one, in order to do the same. Prisoners can also argue that a policy against allowing the continuation of MAT constitutes disparate impact or failure to provide a reasonable accommodation. If the prison has a policy of forbidding prescribed narcotics, the individual with OUD can dispute this by saying that failing to modify the policy would violate the ADA, as the prison is not providing "reasonable accommodations."

3. The Prisoner's Dilemma

A problem arises when an individual either is incarcerated and wishes to begin a MAT program or anticipates incarceration and has not yet completed a rehabilitation program. As to the former, the individual has neither completed a program nor is actively participating in a program, two actions that would accord him protection under the ADA. All of the cases heard thus far have fallen under the latter category: an individual who is in a rehabilitation program, but will soon be incarcerated and, therefore, denied the opportunity to continue his treatment.

While the consensus is that prisoners with OUD have a right to treatment in the correctional system, the ADA does not protect those individuals who are currently using drugs illegally.[126] This limitation means that those currently abusing drugs while incarcerated may be denied the opportunity to participate in whatever, if any, drug treatment program available in the prison where they are serving their sentence. Although "the ADA does say someone currently using drugs illegally is not considered an

[124] 42 U.S.C. § 12102(3)(A).

[125] *Legality of Denying Access to Medication Assisted Treatment in the Criminal Justice System*, LEGAL ACTION CENTER, (Dec. 1, 2011), https://lac.org/wp-content/uploads/2014/12/MAT_Report_FINAL_12-1-2011.pdf.

[126] 28 C.F.R. § 35.108(b)(2).

'individual with a disability'—that term generally applies to a person in recovery—the law also says that even current users cannot be denied health care."[127] Thus, these individuals can argue that MAT falls under the definition of health care.

On the other hand, prison facilities can argue that providing MAT falls under the significant risk exception.[128] The test requires the in-depth consideration of four factors: the nature, duration, severity of the risk, and the probability that the potential injury will occur.[129] The risk in providing MAT medications to prisoners with OUD is that individuals without a MAT prescription will take medications via a prison black market sans prescription.[130]

For many individuals currently incarcerated in a United States correctional facility, proving that they are "known drug addicts" is enough to warrant participation in the facility's drug treatment program. The problem lies in the absence of effective treatment that meets the standard of care afforded to the general population. While MAT programs are widely attainable, few correctional facilities take full advantage of the medications available.

B. The Eighth Amendment

In 1976, the standard for medical care in prison was established. The Supreme Court held that the "deliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain,' proscribed by the Eighth Amendment."[131] A violation of the Eighth Amendment includes "intentionally interfering with the treatment once prescribed."[132] There are two elements that a plaintiff must satisfy to substantiate an Eighth Amendment violation claim.[133] The plaintiff must show a "serious medical need" and that prison doctors' or guards' actions

[127] Beth Schwartzapfel, *How the Americans with Disabilities Act Could Change the Way the Nation's Jails & Prisons Treat Addiction*, AMERICAN BAR ASSOCIATION (Feb. 8, 2019 6:30 AM), http://www.abajournal.com/news/article/how_the_ada_could_change_jails_prisons_addiction_treatment .

[128] "The Fourth Circuit has interpreted the phrase 'qualified individual with a disability' in § 12132 to exclude persons who pose 'a significant risk to the health or safety of others by virtue of the disability that cannot be eliminated by reasonable accommodation.'" *START, Inc*., 295 F. Supp. 2d at 577-78 (quoting Doe v. Univ. of Md. Med. Sys. Corp*.,* 50 F.3d 1261, 1264-65 (4th Cir. 1995)).

[129] Montalvo v. Radcliffe, 167 F.3d 873, 877 (4th Cir. 1999)

[130] *Infra*, Part V.

[131] Estelle v. Gamble, 429 U.S. 97, 104 (1976).

[132] *Id.* at 105.

[133] *Id.* at 104.

were "deliberately indifferent."[134] Satisfying these elements is commonly referred to as a claim of cruel and usual punishment. Courts have held that OUD is a chronic disease[135] and that refusing prescribed MAT medications constitutes "deliberate indifference."[136]

The first element can be summed up by analyzing cases that have defined, or attempted to define, a "serious medical need." In conclusion, "there is no legally principled distinction between drug treatment and other forms of medical care that are constitutionally mandated in prison settings"[137] Recently, courts have held that denying a prisoner medication that was prescribed to treat OUD prior to incarceration is illegal based on an ADA claim, but have not yet reached a decision as to whether the denial also violates the Eighth Amendment.[138]

Prior to hearing cases concerning the denial of medications to treat an OUD, courts have heard cases concerning the denial of pain medication to prisoners who suffered injuries while incarcerated.[139] The United States District Court for the Southern District of Illinois found numerous prison officials, including a prison doctor, a prison nurse and grievance officials, culpable after each failed to provide adequate care.[140] Therefore, it is likely that courts will also find prison officials culpable if they do not provide MAT medications that are prescribed to the prisoners, who are also prison medical staff's patients.

If the court does determine the Eighth Amendment is violated, the ramifications will be felt throughout the correctional system. In an

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[134] *Id.*

[135] *Smith*, 376 F. Supp. 3d at 149; The prescription of MAT by a doctor in and of itself serves to show that it is a medical need that a licensed physician believes warrants treatment. Moreover, courts have ruled that "dismissal is inappropriate" in cases where an Eighth Amendment violation was brought against a prison that refused prescribed methadone to a prisoner in a 21-day treatment program. Messina v. Mazzeo, 854 F. Supp. 116, 140 (E.D.N.Y. 1994); Courts have also found that prisoners who are experiencing symptoms of withdrawal undergo a serious medical need. Foelker v. Outagamie Cty., 394 F.3d 510, 513 (7th Cir. 2005).

[136] Prisons are obligated to provide "services at a level reasonable commensurate with modern medical science and of a quality acceptable within prudent professional standards." United States v. DeCologero, 821 F.2d 39, 43 (1st Cir. 1987). This Note has cited several sources that MAT is the current standard of care for treatment of OUD and that prisoners who are given access to MAT programs are at a lower risk of overdose. *See* supra, Green, note 88.

[137] David Lebowitz, *"Proper Subjects for Medical Treatment?" Addiction, Prison-Based Drug Treatment, & the Eighth Amendment*, 14 DEPAUL J. OF HEALTH CARE L. 271, 295 (2015).

[138] *Pesce*, 355 F. Supp. 3d at 49; *Smith*, 376 F. Supp. 3d at 162.

[139] Perez v. Fenoglio, No. 11-cv-00819-NJR, 2015 U.S. Dist. LEXIS 103785, at *1 (S.D. Ill. Aug. 7, 2015) (allowing plaintiff's claim against the prison doctor, prison nurse, the correctional health care company, prison administrator, and individual corrections officers for deliberate indifference, in violation of the Eighth Amendment, to go forward).

[140] *Id*. at *2-3.

injunction case, a court can order that MAT must be made available to prisoners—an expensive consequence. However, in a case where the plaintiff seeks damages, defendants such as prison officials or corrections officers will be protected by qualified immunity. While most cases currently being brought are injunctive cases, *Perez v. Fenoglio* stands for the fact that a medical practitioner's denial of MAT after the injunction is granted will not be tolerated.[141]

1. Reasonableness

While prisons are required to provide "reasonably adequate" medical care,[142] "reasonableness" has conflicting definitions.[143] The United States District Court for the Western District of Missouri, Western Division articulated that since a convicted prisoner is unable to obtain their own medical care, the prison "authorities have a duty to provide needed medical attention."[144] Yet, the court emphasized that the failure to provide medical care is not a violation of the Eighth Amendment if it results "from simple negligence" and the remedy for such injury lies in tort law.[145] Moreover, since the deliberate indifference prong of an Eighth Amendment claim has both an objective and subjective element, prisoners must prove that prison officials were aware of "and consciously disregarded" the prisoner's medical need.[146] The issue is that so long as the treatment provided to the inmate is "continuing," supported by "a competent, recognized school of medical practice," and amounts "to a denial of needed medical treatment" the treatment is not in violation of the Eighth Amendment.[147] Thus, if there is any competent authority that states that prisoners do not need access to

[141] *See* Complaint at 3, Pesce, at 35; *see also* Smith, 376 F. Supp. at 154; *see also* Perez, No. 11-cv-00819-NJR, at *1.

[142] "The Eighth Amendment provides: 'Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishment inflicted.' U.S. Const. amend. VIII; Courts have held that "pretrial detainees are entitled to the same protection afforded convicted inmates who have serious medical needs." *See* Roberts v. City of Troy, 773 F.2d 720, 723 (6th Cir. 1985); Dan Manville, *Federal Legal Standards for Prison Medical Care*, PRISON LEGAL NEWS, (May 13, 2003), https://www.prisonlegalnews.org/news/2003/may/15/federal-legal-standards-for-prison-medical-care/.

[143] Ricketts v. Ciccone, 371 F. Supp. 1249, 1256 (W.D. Mo. 1974) (granting petitioners writ of habeas corpus based on the fact that confinement was "equally and reasonably available at least at one other prison where treatment can be given under the least adverse conditions); Blakely v. Sheriff of Albermarle County, 370 F. Supp. 814 (W.D. Va. 1974) (holding that a prison official could not have violated the Eighth Amendment when he had no knowledge that that the inmate was in need of medical care).

[144] Ramsey v. Ciccone, 310 F. Supp. 600, 605 (W.D. Mo. 1970).

[145] *Id*. at 605.

[146] Sistrunk v. Khan, 931 F. Supp. 2d 849, 857 (N.D. Ill. 2013).

[147] *Ramsey*, 310 F. Supp. at 604.

MAT to combat their OUD, then the prison will not be in violation of the Eighth Amendment.

2. Specific Treatment

While a prisoner may have a cause of action under the Eighth Amendment when he can prove deliberate indifference on the part of prison employees, a prisoner is not entitled to a specifically requested treatment.[148] Of course, this only applies when the prison is offering an alternate course of treatment for the prisoner.[149] For example, a prison may argue that providing buprenorphine but not methadone is adequate to treat MAT effectively. As long as a reasonable doctor agrees that the current treatment is effective and adequate, a prisoner does not have an Eighth Amendment claim.[150] Therefore, an inmate is only likely to succeed on an Eighth Amendment argument when the prison cannot provide evidence that it is offering adequate medical care.

3. An Endless Cycle

Since those who have been diagnosed with OUD also suffer from addiction, prisoners who are denied a MAT program are forced to find a way to treat themselves, perhaps by engaging in illicit drug use in prison. Prisoners who combat their addiction by using drugs in prison risk the chance of being caught. A prisoner caught with drugs can be punished with increased prison time or segregation from the general population.[151] The punishment for possessing a narcotic as a prisoner can result in an additional imprisonment of not more than twenty years.[152] Thus, prisoners are punished for taking steps to prevent withdrawal from drugs when the prisons have the capabilities for treating the disorder through the use of FDA-approved medications.

The implementation of MAT in prisons decreases the probability of reincarceration by increasing a "patient's adherence to treatment and

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[148] "A prisoner is not entitled to the best healthcare possible or even to a choice among available treatment modalities; instead, the Constitution entitles a prisoner only to reasonable measures to meet a substantial risk of harm." Forbes v. Edgar, 112 F.3d 262, 267 (7th Cir. 1997).

[149] "Mere disagreement over proper treatment does not create a constitutional claim" as long as the treatment is adequate." Farmer v. Brennan, 511 U.S. 825, 837 (1994).

[150] Chance v. Armstrong, 143 F.3d 698, 703 (2d Cir. 1998).

[151] *Detention & Correctional Standards for Maine Counties and Municipalities* at H.2(b), STATE OF MAINE DEP'T OF CORRECTIONS https://www.maine.gov/sos/cec/rules/03/201/201c001.pdf (Aug. 28, 2020).

[152] 18 U.S.C. § 1791 (1958).

reducing illicit opioid use."[153] Rhode Island, the first state to allow all three FDA-approved medications to treat prisoners suffering from an OUD, had a 60 percent decline in its post-incarceration overdose deaths in the first six months of the program.[154] This is significant because in states such as Washington, discussed *supra*, 8.3 percent of all fatal opioid overdoses, during a period of 2000-2009, were recently released individuals.[155]

V. RATIONALES PRISONS USE TO DENY MAT

The next part of this Note accepts the argument that withholding MAT does not violate the ADA or the Eighth Amendment. However, it also analyzes arguments made for and against the implementation of MAT, and comes to the conclusion that, even disregarding the civil rights arguments, MAT is the proper treatment for those who suffer from OUD.

There are three basic principles that are used to argue against the introduction or expansion of MAT programs in prisons: concerns about the black market for drugs in prisons, drug abuse in prisons, and the financial means to implement treatment programs.

A. Black Markets in Prisons

It is uncertain if introducing narcotics into prisons is more likely to help or harm prisoners who do not have MAT prescriptions, especially those who are former and current drug addicts. Many correctional facilities are hesitant to administer MAT medications for fear that the medications will be sold to prisoners to whom the medication was not prescribed. A common method used to store drugs in prison is known as "cheeking."[156] Cheeking involves prisoners storing medications inside their mouth until they are away from prison officials. This process "may divert their prescribed medications to the black market within the facility"[157] In such a scenario, those who are prescribed MAT medications abuse their

[153] *Medication-Assisted Treatment Improves Outcomes for Patients with Opioid Use Disorde*r, PEW, https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2016/11/medication-assisted-treatment-improves-outcomes-for-patients-with-opioid-use-disorder (Nov. 22, 2016).

[154] Vestal, *supra* note 31 (explaining that Rhode Island was the first state to allow buprenorphine, methadone, and naloxone to treat OUD); Abbe R. Gluck & Kath Stith, *Don't Sentence Prisoners to Addiction* WSJ https://www.wsj.com/articles/dont-sentence-prisoners-to-addiction-1544487128 (Dec. 10, 2018 7:12 PM).

[155] Ingrid A. Binswanger et al., *Mortality After Prison Release: Opioid Overdose & Other Causes of Death, Risk Factors, & Time Trends From 1999 To 2009*, 159(9) ANNALS INTERNAL MED. 592, 592-93 (2013).

[156] *Medication-assisted Treatment Inside Correctional Facilities*, SAMSHA https://store.samhsa.gov/system/files/pep19-mat-corrections_0.pdf (Aug. 2019).

[157] *Id.*

access to narcotics and contribute to the overall abuse of drugs in the prison system. This is especially harmful when the narcotics are given to those who do not have OUDs because it creates new addicts and a strain on the prison system to take care of those who now have an increased chance of overdose.[158] Many prisons have already taken steps to reduce the opportunities available for these prescribed narcotics to make their way into the prison system.[159]

B. Drug Abuse in Prison

Moreover, many prisons limit MAT programs in an attempt to steer clear from tolerating any drug use in prisons, even by those who have prescriptions.[160] A Bureau of Justice report released in June 2017 reveals that 21 percent of prisoners in state and local prisons are incarcerated for drug related offenses; including crimes that were committed to obtain drugs or money for drugs.[161] Meaning, "over 473,000 people are behind bars for seeking drugs."[162] Daniel Rosen, an inmate at the Greensville Correctional Center in southern Virginia, spoke candidly about his knowledge of drug abuse in the 3,000-person (as of 2008) prison.[163] Rosen stated that drug abuse in his prison is rampant, where the drug of choice is K2,[164] and prisoners are unafraid of being written up by correctional officers.[165] While

[158] Few corrections officials see things the same way. The problem, many say, is that "both medications are themselves narcotics, something the criminal justice system works hard to keep out of its facilities. As with any controlled substance, corrections officials are wary of methadone and buprenorphine being diverted to other inmates who are not in drug treatment or leaking out of the prison to illicit drug markets." *Id.*

[159] "Buprenorphine isn't simply swallowed like most medication; it has to dissolve under the tongue, which takes seven to 10 minutes. Inmates taking buprenorphine will need a place to sit and absorb the medication for several minutes, while under watch by security personnel — to make sure they take it all and don't bring any of it inside to give or sell to someone else. The medical staff will dispense buprenorphine in pill form and crush the pills before giving them to the patient." Freyer, *supra*, note 74.

[160] To create an environment where individuals can "safely" withdraw from opioid addiction, "Middleton is committed to maintaining a drug-free environment." Pesce v. Coppinger, 355 F. Supp. 3d 35, 42 (D. Mass. 2018).

[161] Wendy Sawyer, *BJS Report: Drug Abuse & Addiction at the Root of 21% of Crimes*, PRISON POLICY INITIATIVE (June 28, 2017), https://www.prisonpolicy.org/blog/2017/06/28/drugs/.

[162] *Id.*

[163] Dan Rosen, *The Never-Ending Drug Hustle Behind Bars*, THE MARSHALL PROJECT (Nov. 7, 2019), https://www.themarshallproject.org/2019/11/07/the-never-ending-drug-hustle-behind-bars.

[164] K2 is a synthetic cannabinoid. *Synthetic Cannabinoid*, NAT'L INSTITUTE ON DRUG ABUSE, https://www.drugabuse.gov/drugs-abuse/synthetic-cannabinoids-k2spice (last visited Jan. 25, 2020).

[165] Rosen, *supra*, note 166.

one in five prisoners are incarcerated for a drug offense in state prisons,[166] 46.2 percent of federal inmates are incarcerated for drug offenses.[167]

C. MAT and Medicaid

Occasionally a prison's failure to implement MAT is through no fault of its own; MAT is expensive to implement, especially in states that did not expand Medicaid.[168] While all states reimburse prisons for some form of MAT medication, including some forms of buprenorphine and naloxone, only forty-two states reimburse for the use of methadone and even fewer states reimburse for implanted or extended release buprenorphine.[169] Furthermore, many states impose limits on the quantity of MAT medications given to patients and require that prisoners receiving MAT medications also undergo psychosocial treatment.[170] In deciding whether to reimburse for MAT medications, state Medicaid programs examine the cost offset and cost-effectiveness of supplying the medications.[171]

VI. ARGUMENTS IN FAVOR OF MAT IMPLEMENTATION AND EXPANSION

The leading argument in support of MAT programs is that treating prisoners while they are incarcerated reduces the chances of reincarceration. According to a 2017 Bureau of Justice Statistics report, "two-thirds of offenders held in state prisons and local jails had substance abuse problems."[172] Moreover, "between 24 and 36 percent of opioid-dependent adults cycle in and out of jails each year."[173] MAT programs that treat

[166] Wendy Sawyer & Peter Wagner, *Mass Incarceration: The Whole Pie 2019*, PRISON POLICY INITIATIVE, https://www.prisonpolicy.org/reports/pie2019.html (March 19, 2019).

[167] *Inmate Statistics*, FEDERAL BUREAU OF PRISONS, https://www.bop.gov/about/statistics/statistics_inmate_offenses.jsp (last visited Jan. 25, 2020).

[168] States are currently prohibited from using Medicaid to cover inmates "unless they are taken to a hospital, meaning that medicines, mental health treatment, or substance abuse treatment are paid for by the county or state." Dan Goldberg, *State wants to Expand Medicaid into Jails, Prisons*, POLITICO, available at https://www.nyaprs.org/e-news-bulletins/2019/1/28/pt-nys-state-wants-to-expand-medicaid-into-jails-prisons - :~:text=Currently, states are prohibited from,has asked to cover inmates.

[169] Medicaid Coverage of Medication-Assisted Treatment for Alcohol & Opioid Use Disorders & of Medication for the Reversal of Opioid Overdose, SAMHSA, https://store.samhsa.gov/system/files/medicaidfinancingmatreport_0.pdf (2018).

[170] Id.

[171] "The total economic burden associated with fatal overdose, misuse, and use disorder attributable to prescription opioid misuse in 2013 was estimated to be $78.5 billion, of which $28.9 billion was associated with increased health care and SUD treatment costs and one-quarter was associated with public sector health care, treatment, and criminal justice costs." *Id*.

[172] Steve Horn, *Opioid Epidemic Impacts Prisons & Jails*, PRISON LEGAL NEWS, (Sept. 5, 2019), https://www.prisonlegalnews.org/news/2019/sep/5/opioid-epidemic-impacts-prisons-and-jails/.

[173] *Id.*

those with an OUD during their incarceration reduce the risk of reincarceration. While the cases in Part II of this Note focus only on injunctive relief for prisoners who currently have a prescription for MAT medication, the problem lies in those instances where a prisoner wishes to begin MAT treatment, but is denied medication. Creating MAT programs in prisons will reduce the cycle of incarceration and potentially the lives of those who would otherwise overdose if not for proper treatment.

VII. CONCLUSION

While drug addiction in prison is not a new concept, many states are taking steps to rectify the longstanding effects the War on Drugs has had on prisoners with OUD. More importantly, prisons are beginning to acknowledge the opioid problem that exists within American prisons and implementing programs, such as MAT, to treat prisoners and make the integration back into society easier. This Note proposes, based on court precedent laid out in Part III, that states should follow Rhode Island's lead and allow prisoners who suffer from OUD access to all FDA approved medications that are used to treat the illness. Doing so not only helps those with an OUD recover, but also protects the prisons from potential liability and constitutional claims. States that continue to refuse to treat those in their care violate both the ADA and the Eighth Amendment. While states may be hesitant to treat OUD with medication, this fear cannot be outweighed by the potentially deadly impact that refusing to treat someone with an illness may have.