OPIOID ADDICTION ON THE INSIDE: THE HARSH REALITY OF DETOXING BEHIND BARS

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INTRODUCTION

In a time when it is hard to get people to agree on anything, it is widely accepted that the United States faces a severe opioid epidemic. Since 1999, overdoses have claimed the lives of over one million people, with 75% of those overdoses involving an opioid.[1] In 2018 alone, 4.2 million Americans had opioid use disorder.[2] This issue has been acknowledged by the highest levels of the government, including the president. In 2017, President Trump established the President's Commission on Combating Drug Addiction and the Opioid Crisis.[3] The Commission produced a report outlining the severity of the problem, current solutions, and future recommendations.[4] Since then, the problem has only gotten worse, with 110,000 people dying from drug overdoses in the U.S. in 2022.[5] This problem, though still running rampant through the United States, is clearly on the radar of the people in positions to make a change.

The issue not being properly addressed, however, is the problem that arises when people suffering from addiction end up in jail or prison. Someone going through opioid withdrawal experiences many symptoms, including uncontrolled pain, psychological distress, and, in severe cases, suicide.[6] The United States has

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1. *The Drug Overdose Epidemic: Behind the Numbers*, CTRS. FOR DISEASE CONTROL AND PREVENTION (Aug. 8, 2023), https://web.archive.org/web/20240203161834/https://www.cdc.gov/opioids/data/index.html.

2. Terri D'Arrigo, *Stigma, Misunderstanding Among the Barriers to MAT Treatment*, PSYCHIATRY NEWS, Oct. 4, 2019, at 1.

3. Exec. Order No. 13,784, 82 Fed. Reg. 16,283 (Apr. 3, 2017).

4. *See generally The President's Commission on Combating Drug Addiction and the Opioid Crisis*, WHITE HOUSE (Nov. 1, 2017), https://trumpwhitehouse.archives.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-15-2017.pdf (detailing the Commission's recommendations to combat the opioid crisis).

5. *Covid-19 and Substance Use*, NAT'L INST. ON DRUG ABUSE (Nov. 2023), https://nida.nih.gov/research-topics/covid-19-substance-use#frequency-of-overdoses.

6. *FDA Identifies Harm Reported from Sudden Discontinuation of Opioid Pain Medicines and Requires Label Change to Guide Prescribers on Gradual, Individualized Tapering*, U.S. FOOD &

the "highest incarceration rate in the world"[7] with an estimated 30-60% of inmates battling a substance abuse problem.[8] Medications, such as buprenorphine or methadone, can drastically decrease the likelihood of severe withdrawal symptoms.[9] These medications "have been associated with a reduced likelihood of in-custody deaths by overdose or suicide and an overall 75 percent reduction in all-cause custody mortality."[10] Using such medications as treatment of those going through withdrawal is known as "medication-assisted treatment" ("MAT").[11] There are many advocates for the utilization of MAT in prison, including the Department of Justice[12] and President Biden,[13] but others are opposed to the practice.

There are generally two reasons why law enforcement pushes back on using these medications in their facilities. First, the medications are opioids themselves, and officers feel inmates should not be provided with drugs.[14] Second, because they are drugs, these medications are "sought-after contraband," so introducing drugs into the facility has the potential to make the problem worse.[15] There are at least eight states that accept these arguments, and provide no treatment to relieve their inmates' withdrawal symptoms.[16] There are fifteen states that limit their drug treatment services.[16] However, since an effective treatment is readily available, these states violate the Rehabilitation Act, the Americans with Disabilities Act ("ADA"), and the Eighth Amendment's ban on cruel and unusual punishment when they withhold treatment from inmates who suffer from withdrawal associated with substance use disorder.

I. REHABILITATION ACT AND AMERICANS WITH DISABILITIES ACT

Section 504 of the Rehabilitation Act states:

DRUG ADMIN. (Apr. 9, 2019), https://www.fda.gov/drugs/drug-safety-and-availability/fda-identifies-harm-reported-sudden-discontinuation-opioid-pain-medicines-and-requires-label-changes.

7. *Public Policy Statement on Treatment of Opioid Use Disorder in Correctional Settings*, AM. SOC'Y OF ADDICTION MED. (July 15, 2020), https://www.asam.org/docs/default-source/public-policy-statements/2020-statement-on-treatment-of-oud-in-correctional-settings.pdf.

8. *Detoxification of Chemically Dependent Inmates*, FED. BUREAU OF PRISONS (Feb. 2014), https://www.bop.gov/resources/pdfs/detoxification.pdf.

9. Andrew Brown, *How Methadone, Other Meds Are Helping to Lower CT Opioid Deaths*, CT MIRROR (Dec. 5, 2023, 5:00 AM), https://ctmirror.org/2023/12/03/ct-opioid-epidemic-methadone-buprenorphine/.

10. Smith v. Aroostook Cnty., 376 F. Supp. 3d 146, 150 (D. Me. 2019).

11. *Medication-Assisted Treatment (MAT) in the Criminal Justice System: Brief Guidance to the States*, SUBSTANCE ABUSE & MENTAL HEALTH ADMIN., https://store.samhsa.gov/sites/default/files/pep19-matbriefcjs_0.pdf (last visited Oct. 1, 2024).

12. Jaclyn S. Tayabji, Note, *Rehabilitation Under the Rehabilitation Act: The Case for Medication-Assisted Treatment in Federal Correctional Facilities*, 101 B.U. L. REV. Online 79, 89 (2021).

13. Noah Weiland, *In Jails and Prisons, the White House Sees a Chance to Curtail Opioid Overdoses*, N.Y. TIMES (Apr. 21, 2023), https://www.nytimes.com/2023/04/21/us/politics/prisons-opioid-addiction-treatment.html.

14. *Aroostook Cnty.*, 376 F. Supp. 3d at 151.

15. *Id.*

16. *Id.*

> No otherwise qualified individual with a disability in the United States, as defined in section 705(20) of this title, shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance[.][17]

Similarly, Title II of the ADA states, "[n]o 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."[18]

Given the similarity of the two statutes, courts have determined the standards for determining liability under the ADA and the Rehabilitation Act are the same[19] and thus may be addressed in the "same breath."[20]

Though no cases regarding state prisons withholding MAT from inmates have reached the United States Supreme Court, the issue has been heard in the federal court system. In *Parker v. Universidad de Puerto Rico*, the court outlined the elements a plaintiff must establish to prove a violation of Title II of the ADA.[21] In that case, the court held a plaintiff must show they are a qualified individual with a disability; were either excluded from participation in or denied the benefits of some public entity's services, programs, or activities, or were otherwise discriminated against; and the adverse actions occurred because of their disability.[22] "The phrase 'service, program, or activity'… 'is extremely broad in scope and includes anything a public entity does.'"[23] Under Title II of the ADA, "plaintiffs can pursue 'several different types of claims of disability discrimination,' including claims for 'disparate treatment…, i.e., that the disability actually motivated the defendant's adverse conduct,' and claims that the defendant 'refused to affirmatively accommodate his or her disability where such accommodation was needed to provide 'meaningful access to public service.'"[24] Further, failure to accommodate a disability will often have the same practical effect as outright exclusion.[25]

A. Strickland v. Delaware County

The Eastern District of Pennsylvania applied the above standard in *Strickland v. Delaware County*.[26] This case involved the plaintiff, Shaun Strickland, an individual with opioid use disorder ("OUD"). Prior to being incarcerated, Strick-

17. Rehabilitation Act of 1973 § 504, 29 U.S.C. § 794(a) (2016).

18. 42 U.S.C. § 12132 (2001).

19. McDonald v. Pa. Dep't of Pub. Welfare, Polk Ctr., 62 F.3d 92, 95 (3d Cir. 1995).

20. Chambers *ex rel.* Chambers v. Sch. Dist. of Phila. Bd. of Educ., 587 F.3d 176, 189 (3d Cir. 2009).

21. Parker v. Universidad de P.R., 225 F.3d 1, 5 (1st Cir. 2000).

22. *Id.*

23. Furgess v. Pa. Dep't of Corr., 933 F.3d 285, 289 (3d Cir. 2019) (quoting Disability Rts. N.J., Inc. v. Comm'r, N.J. Dep't of Hum. Servs., 796 F.3d 293, 301 (3d Cir. 2015).

24. Smith v. Aroostook Cnty., 376 F. Supp. 3d 146, 158 (D. Me. 2019) (quoting Nunes v. Mass. Dep't of Corr., 766 F.3d 136, 145-46 (1st Cir. 2014)).

25. Strickland v. Del. Cnty., 2022 WL 1157485, at *5 (E.D. Pa. 2022).

26. *See generally id.*

land was in treatment for his OUD, where he took methadone daily as part of his program.[27] After being arrested during a traffic stop, Strickland was jailed at George W. Hill Correctional Facility in Delaware County.[28] When he entered the facility, Strickland informed the defendants of his condition, ongoing treatment, and medication program including the daily use of methadone.[29] He requested that he be provided with his methadone treatment.[30] His request was denied "pursuant to George W. Hill's official policy[.]"[31] The jail then created a "care plan" for Strickland, which included Strickland "undergoing forced withdrawal" from methadone.[32] Strickland then went through withdrawal symptoms that included "bone and joint pain, aches, vomiting, diarrhea, nausea, anxiety, and depression," which continued for the entirety of his incarceration.[33] Upon release, Strickland filed suit alleging a violation of the ADA, Rehabilitation Act, and the Fourteenth Amendment.

The court found that, because the ADA defines disability as "physical or mental impairment that substantially limits one or more life activities" and the ADA's regulations "explicitly state that 'drug addiction' constitutes a physical or mental impairment,"[34] Strickland was a qualified individual, with his "disability" being the OUD.[35] The court then turned to the second prong to determine if Strickland was "precluded from participating" in any services, programs, or activities provided by a government entity. The court held that, in denying Strickland his prescribed medical treatment, the facility "denied Strickland the benefit of the facility's medical services."[36] In reaching this decision, the court relied on reasoning introduced by the United States Supreme Court in *Pennsylvania Department of Corrections v. Yeskey*, which said that "[m]odern prisons provide inmates with many recreational 'activities,' medical 'services,' and educational and vocational 'programs,' all of which at least theoretically 'benefit' the prisoners."[37]

B. Hill v. Westermoreland County Prison

The Western District of Pennsylvania heard a similar case in *Hill v. Westermoreland County Prison*. Plaintiff, William J. Hill, brought a civil action against Westermoreland County Prison ("WCP") under the ADA and the Rehabilitation Act, as well as the Fourteenth and Eighth Amendments.[38] The case arose when Hill, a man with OUD, was incarcerated and the facility failed to

27. *Id.* at *1.
28. *Id.*
29. *Id.*
30. *Id.*
31. *Id.* at *3.
32. *Id.* at *1.
33. *Id.*
34. *Id.* at *3.
35. *Id.*
36. *Id.* at *3.
37. *Id.* (quoting Pa. Dep't of Corr. v. Yeskey, 524 U.S. 206, 210 (1998)).
38. Hill v. Westermoreland Cnty. Prison, 2022 WL 17740415, at *2 (W.D. Pa. 2022).

provide the correct treatment for his withdrawal symptoms.[39] Hill claimed the defendants knew of the disorder.[40] The claims were ultimately dismissed because Hill, unlike Strickland, failed to assert the prison had a standing policy against providing the necessary MAT to withdraw patients.[41] This case seems to suggest that for a plaintiff to succeed in bringing claims under the ADA and Rehabilitation Act for denial of MAT, they must establish that prisons have standing policies against them.

C. Pesce v. Coppinger

The Massachusetts District Court heard a case that addressed this issue in *Pesce v. Coppinger*. In this case, Pesce was in active recovery from OUD.[42] His treatment plan, which he had been following for two years at the time, was prescribed by his physician and included the use of methadone, similar to most modern MAT programs.[43] However, after being arrested for driving on a suspended license in violation of his probation, Pesce was facing incarceration in a facility known as Middleton.[44] The facility, "[a]s part of its substance abuse treatment program… require[d] incarcerated individuals to undergo forced withdrawal under medical supervision, followed by a treatment plan that includes substance abuse therapy, educational programming, re-entry services, and after-care[.]"[45] This treatment program had recently been awarded a "three-year, $1.5 million grant from the Department of Health and Human Services Substance Abuse and Mental Health Services Administration."[46] Pesce, being aware of this policy, attempted to taper himself off of methadone by reducing his dosage from 120 milligrams per day to twenty milligrams per day.[47] This caused him to suffer from insomnia, anxiety, fatigue, and depression.[48] Pesce's doctor, Dr. Yuasa, said to effectively taper, Pesce needed to be on eighty to one hundred milligrams of methadone per day, and that "sudden, involuntary withdrawal of treatment will cause Pesce 'severe and needless suffering, jeopardize[s] his long-term recovery, and is inconsistent with sound medical practice.'"[49] Dr. Yuasa went on to say that denying Pesce MAT for his methadone addiction would place him at an increased risk of "overdose and death upon his release."[50] After failing to taper himself off of methadone, Pesce filed a motion seeking a preliminary injunction.[51]

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39. *Id.* at *2.
40. *Id.*
41. *Id.* at *6.
42. Pesce v. Coppinger, 355 F. Supp. 3d 35, 38 (D. Mass. 2018).
43. *Id.*
44. *Id.* at 41.
45. *Id.* at 42.
46. *Id.*
47. *Id.* at 41.
48. *Id.*
49. *Id.*
50. *Id.*
51. *Id.* at 42.

In determining whether Pesce was likely to succeed on his ADA claim, the court stated there was no dispute between the parties that Pasce qualified as an individual with disabilities under the ADA.[52] The court then turned to Pesce's claim that "[d]efendants' refusal to administer methadone deprive[d] him of the benefit of health care programs, and that such conduct constitute[d] discrimination on the basis of his disability."[53] Citing *Yeskey*, the court ruled that "the medical care provided to Middleton's incarcerated population qualifies as a 'service' that disabled inmates must receive indiscriminately under the ADA."[54] Because Dr. Yuasa strongly recommended the continuation of methadone treatment while incarcerated due to his concerns of "severe physical and mental illness, relapse into addiction, and death," and because defendants would not conduct an "individualized assessment of Pesce's medical needs or his physician's recommendation" before requiring Pesce to "participate in a treatment program that bares strong resemblance to the methods that failed Pesce for five years," the facilities were likely discriminating on the basis of the disability.[55]

Middleton then invoked the First Circuit's ruling in *Kiman* to assert that "disagreement with reasoned medical judgment is not sufficient to state a disability discrimination claim."[56] However, in *Kiman*, the prison consulted with the plaintiff's medical records and a specialist in the area before it determined a treatment plan.[57] Obviously distinguishable from *Kiman*, in Pesce's case, defendants made no attempt to inquire about Pesce's condition before determining a proper course of action.[58] They simply subjected him to the same cookie-cutter treatment that all other OUD inmates endured.[59]

Middleton then argued that they have a legitimate reason (prison security) for prohibiting opioids from their facility.[60] They cited a case from Massachusetts, in which the court explained that "concerns over prison security may be legitimate non-discriminatory grounds for limiting access to a jail program."[61] Middleton, however, did not expressed "specific security concerns relevant to Pesce's proposed methadone intake." Middleton could have done this by explaining why it could not administer Pesce's treatment without sacrificing prison security.[62]

As a last-gasp effort, Middleton argued that when there is a dispute over the "adequacy of the treatment," federal courts are "reluctant to second guess medical judgments."[63] This argument falls short because there was evidence in the record

52. *Id.*

53. *Id.* at 45.

54. *Id.*

55. *Id.*; *see also* Pa. Dep't of Corr. v. Yeskey, 524 U.S. 206, 210 (1998).

56. *Pesce*, 355 F. Supp. 3d at 46 (citing Kiman v. N.H. Dep't of Corr., 451 F.3d 274, 285 (1st Cir. 2006)).

57. *Id.*

58. *Id.*

59. *Id.*

60. *Id.*

61. *Id.* (quoting Kogut v. Ashe, 602 F. Supp. 2d 251, 253 (D. Mass. 2009)).

62. *Id.*; *see Kogut*, 602 F. Supp. 2d at 253.

63. *Pesce*, 355 F. Supp. 3d at 46 (quoting Graham *ex. rel.* Est. of Graham v. Cnty. of Washtenaw, 358 F.3d 377, 385 (6th Cir. 2004)).

that Middleton's treatment program was "ineffective at treating Pesce's disorder and could potentially place Pesce at a higher risk of relapse and overdose upon release."[64] Ultimately, the court ruled that Pesce was likely to succeed on the merits of his ADA claim against Middleton.[65]

D. Smith v. Aroostook County

Set in the District Court of Maine*, Smith v. Aroostook County* is another example of these rules at work. This case involved a plaintiff who had been abusing opioids since they were eighteen years old.[66] Smith's drug addiction escalated into a massive issue, leaving her "unable to maintain employment or to care for her family, culminating in the loss of custody over her children."[67] As a result, Smith's doctor diagnosed her with OUD and started her on a treatment program that included using Suboxone.[68] After five years on the program, Smith's doctor switched her to buprenorphine, which she was still taking at the time of this case in 2019.[69] Her doctor had tried to taper her dose multiple times, but was unsuccessful and as a result, Ms. Smith was still dependent on her treatment, though her condition was stable at the time of this case.[70] The ten years of treatment was a success, helping Ms. Smith regain custody of her children and obtain employment.[71]

The issue in this case arose when Smith was incarcerated in the York County Jail, Aroostook, for a week.[72] Like many others, the jail "prohibit[ed] inmates from continuing to use opioid replacements such as buprenorphine while they are incarcerated in the facility," and offered only substance abuse counseling for people in Smith's position.[73] Pursuant to this policy, the jail did not allow her to continue taking her prescribed medication, leading to Smith experiencing what was "the wors[t] pain she has ever endured."[74] She noted that she recalls experiencing "suicidal thoughts for the first time in her life."[75] She was fortunate to only be in the jail for a week, and upon leaving, was able to resume her MAT. However, she was aware of one of her cellmates who "did not return to treatment, overdosed, and died shortly after her release."[76] Smith brought a claim against the defendants for violating the ADA either by "denying her the benefit of the jail's health care programs because of her disability or by refusing to make reasonable modifications

64. *Id.* at 47.
65. *Id.*
66. Smith v. Aroostook Cnty., 376 F. Supp. 3d 146, 149 (D. Me. 2019).
67. *Id.*
68. *Id.*
69. *Id.*
70. *Id.*
71. *Id.*
72. *Id.* at 150.
73. *Id.*
74. *Id.*
75. *Id.*
76. *Id.*

to a policy or practice in order to allow her to access necessary treatment for her disability."[77]

In determining whether an ADA claim will be allowed to continue, the court noted that the "First Circuit has 'differentiated ADA claims based on negligent medical care from those based on discriminatory medical care.'"[78] The court elaborated further:

> The First Circuit has allowed that treatment decisions can be so unreasonable as to constitute evidence of discrimination under the ADA, but has clarified that the "showing of medical unreasonableness… must be framed within some larger theory of disability discrimination. For example, a plaintiff may argue that her physician's decision was so unreasonable—in the sense of being arbitrary and capricious—as to imply that it was pretext for some discriminatory motive, such as animus, fear, or apathetic attitudes. Or, instead of arguing pretext, a plaintiff may argue that her physician's decision was discriminatory on its face, because it rested on stereotypes of the disabled rather than an individualized inquiry into the patient's condition—and hence was unreasonable in that sense."[79]

Diving into the analysis, the court went on to say that there is no dispute that Aroostook was a public entity or that Smith was qualified as disabled.[80] Aroostook also conceded that Smith was entitled to adequate medical care while she was incarcerated.[81] Aroostook's case relied on the assertion that they "have yet to deny the Plaintiff any benefit or accommodation, and that if they do so it will be because their medical staff has made an individualized determination that she does not need her medication and not because of her disability."[82] The court rejected this argument, noting that the evidence suggested Smith was denied her medication because she suffered from an OUD. Aroostook never made an effort to make their own assessment of Ms. Smith's situation, instead leaving her doctor's conclusions "uncontroverted."[83] The court held: "The Defendants' out-of-hand, unjustified denial of the Plaintiff's request for her prescribed, necessary medication—and the general practice that precipitated that denial—is so unreasonable as to raise an inference that the Defendants denied the Plaintiff's request because of her disability."[84]

Applying the logic set forth by the courts in the above cases, it seems clear that denying inmates the necessary medication to assist them as they go through withdrawal is a violation of the ADA and Rehabilitation Act. The inmates fit the definition of "qualified individual" under the ADA because OUD has been recognized as a disability. Therefore, it is illegal for these individuals to be denied care because of the disability itself. This analysis inevitably leads to the conclusion

77. *Id.* at 158.
78. *Id.* at 159 (quoting Kiman v. N.H. Dep't of Corr., 451 F.3d 274, 284-85 (1st Cir. 2006)).
79. *Id.* (quoting *Kiman*, 451 F.3d at 284-85).
80. *Id.*
81. *Id.*
82. *Id.*
83. *Id.*
84. *Id.* at 159-60.

that states are violating the ADA, and since the standards for determining liability under the ADA and the Rehabilitation Act are the same, they are also violating the Rehabilitation Act.

II. EIGHTH AMENDMENT

The Eighth Amendment prohibits cruel and unusual punishment. Specifically, it reads, "[e]xcessive bail shall not be required, nor excessive fines imposed, *nor cruel and unusual punishments inflicted.*"[85] Therefore, the government violates the Eighth Amendment when an individual with OUD is incarcerated and subsequently forced to undergo excruciating withdrawal.

In *Pesce*, the court also ruled on the likelihood of success of Pesce's Eighth Amendment claim.[86] The court first set forth the analysis used in evaluating such a claim: "To prevail on an Eighth Amendment claim of deliberate indifference based on inadequate or delayed medical care, the plaintiff must satisfy both an objective and subjective inquiry."[87] To satisfy the objective inquiry, the plaintiff must show that the alleged medical need was "sufficiently serious."[88] "Sufficiently serious" means that the medical need was "either diagnosed by a physician as mandating treatment or is obvious to the point that a layperson would recognize the need for medical assistance."[89]

In order for plaintiffs to fulfill the subjective prong, they must show intent or wanton disregard by the facility when they provided the alleged inadequate care,[90] or that a prison official acted with deliberate indifference.[91] Deliberate indifference "may appear when prison officials deny, delay, or intentionally interfere with medical treatment, or it may be shown by the way in which prison physicians provide medical care."[92] Using these tests, the court found that Pesce was reasonably likely to succeed on his Eighth Amendment claim.[93] Pesce satisfied the objective inquiry because he had treatment prescribed by a doctor, which is enough on its own, but also any layperson could have seen that his problem was severe. For the subjective element, Pesce likely could have shown the intent or wanton disregard necessary. Middleton clearly knew of the risks of forced opioid withdrawal but required it anyway.

85. U.S. CONST. amend. VIII (emphasis added).

86. Pesce v. Coppinger, 355 F. Supp. 3d 35, 47-48 (D. Mass. 2018).

87. *Id.* at 47; *see also* Perry v. Roy, 782 F.3d 73, 78 (1st Cir. 2015).

88. *Pesce*, 355 F. Supp. 3d at 47 (quoting Burrell v. Hampshire Cnty., 307 F.3d 1, 8 (1st Cir. 2002)).

89. *Id.*; *see also* Gaudreault v. Mun. of Salem, Mass., 923 F.2d 203, 208 (1st Cir. 1990).

90. *Pesce*, 355 F. Supp. 3d at 47; *see also Perry*, 782 F.3d at 79.

91. Toguchi v. Chung, 391 F.3d 1051, 1057 (9th Cir. 2004).

92. Hutchinson v. United States, 838 F.2d 390, 394 (9th Cir. 1988).

93. *Pesce*, 355 F. Supp. 3d at 47.

A. Rokita v. Pennsylvania Department of Corrections

The Commonwealth Court of Pennsylvania heard a similar case and applied the tests set out by the court in Pesce.[94] The plaintiff, Rokita, was prescribed opioids following an injury and developed a dependance. Once he could no longer get them legally, he turned to illegal channels and was eventually arrested.[95] Rokita was diagnosed with substance use disorder and incarcerated at the State Correctional Institution at Houtzdale.[96] He made a request that the prison provide him with either MAT or "the opportunity to see a doctor who could prescribe him MAT."[97] The only assistance offered by the Pennsylvania Department of Corrections for someone in Rokita's position was group counseling sessions.[98]

After being denied treatment, Rokita became desperate and obtained opioids on the prison black market.[99] This is noteworthy because the facility manager used it as a reason to deny him the treatment, saying "'[y]our own actions have led to the issue you grieved and your own failure to follow the proper process has led to your non-treatment.'"[100] Rokita challenged his lack of treatment in court, alleging a violation of his Eighth Amendment rights and requesting an order compelling the Department to grant his requests for MAT, or a doctor who will prescribe MAT.[101] Pertaining to the Eighth Amendment claim, the Department argued that Rokita did not "satisfy the governing standard under the Eighth Amendment with respect to the denial of medical treatment."[102]

In ruling on the Department's motion to dismiss the Eighth Amendment claim, the court reiterated a rule from *Estelle v. Gamble,* a United States Supreme Court case, stating "the government has an 'obligation to provide medical care for those whom it is punishing by incarceration.'"[103] "[A]fter all, a prison 'inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met.'"[104] The court, after reiterating the standard established in *Pesce*, distinguished Rokita's situation from that in *Pesce* by noting that Pesce had already been prescribed a MAT by a physician by the time he "faced impending incarceration."[105] However, the court decided that this distinction did not preclude Rokita from claiming the protection of the Eighth Amendment, reasoning that interfering with treatment prescribed by a physician and not allowing a treatment to be prescribed is not all that different [106] In the end, the court

94. Rokita v. Pa. Dep't of Corr., 273 A.3d 1260 (Pa. Commw. Ct. 2022).
95. *Id.* at 1263.
96. *Id.*
97. *Id.*
98. *Id.*
99. *Id.*
100. *Id.* at 1264.
101. *Id.*
102. *Id.*
103. *Id.* at 1265 (quoting Estelle v. Gamble, 429 U.S. 97, 103 (1976)).
104. *Id.* at 1265 (quoting *Estelle*, 429 U.S. at 103).
105. *Id.* at 1268.
106. *Id.*

overruled the Department's motion, allowing Rokita's Eighth Amendment claim to continue.[107]

III. FOURTEENTH AMENDMENT

The Fourteenth Amendment states:

> All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the state wherein they reside. No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, *without due process of law*; nor deny to any person within its jurisdiction the equal protection of the laws.[108]

When states deny their incarcerated population access to the necessary medication to assist in their OUD withdrawal, they are violating the Fourteenth Amendment's Due Process Clause.

The Fourteenth Amendment applies in cases where inmates are denied their medication after being detained, but prior to trial.[109] In 2005, in *Hubbard v. Taylor*, the Third Circuit ruled that a detainee may not be punished prior to an adjudication of guilt in accordance with due process.[110] Likewise, in *Natale v. Camden County Correctional Facility,* the Third Circuit set out the standard for pleading inadequate medical treatment during pretrial detention.[111] The court held that inadequate medical treatment rises to the level of punishment under the Fourteenth Amendment when the plaintiff can allege both a serious medical need and acts or omissions by jail officials that indicate deliberate indifference to that need.[112] A year later, in *Spruill v. Gillis*, the same court discussed how the deliberate indifference standard can be met. The court said the standard is satisfied, "[w]here prison authorities deny reasonable requests for medical treatment… and such denial exposes the inmate to undue suffering or the threat of tangible residual injury," and "where knowledge of the need for medical care is accompanied by the… intentional refusal to provide that care."[113]

When evaluating a Fourteenth Amendment claim, courts use a four-element test:[114]

1. "The defendant made an intentional decision about the plaintiff's medical care"[115];

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107. *Id.* at 1271.
108. U.S. CONST. amend. XIV (emphasis added).
109. Bell v. Wolfish, 441 U.S. 520, 523 (1979).
110. Hubbard v. Taylor, 399 F.3d 150, 158 (3d Cir. 2005).
111. Natale v. Camden Cnty. Corr. Facility, 318 F.3d 575, 582 (3d Cir. 2003).
112. *Id.*
113. Spruill v. Gillis, 372 F.3d 218, 235 (3d Cir. 2004).
114. Est. of Miller v. Cnty. of Sutter, 2020 WL 6392565, at *11 (E.D. Cal. 2020).
115. *Id.*; *see also* Gordan v. Cnty. of Orange, 888 F.3d 1118, 1125 (9th Cir. 2018).

2. The defendant's decision "'put the plaintiff at substantial risk of suffering serious harm'"[116];

3. The defendant did not take objectively reasonable, available measures to abate said risk, even though a reasonable official in the circumstances would have appreciated the high risk of degree involved[117]; and

4. "'[B]y not taking such measures, the defendant caused the plaintiff's injuries.'"[118] Both actual cause and proximate cause are required.[119]

There have yet to be any cases applying these four elements to a scenario in which someone with an OUD is detained while awaiting trial and subsequently denied a MAT that would have prevented subsequent harmful effects. It is easy to see, however, how this would apply. Assume a hypothetical scenario like those cases that we have seen thus far. A plaintiff is suffering from an OUD diagnosed by a physician who had also been treating plaintiff with MAT. Then the plaintiff is detained and held in a jail in which there is a standing policy against providing opioids for detainees, so the person is forced to go through withdrawal in which typical symptoms are experienced.

In said scenario, the first element would be met because the facility makes an intentional decision not to provide the MAT. This decision is evident by the standing policy against MATs. The second element would be met because there is a vast array of evidence showing the effects of forced withdrawal. The third element would likely be the center of dispute. Most facilities that have these policies in place also provide counseling for individuals experiencing withdrawal.[120] Defendants would likely argue that this is a reasonable measure attempting to abate the risk of serious harm. However, courts may find that they are doing nothing to prevent the medically acknowledged harmful effects, and thus the third element would be fulfilled.[121] Finally, there is a strong connection between the sudden stoppage of opioid use and severe side effects,[122] so there would be little dispute that if a facility forced an individual to undergo withdrawal, the resulting harm would be causally and proximately caused by that decision.

Given the prevalence of OUD in the United States, and given how many facilities in the country enforce policies against MAT, this scenario, or one similar, will inevitably occur. When that happens, it is reasonable to believe that the court will rule that these policies are unconstitutional as a violation of the Due Process Clause of the Fourteenth Amendment.

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116. *Est. of Miller*, 2020 WL 6392565, at *11 (quoting *Gordon*, 888 F.3d at 1125).

117. *Est. of Miller*, 2020 WL 6392565, at *11; Castro v. Cnty. of L.A., 833 F.3d 1060, 1071 (9th Cir. 2016) (explaining that under the third element, the defendant's conduct must be objectively unreasonable).

118. *Est. of Miller*, 2020 WL 6392565, at *11 (quoting *Gordon*, 888 F.3d at 1125).

119. Lemire v. Cal. Dep't of Corr. & Rehab., 726 F.3d 1062, 1074 (9th Cir. 2013).

120. Pesce v. Coppinger, 355 F. Supp. 3d 35, 40 (D. Mass. 2018).

121. *Id.* at 45.

122. *Id.*

IV. 42 U.S.C. § 1983

Section 1983 states:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress, except that in any action brought against a judicial officer for an act or omission taken in such officer's judicial capacity, injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable.[123]

In simple terms, Section 1983 allows individuals to sue state and local government officials for civil rights violations. *Graham ex rel. Estate v. County of Washtenaw* sets the standard. That case involved a man who was arrested for possession of marijuana.[124] Once in custody, but out of the view of police, Graham ingested "large quantities of cocaine."[125] He began "acting erratically," but lied about the ingestion and only admitted to marijuana use.[126] After experiencing seizures, Graham died.[127]

The personal representative of Graham's estate sued the county under Section 1983, claiming that the county's policy regarding the provision of medical care to prisoners in the county jail contributed to Graham's death.[128] The Sixth Circuit held that "municipal liability under section 1983 may only attach where the 'execution of a government's policy or custom, whether made by its lawmakers or by those whose edicts or acts may fairly be said to represent official policy, inflicts the injury' complained of."[129] To succeed, Graham had to prove "(1) that a constitutional violation occurred; and (2) that the County 'is responsible for that violation.'"[130]

He failed to do so because he was unable to show that the county was responsible for the violation since the health care in the facility was contracted out to outside healthcare providers.[131] However, it is easy to see how Section 1983 could be invoked by someone with an OUD who is denied their treatment by a prison and subsequently suffers harm. This point is illustrated in *Hall v. Kenton County*.[132]

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123. 42 U.S.C. § 1983 (2024).
124. Graham *ex rel.* Est. of Graham v. Cnty. of Washtenaw, 358 F.3d 377, 379 (6th Cir. 2004).
125. *Id.*
126. *Id.*
127. *Id.*
128. *Id.* at 379.
129. *Id.* at 382 (quoting Monell v. Dep't of Social Servs., 436 U.S. 658, 694 (1978)).
130. *Id.* at 379; *see also* Doe v. Claiborne Cnty., 103 F.3d 495, 505-06 (6th Cir. 1996).
131. *Graham*, 358 F.3d at 383.
132. Hall v. Kenton Cnty., 2022 WL 2442199 (E.D. Ky. 2022).

In *Hall*, a pregnant woman, Jennifer Hall, was taken into custody at the Kenton County Detention Center ("KCDC") on April 19, 2018, with a due date of June 2, 2018.[133] KCDC contracted with Southern Health Partners, Inc. ("SHP") to provide "al [sic] medical, dental, and mental health services to inmates of [the] Jail."[134] Hall was addicted to opioids and had been taking methadone for about two years to manage the addiction.[135] For the first month at KCDC, Hall was taken to a methadone clinic for treatment of opioid use disorder.[136] Shortly after a prenatal checkup that concluded with the doctor noting that the baby was active, Hall was switched from methadone to buprenorphine.[137] Dr. Mark Schaffield, who had contracted with SHP to serve as the Medical Director at the KCDC, made that decision.[138] Hall took the buprenorphine without talking to her doctor and without being given the option to stay on methadone.[139] Hall almost immediately experienced severe withdrawal symptoms, and the next day noticed that her baby was no longer moving.[140] The baby was delivered stillborn,[141] and Hall's father and administrator of estate subsequently sued under Section 1983, alleging violations of the Eighth and Fourteenth Amendments.[142]

As in *Graham*, the court found that KCDC was not liable because it did not take part in the medical decisions regarding the plaintiffs.[143] However, the court found a reasonable jury could find that Dr. Schaffield was deliberately indifferent and thus potentially liable for the Eighth Amendment violation.[144] Further, the court explained that private medical professionals who provide healthcare services to inmates qualify as government officials acting under the color of state law.[145] Therefore, if Dr. Schaffield was deliberately indifferent, Hall could succeed.

V. THE SOLUTION

The problem is common and severe enough to warrant vast legislative changes to the existing laws governing inmates' medical treatment. The solution is twofold. First, the ADA should be amended to include explicit language outlining that OUD is a disability. Second, an entirely new federal statute needs to be enacted that lays out the minimum medical aid that prisons and jails must provide to their inmates.

133. *Id.* at *5.
134. *Id.* at *2.
135. *Id.* at *5.
136. *Id.*
137. *Id.* at *6.
138. *Id.*
139. *Id.* at *11-12.
140. *Id.* *12-13.
141. *Id.* at *5.
142. *Id.* at *7.
143. *Id.* at *9-10.
144. *Id.* at *13.
145. *Id.* at *9.

A. Amending the ADA

Prior to passing the ADA, Congress found that many people with disabilities had been precluded from "fully participating in all aspects of society."[146] Further, Congress found that "unlike individuals who have experienced discrimination on the basis of race, color, sex, national origin, religion, or age, individuals who have experienced discrimination on the basis of disability have often had no legal recourse to redress such discrimination."[147] As a result of these findings, Congress passed the ADA to:

> 1. provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities;
> 2. provide clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities;
> 3. ensure that the Federal Government plays a central role in enforcing the standards established in this chapter on behalf of individuals with disabilities; and
> 4. invoke the sweep of congressional authority, including the power to enforce the [F]ourteenth [A]mendment and to regulate commerce, to address the major areas of discrimination faced day-to-day by people with disabilities.[148]

The ADA defines disability as "a physical or mental impairment that substantially limits one or more major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment."[149] When passing the ADA, Congress expected that the definition of disability would be applied in the same way that courts had applied the definition of a "handicapped individual" under the Rehabilitation Act.[150] However, over the years, the Supreme Court has issued decisions severely limiting this definition.[151] There is one specific case that is known for limiting the definition of disability under the ADA.

The aforementioned case involved twin sisters Karen Sutton and Kimberly Hinton, who were severely myopic (nearsighted).[152] Without corrective lenses, they could not perform normal daily activities such as driving, watching television, or shopping.[153] With corrective lenses, however, they could easily function as if they had 20/20 vision.[154] Sutton and Hinton applied to be commercial airline pilots but were denied because of their myopia.[155] They subsequently sued in the District

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146. *Americans with Disabilities Act of 1990, as Amended*, U.S. DEP'T OF JUST. CIV. RTS. DIV., https://www.ada.gov/law-and-regs/ada/ (last visited Oct. 1, 2024).

147. *Id.*

148. *Id.*

149. 42 U.S.C. § 12102.

150. *Americans with Disabilities Act of 1990, as Amended*, *supra* note 146.

151. *See* Toyota Motor Mfg., Ky., Inc. v. Williams, 534 U.S. 184, 197-98 (2002); *see also* Sutton v. United Air Lines, Inc., 527 U.S. 471, 482 (1999).

152. *Sutton*, 527 U.S. at 475.

153. *Id.*

154. *Id.*

155. *Id.* at 475-76.

of Colorado, alleging ADA violations.[156] When the case reached the Supreme Court, the Court found that because Sutton and Hinton could see with corrective measures, they were not actually disabled.[157] This decision set the precedent that disabilities that could be mitigated by corrective measures were not protected under the ADA.

Congress found that the limitation set forth by the Supreme Court rendered the ADA "inconsistent with congressional intent."[158] To address the concerns that came with the Supreme Court limitation, Congress passed the ADA Amendments Act of 2008 ("ADAAA").[159]

When incarcerated individuals are denied the care necessary to prevent their withdrawal symptoms, the goals of the ADA are thwarted. As such, an amendment like the ADAAA is necessary to ensure the full purpose of the ADA is realized. If language was added to the ADA to ensure coverage of individuals with OUD, there would be both a "clear and comprehensive national mandate for the elimination of discrimination" and a "clear, strong, consistent, and enforceable standard for addressing discrimination" as the drafters of the ADA originally intended.[160]

The ADA does not list the disabilities that it covers.[161] Doing so would go against the drafters' intent to keep the definition of disability broad. However, even without expressly stating that OUD is a covered disability, Congress could add language to the definition of disability to say that the disability need not be brought about by natural effects. Specifically, Section 12102(4) of the ADA should be amended to include another subsection that states "[a]n impairment brought about by the withdrawal of legal or illegal substances is a disability if it would substantially limit a major life activity." The term "withdrawal" would then need to be added to Section 12103. This definition should be consistent with the societal understanding of withdrawal but should be defined loosely enough to ensure that the ADA continues to achieve coverage for a broad range of people.

This step is necessary to establish uniformity throughout the judicial branch. The adjudication of these cases has seen too much time and money wasted arguing over whether a person with an OUD is qualified. Amending the ADA to include said language would settle this debate and thus promote efficiency, allowing victims easier access to redress.

A less apparent, though potentially more important, impact of this amendment is the message that it would send to jails and prisons across the county. That message is this: treat these individuals as needed or be held liable for the damage that may occur because of your inaction. It is possible that the officials in these facilities do not know that they are in violation of the ADA when they withhold treatment. The proposed amendment would make it clear that withdrawal symptoms render someone disabled and that they should not be denied treatment.

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156. *Id.* at 476.
157. *Id.* at 481-82.
158. *Americans with Disabilities Act of 1990, as Amended*, *supra* note 146.
159. *Id.*
160. *Id.*
161. *See generally id.*

B. New Legislation

As seen above, there is an astonishingly high number of cases involving people with OUD being incarcerated and subsequently being denied the medication necessary to manage withdrawal symptoms. Given the high frequency of occurrence, it is necessary to draft a law that specifically addresses this issue. As it stands, affected individuals may seek redress through the ADA, Rehabilitation Act, Eighth Amendment, Fourteenth Amendment, and Section 1983. These options, though increasingly viable, come with the challenges of varying judicial interpretations and complex legal issues that make it difficult for a victim to succeed. Adding another course of redress that specifically targets the situation at hand would guarantee the victims are compensated for their suffering without having to battle the challenges that come with arguing under the current litigation pathways. Doing so would also make it abundantly clear to prison officials and policymakers at both the state and federal levels that withholding necessary treatment is against the law and exposes them to civil liability.

The purpose of the new law should be to alleviate the unnecessary suffering of the people in government custody. The government has an implied responsibility to ensure safety to the people in its custody. With that principle in mind, the law should be written broadly so as not to exclude people with substance use disorders other than OUD. The law itself should be broken down into a five-element test:

1. An individual with a known substance use disorder (or similar condition);
2. Becomes incarcerated at a government-run prison or jail;
3. Experiences symptoms of withdrawal associated with the known substance use disorder;
4. Is denied the best available care to assist with the withdrawal; and
5. Suffers damages that would have been prevented if they received the denied care.

If all elements are met, the government is in violation of the law and shall be held liable for all damages incurred by the victim.

This test poses a lot of questions. First, what does it mean for a substance use disorder to be "known"? To diagnose substance use disorders, healthcare professionals look at medical history and behavior surrounding substance use,[162] and thus such disorders can be established by a medical professional prior to incarceration or by a medical professional within the facility. In most cases, knowledge of said disorder should be implied because a simple check of the medical records would provide officials with the information necessary to abate the risk of withdrawal. Knowledge can also be implied based on the circumstances regarding the person's imprisonment. For example, if a person is arrested for possession of fentanyl and admits to using it every day for the past month, a reasonable person would know that the detainee has a substance use disorder and will experience withdrawal once confined. In such a scenario, if a healthcare professional is not consulted, knowledge should be implied. If knowledge is not implied under those circumstances,

162. Jeremy Ledger, *Opioid Use Disorder*, YALE MED., https://www.yalemedicine.org/conditions/opioid-use-disorder (last visited Oct. 1, 2024).

the facilities would be encouraged to avoid consulting a medical professional so that a substance use disorder is not established.

Also, what does it mean for the care to be the "best available" under the fourth element of the proposed test? Using OUD as an example, as it stands, the FDA has approved three medications for the treatment of OUD: methadone, buprenorphine, and naltrexone.[163] If a licensed medical professional has declared that the use of these medications is the best course of treatment for the individual, their medical opinion should be accepted. The issue that arises, then, is what happens when the in-house medical professional's opinion and a previous treating medical professional's opinion differ? There is much room for debate here, but if the individual was put on a plan prior to being taken into custody, the in-house medical professional should give deference to that decision. This situation could provide a safe harbor for the in-house medical professional. If they are following a treating physician's order, they could be immune from suit.

The most important piece of the law would be making sure that it applies to state governments. In order to do so, the law must either fall under those which can be brought under a Section 1983 claim by protecting a constitutionally guaranteed civil right,[164] or if the law is a statute, the enforcement mechanism would be laid out in said statute.[165] Here, the proposed law would fall into the former category because it protects individuals from being discriminated against based on a mental disorder and would thus apply to the states.

VI. CONCLUSION

People dealing with OUDs are among the most vulnerable in our society. They often suffer for years until finally finding some relief when their physician prescribe MAT. Unfortunately, when incarcerated, this group of people suffer both physical and mental pain, as well as a gross violation of their rights because, more often than not, the facility at which they are kept will deny the MAT that was able to provide their long-awaited relief. This, along with the pain and suffering experienced in the facility, greatly increases the chances of relapse and death upon release.

It is time for lawmakers to act. Courts, although not yet the Supreme Court of the United States, are increasingly likely to rule that these facilities are acting unconstitutionally when they enforce policies withholding necessary treatment. Given that these actions are clear violations of the Americans with Disabilities Act, the Rehabilitation Act, the Eighth Amendment's ban on cruel and unusual punishment, and the Fourteenth Amendment's Due Process Clause, a group of people who are underrepresented by the governing bodies of this country are suffering greatly with no end in sight. If allowed to continue, facilities across America will

163. *Id.*

164. W. Ellis Boyle & Taylor Rodney Marks, *Civil Rights Claims: Bringing a Lawsuit Under Section 1983*, NAT'L L. REV. (Apr. 21, 2023), https://www.natlawreview.com/article/civil-rights-claims-bringing-lawsuit-under-section-1983.

165. Alicia Reynolds, *What Is Statutory Law?*, CONSTITUTIONUS.COM, https://constitutionus.com/law/what-is-statutory-law/ (last visited Oct. 1, 2024).

continue to put these people through unimaginable pain and suffering that is easily avoidable.

That is why an amendment to the ADA and the introduction of a new law targeting this issue makes sense. Amending the ADA would make it clear to every prison and jail in the country that people with OUD are members of a protected class and cannot be discriminated against, just as members of religious, racial, and ethnic groups cannot be discriminated against. Furthermore, a new law targeting the mistreatment of substance use disorder in government-run facilities would give an under-represented class further means to seek redress when their rights are violated. Change is long overdue.