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**RESOLVING THE OVERLOOKED TRAGEDY
IN CORRECTIONAL FACILITIES:
MEDICATION ASSISTED TREATMENT
ACCESS FOR INMATES**

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*"A remedy for unsafe conditions need not await a tragic event."*²

INTRODUCTION

Not getting access to appropriate medication violates the Eighth Amendment. Opioid use disorder (OUD) is covered under the Americans with Disabilities Act (ADA) which requires access to services, such as medication, that is in connection with drug rehabilitation. Therefore, even if there are loopholes under the Eighth Amendment, the ADA tightly restricts those by requiring correctional facilities to provide medication-assisted treatment (MAT) to qualified individuals. A willfully ignorant administrative authority should not have the power to decide on someone's health care, especially when such a decision is influenced by deeply ingrained stigma. The American Bar Association (ABA) Standards, as well as case law, continue to find that only a qualified medical professional should be allowed to make these types of health decisions. Although courts have begun to enforce compliance with the Eighth Amendment, ADA, and ABA Standards, correctional facilities continue to prohibit access to MAT through various loopholes; therefore, this article proposes that courts find a constitutional right to MAT to ensure compliance among correctional facilities.

The proposal offered here works for three reasons. First, as a constitutional matter; the Eighth Amendment requires that incarcerated individuals receive medical attention when there is a serious medical need. By mandating that correctional facilities provide MAT, correctional facilities would then be complying with the constitution. Second, from a human rights perspective; by providing MAT to incarcerated individuals, correctional facilities are providing adequate protections to marginalized individuals who experience various types of discrimination based on their disability. Third, it is more likely to change the stigma that is deeply embedded in our society. If correctional facilities have to provide MAT to incarcerated individuals, their preconceived notions could be eradicated

² *Helling v. McKinney*, 509 U.S. 25, 33 (1993).

because they will observe first-hand that MAT decreases recidivism and poses no security issue. This, in addition to the decrease in substance abuse and recidivism, could shift society's views of people with substance abuse disorders and result in more equal rights.

Part I will provide background as to why opioid use disorder should be addressed in correctional facilities. Part II will explore the constitutional right to receive appropriate treatment despite being incarcerated, as well as explore statutory guidelines within the ADA and suggestions made by the ABA. Part III will compare state policies to demonstrate how states have begun to make systemic changes and will discuss which approaches have been successful. This comment concludes by offering solutions on how to ensure constitutional compliance among correctional facilities in a way that serves the incarcerated individual's best medical interest.

PART I: BACKGROUND AND CURRENT ISSUES

While the incarceration rate in the United States is starting to decline, there are almost 2.3 million people confined, making the United States one of the countries with the highest incarceration rate.³ Nearly 65% of individuals in correctional facilities have a substance use disorder.⁴ This does not account for the people in the general population who have an opioid use disorder. In 2017, 2.1 million people in the United States had an opioid use disorder.⁵ Over 70,000 drug deaths occurred in 2017, which is a 9.6% increase from 2016.⁶ Opioids were involved in

³ Wendy Sawyer & Peter Wagner, *Mass Incarceration: The Whole Pie 2019*, PRISON POLICY INITIATIVE (Mar. 19, 2019), <https://www.prisonpolicy.org/reports/pie2019.html>.

⁴ *Medication-Assisted Treatment for Opioid Use Disorder in the Justice System*, AM. ASS'N FOR THE TREATMENT OF OPIOID DEPENDENCE, INC. (Oct. 2017), <http://www.aatod.org/advocacy/fact-sheets/>.

⁵ 2017 NATIONAL SURVEY ON DRUG USE AND HEALTH: DETAILED TABLES, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION: CENTER FOR BEHAVIORAL HEALTH STATISTICS AND QUALITY (Sept. 7, 2018).

⁶ *Opioid Overdose: Drug Overdose Deaths*, CENTERS FOR DISEASE CONTROL AND PREVENTION <https://www.cdc.gov/drugoverdose/data/statedeaths.html> (last visited Oct. 2, 2020).

47,600 overdose deaths in 2017, making opioids the main driver of drug deaths.⁷

Opioid Use Disorder (OUD) is a mental illness defined as a “problematic pattern of opioid use leading to clinically significant impairment or distress.”⁸ OUD is the “maladaptive use of opioids, prescribed or illicit, resulting in two or more criteria that reflect impaired health or function over a twelve-month period.”⁹ Withdrawal symptoms, which can include increased pulse, vomiting, diarrhea, excessive sweating, bone and joint aches, anxiety, and irritability,¹⁰ may begin within four to six hours of the last opioid use and may last for up to several months.¹¹ Long-term withdrawal symptoms can occur for much longer and include anxiety, depression, sleep disturbances, fatigue, dysphoria, and irritability.¹² There is a high likelihood of relapse after withdrawal.

The criminal justice system is the “largest source of organizational referrals to addiction treatment;” therefore, there is a valuable opportunity to facilitate the path to recovery.¹³ While 63% of inmates meet the criteria for OUD,¹⁴ only a limited percentage of incarcerated individuals with opioid addiction receive the treatment deemed necessary by medical professionals: medication-assisted treatment (MAT).¹⁵ MAT is a medication treatment that satisfies the chemical dependence to help the individual refrain from illicit opioid-use

⁷ *Id.*

⁸ AMERICAN PSYCHIATRIC ASS'N., DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, 5th ed. 541 (2013).

⁹ Hilary S. Connery, *Medication-Assisted Treatment of Opioid Use Disorder: Review of the Evidence and Future Directions*, 23 HARV. REV. OF PSYCHIATRY 63, 63 (2015).

¹⁰ *Id.*

¹¹ NAT'L SHERIFFS' ASS'N & NAT'L COMM'N ON CORR. HEALTH CARE JAIL-BASED MEDICATION-ASSISTED TREATMENT: PROMISING PRACTICES, GUIDELINES, AND RESOURCES FOR THE FIELD 21 (2018).

¹² Ctr. for Substance Abuse Treatment, *Protracted Withdrawal*, vol. 9 Issue 1 SUBSTANCE ABUSE TREATMENT ADVISORY (2010).

¹³ NAT'L SHERIFFS' ASS'N & NAT'L COMM'N ON CORR. HEALTH CARE, *supra* note 11.

¹⁴ *Id.*

¹⁵ This Comment refers to MAT concerning treatment for OUD only, even though it is used as a treatment for other addictions, such as alcohol and tobacco.

while the individual stabilizes the physical and social dependence to opioid use. MAT includes medications such as methadone, buprenorphine—neither of which can be abruptly discontinued¹⁶—and naloxone, which are prescribed as part of a comprehensive treatment plan that includes counseling and support groups. Once the physical and social dependencies are stabilized, physicians recommend that the individual ween off the medication.

Methadone has been used for addiction treatment since 1964 and was approved by the Food and Drug Administration in 1972.¹⁷ It works by activating opioid receptors in the body to suppress cravings. Typically, only detainees who are already on methadone at the start of detention may receive a week's worth of treatment. Pregnant women, however, are allowed to remain on treatment until they give birth as MAT helps reduce the withdrawal effects on a fetus.¹⁸ The FDA approved Buprenorphine in 2002 as a treatment method for OUD.¹⁹ Buprenorphine is an "opioid partial agonist" meaning that it produces effects such as euphoria in low doses.²⁰ These effects are weaker than other drugs, such as methadone. Buprenorphine's effects increase with each dose until it levels off, which is known as the "ceiling effect."²¹ The ceiling effect lowers the risk of misuse, dependency, and side effects.²² Naloxone is another drug that was approved by the FDA and works to prevent overdose by blocking opioid receptor sites,

¹⁶ NAT'L SHERIFFS' ASS'N & NAT'L COMM'N ON CORR. HEALTH CARE, *supra* note 11, at 9.

¹⁷ *Methadone*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, <https://www.samhsa.gov/medication-assisted-treatment/treatment/methadone> (last visited Oct. 2, 2020).

¹⁸ German Lopez, *How America's prisons are fueling the opioid epidemic*, VOX. (Mar. 26, 2018), <https://www.vox.com/policy-and-politics/2018/3/13/17020002/prison-opioid-epidemic-medications-addiction>.

¹⁹ *Buprenorphine*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, <https://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine> (last visited Oct. 2, 2020).

²⁰ *Id.*

²¹ *Id.*

²² *Id.*

which reverses the toxic effects of the overdose.²³ When switching from one form of MAT to another, there are specific guidelines to how much time should lapse to ensure safe conditions for the recipient.²⁴ Despite being a federally approved treatment option, fewer than 40 of the 3,200 correctional facilities offer methadone.²⁵ Only five states have correctional facilities that offer both methadone and buprenorphine, while only Rhode Island offers all three MAT options.²⁶

Individuals referred to MAT treatment through the criminal justice system were less likely to receive treatment compared to individuals who were referred to treatment outside of the criminal justice system based on the same qualifications.²⁷ Only 4.6% of justice-referred people received treatment while incarcerated when compared to the 40.9% of individuals referred to MAT treatment through other methods, such as probation or parole.²⁸ Only 16% of correctional facilities offer addiction treatment in settings segregated from the general prison population.²⁹ Approximately 10% of inmates receive addiction treatment services, while an even smaller subset receives evidence-based care.³⁰ Correctional facilities do not want to provide MAT for two primary beliefs: (1) the provided medications are narcotics, which is something that the criminal justice system wants to keep out of facilities, and (2)

²³ *Naloxone*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, <https://www.samhsa.gov/medication-assisted-treatment/treatment/naloxone> (last visited Oct. 2, 2020).

²⁴ NAT'L SHERIFFS' ASS'N & NAT'L COMM'N ON CORR. HEALTH CARE, *supra* note 11, at 10-11.

²⁵ Christin Vestal, *New Momentum for Addiction Treatment Behind Bars*, THE PEW CHARITABLE TRUSTS (Apr. 4, 2018), <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/04/04/new-momentum-for-addiction-treatment-behind-bars>.

²⁶ *Id.*

²⁷ Noa Krawczyk et al., *Only One in Twenty Justice-Referred Adults in Specialty Treatment for Opioid Use Receive Methadone or Buprenorphine*, 36 *Health Aff.* 2046, (2017).

²⁸ *Id.*

²⁹ THE NAT'L CTR. ON ADDICTION AND SUBSTANCE USE AT COLUM. UNIV., *BEHIND BARS II: SUBSTANCE ABUSE AND AMERICA'S PRISON POPULATION*, 4 (2010).

³⁰ *Id.*

methadone merely substitutes one addiction for another and is not viewed as a true tool of recovery. However, inmates are at a higher risk of overdose within the first two weeks of release from correctional facilities that do not provide MAT.³¹

The beliefs of the correctional facilities concerning MAT access are based on stigma. The Constitution, Americans with Disabilities Act (ADA), and the American Bar Association (ABA) Standards all outline the importance of providing adequate medication to inmates, while directly rebuking the misplaced beliefs of the correctional facilities.

PART II: CONSTITUTIONAL AND STATUTORY INTERPRETATION

I. The Eighth Amendment

The Eighth Amendment to the United States Constitution prohibits the infliction of “cruel and unusual punishments.”³² The Supreme Court began to review prisoner’s medical care under the Eighth Amendment in the landmark case *Estelle v. Gamble*, holding that prisons are required to provide adequate medical treatment to incarcerated individuals because incarceration removes an individual’s ability to access alternative care.³³ The Court applied the same ruling to state prisons through the Fourteenth Amendment.

In *Estelle*, the plaintiff was injured when a 600-pound bale of cotton fell on him while unloading a truck during a prison work assignment.³⁴ After enduring months of pain, prison guards refused to follow the doctor’s directions, including altered sleeping arrangements and providing his prescribed pain medication, claiming that the prescription was lost.³⁵ The plaintiff was kept in solitary confinement for two months after

³¹ Akin Gump Strauss Hauer & Feld, LLP, *A Legal Right to Access to Medications for the Treatment of Opioid Use Disorder in the Criminal Justice System*, Bloomberg Am. Health Initiative (Dec. 2018), https://americanhealth.jhu.edu/sites/default/files/inline-files/AkinGump_Memo_Opioids_121218.pdf.

³² U.S. CONST. amend. VIII.

³³ *Estelle v. Gamble*, 429 U.S. 97, 103 (1976).

³⁴ *Id.* at 99.

³⁵ *Id.*

refusing to work due to the heightened pain.³⁶ While in solitary confinement, the plaintiff continued to experience severe back pain, chest pains, high blood pressure, and “blank outs” but was denied access to the prison doctor on at least two occasions.³⁷

The Court was hesitant to use the Eighth Amendment to enforce protections for inmates, noting that “the primary concern of the drafters was to proscribe tortures and other barbarous methods of punishment.”³⁸ However, the Court held that correctional institutions cannot be “*deliberately indifferent*” to the “*serious medical needs*” of individuals within their custody, since that would contravene the Eighth Amendment’s ban against cruel and unusual punishment.³⁹ An inmate must rely on prison authorities to treat his medical needs and, if the authorities fail to do so, then the needs will not be met.⁴⁰

a. SERIOUS MEDICAL NEED

In *Estelle*, the Supreme Court loosely defined “serious medical need” as “unnecessary and wanton infliction of pain” caused by the failure to treat.⁴¹ A serious medical need is “one that has been diagnosed by a physician as mandating treatment or one that is so obvious that even a lay person would easily recognize the necessity for a doctor’s attention.”⁴² The idea of serious medical need has no formal standard, but it has been explored by many courts. The First Circuit in *Laaman v. Helgemoe* identifies a serious medical need as one that “has been diagnosed by a physician as mandating treatment or one that is so obvious that even a lay person would easily recognize the necessity for a doctor’s attention.”⁴³ The Second Circuit in *Brock v. Wright* established three factors: (1) whether a reasonable

³⁶ *Id.* at 100 n.5. The plaintiff refers to it as “administrative segregation,” but the State never specified what that meant; therefore, the Court of Appeals deemed it the equivalent of solitary confinement.

³⁷ *Id.* at 101.

³⁸ *Id.* at 102.

³⁹ *Id.* at 104. (emphasis added).

⁴⁰ *Id.*

⁴¹ *Id.*

⁴² *Mann v. Taser Int’l, Inc.*, 588 F.3d 1291, 1306-07 (11th Cir. 2009).

⁴³ *Laaman v. Helgemoe*, 437 F. Supp. 269, 311 (D. N.H. 1977).

doctor or patient would perceive the medical need in question as important and worthy of comment or treatment; (2) whether the medical condition significantly affects daily activities; and (3) the existence of chronic and substantial pain.⁴⁴ Lower courts generally consider three different factors: (1) whether the condition can be treated; (2) the consequences of foregoing treatment; and (3) the likelihood of a favorable outcome from the treatment.⁴⁵

b. DELIBERATE INDIFFERENCE

The Supreme Court elaborated on the definition of deliberate indifference in *Farmer v. Brennan*, holding that a “prison official may be held liable under the Eighth Amendment for denying human conditions of confinement only if he knows that inmates face a serious risk of harm and disregards that risk by failing to take reasonable measures to abate it.”⁴⁶ Thus, deliberate indifference is when a prison official recklessly disregards a substantial risk of harm to a prisoner and has a “sufficiently culpable state of mind” such that the failure to treat the serious medical need is cruel.⁴⁷ “Whether a prison official had the requisite knowledge of a substantial risk is a question of fact . . . and a factfinder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious.”⁴⁸

Many lower courts have followed suit and have defined deliberate indifference as conduct that is more than mere negligence, including:

- (1) knowledge of a serious medical need and a failure or refusal to provide care; (2) delaying treatment for non-medical reasons; (3) grossly inadequate care; (4) a decision to take an easier but less efficacious course of treatment; or (5)

⁴⁴ Brock v. Wright, 315 F.3d 158, 162 (2d Cir. 2003).

⁴⁵ William J. Rold, *Thirty Years After Estelle v. Gamble: A Legal Retrospective*, 14:1 J. OF CORRECTIONAL HEALTH Care 11, 16 (2008).

⁴⁶ *Farmer v. Brennan*, 511 U.S. 825, 847 (1994).

⁴⁷ *Id.* at 834, 836 (citing *Wilson v. Seiter*, 501 U.S. 294, 297 (1991)).

⁴⁸ *Id.* at 842.

medical care that is so cursory as to amount to no treatment at all.⁴⁹

Courts agree that “prisoners are guaranteed the right under the Eighth Amendment to be free from deliberate indifference by correctional institutions to their serious physical or psychological needs.”⁵⁰ However, courts differ on the level of inadequate care needed to constitute deliberate indifference. A “simple difference in medical opinion between the medical staff and an inmate as to the latter’s diagnosis or course of treatment” does not establish deliberate indifference.⁵¹ Courts avoid second-guessing the professional judgment of a particular course of treatment or diagnosis⁵² and have found that ignoring prior diagnoses and treatment is deliberate indifference.⁵³ However, courts have consistently held that denying an inmate treatment for a painful condition based on non-medical reasons, such as funding, falls within the scope of deliberate indifference.⁵⁴ Courts have also held that refusal of medical attention based on “ease and less efficacious treatment” rather than the exercise of professional judgment is deliberate indifference.⁵⁵

What is clear is that “failure to provide basic psychiatric and mental health care states a claim of deliberate indifference to the serious medical needs of prisoners.”⁵⁶ Courts have interpreted *Estelle* to hold that inmates are entitled to psychological or psychiatric treatment if a physician concludes that the prisoner has symptoms of a serious disease that could be substantially alleviated and that denying care could cause the prisoner

⁴⁹ *Baez v. Rogers*, 522 Fed. Appx. 819, 821. (11th Cir. 2013) (citing *McElligott v. Foley*, 182 F.3d 1248, 1255 (11th Cir. 1999)).

⁵⁰ *Harris v. Thigpen*, 941 F.2d 1495, 1505 (11th Cir. 1991).

⁵¹ *Id.*

⁵² *Bowring v. Godwin*, 551 F.2d 44, 48 (4th Cir. 1977).

⁵³ *Rivera v. Goord*, 119 F. Supp. 2d 327, 337 (S.D.N.Y. 2000).

⁵⁴ See *Jones v. Johnson*, 781 F.2d 769, 771 (9th Cir. 1986); *Dunn v. Dunn*, 219 F. Supp. 3d 1100, 1130 (M.D. Ala. 2016); *Ancata v. Prison Health Servs.*, 769 F.2d 700, 704 (11th Cir. 1985).

⁵⁵ See *Williams v. Vincent*, 508 F.2d 541, 544 (2d Cir. 1974); *United States ex rel. Hyde v. McGinnis*, 429 F.2d 864 (2d Cir. 1970); *McElligott*, 182 F.3d at 1248.

⁵⁶ *Rogers v. Evans*, 792 F.2d 1052, 1058 (11th Cir. 1986).

substantial harm.⁵⁷ Even if there is deliberate indifference, there must also be a serious medical need for the situation to be violative of the Eighth Amendment. Both parts of the Eighth Amendment analysis are inconsistently applied throughout courts causing uncertainty in treatment modalities for individuals with OUD. Despite this inconsistent application, inmates with OUD are still entitled to MAT under the ADA.

II. AMERICANS WITH DISABILITIES ACT

Although limited, case law has begun to provide people with OUD protections under the ADA. The ADA defines disability as a “physical or mental impairment that substantially limits one or more major life activities of [an] individual.”⁵⁸ Physical or mental impairment includes drug addiction.⁵⁹ People with OUD suffer from a physical or mental impairment that limits major life activities including caring for oneself, learning, concentrating, thinking, and communicating.⁶⁰ OUD also limits the operation of major bodily functions, such as neurological and brain functions;⁶¹ therefore, OUD is a disability within the ADA’s protections.⁶²

Title II of the ADA states that “no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.”⁶³ Correctional facilities constitute a public entity⁶⁴ which is defined as “any state or local government; any department [or] agency . . . of a State or . . . local government,”⁶⁵ and are clearly subject to the ADA.⁶⁶ The ADA also states “an individual shall not be denied health

⁵⁷ *Bowring*, 551 F.d at 47; *see also* *Newman v. Alabama*, 503 F.2d 1320 (5th Cir. 1974); *Laaman*, 437 F. Supp. at 313; *Mitchell v. Untreiner*, 421 F. Supp. 886, 891 (N.D. Fla. 1976); *Collins v. Schoofield*, 344 F. Supp. 257, 277 (D. Md. 1972).

⁵⁸ 42 U.S.C. § 12102(1)(A).

⁵⁹ 28 C.F.R. § 35.108(b)(2).

⁶⁰ 42 U.S.C. § 12102(2)(A).

⁶¹ 42 U.S.C. § 12102(2)(B).

⁶² 42 U.S.C. § 12102; 28 C.F.R. § 35.108(b)(2).

⁶³ 42 U.S.C. § 12132.

⁶⁴ *Pa. Dep’t of Corrs. v. Yeskey*, 524 U.S. 206, 209 (1998).

⁶⁵ 42 U.S.C. § 12131.

⁶⁶ *Yeskey*, 524 U.S. at 211-12.

services, or services provided in connection with drug rehabilitation, on the basis of the current illegal use of drugs”⁶⁷ To assert a claim under the ADA, an individual must establish:

- (1) he is a qualified individual with a disability;
- (2) that he was excluded from participation in or denied the benefits of some public entity’s services, programs, or activities or was otherwise discriminated against; and (3) that such exclusion, denial of benefits, or discrimination was by reason of the plaintiff’s disability.⁶⁸

Under the ADA, a plaintiff can pursue different types of disability discrimination claims, such as stating that:

- (a) the imposition of adverse consequences on a prisoner based on the prisoner’s disability, (b) a prison policy that is neutral in its terms, but impacts prisoners with a disability more significantly, or (c) the refusal by the prison administrators to grant the prisoner a reasonable accommodation so that the prisoner can have meaningful access to a prison program or service.⁶⁹

Under the third option, a “prison program or service” includes medical services.⁷⁰ To state a claim, a plaintiff must identify the disability and the relationship between the disability and policy on which the discrimination claim is based.

Under the ADA, correctional facilities are clearly discriminating against inmates. Because individuals diagnosed with OUD are considered qualified individuals under the ADA, they must have access to any medically approved treatment option while under the supervision of a public entity. By not

⁶⁷ 42 U.S.C. § 12210(c).

⁶⁸ *Gray v. Cummings*, 917 F.3d 1, 15 (1st Cir. 2019).

⁶⁹ *Wilbur v. Fitzpatrick*, 2018 U.S. Dist. LEXIS 136898 (D. Me. 2018); *see also*, *Nunes v. Mass. Dep’t of Corr.*, 766 F.3d 136, 144 (1st Cir. 2014).

⁷⁰ *Yeskey*, 524 U.S. at 210.

providing MAT to inmates and pretrial detainees who are diagnosed with OUD, correctional facilities are intentionally denying health services on the assumption of current illegal drug use, which violates the ADA. Not providing the appropriate medication—MAT—causes excessive physical ailments, of which inmates would not experience if it were not for the facility's policy; therefore, the facility imposes adverse consequences based on the inmate's disability. To succeed under the third approach, an individual does not need to show that other individuals receive more favorable treatment—that other individuals have access to MAT—but must only show that they are being denied proper access to a prison program based on their disability.⁷¹ Correctional facilities are failing to accommodate individuals with OUD by not providing MAT; therefore denying access to the prison's medical service.

III. AMERICAN BAR ASSOCIATION STANDARDS

The American Bar Association House of Delegates used constitutional and statutory law, correctional policies and professional standards, and professional consulting to establish functional parameters to guide the operation of American correctional facilities to promote “safety, humaneness, and effectiveness of our correctional facilities.”⁷² The purpose of these Standards is “to shape the institutions of government in such fashion as to comply with the laws and the Constitution” and are intended to establish the conditions expected in confinement facilities.⁷³ The Standards acknowledge *Estelle's* role in setting precedent for the treatment of prisoners, but further develop the test by stating “what is needed is not care that barely passes the ‘deliberate indifference’ test, but rather a standard of care set by reference to the community.”⁷⁴ The ABA establishes the Standards based on the idea that there is a universal belief among correctional facilities, which is “if

⁷¹ *Henrietta D. v. Bloomberg*, 331 F.3d 261, 274 (2d Cir. 2003).

⁷² A.B.A., *TREATMENT OF PRISONERS* 1 (3d ed. 2011), available at https://caitlinkellyhenry.com/wp-content/uploads/2014/06/ABA-Health-Care-Treatment_of_Prisoners-2010.pdf.

⁷³ *Id.* at 5-6.

⁷⁴ *Id.* at 150.

medical science has determined the appropriate treatment for a given illness, that treatment is no less appropriate in prison.”⁷⁵

First, according to the Standards, correctional authorities should ensure that “a qualified health care professional is designated the responsible health authority for each facility, to oversee and direct the provision of health care in that facility”⁷⁶ because “prisoners should be provided timely access to appropriately trained and licensed health care staff in a safe and sanitary setting designed and equipped for diagnosis or treatment.”⁷⁷ The qualified medical professional should be available for inmates suffering from severe pain.⁷⁸ Having one qualified medical care professional is not enough to satisfy the Standards. Correctional facilities should have multiple qualified medical and mental health professionals at each facility to provide appropriate health care in a timely manner.⁷⁹

After a facility has satisfied the need for qualified health care professionals, a correctional facility “should ensure each prisoner’s continuity of care, *including with respect to medication*, upon entry into the correctional system [and] during confinement”⁸⁰ A prisoner who is found to be “lawfully taking prescription drugs . . . when they enter a correctional facility . . . should be maintained on that course of medication or treatment or its equivalent until a qualified health care professional directs otherwise”⁸¹ This includes treatment and habilitation services to prisoners with mental illness or other cognitive impairments.⁸² If there are any difficulties with providing treatment to those with mental illnesses or other cognitive impairments, “a correctional facility should provide prisoners . . . appropriate housing assignments and programming opportunities in accordance with their diagnoses . . . and treatment or habilitation plans.”⁸³

⁷⁵ *Id.*

⁷⁶ *Id.* at 152.

⁷⁷ *Id.* at 153.

⁷⁸ *Id.* at 157.

⁷⁹ *Id.* at 160.

⁸⁰ *Id.* at 163. (emphasis added).

⁸¹ *Id.*

⁸² *Id.* at 179.

⁸³ *Id.* at 180.

The ABA Standards clearly outline expectations of medical treatment within correctional facilities after adopting the rationale behind the Supreme Court's decision in *Estelle*. Despite these explicit standards, very few states comply.

PART III: CASE REVIEW

I. PRETRIAL DETAINEES

Very few states have addressed MAT access to all prisoners; however, circuits have addressed MAT access to pretrial detainees. There are approximately 540,000 pretrial detainees in correctional facilities.⁸⁴ Courts distinguish between convicted prisoners and pretrial detainees because pretrial detainees can only bring claims under the Fourteenth Amendment as they are only confined to ensure their presence at trial.⁸⁵ Because they have not been found guilty of a crime, the only rights a pretrial detainee shall lose are those necessarily lost through the fact of confinement.⁸⁶ Pretrial confinement must be consistent with the least restrictive means available to achieve a valid governmental objective unless further deprivation is justified through a valid state interest.⁸⁷ Despite the constitutional differences between pretrial detainees and convicted inmates, the legal analysis is similar.⁸⁸

Furthermore, the reasons cited for keeping MAT out of correctional facilities—criminal justice system does not want narcotics in the facilities and methadone is merely an addiction substitute—have been rejected by many courts, specifically in the pretrial context. In *Norris v. Frame*, the court held that despite there being “no constitutional right to methadone,” the correctional facility must provide methadone to pretrial detainee because the defendant demonstrated that he had regular methadone prescribed to him by a licensed clinic, “that

⁸⁴ Sawyer & Wagner, *supra* note 3.

⁸⁵ Cudnik v. Kreiger, 392 F. Supp. 305, 311 (N.D. Ohio 1974); *see also* Tyrrell v. Speaker, 535 F.2d 823, 827 (3d Cir. 1976); United States v. El-Hage, 213 F.3d 74, 79 (2d Cir. 2000).

⁸⁶ Cudnik, 392 F. Supp. at 311.

⁸⁷ *Id.*; *see also* Wolfish v. Levi, 573 F.2d 118, 124 (2d Cir. 1978); Norris v. Frame, 585 F.2d 1183, 1187 (3d Cir. 1978).

⁸⁸ Frost v. Agnos, 152 F.3d 1124, 1128 (9th Cir. 1998).

this treatment was legal and medically accepted, and the prison was on notice of these facts.”⁸⁹ In this case, the correctional facility could arrange for the transfer of prisoners with drug problems to a facility where the appropriate treatment was available; however, the physician determined that it was unnecessary.⁹⁰ The court stated that because the defendant was already receiving the medication in an approved program, the correctional facility could only refuse to continue treatment if there was a legitimate interest in doing so, of which the state did not provide.⁹¹ Therefore, the decision to cease treatment must be left to the authorized methadone facility rather than be delegated to penal authorities due to their lack of understanding of OUD.⁹²

Similarly, the court in *Cudnik v. Kreiger* held that a jail policy which prohibited dispensing narcotic drugs was unconstitutional because the plaintiff’s pain, temporary incapacitation, and loss of liberty did not further the state’s interest of securing the presence of an individual for trial nor is it related to advancing jail security.⁹³ The court rejected the argument that, by allowing methadone access, other inmates would also seek methadone and similar drugs because the facility can address that problem if it arises by separating those receiving MAT treatment from others as they do with men and women. To use this basis to deny methadone where there are other means to ensure jail security “would not be consistent with the least restrictive means of confinement.”⁹⁴ The court also rejected the argument that providing methadone to pretrial detainees would create “an illicit jail market for methadone and the possibility of theft of the drug”⁹⁵ on two parts. First, the court said that physicians or treatment staff may bring the medication to them daily. Second, the court said that a jail market for the drug is “unlikely” because methadone can be administered in liquid form and must be consumed in the presence of whoever administers the drug.⁹⁶ The court

⁸⁹ *Norris*, 585 F.2d at 1188.

⁹⁰ *Id.* at 1185.

⁹¹ *Id.*

⁹² *Id.* at 1189.

⁹³ *Cudnik*, 392 F. Supp. at 312.

⁹⁴ *Id.*

⁹⁵ *Id.*

⁹⁶ *Id.*

instructed the jail to provide pretrial detainees with methadone in a secure area of the jail with the appropriate staff so long as they were receiving methadone treatment prior to confinement.⁹⁷

I. CONVICTED INMATES

Courts recognize that pretrial detainees and prisoners have different liberties while confined. However, courts agree that methadone should be accessible to those who had a regular prescription by a physician prior to confinement, that the treatment must be legal and medically accepted, and that the prison must be aware of the treatment.⁹⁸ Courts also agree that refusal of medication access is only permissible when it furthers the state's interest, but an appropriate state interest does not include fear of an illicit market, the belief that other prisoners will want drugs or theft.⁹⁹ These fears have been the sole reasons why correctional facilities do not provide MAT access to any type of detainee. However, recent decisions in various circuits have determined that MAT should be accessible to convicted inmates as well.

a. COURT CASES

Courts are stuck analyzing situations on a case-by-case basis and are inconsistently protecting inmate's constitutional rights. It is recognized that severe opiate withdrawal symptoms can amount to a serious medical need,¹⁰⁰ however, the Eighth

⁹⁷ *Id.* at 313.

⁹⁸ *See Norris*, 585 F.2d at 1188; *Cudnik*, 392 F. Supp. at 312; *Holly v. Rapone*, 476 F. Supp. 226 (E.D. Pa. 1979); *Kirsch v. Racine Cty. Sheriff*, 2008 WL 4872595 (E.D. Wisc. 2008).

⁹⁹ *Id.*

¹⁰⁰ *See Shaver v. Brimfield Twp.*, 628 Fed. Appx. 378 (6th Cir. 2015); *Foelker v. Outagamie Cty.*, 394 F.3d 510, 513 (7th Cir. 2005) (finding opiate withdrawal amounts to a serious medical need); *Gonzalez v. Cecil Cty.*, 221 F. Supp. 2d 611, 616 (D. Md. 2002) (finding heroin withdrawal is a serious medical need); *Hernandez v. Cty. of Monterey*, 110 F. Supp. 3d 929, 948 (N.D. Cal. 2015) ("withdrawal is a serious and potentially deadly medical condition, with symptoms including seizures, hallucinations, agitations and increased blood pressure"); *Pajas v. Cty. of Monterey*, 2016 U.S. Dist. LEXIS 88955, 17

Amendment burden of deliberate indifference to a serious medical need is extremely high and difficult for plaintiffs to meet.¹⁰¹ For example, in one case, the court held that there was no severe medical need under the Eighth Amendment when a defendant was denied methadone despite being unable to sleep or eat without vomiting for two and a half months after withdrawing from using five to ten bags of heroin daily.¹⁰² In another case, excessive vomiting did constitute a serious medical need when an inmate who had used seven bags of heroin and two bottles of cocaine two days prior; however, the court determined that there was no deliberate indifference because he was given Clonidine, Benadryl, and anti-nausea medication for his withdrawal symptoms.¹⁰³ The court stated that deliberate indifference does not include situations in which medical professionals “should have done more, or done it differently, or done it better.”¹⁰⁴

(N.D. Cal. 2016) (stating drug withdrawal constitutes a serious medical need requiring appropriate medical care under the Eighth Amendment); *Quatroy v. Jefferson Par. Sheriff's Office*, 2009 U.S. Dist. LEXIS 40807, 29 (E.D. La. 2009) (“acute symptoms of withdrawal easily present a serious medical need”); *Sirois v. Cichon*, 2013 U.S. Dist. LEXIS 159425, 6 (D.Me. 2013) (concluding that opiate withdrawal symptoms can arise to the level of an objectively serious medical need). *But see*, *Iacovangelo v. Corr. Med. Care, Inc.*, 2014 U.S. Dist. LEXIS 140679, 10 (W.D.N.Y. 2014) (finding that “mild withdrawal symptoms, such as vomiting, do not necessarily qualify as an objectively serious medical condition”); *Avallone v. Hofmann*, 2009 U.S. Dist. LEXIS 86408, 5 (D.Vt. 2009) (symptoms for two days “do not generally provide the basis for an Eighth Amendment claim”).

¹⁰¹ *See* *Steele v. Choi*, 82 F.3d 175 (7th Cir. 1996) (holding that negligent care from a subarachnoid hemorrhage resulting in paralysis, disfigurement, loss of ambulatory functions, and severe hand spasms does not rise to the level of deliberate indifference under the Eighth Amendment); *Farmer*, 511 U.S. at 837 (holding that a prison official cannot be liable under deliberate indifference within the Eighth Amendment for denying an inmate human conditions of confinement unless they do so knowing that the denial could cause an excessive risk to inmate health and safety).

¹⁰² *Alvarado v. Westchester Cty.*, 22 F. Supp. 3d 208, 217 (S.D.N.Y. 2014).

¹⁰³ *Sylvester v. City of Newark*, 120 Fed. Appx. 419, 424 (3d Cir. 2005).

¹⁰⁴ *Id.*

When a prison employee knows that an inmate is suffering from withdrawal and fails to treat the symptoms¹⁰⁵ or not does not provide appropriate medication, deliberate indifference can be satisfied.¹⁰⁶ For example, an inmate told the staff that he was a heroin addict who would likely go into withdrawal without methadone.¹⁰⁷ Despite being a heroin addict, the inmate was refused methadone and given only Clonidine (a blood pressure medication) as a way to curb withdrawal symptoms.¹⁰⁸ His symptoms were exacerbated as he became violently ill and was diagnosed with pneumonia which, due to only receiving an over-the-counter stomach medication, led to his death.¹⁰⁹ The court found that a policy of refusing appropriate withdrawal treatment “could lead to an inference of deliberate indifference.”¹¹⁰

Stigma can result in denying methadone, which some courts consider to be deliberate indifference.¹¹¹ Despite the jail’s policy of allowing methadone and the recommendation to give him a reduced dose, an inmate was denied access to methadone because he had been off his prescription for three days.¹¹² The inmate had severe withdrawal symptoms, including defecating on himself and in his cell, hearing voices, being disoriented, and believing he was at the “wedding hotel.”¹¹³ A registered nurse in the facility believed that the inmate was “playing the system” and did not require medical attention. The inmate continued to

¹⁰⁵ *Lancaster v. Monroe Cty.*, 116 F.3d 1419, 1425 (11th Cir. 1997).

¹⁰⁶ *See Corby v. Conboy*, 457 F.2d 251, 254 (2d Cir. 1972) (“a charge of deliberate indifference by prison authorities to a prisoner’s request for essential medical treatment is sufficient to state a claim”); *Gonzalez*, 221 F. Supp. 2d at 617 (holding that a policy of refusing meaningful treatment for heroin withdrawal could support a finding of deliberate indifference).

¹⁰⁷ *Gonzalez*, 221 F. Supp. 2d at 613.

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ *Id.* at 617.

¹¹¹ *See Harper v. Lawrence Cty.*, 592 F.3d 1227, 1237 (11th Cir. 2010) (“our prior pronouncements on the illegality of delayed or inadequate treatment for alcohol withdrawal should have sufficed to put the supervisory Defendants on notice . . . that delayed or inadequate treatment of alcohol withdrawal would be unlawful”); *Foelker v. Outagamie Cty.*, 394 F.3d 510 (7th Cir. 2005).

¹¹² *Foelker*, 394 F.3d 510 (7th Cir. 2005).

¹¹³ *Id.* at 511.

deteriorate, and the staff transported him to the hospital two days later.¹¹⁴ The court found that there was a severe medical need because the inmate had delusions and defecated on himself.¹¹⁵ The court stated that “not [being] in extreme distress does not necessarily mean that [there is not a] serious medical need.”¹¹⁶ Because “direct evidence is not always necessary to state a claim” regarding the severity of one’s medical condition, the court also found that there was deliberate indifference since the facility knew the inmate had not taken his methadone and no additional medical attention was provided to the inmate even after he defecated on himself and in the cell.¹¹⁷ In another case, two inmates suffered withdrawal symptoms after being denied methadone.¹¹⁸ Both had their daily vital signs monitored instead, while one received Tylenol.¹¹⁹ The lower court ruled in favor of the jail alluding to “the tendency of a drug dependent person to exaggerate his or her symptoms in order to obtain drugs.”¹²⁰ The Fourth Circuit affirmed for security reasons; however, they did nothing to negate the outrageous stigma that influenced the lower court’s decision.

Some courts hold tightly onto the idea that, despite there being an Eighth Amendment analysis to the medical needs of inmates, there is still no constitutional right to methadone.¹²¹ However, other courts have found that there is deliberate indifference on behalf of the facility when prison officials “deliberately ignore the express orders of a prisoner’s prior physician for reasons unrelated to the medical needs of the prisoner,” and that security concerns are not related to the medical needs of prisoners.¹²²

¹¹⁴ *Id.*

¹¹⁵ *Id.* at 513.

¹¹⁶ *Id.*

¹¹⁷ *Id.*; see also *Walker v. Benjamin*, 293 F.3d 1030 (7th Cir. 2002) (refusing to provide medication based on the idea that the complainant was malingering, not in pain but wanting to get high, is deliberate indifference).

¹¹⁸ *Fredericks v. Huggins*, 711 F.2d 31, 31 (4th Cir. 1983).

¹¹⁹ *Id.* at 32.

¹²⁰ *Id.* at 33.

¹²¹ *Norris*, 585 F.2d at 1188; *Love v. Thompson*, 2016 WL 6991202, 1-5 (W.D. Pa. 2016).

¹²² *Hamilton v. Endell*, 981 F.2d 1062, 1066 (9th Cir. 1992); see also *Strain v. Sanham*, 2009 WL 172898, at 6 (E.D. Cal. 2009).

While some facilities may not provide MAT to inmates with OUD, some facilities do grant access to inmates who use methadone for pain management. Prison doctors prescribed an inmate with methadone to treat chronic pain disease resulting from a spinal injury; however, the new facility to which he was transferred gave him Tylenol instead, as they had a policy that prohibited the distribution of narcotics “under [any] circumstances.”¹²³ The defendants stated that they had no problem administering methadone for pain management and, if an inmate had an existing, valid prescription for methadone for chronic pain, the prescription would be honored subject to the jail physician’s medical judgment.¹²⁴ The court ruled in favor of the inmate because despite meeting all jail criteria, he was still refused his medication for no valid reason.¹²⁵

In a similar case, the court ruled in favor of an inmate when a facility denied access to methadone simply because he was not housed in the section of inmates who could receive methadone.¹²⁶ Instead, the facility provided the inmate with Tylenol and Naproxen for pain management.¹²⁷ The court ruled that this could result in deliberate indifference to a serious medical need under the Eighth Amendment.¹²⁸ Other courts have held similarly when no-narcotics jail policies resulted in inmates receiving Tylenol for pain instead of their physician-prescribed methadone.¹²⁹ This clearly demonstrates an issue

¹²³ *Kirsch v. Racine Cty. Sheriff*, 2008 U.S. Dist. LEXIS 91538, 5 (E.D. Wis.2008).

¹²⁴ *Id.* at *7-8.

¹²⁵ *Id.*

¹²⁶ *Chess v. Dovey*, No. CIV S-07-1767 LKK DAD P, 2011 U.S. Dist. LEXIS 15835, at *57 (E.D. Cal. Feb. 14, 2011).

¹²⁷ *Id.* at *62.

¹²⁸ *Id.* at *64; *see also Anderson v. Benton Cty.*, Nos. 03-6155-TC, 03-806-TC, 2004 U.S. Dist. LEXIS 19453 at *19 (D. Or. Sep. 21, 2004) (denying summary judgment to the defendant after finding that a reasonable jury could find deliberate indifference after the facility denied an inmate methadone for pain management despite having a physician’s prescription).

¹²⁹ *See Franklin v. Dudley*, 2:07-cv-2259 FCD KJN P, 2010 U.S. Dist. LEXIS 138549, at 6-8 (E.D. Cal. Dec. 29, 2010) (finding evidence of triable issue of fact as to whether the defendant violated the Eighth Amendment when the plaintiff was previously prescribed narcotic pain medication but now was given only over-the-counter

under the ADA. When methadone is used for pain management, courts are more favorable to ensuring inmates have access when compared to inmates who are using it as a substance use treatment method, despite both categories of people having prior physician prescriptions and experiencing withdrawal symptoms from cessation. Courts have consistently found that Tylenol instead of methadone is not an appropriate alternative for pain management but is an appropriate alternative for substance use withdrawals. It is clear that the difference lies only with the purpose of the medication and that those with OUD have an everlasting stigma that inhibits them from adequate treatment. However, this is beginning to change.

Most recently, the First Circuit in *Smith v. Aroostook County* held that Aroostook County Jail must provide MAT to an inmate under the Eighth Amendment because she faced “an imminent, painful and dangerous withdrawal and an attendant risk of continued treatment, overdose, and death.”¹³⁰ The court found that (1) the jail’s practice of denying individuals prescribed MAT is a derivative from the jail, not a medical decision by Katahdin Valley Health Center (KVHC);¹³¹ (2) it is unclear if KVHC may even be capable of assessing inmates’ needs for MAT, as none of their staff are licensed and one of their nurses testified that they did not know the standards of care nor the symptoms of OUD; and (3) the defendants had five months before the plaintiff was incarcerated to medically assess her needs for MAT, and they did not do so.¹³² The First Circuit also found that the jail violated the ADA by being an undisputed public entity that denied an undisputed qualified individual with a disability her necessary medication without assessing her medical needs or providing any “true

medication such as Tylenol due to the prison’s no-narcotics policy); *Strain*, 2009 U.S. Dist. LEXIS 4760, at *7 (denying summary judgment after the plaintiff raised the issue that over-the-counter medications, such as Tylenol, were not appropriate substitutes for Methadone.).

¹³⁰ *Smith v. Aroostook Cty.*, 376 F. Supp. 3d 146, 157 (D. Me. 2019); see also *Smith v. Fitzpatrick*, No. 1:18-cv-00288-NT (D. Me. 2018) (finding a settlement agreement with the Maine Department of Corrections allowing the plaintiff to receive buprenorphine or an equivalent medication while incarcerated).

¹³¹ KVHC was the medical center with which the jail was contracted

¹³² *Aroostook Cty.*, 376 F. Supp. 3d at 157.

justification.”¹³³ Because the jail previously provided MAT to a pregnant woman in the jail itself without any problems,¹³⁴ the court believed that the defendants’ decision to deny MAT access was not based on a medical assessment but on their general attitude towards OUD.¹³⁵ The court found that the defendants’ representatives “lacked a baseline awareness of what OUD was despite serving a population that disproportionately dies of that condition” and the representatives claimed “learning more about how to treat the disorder was boring.”¹³⁶ The court instructed the jail to provide the plaintiff with her medication in whatever way the defendants deemed most appropriate for security needs, including providing the medication in the jail, taking the plaintiff into the community to receive medication, transferring her to another facility capable of providing the medication or “releasing the plaintiff on medical furlough if the jail is otherwise unable to accommodate her needs.”¹³⁷

The court in *Pesce v. Coppinger* also held that under the Eighth Amendment and the ADA, a correctional facility was required to provide methadone treatment to an inmate during his sixty-day incarceration.¹³⁸ The court found that the correctional facility’s attempt to require the defendant to “participate in a treatment program that bares [sic] strong resemblance to the methods that failed [him] for five years, including detoxification,”¹³⁹ would contradict the plaintiff’s physician’s recommendations, place him at a higher risk of relapse, and make him physically ill for several days.¹⁴⁰ The court found that the facility’s policy against methadone treatment does not consider inmates’ specific medical needs stating “medical decisions that rest on stereotypes about the disabled rather than ‘an individualized inquiry into the patient’s condition’ may be considered discriminatory.”¹⁴¹ The

¹³³ *Id.* at 158.

¹³⁴ *Id.*

¹³⁵ *Id.* at 160.

¹³⁶ *Id.*

¹³⁷ *Id.* at 162.

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

¹³⁹ *Id.* at 45.

¹⁴⁰ *Id.* at 46.

¹⁴¹ *Id.* (citing *Kiman v. N.H. Dep’t of Corr.*, 451 F.3d 274 (1st Cir. 2006)).

defendants did not provide any explanation for why they could not safely and securely administer the medication under the supervision of medical staff; therefore, the policy is either “‘arbitrary or capricious-as to imply that it was pretext for some discriminatory motive’ or ‘discriminatory on its face.’”¹⁴² The court found that the policy implemented by the correctional facility was a blanket policy and had no indication of whether it would consider an individual’s medical history and prescribed treatment; therefore, the facility had “deliberate indifference to his medical condition.”¹⁴³

Despite these courts mandating access to MAT on an individual level, the reasoning applies to inmates with OUD as a class. In Washington, the American Civil Liberties Union reached a settlement with Whatcom County Jail in which the jail must provide MAT to “clinically appropriate [male and female] inmates who are in withdrawal from opioids as medically indicated . . . regardless of whether they were already taking MAT at their time of entry.”¹⁴⁴ Prior to this settlement, buprenorphine was distributed solely to pregnant women with OUD despite having a policy that states medication services must be “clinically appropriate and provided in a timely, safe, and sufficient matter.”¹⁴⁵

Individuals are forced to endure excruciating pain simply because they have a disability. Correctional facilities resort to a myriad of excuses for not providing MAT; however, courts consistently reject those. Despite that, the courts have posed a nearly impossible hurdle of proving both a serious medical need and a deliberate indifference an individual with OUD must face to receive legally and medically accepted medication to treat their disability. MAT is provided to treat pain for individuals without OUD, and courts reject the proposition that Tylenol is an acceptable substitute. However, courts hold the exact opposite when faced with a plaintiff who

¹⁴² *Id.*

¹⁴³ *Id.*; see also *Alexander v. Weiner*, 841 F. Supp. 2d 486, 493 (D. Mass. 2012) (“[P]laintiff[s] who allege[] that prison officials repeatedly ignore[] [a] physician’s recommendations[] [have] stated sufficient facts to establish an Eighth Amendment violation”).

¹⁴⁴ Settlement Agreement at 5, *Kortlever et al. v. Whatcom County*, (No. 2:18-cv-00823).

¹⁴⁵ Complaint by Petitioner at 11, *Kortlever et al. v. Whatcom County*, (No. 2:18-cv-00823).

has OUD. It is clear that the stigma associated with illicit substances runs deeper than the illegal substance itself, but also affects individuals who are on a legally and medically accepted regiment. Despite the courts' inconsistency, states have begun protecting these individuals.

b. State Initiative

Whether by case law or legislation, states are beginning to act. Many individual states have created programs to target recidivism rates and to combat overdose and death. The states themselves are not concerned with the security reasons quoted by correctional facilities, as these are considered inappropriate bars to medication access by the courts. When jail-based state programs have encountered security issues, such as those in Rhode Island, they have been addressed with little issue.

Two model states have implemented successful programs—New York and Rhode Island. In 1987, New York became the first state to initiate a methadone treatment program for incarcerated opiate-dependent inmates.¹⁴⁶ The Key Extended Entry Program (KEEP) has two components; the first being jail-based in Rikers Island Correctional Facility¹⁴⁷ and the second being community-based.¹⁴⁸ KEEP has two withdrawal protocols: heroin withdrawal involves twelve days of tapering methadone, and methadone withdrawal involves tapering based on the community dosage.¹⁴⁹ To be eligible for KEEP, inmates must receive a sentence of one year or less or pretrial detainees who face a possible sentence of one year or less. Anyone who has a sentence of more than one year is not eligible for KEEP.¹⁵⁰ Once an inmate or pretrial detainee begins the program, they undergo specific medication distribution protocols and psychoeducation.¹⁵¹ The medication distribution protocols include the direct observation therapy (DOT)

¹⁴⁶ Vincent Tomasino, et al., *The Key Extended Entry Program (KEEP): A Methadone Treatment Program for Opiate-Dependent Inmates*, 68 MOUNT SINAI J. OF MEDICINE, 14 (Jan. 2001).

¹⁴⁷ Hereinafter "Rikers."

¹⁴⁸ Tomasino, *supra* note 146, at 14.

¹⁴⁹ *Id.* at 15.

¹⁵⁰ *Id.*

¹⁵¹ *Id.* at 16.

method.¹⁵² With this method, inmates are observed taking the medication and must verbally respond to a question asked by the correction officer to insure ingestion. The DOT method has significantly decreased drug diversion.¹⁵³ Through psychoeducation, inmates and pretrial detainees regularly meet with counselors to discuss dose maintenance and treatment issues.¹⁵⁴ KEEP also offers relapse prevention through individual and group counseling in which inmates and pretrial detainees “identify triggers to relapse and identify methods of dealing with those triggers.”¹⁵⁵ KEEP participants may also receive alternatives to incarceration, such as residential and outpatient programs, if drug treatment is determined to be more effective than incarceration.¹⁵⁶ KEEP statistics show that individuals who receive a higher post-release dose of MAT are more likely to continue reporting to their designated community-based organization because individuals must “achieve a true ‘blocking dose’ in order to remain in treatment and to eliminate the craving for heroin.”¹⁵⁷

While KEEP has exhibited success in decreasing recidivism and managing substance abuse to avoid overdose, issues have begun to rise as Rikers is being shut down and inmates in KEEP are being relocated throughout the state. These inmates were being tapered off their medication in preparation for their transfer; however, the issue for these inmates still persists.¹⁵⁸ As of July 1st, a new program allows inmates who were transferred to Elmira prison to receive methadone, making this the first program to allow MAT in New York state prisons.¹⁵⁹ This allows inmates who were transferred from Rikers to Elmira to continue methadone, rather than undergo tapering protocols, but only if their sentence is for two years or less.¹⁶⁰ Elmira had no licensed

¹⁵² *Id.*

¹⁵³ *Id.*

¹⁵⁴ *Id.*

¹⁵⁵ *Id.* at 17.

¹⁵⁶ *Id.*

¹⁵⁷ *Id.* at 18.

¹⁵⁸ Alison Knopf, *Methadone Now Allowed in Upstate NY Prison, If Inmates Come from Rikers OTP First*, ADDICTION TREATMENT FORUM (Aug. 7, 2019).

¹⁵⁹ *Id.*

¹⁶⁰ *Id.*

physician to dispense MAT; however, they partnered with United Health Services and the Opioid Treatment Program who send licensed physicians to the Elmira facility weekly to distribute the medication.¹⁶¹ As of right now, only the medication will be provided in the Elmira facility—no counseling or other services will be provided—however, this is a crucial start to maintaining treatment compliance with these individuals and piloting a program for other state facilities to follow.¹⁶²

To further this program, the Senate passed a bill to establish a MAT program for state and county correctional facilities, which would create a substance abuse treatment program in each state and county correctional facility.¹⁶³ The program would be similar to KEEP in that inmates and pretrial detainees will be screened for OUD and provided one of the three MAT options approved by the FDA.¹⁶⁴ Individuals will then work with a specialist to determine an individualized biopsychosocial treatment plan, including counseling. Per the bill, the only individual who can adjust the dosage, commence or cease MAT is a licensed physician.¹⁶⁵ The bill also creates a re-entry program to inmates who receive MAT while incarcerated that includes resources for local treatment facilities, housing, employment, and other information that will assist an inmate in continuing recovery once released.¹⁶⁶

In 2016, the Rhode Island Legislature approved a \$2 million annual budget to expand MAT programs in prisons as part of a fully federally-regulated opioid treatment program.¹⁶⁷ Since then, Rhode Island is the only state that offers all three primary MAT options to inmates, regardless of whether they are pretrial detainees or convicted inmates, in all Rhode Island Department of Corrections (RIDOC) facilities. Currently,

¹⁶¹ *Id.*

¹⁶² *Id.*

¹⁶³ S. 2161B, 2019-2020 Leg., Reg. Sess., (N.Y. 2019) (as of Feb. 27, 2020, the bill has been advanced for a third reading in the Senate).

¹⁶⁴ *Id.*

¹⁶⁵ *Id.*

¹⁶⁶ *Id.*

¹⁶⁷ Nicole Beckman, Hanna Bliska, & Eliza Jane Schaeffer, *Medication Assisted Treatment Programs in Vermont State Correctional Facilities: Evaluating H.468 through a State by State Comparison*, THE NELSON A. ROCKEFELLER CENTER AT DARTMOUTH C. (Feb. 22, 2018).

approximately 300 inmates receive MAT every day.¹⁶⁸ The MAT program is run by Comprehensive Health Care, Centered on You (CODAC) Behavioral Healthcare and includes creating a re-entry treatment plan prior to release that includes various recovery services such as primary care physicians, specialty physicians, specialized healthcare needs, housing, education, transportation, mental health services, and legal support.¹⁶⁹ Upon entering the facility, inmates are screened by CODAC physicians for OUD and are given the option to continue treatment for up to a year or, if they had not previously received treatment and screen positive, they may opt in to receive treatment for a year, so long as their sentence is a year or less.¹⁷⁰ After opting in to MAT, inmates must complete a biopsychosocial assessment by a CODAC physician, who then creates a treatment plan, as well as manages doses.¹⁷¹ The RIDOC requires that inmates receiving MAT participate in behavioral health groups run by CODAC, as well as individual therapy if deemed necessary. To combat security issues with drug diversion, RIDOC switched from pill medication to strips, such as buprenorphine strips, which melt on the tongue. Since this switch, the black market for drugs is waning.¹⁷²

Vermont implemented a MAT program as a result of a court decision and bad press. In 1999, Keith Griggs was charged with forgery and entered into a plea agreement that allowed him to enter into furlough so he could continue taking his methadone.¹⁷³ In 2001, the Vermont Department of Corrections (VDOC) suspended his furlough for two weeks and refused to provide methadone, causing abrupt withdrawal. The Vermont Supreme Court affirmed the decision that he was entitled to his medication; however, the jail released him early rather than provide his medication.¹⁷⁴ The same situation happened to

¹⁶⁸ *Id.*

¹⁶⁹ *Id.*

¹⁷⁰ *Id.*

¹⁷¹ *Id.*

¹⁷² *Id.*

¹⁷³ Alicia Freese, *How Drug Treatment Policies in Vermont Prisons Contribute to the Opiate Crisis*, SEVEN DAYS (Nov. 1, 2017), <https://www.sevendaysvt.com/vermont/how-drug-treatment-policies-in-vermont-prisons-contribute-to-the-opiate-crisis/Content?oid=9714430>.

¹⁷⁴ *Id.*

Shawn Gibson, who was denied methadone access while incarcerated, forcing him to undergo abrupt withdrawal.¹⁷⁵

These cases highlight the controversy over OUD in many states, while also highlighting the power of media coverage. Although the Vermont Supreme Court ruled that inmates must have access to MAT while incarcerated, correctional facilities were still denying MAT access. As a result of web articles discussing the lack of MAT access in correctional facilities, the VDOC adopted a year pilot program, which allowed inmates to receive MAT for a year of their incarceration sentence.¹⁷⁶ However, the application of the program only provided ninety days of MAT access and approval for MAT access is highly selective, leaving many inmates with terminated treatment plans and prescriptions.¹⁷⁷ The correctional facilities terminate MAT access for three reasons: (1) expected length of stay exceeds thirty days, (2) the individual was seen or is suspected of diverting drugs,¹⁷⁸ and (3) the urine test turned up another illicit drug that is not marijuana.¹⁷⁹

Similar to Rhode Island, VDOC has taken precautions to decrease drug diversion. For example, inmates must wear certain clothes that do not have pockets when getting their medication.¹⁸⁰ This raises issues with other inmates who want the medication because they are then better able to identify those who are receiving the medication, which causes targeting. Some inmates divert drugs because the doses are so low that they are going through withdrawal before their next dose.¹⁸¹ The jail claims that using illicit drugs with MAT can cause a health and safety risk.¹⁸² However, medical professionals disagree that it is enough of a health and safety risk to constitute

¹⁷⁵ *Id.*

¹⁷⁶ *Id.*

¹⁷⁷ *Id.*

¹⁷⁸ This includes diversions of drugs on previous stays.

¹⁷⁹ Freese, *supra* note 173.

¹⁸⁰ Alicia Freese, *Hundreds of Vermont Prisoners Get Addiction Meds, but Challenges Remain*, SEVEN DAYS (Dec. 19, 2018), <https://www.sevendaysvt.com/vermont/hundreds-of-vermont-prisoners-get-addiction-meds-but-challenges-remain/Content?oid=24280732>.

¹⁸¹ *Id.*

¹⁸² Freese, *supra* note 173.

ceasing treatment because the alternative is worse. Jails also view methadone and other MAT methods as a privilege and provide alternatives to managing withdrawal symptoms.¹⁸³ Jails frequently receive complaints that these alternatives do not subside the withdrawal symptoms enough to make them manageable; however, the jail administration views it as “patients being upset that their medication wasn’t continued.”¹⁸⁴ After another web article was published highlighting the personal stories of inmates who underwent excruciating withdrawal symptoms after being denied access or abruptly taken off medication rather than tapered, the VDOC expanded treatment from 30 days to 120 days.¹⁸⁵

In 2018, Vermont Lawmakers voted to make opioid treatment widely available in correctional facilities. The new law allowed inmates to receive MAT for more than 120 days if necessary, as well as allowed inmates to get a prescription while in prison, rather than limiting treatment to inmates who received MAT prior to incarceration.¹⁸⁶ Under the new law, inmates must be medically assessed within fourteen days of incarceration. If at any point an inmate is no longer deemed medically necessary to continue MAT, only a licensed medical physician may discontinue MAT.¹⁸⁷

Other states have also taken the initiative to implement MAT policies without waiting for court decisions. In 2015, New Hampshire implemented a policy that provides MAT to inmates while they are incarcerated and before release.¹⁸⁸ However, they may only receive medication after they complete six months of behavioral, educational, and counseling treatment components.¹⁸⁹ Upon release, inmates are mandated

¹⁸³ These alternatives include clonidine for anxiety and muscle aches; hydroxyzine for nausea and vomiting; Imodium for diarrhea and Tylenol for general pain.

¹⁸⁴ Tomasino, *supra* note 146.

¹⁸⁵ Alicia Freese, *Vermont Lawmakers Vote to Make Opioid Treatment Widely Available in Prison*, SEVEN DAYS (Apr. 26, 2018), <https://www.sevendaysvt.com/OffMessage/archives/2018/04/26/vermont-lawmakers-vote-to-make-opioid-treatment-widely-available-in-prison>.

¹⁸⁶ S. 166, No. 176, 2017-2018 Leg., Reg. Sess. (Vt. 2018).

¹⁸⁷ *Id.*

¹⁸⁸ Beckman, Bliska, & Schaeffer, *supra* note 167.

¹⁸⁹ *Id.*

to follow up with a licensed alcohol and drug counselor to ensure successful re-entry and treatment compliance.¹⁹⁰ While this policy protects inmates from overdosing upon release, it still does not protect inmates under the Eighth Amendment and ADA because inmates are forced to experience the same withdrawal symptoms.

Missouri has implemented a policy that provides an incentive to participating inmates. After being screened and referred to the program, inmates are granted a reduction in sentence time if they cooperate with MAT, which has increased program participation and decreased recidivism.¹⁹¹ Upon release, inmates receive a different form of MAT, Vivitrol,¹⁹² and receive consistent one-on-one interaction with a post-release caseworker to ensure that individuals are maintaining sobriety and complying with treatment recommendations.¹⁹³ The flaw in Missouri's plan is that inmates can only be referred to enter substance abuse treatment by the court or by the Board of Probation and Parole.¹⁹⁴

There has been movement in Congress as well. The Senate proposed the Community Re-Entry through Addiction Treatment to Enhance (CREATE) Opportunities Act, which would "establish a grant program to provide more MAT options while incarcerated and continued access to care upon release."¹⁹⁵ This Senate bill has a House companion bill that would create a grant program to allow states and local government to "develop, implement, or expand programs to provide MAT in prisons and jails."¹⁹⁶ The companion bill would

¹⁹⁰ *Id.*

¹⁹¹ *Id.*

¹⁹² Vivitrol blocks opioid receptors in the brain so opioid consumption does not result in addiction-reinforcing euphoria. This is typically not a common MAT option in correctional facilities because it does not subdue the withdrawal symptoms like methadone, naloxone, and buprenorphine.

¹⁹³ Beckman, Bliska, & Schaeffer, *supra* note 167.

¹⁹⁴ *Id.*

¹⁹⁵ CREATE Opportunities Act, S. 1983, 116th Cong. (2019) (as of June 16, 2019, the bill has been referred to the Committee on the Judiciary).

¹⁹⁶ CREATE Opportunities Act, H.R. 3496, 116th Cong. (2019) (as of July 30, 2019, the bill has been referred to the subcommittee on Crime, Terrorism, and Homeland Security).

also make more medications available, require staff to be appropriately trained in addiction services, and address the increased risk of overdose by connecting individuals to continued MAT treatment upon release from incarceration.

State and federal governments have realized that reliance on the court is moot; therefore, they are working to recognize and address the needs of individuals with OUD to ensure individual success. While there may be legislative action, there are other routes correctional facilities and states as a whole can pursue.

PART IV: SOLUTIONS

The ABA provides clear guidelines as to how inmates should receive medical treatment. Correctional facilities continue to try and provide medication such as Tylenol, Clonidine, and Naproxen instead of MAT out of fear of diversion and introducing narcotics into facilities; however, this violates ABA Standards. Because correctional facilities are not providing adequate treatment and are outright refusing services that are related to drug rehabilitation, the ADA is also violated. By not providing them the adequate medication, inmates are undergoing excruciating pain, thus correctional facilities are also violating the Eighth Amendment by having deliberate indifference to the serious medical harm and are not considering individuals on a case-by-case basis. Only when MAT access is constitutionally protected will these hurdles be overcome. This can only be achievable once courts (1) acknowledge the bad precedent upon which many are relying; (2) adopt bright-line definitions; and (3) mandate that relevant policies be decided by the appropriate professionals.

I. FAULTY RELIANCE ON BAD PRECEDENT

Despite the favorable holding in *Norris v. Frame*, many courts heavily rely on its statement that there is no constitutional right to methadone.¹⁹⁷ This reliance is extremely flawed for two reasons. First, *Norris v. Frame* determined a lack of constitutional rights under the Fourteenth Amendment Due Process clause because the plaintiffs were pretrial detainees and

¹⁹⁷ *Norris*, 585 F.2d at 1188.

were not granted rights under the Eighth Amendment.¹⁹⁸ However, that court *still* found in favor of the plaintiff under the Due Process Clause because the correctional facility refused to review his needs on an individualized basis.¹⁹⁹ Courts should not rely so heavily on a singular dictum statement. Instead, courts should be following the constitutionally mandated test under the Eighth Amendment. In addition to outlining the serious medical need and deliberate indifference prongs to the Eighth Amendment, the court in *Estelle* found that the obligation to provide medical care to inmates extends to both situations in which the denial “may actually produce physical torture or a lingering death” and those in which “denial of medical care may result in pain and suffering with which no one suggests would serve any penological purpose.”²⁰⁰ Excessive pain, vomiting, uncontrollable defecation, and hallucinations are only some of the symptoms of withdrawal from opioids and MAT. By denying MAT, correctional facilities are knowingly inducing these symptoms, none of which are symptoms that a rational person would believe serves any penological purpose; therefore, it is a blatant violation of the Eighth Amendment. Furthermore, because courts have determined that inmates have a constitutional right under the Eighth Amendment to psychiatric and psychological medication to alleviate symptoms of a serious disease if denial of such treatment would cause substantial harm to the inmate,²⁰¹ inmates should undoubtedly already have access to MAT. MAT is an FDA-approved treatment for OUD that is intended to alleviate the harsh symptoms and denial of treatment can result in substantial harm and even death. Inmates are forced to rely on correctional facilities to treat their medical needs;²⁰² however, doctors cannot act on their duty to properly treat their patients if the medication is not even an option.

Second, *Norris v. Frame* relied on an FDA regulation²⁰³ with no specification as to how the FDA regulation denied constitutional rights to methadone. The FDA regulation in

¹⁹⁸ *Id.* at 1185, 1187.

¹⁹⁹ *Id.* at 1188-89.

²⁰⁰ *Estelle*, 429 U.S. at 103.

²⁰¹ *Bowring*, 551 F.2d at 43.

²⁰² *Estelle*, 429 U.S. at 104.

²⁰³ 21 C.F.R. § 310.505 (reserved Jan. 8, 2007).

question outlines methadone treatment programs, including “maintenance treatment” programs which are medical services that provide “stable dosage levels for a period in excess of 21 days as an oral substitute for heroin or other morphine-like drugs, for an individual dependent on heroin.”²⁰⁴ Because inmates would receive MAT for more than twenty-one days, correctional facilities would constitute maintenance treatment programs. The FDA regulation then describes how methadone dosage should be determined based on the symptoms that each individual exhibits.²⁰⁵ The FDA regulations cited by *Norris* neither explicitly nor implicitly state that an inmate does not have a right to MAT. The same definitions and criteria are applicable today under Federal Public Health regulations.²⁰⁶ The misinterpretation of the regulations, as well as the faulty reliance on bad precedent, are blocking individuals from receiving appropriate medical treatment for a disability.

II. ADEQUATE DEFINITIONS

The Eighth Amendment analysis under *Estelle* includes phrases such as “serious medical need” and “deliberate indifference” but there is little help defining such terms, which results in inconsistent constitutional protection. There is no consistent test to determine whether a physical ailment constitutes a serious medical need. Under the current guidance, some courts have interpreted excessive vomiting to constitute a serious medical need, while others say it is not sufficient. This lack of clarity allows correctional facilities to deny medical treatment under any façade they choose, opening the door for increased discrimination. Additionally, courts and correctional facilities are both demonstrating discriminatory behaviors by inconsistently analyzing deliberate indifference. Courts have found the use of Tylenol instead of methadone can constitute a deliberate indifference in regard to pain management but is perfectly acceptable in regard to treating OUD. This inconsistency is a clear demonstration of the court’s stigma towards individuals with OUD. Ignoring prior diagnoses,²⁰⁷

²⁰⁴ 21 C.F.R. § 310.505(a)(2).

²⁰⁵ 21 C.F.R. § 310.505(d)(6)(c).

²⁰⁶ 42 C.F.R. § 8.12(e)(1) (2016).

²⁰⁷ *Rivera*, 119 F. Supp. 2d at 337.

denying medication for non-medical reasons,²⁰⁸ and choosing a treatment method that is easier and less effective²⁰⁹ are all recognized methods of satisfying deliberate indifference, yet correctional facilities continue to escape liability when denying medication for these exact reasons because there is no consistency among courts. For this two-part test to be applied consistently and fairly, there must be a clear definition written into a binding agent.

III. FACILITY POLICIES

Correctional facilities do not need to wait for court and legislative decisions. They may begin prioritizing the needs of the underserved by reviewing their policies surrounding MAT. These policies should shift the responsibility of medical decisions to qualified individuals, address the necessary concerns within the facility, and implement effective MAT programming.

a. PHYSICIANS AS DECISIONMAKERS

The ABA Standards has reviewed all necessary constitutional and statutory provisions as well as case law and has determined that there should be a standard of care,²¹⁰ which includes leaving all medical decisions to a qualified health professional, adopting treatment that is medically accepted, ensuring an inmate's continuity of care upon entrance into a facility.

There is a trend towards giving deference to medical professionals when determining access to MAT; however, this is not moving fast enough. Currently, jail administrators are deciding to cease MAT before consulting with a physician, simply because they believe that providing MAT will cause security issues and that MAT is replacing one addiction with another. This contrasts with the ABA Standards, which were developed based on the idea that there is a universal belief among correctional facilities and that universal belief includes

²⁰⁸ See *Jones*, 781 F.2d at 771; *Dunn*, 219 F. Supp. 3d at 1130; *Ancata*, 769 F.2d at 704.

²⁰⁹ See *Williams*, 508 F.2d at 544; *McGinnis*, 429 F.2d 864; *McElligot*, 182 F.3d at 1248.

²¹⁰ *Supra* note 72, at 150.

trusting “a qualified health care professional . . . to oversee and direct the provision of health care in that facility.”²¹¹ OUD is a medical concern and should be addressed only by a licensed physician, rather than by uninformed and uninterested jail administrators. Despite courts placing the decision on the jail administrators, states are following the recommendation of the ABA Standards by putting the power into the hands of the physicians. The bills passed by individual states explicitly state that medical decisions regarding dosage, commencement, and discontinuation of MAT should only be done by a licensed physician. These state bills are forcing correctional facilities to comply with the ADA by first assessing an inmate’s or pretrial detainee’s medical needs before determining the appropriate treatment.

As the ABA Standards suggest, the physicians should create one distinct policy that is applicable to all correctional facilities to both inmates and pretrial detainees. As it stands, in many cases, a difference among physician opinions can keep inmates from receiving MAT; however, courts do not consider this deliberate indifference.²¹² Furthermore, inmates cannot pass the deliberate indifference hurdle if there is no specific policy implemented by the facility that denies access to methadone.²¹³ Courts seem to approve of facilities with a case-by-case MAT screening system and object to facilities that have a blanket no-narcotics policy. However, this creates a path for facilities to claim they have a case-by-case screening system, such as that in *Aroostook County*,²¹⁴ and still deny everyone anyway. By making MAT access constitutional, and creating a blanket policy for all correctional facilities, these issues will be eradicated, and every inmate, administrator, and physician will have a clear expectation regardless of national location.

The blanket policy should also consider the appropriate alternative medications. Many correctional facilities provide

²¹¹ *Id.* at 152.

²¹² See *Wood v. Chadwick*, No. 5:10-CT-3039-D, 2012 U.S. Dist. LEXIS 59070 (E.D. N.C. Apr. 26, 2012).

²¹³ See *Womack v. Windsor*, No. 2:15-cv-0533 MCE KJN P, 2018 U.S. Dist. LEXIS 21922 (E.D. Cal. Feb. 8, 2018) (finding that denial of methadone for pain management would constitute deliberate indifference if the jail had an explicit policy that denied the medication).

²¹⁴ 376 F. Supp. 3d 146 (D. Me. 2019).

Tylenol, Clonidine, Naproxen, and other medications because there is no consistent medically approved alternative. These medications should only be used when an inmate opts out of using MAT or has any other aversion to its use, such as an allergy. In no way should these alternative medications be used as a way for facilities to not provide the proposed constitutionally mandated MAT. It is also important that the physicians who make these policies be unaffiliated with correctional facilities in an attempt to diminish the risk that doctors will determine detainees ineligible for MAT due to facility influence.

The ABA Standards also reinforce the assurance that there must be a continuity of care once an inmate enters a facility.²¹⁵ By creating a constitutional protection, individuals will be able to continue on their prescribed treatment modality until they are evaluated by a licensed professional, who may then determine if there is a continued need. Creating a constitutional protection to MAT will not provide MAT to everyone who steps foot into a correctional facility. The constitutional mandate will, however, ensure that people have access to safe and FDA-approved medication to treat their disabilities. MAT recipients can still be evaluated by physicians at any point during treatment and removed from medication if a trained physician deems it no longer necessary. The inverse is true in that people may be re-eligible for it at another point in their journey to recovery. A constitutional protection for MAT will not increase the worries of correctional facilities, as there are ample ways to address these concerns.

b. ADDRESS CONCERNS WITHIN FACILITIES

Correctional facilities cite drug diversion as a core reason why MAT should not be provided in facilities; however, there are ample successful alternatives—medicine strips that melt in one's mouth,²¹⁶ liquid medication, injections, having the inmate answer questions during medication distribution to ensure consumption, and even separating MAT recipients from other inmates. Vermont makes inmates who receive MAT to wear clothes without pockets; however, this creates an issue

²¹⁵ *Supra* note 72, at 180.

²¹⁶ This is the method used by RIDOC to address this specific concern.

because recipients are more likely to be targeted by drug-seeking inmates. Therefore, this should only be used if MAT recipients are already separated from other inmates.

Proper education and preparation are vital in ensuring that MAT is not diverted. By not offering MAT, correctional facilities are inadvertently promoting diversion from inmates with OUD who would benefit from MAT treatment.²¹⁷ Medication must be counted, recorded, and stored in locked cabinets. The administration of medication should take a few minutes and recipients must be closely observed. If diversion remains a concern, regular drug screens can be used to check inmates for abnormal levels. Most importantly, MAT should never be taken away as part of a punishment. That would be like taking away diabetes or heart disease medication. Knowing that excruciating withdrawal symptoms would result by taking away MAT medication simply for “bad” behavior borders on torture. Furthermore, forced detoxification from medication can undermine an individual’s willingness to engage in MAT in the future which compromises the likelihood of long-term recovery.²¹⁸ To determine the most appropriate methods for addressing concerns, correctional facilities could resort to programming resources²¹⁹ or look to states with successful programs.

c. EFFECTIVE PROGRAMMING

Some states, such as Vermont, have programs in place that provide MAT prior to release, but not upon entrance into a correctional facility. While providing MAT before release is important to decrease the risk of overdose once in the community, it does not address the withdrawal symptoms inmates experience upon entering a correctional facility;

²¹⁷ NAT’L SHERIFFS’ ASS’N & NAT’L COMM’N ON CORR. HEALTH CARE, *supra* note 11, at 17.

²¹⁸ NAT’L SHERIFFS’ ASS’N & NAT’L COMM’N ON CORR. HEALTH CARE, *supra* note 11, at 21.

²¹⁹ See *Evidence-Based Resource Guide Series: Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings*, SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., 67 (July 2019) (providing multiple training videos, fact sheets, guidelines, and other resources for correctional facilities to create a successful MAT treatment program).

therefore, it is still in violation of the ADA and the Eighth Amendment. These programs do not medically assess individuals before determining their medical needs and they force inmates to undergo excruciating withdrawal symptoms. The ideal nationally implemented program would reflect similarities in programs such as the one implemented in Rhode Island which provides MAT upon entrance for up to a year and ninety days prior to release. This complies with both the ADA and the Eighth Amendment because it allows individuals to be treated for their medical needs and alleviates withdrawal symptoms, making it a more effective program for treatment and successful release. Furthermore, the ABA Standards used *Estelle* to determine that an inmate “who is lawfully taking prescription drugs . . . should be maintained on that course of medication”²²⁰ Screening should be routine to ensure that the appropriate medication and dosage is being administered. President Trump reports an amplitude of support to identifying and treating offenders in the criminal justice system who have OUD, including screening every federal inmate for OUD upon intake.²²¹ This should not only include federal inmates. OUD screening must include all levels of detainees with prior diagnoses and others who may meet the criteria. Despite suggestions under the ADA, simply being a “prior user” before incarceration does not inhibit them from ADA and Eighth Amendment protections.

CONCLUSION

The Supreme Court said that a remedy for unsafe conditions need not await a tragedy.²²² However, tragedies are occurring daily as individuals with a disability are being denied their medically accepted medication and being forced to endure excruciating pain, and sometimes death, with little to no reprieve. How severe must the tragedy be before courts, correctional facilities, and legislators see that these individuals

²²⁰ *Supra* note 72, at 163.

²²¹ President Donald J. Trump’s Initiative to Stop Opioid Abuse and Reduce Drug Supply and Demand, HEALTHCARE (Oct 24, 2018) <https://www.whitehouse.gov/briefings-statements/president-donald-j-trumps-initiative-stop-opioid-abuse-reduce-drug-supply-demand-2/>.

²²² *Helling*, 609 U.S. at 33.

deserve to be viewed as valuable rather than disposable? These decisions to deny access to MAT affect the lives of thousands of Americans. Correctional facilities are choosing to ignore decades of scientific evidence, as well as the successful programs implemented in Riker's Island, Rhode Island, and other jurisdictions, all of which illustrate the success of MAT access and the capability of facilities throughout the country.

It is well known that the correctional system is flawed and that individuals with a history of substance use are disproportionately affected. Correctional facilities cannot continue to hide behind the façade of safety and security, because their unconstitutional methods are having the exact opposite effect. Denial of MAT to qualified individuals is a violation of both the Eighth Amendment's prohibition of cruel and unusual punishment because it is a deliberate indifference to a serious medical need and Title II of the ADA for denying a qualified individual access to a public entity's service based on a disability. The ample guidelines available for correctional facility administrators to follow leave no more room for excuses. It is time for the blatant discrimination to cease.