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Battleground of the Opioid Crisis: The Eighth Amendment Right to Medication-Assisted Treatment in Prisons and Jails, and Upon Release

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BATTLEGROUND OF THE OPIOID CRISIS: THE EIGHTH AMENDMENT RIGHT TO MEDICATION-ASSISTED TREATMENT IN PRISONS AND JAILS, AND UPON RELEASE

ABSTRACT

About eighty percent of all inmates in the United States need but will not receive treatment for their Opioid Use Disorder (OUD). Instead, they will leave prison with a 140 times greater chance of a fatal overdose than before their prison sentence. Although incarceration is conceivably an opportune time for the state to connect individuals with treatment, only about one percent of prisons and jails allow the use of Medication-Assisted Treatment (MAT). This failure has a myriad of causes. Notably, beliefs that OUD is a moral failure and that MAT either does not work or is dangerous are both among the most salient and most dubious justifications for withholding treatment. Inmates instead undergo forced withdrawal, a form of cruel and unusual punishment under the Eighth Amendment.

Worse yet, regardless of whether an individual receives MAT in prison, facilities overwhelmingly lack reentry procedures that connect former inmates with MAT programs in the community. Because even one day without MAT can propel an individual with OUD into relapse and a fatal overdose, post-release treatment is crucial. Prison policies directly impact inmates' tolerance and likelihood of overdose upon release. Accordingly, this Comment argues that MAT, both in jail and post-release, is within the purview of the Eighth Amendment.

This Comment focuses on Pesce v. Coppinger *to illustrate the shortcomings of the Eighth Amendment jurisprudence, which have left a large subset of the population without treatment for OUD and do nothing to address post-release overdose rates directly linked to the state. Although some plaintiffs have successfully obtained MAT on Eighth Amendment grounds, the current jurisprudence is insufficient to effectuate inmates' right to treatment, both during and after incarceration.*

To fully effectuate the Eighth Amendment right to be free from cruel and unusual punishment, this Comment argues that changes are needed in the current jurisprudence to recognize the State's carceral bargain and a corresponding expanded definition of "punishment." Coupled with a harm reduction argument, these two changes fully recognize inmates' right to MAT and society's evolving standard of decency.

INTRODUCTION

A look inside the United States' prisons and jails reveals the key battleground of the nation's decades-long opioid crisis that has come out of the war on drugs.[1] An estimated 80% of the 2.3 million inmates need life-saving treatment for opioid use disorder ("OUD"),[2] but because "only a small percentage receive any help at all,"[3] they face a shockingly high and seemingly insurmountable risk of overdose upon release.[4] If forced to withdraw and abstain from opioids while in jail, a person with OUD loses their tolerance and "raise[s] the risk of . . . overdose in the first few weeks of reentry by a factor of 140" compared to the general population.[5]

The solution to this problem? A prescription for one of the three evidence-based,[6] Federal Drug Administration (FDA)-approved Medication-Assisted Treatment (MAT) drugs for opioid dependency—Buprenorphine, Methadone,

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[1] *See* Leo Beletsky, *Sequester the Drug War: Drug Control Spending and the Opportunity to Stop Throwing Good Money After Bad*, HUFFPOST, https://www.huffpost.com/entry/war-on-drugs-spending_b_3367725 (July 31, 2013) (detailing the United States' supply and demand reduction tactic, and the accompanying massive spending, as having no real effect on Americans' drug abuse but nonetheless increasing international violence and human rights abuses).

[2] Leo Beletsky, Lindsay LaSalle, Michelle Newman, Janine Par, James Tam & Alyssa Tochka, *Fatal Re-Entry: Legal and Programmatic Opportunities to Curb Opioid Overdose Among Individuals Newly Released from Incarceration*, 7 NE. U. L.J. 149, 151 (2015); *see also* Press Release, Wendy Sawyer & Peter Wagner, Prison Policy Initiative, Mass Incarceration: The Whole Pie 2020 (Mar. 24, 2020) (available at https://www.prisonpolicy.org/reports/pie2020.html) ("450,000 are incarcerated for nonviolent drug offenses on any given day.").

[3] Beletsky et al., *supra* note 2, at 152.

[4] The risk of overdose is not limited to post incarceration. *Id*. at 156. Drugs are "sporadic[cally] availab[le]" in jail, and inmates' decreased tolerance and intense cravings from withdrawal make them susceptible to overdose in jail as well. *Id.*; *see id.* at 156 n.29 (listing instances of drug overdoses in prisons).

[5] Leo Beletsky & Jeremiah Goulka, *The Opioid Crisis: A Failure of Regulatory Design and Action*, 34 CRIM. JUST. 35, 39 (2019). A 2017 report found that fifty-eight percent of people in state prisons either have a drug dependence or misuse drugs, while about five percent of the general population meet these same criteria. German Lopez, *How America's Prisons Are Fueling the Opioid Epidemic*, VOX, https://www.vox.com/policy-and-politics/2018/3/13/17020002/prison-opioid-epidemic-medications-addiction (Mar. 26, 2018, 9:20 AM). However, the disparity in treatment produces the opposite outcome for inmates: "[L]ess than five percent of people who were referred to [OUD] treatment through the justice system received [M]ethadone or [B]uprenorphine, compared to nearly forty-one percent of people referred through other sources." *Id.*

[6] NAT'L INST. ON DRUG ABUSE, HOW EFFECTIVE ARE MEDICATIONS TO TREAT OPIOID USE DISORDER? 4 (2021), https://www.drugabuse.gov/publications/research-reports/medications-to-treat-opioid-addiction/efficacy-medications-opioid-use-disorder. Evidence-based medicine (EBM) is defined as "the conscientious, explicit, judicious and reasonable use of modern, best evidence in making decisions about the care of individual patients" by "integrat[ing] clinical experience and patient values with the best available research information." Izet Masic, Milan Miokovic & Belma Muhamedagic, *Evidence Based Medicine–New Approaches and Challenges*, 16 ACTA INFORMATIC MEDICA: J. ACAD. MED. SCI. BOSN. & HERZ. 219, 219 (2008), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3789163.

or Naltrexone[7]—marketed as "safe to use for months, years, or even a lifetime."[8] MAT has been "unequivocally recommended" for jails and prisons by the Office of National Drug Control Policy and the Centers for Disease Control and Prevention.[9]

Importantly, there are real people affected by the bureaucratic policies, as well as massive financial figures and a staggering death toll associated with the opioid crisis. Prisons' opioid treatment and reentry policies are felt at an individual, family, and community level throughout the country.[10] Geoffrey Pesce recently sued Essex County so that he could continue to take his prescription Methadone treatment while serving a sixty-day sentence.[11] Before starting Methadone, Pesce was unemployed, homeless, and estranged from his family for years;[12] he overdosed six times and attempted detoxification four times.[13] Now, with Methadone, he financially supports his family as a mechanic and once again parents his son.[14] In 2018, Brenda Smith sued the Aroostook County Sheriff in Maine so that she could continue to take the Buprenorphine that she has been prescribed since 2014.[15] Like Mr. Pesce, Ms. Smith's maintenance dose of Buprenorphine enabled her to "regain[] custody of her four

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[7] Naltrexone works differently than Methadone and Buprenorphine and "ha[s] thus far been shown to be inferior . . . and far less cost-effective," resulting in "double the number of overdoses . . . compared with . . . [B]uprenorphine." Leo Beletsky, *21st Century Cures for the Opioid Crisis: Promise, Impact, and Missed Opportunities*, 44 AM. J.L. & MED. 359, 365, 365 n.54 (2018). Naltrexone works by blocking the euphoric effect of opioids, whereas Buprenorphine and Methadone prevent withdrawal symptoms and "facilitate extinction learning . . . because patients learn that they will not get the same 'high' from taking illicit drugs." Complaint & Request for Emergency Injunctive Relief at 8, Pesce v. Coppinger, 355 F. Supp. 3d 35 (D. Mass. 2018) (No. 18-CV-11972).

[8] U.S. Dep't of Health & Hum. Servs., *MAT Medications, Counseling, and Related Conditions*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions (Mar. 4, 2022).

[9] Beletsky et al., *supra* note 2, at 163.

[10] *See, e.g.*, Lopez, *supra* note 5 ("Overdose deaths are a tragic proxy for general problems with addiction here, but addiction has many more effects. It destroys people's career, drives them to crime, breaks up families, and causes secondary health problems . . . made much more likely when people can't get access to adequate treatment [while in prison].").

[11] Memorandum in Support of Plaintiff's Emergency Motion for TRO & Preliminary Injunction at 1, *Pesce*, 355 F. Supp. 3d 35 (No. 18-CV-11972). In a cruel twist, Mr. Pesce's license had been revoked pre-recovery and his mother typically drove him to the treatment facility where he received his Methadone. *Id.* When she was unexpectedly unavailable, Mr. Pesce drove himself to the facility and was pulled over while driving six miles over the speed limit with a revoked license. *Id.*

[12] *Id.*

[13] Complaint, *supra* note 7, at 14.

[14] Memorandum, *supra* note 11, at 1.

[15] Smith v. Aroostook County, 376 F. Supp. 3d 146, 149 (D. Me. 2019) (order granting preliminary injunction). Ms. Smith has been on MAT since 2009. *Id.* A lengthy treatment time is not uncommon, as "[m]uch like other chronic and relapsing conditions, OUD typically requires long-term (even life-long) treatment." Beletsky, *supra* note 7, at 364.

children, secure[] stable housing[,] . . . obtain[] employment[,] . . . earn[] her high school diploma[,] and . . . take college courses."[16] Ms. Smith has not used drugs in five years.[17] Inmates and advocates are catching on. Mr. Pesce and Ms. Smith are just a few of the recent plaintiffs who have argued against prisons' prohibition on MAT based on either the Eighth Amendment or Title II of the Americans with Disabilities Act (ADA).[18]

The fact remains that, in the vast majority of cases, inmates with OUD undergo forced withdrawal in prison,[19] resulting in a drastically decreased opioid tolerance and devastatingly high risk of death upon release.[20] More often than not, inmates receive no treatment in prison or post-release and can relapse in "a matter of days."[21] Although some inmates have been able to assert protection for MAT treatment under the ADA, the Act is alarmingly underinclusive relative to the number of people who need treatment.[22] Further, even in prisons and jails that provide MAT, poor reentry policies often negate the resources expended and any medical progress made in prison.[23] Inmates with OUD are essentially forced into a lose-lose situation: undergo withdrawal in custody or start treatment and risk overdose upon release if they are not connected to a MAT provider in the community.[24]

This Comment argues that an individual's time in prison and subsequent reentry are so inextricably linked that the Eighth Amendment requires prisons and jails to at least minimally facilitate connecting individuals with MAT in the community if they received it in prison or have a known OUD. Based on Sharon Dolovich's theory of the state's carceral bargain and an alternative definition of

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16 *Smith*, 376 F. Supp. 3d at 149 (order granting preliminary injunction).

17 *Id.* at 150.

18 *See infra* notes 196–97 and accompanying text.

19 Beletsky & Goulka, *supra* note 5.

20 *See supra* note 5 and accompanying text.

21 Lopez, *supra* note 5. Lopez details the story of a man named Casey, who, before receiving medication for opioid addiction in a Rhode Island prison, had relapsed repeatedly after release, "not only exposing himself to the risk of a deadly overdose but leading to a spiral of drug use that . . . often[] landed him in prison again." *Id.*

22 *See* Beth Schwartzapfel, *When Going to Jail Means Giving Up the Meds That Saved Your Life*, THE MARSHALL PROJECT (Jan. 29, 2019, 6:00 AM), https://www.themarshallproject.org/2019/01/29/when-going-to-jail-means-giving-up-the-meds-that-saved-your-life ("[M]uch of how the ADA applies in these situations is open to interpretation . . . ."). According to the ADA, someone "currently using drugs illegally," even with a prescription for MAT, does not qualify for protection under the Act. *Id.*

23 *See* Erick Trickey, *How the Smallest State Is Defeating America's Biggest Addiction Crisis*, POLITICO MAG. (Aug. 25, 2018), https://www.politico.com/magazine/story/2018/08/25/rhode-island-opioids-inmates-219594 ("You shouldn't even think about doing a [MAT program] . . . in a correctional setting if you don't connect with [inmates] after release." (second alteration in original)).

24 *See id.*

"punishment," this Comment will show that not providing access to MAT post-release is cruel and unusual punishment in violation of the Eighth Amendment, recognizing that even with the shortest sentences, "sending people with addiction into jail or prison may be a death sentence" once they are released.[25] It is not only cruel and unusual but it is also unacceptable for a seven-day jail sentence to end in death.[26]

To begin, Part I examines the origins of the United States' opioid crisis and provides a basic understanding of the science of addiction, withdrawal, and MAT, as well as prison and jail withdrawal policies. Then, Part II details the Supreme Court's jurisprudence, recent successful cases in which plaintiffs obtained injunctive relief against prisons barring MAT use, and the limitations of current Eighth Amendment jurisprudence in the MAT context in relation to the ADA. Part III explains Sharon Dolovich's alternative Eighth Amendment framework based on constructive knowledge, the carceral bargain, and a more inclusive definition of "punishment."[27] Part III then applies Dolovich's framework to recent MAT litigation and argues for its adoption and application to cases of post-release treatment. In further support of an alternative framework, Part III also details a harm reduction argument for supplying MAT. In light of a difficult Eighth Amendment argument and the life-or-death nature of this issue, Part IV details the compelling public policy arguments in favor of widespread access to MAT both within prisons and post-release.

I. OPIOIDS AND MEDICATION-ASSISTED TREATMENT: HISTORY AND BACKGROUND

The 1990s saw an increase in the legitimate, prescription use of opioids.[28] As doctors began to prescribe opioids for serious illnesses,[29] pharmaceutical companies aggressively marketed their products as safe and effective to the tune of a $2.9 billion increase in OxyContin sales between 1996 and 2002.[30] Predictably, between 1990 and 2001, lethal overdoses doubled.[31] The Drug Enforcement Administration (DEA) responded by prosecuting doctors at an

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25 Beletsky & Goulka, *supra* note 5.

26 *See infra* Part III.C.

27 *See infra* Part III.A–B.

28 Beletsky & Goulka, *supra* note 5, at 36.

29 *Id.*

30 Joseph Y. Shenkar, *All Hands on Deck: The Case for Incorporating Medically Assisted Treatment into the Criminal Justice System in South Carolina*, 70 S.C. L. REV. 849, 852 (2019) (describing persistent minimization of addiction risks for opioid users on behalf of pharmaceutical company Purdue).

31 Beletsky & Goulka, *supra* note 5, at 36.

alarming rate,[32] resulting in both an acute shortage of opioids for legitimate patients and a shift to black market pain medications and heroin.[33]

For many, heroin has recently become the drug of choice because it is "five to eight times cheaper than a black-market OxyContin."[34] Accordingly, lethal overdose rates tripled between 2010 and 2015.[35] In response, the DEA quintupled heroin seizures while the Department of Justice began using strict-liability statutes to hold suppliers responsible for overdose deaths.[36] These strategies "add[ed] substantial barriers and costs to an illicit drug supply chain" but did not reduce demand.[37] Traffickers were incentivized to "minimize the volume of trafficked goods while maximizing their potency to maximize profit."[38] This resulted in fentanyl and the current state of the opioid crisis. Traffickers certainly achieved potency—fentanyl, a synthetic opioid, "is now the leading cause of death for people under fifty five."[39] From June 2020 to June 2021, over ninety-nine thousand people died because of fentanyl.[40]

As if the massive loss of life is not enough, reports estimate that from 2001 to 2017 the "cost of the opioid crisis . . . exceeded $1 *trillion* in the form of lost wages, lost productivity, lost tax revenue, as well as government spending on health care, social services, education, and criminal justice."[41]

It is against this backdrop that inmates suffer and die from a of lack of access to effective OUD treatment.[42] The potency of the opioid crisis and unfettered access to opioids makes it even more problematic to reintroduce inmates into the

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[32] *Id.* at 36–37. At the same time, doctors and health care providers had advocated for Buprenorphine and protested to no avail against its rescheduling to a more restrictive category of the Controlled Substance Act. *Id.* at 36.

[33] *Id.* at 37.

[34] *Id.* (reporting that ninety-four percent of heroin users switched to heroin because prescription opioids were more costly and harder to get). OxyContin is a brand name for the drug Oxycodone. U.S. DRUG ENF'T ADMIN., *Oxycodone*, https://www.dea.gov/factsheets/oxycodone (last visited May 3, 2022). It is a semi-synthetic opioid drug prescribed for pain. *Id.*

[35] Beletsky & Goulka, *supra* note 5, at 38.

[36] *Id.*

[37] *Id.*

[38] *Id.*

[39] *Id.* at 39 ("[F]rom 2014 to 2015, deaths involving opioid synthetics almost doubled.").

[40] Ahmad FB, Rossen LM & Sutton P, *Vital Statistics Rapid Release: Provisional Drug Overdose Death Counts*, NAT'L CTR. FOR HEALTH STATS. (2020), https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.

[41] Aila Hoss, *Legalizing Harm Reduction*, 80 OHIO ST. L.J. 825, 826 (2019) (emphasis added).

[42] Lopez, *supra* note 5 ("[T]he majority of state prisons don't offer full access to . . . the mainline form of treatment for opioid addiction.").

community without access to MAT.[43] Coupled with a scientific understanding of addiction, the inefficacy of prison and jail policies is even more apparent.

This Part will explain three background concepts crucial to understanding why withholding MAT is "incompatible with the evolving standards of decency . . . of a maturing society," and thus a violation of the prohibition on cruel and unusual punishment:[44] (1) the science of addiction versus the societal misunderstanding of addiction as a moral failure; (2) the preference of prisons and jails for forced withdrawal; and (3) the physical and psychological consequences of forced withdrawal for inmates.

A. The Science of Addiction and Withdrawal Versus Addiction as a Moral Affliction

To many, it is hard to understand why opioid users would go to such great lengths to use a drug that is extremely dangerous and potentially lethal.[45] The reality is that incarceration is often a byproduct of addiction, with "4 in 10 state prisoners and sentenced jail inmates"[46] incarcerated either "*because* of their drug use"[47] or crimes committed in an effort to procure drugs.[48] This section will first provide a scientific explanation of how opioid use rewires a person's brain. Then, this section juxtaposes the scientific explanation with the societal misconceptions about OUD and MAT to show the incongruity between the two.

The explanation for such "reckless" behavior is simple—people with OUD are addicted and their brains have the neurobiological adaptations to match.[49] Neurobiological adaptations are a result of continuous opioid use during which opioid receptor agonists "bind[] to and [activate] certain receptors on cells, preventing a biological response" and resulting in a "chronic, relapsing disorder

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[43] The problem is not new. Since the 1990s, the United States' unyielding response has been to ignore evidence-based treatment while policing drugs and failing to reduce supply. Beletsky & Goulka, *supra* note 5, at 36.

[44] Estelle v. Gamble, 429 U.S. 97, 102 (1976) (quoting Trop v. Dulles, 356 U.S. 86, 100–01 (1958)).

[45] *See, e.g.*, Lopez, *supra* note 5 ("One big reason for the dire circumstances [driving prisons' resistance to offering medications] is stigma.").

[46] JENNIFER BRONSON, JESSICA STROOPS, STEPHANIE ZIMMER & MARCUS BERZOFSKY, DRUG USE, DEPENDENCE, AND ABUSE AMONG STATE PRISONERS AND JAIL INMATES, 2007-2009, at 6 (2017) (finding that one-third of drug offenders committed crimes to obtain drugs and one in six violent offenses were committed to obtain drugs).

[47] Lopez, *supra* note 5.

[48] *See id.* (discussing how Casey's addiction "landed him in prison").

[49] *See* R. Douglas Bruce & Rebecca A. Schleifer, *Ethical and Human Rights Imperatives to Ensure Medication-Assisted Treatment for Opioid Dependence in Prisons and Pre-Trial Detention*, 19 INT'L J. DRUG POL'Y 17, 18 (2008) ("[T]he overwhelming physical and psychological reward that comes from heroin derails a neurobiological system designed to preserve the individual.").

requiring longitudinal therapy."[50] Thus, as a person goes through the three stages of addiction—binging, withdrawal, and anticipation[51]—the brain expects opioids and "will do all it can to move the individual to obtain[] and us[e] [them]."[52]

A common scenario that illustrates the widespread misunderstanding of opioid use is the experience of Dr. Josiah Rich, co-director of Rhode Island's Center for Prisoner Health and Human Rights.[53] Dr. Rich recalls asking a prison nurse to give an inmate in withdrawal medicine to ease his physical symptoms.[54] The nurse responded, "No, we don't do that. He's supposed to suffer. That way he won't come back again."[55] The nurse's response reflects not only a misunderstanding of the science of opioid addiction[56] but also what Dr. Rich refers to as a view toward people with OUD as "somewhat subhuman."[57] In reality, individuals suffering from OUD have essentially rewired their brains from prolonged opioid use such that they have "derail[ed] a neurobiological system designed to preserve the individual"[58]—the inmate could have no longer "learned a lesson" through withdrawal. To make rational choices to avoid, for example, "infectious diseases . . . [or] incarceration," an opioid user has to literally "go against this neurobiological [adaptation]."[59] A person does not merely choose to work against this latent neurobiological adaptation. Once society stops conceptualizing addiction as a choice or matter of will, MAT will be all the more compelling.

The reality is that people need MAT to overcome their brain's rewiring, but the lack of understanding and empathy, illustrated by the prison nurse, point to two major barriers to providing it in jails, in prisons, and upon release.[60] Remarkably, these barriers are neither financial nor bureaucratic, but are instead based on the personal beliefs and misunderstandings of prison officials and

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50 U.S. DEP'T OF HEALTH & HUM. SERVS., OFF. OF THE SURGEON GEN., FACING ADDICTION IN AMERICA: THE SURGEON GENERAL'S REPORT ON ALCOHOL, DRUGS, AND HEALTH 2-9 (2016); Bruce & Schleifer, *supra* note 49.

51 U.S. DEP'T OF HEALTH & HUM. SERVS., *supra* note 50, at 2-6.

52 Bruce & Schleifer, *supra* note 49.

53 Trickey, *supra* note 23.

54 *Id.*

55 *Id.*

56 *See* Bruce & Schleifer, *supra* note 49 ("[T]here is widespread failure in prisons to understand that opioid dependence is a medical disorder resulting from complex neurobiological systems.").

57 Trickey, *supra* note 23.

58 Bruce & Schleifer, *supra* note 49.

59 *Id.*

60 *See* Lopez, *supra* note 5. ("First, there's the fact that these are prisoners, which simply makes it much harder for people to empathize with them.").

society.[61] First, because of the "conflation of substance use and morality," many people do not view MAT as an appropriate treatment for OUD.[62] Instead of a disease, OUD is seen as a blameworthy "moral failure."[63] This paints the picture of opioid users as unworthy or undeserving of adequate treatment and provides an easy justification for prison policies.[64] Second, there is a widespread belief[65] among the general public, certain policymakers, prison officials, and healthcare providers "that [MAT] simply 'substitute[es] one drug for another.'"[66] Coupled with the idea of drug use as a moral failure, it becomes nearly unthinkable to provide MAT in prisons and jails.

In reality, MAT stabilizes an individual with OUD so that they "can function normally,"[67] without producing a high or intoxication.[68] Methadone and Buprenorphine are forms of opioids, meaning they also produce a biological response,[69] but the dosage, called a maintenance dose, is only enough to prevent "withdrawal symptoms, control[] cravings, and stabilize[] patients."[70] Additionally, Naltrexone works by "blocking the psychoactive effect of opioids,"[71] but it causes withdrawal if there are opioids in the system and can only be used "after a complete detoxification."[72] MAT is proven to "reduce risk-

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[61] Other barriers include the cost of providing MAT in prisons and jails given that "health care services already constitute[] the largest and fastest-rising component of correctional spending." Beletsky et al., *supra* note 2, at 159. Additionally, prison and jail populations are inherently "some of the most disenfranchised members of our society" who often lack the capital and opportunity to demand a change in treatment. *Id.* at 159–60.

[62] Beletsky, *supra* note 7, at 367.

[63] *See* Lopez, *supra* note 5. Most prisons provide an exception to MAT-prohibition policies for pregnant inmates because withdrawal during pregnancy could be fatal to the fetus. *Id.* Lopez identifies the underlying assumption that "the inmate is to blame for her opioid addiction," but since the fetus "is obviously innocent . . . everything must be done to save it." *Id.*

[64] *Id.*

[65] Trickey, *supra* note 23.

[66] U.S. DEP'T OF HEALTH & HUM. SERVS., *supra* note 50, at 4-22; Trickey, *supra* note 23.

[67] Bruce & Schleifer, *supra* note 49.

[68] Maia Szalavitz, *The Wrong Way to Treat Opioid Addiction*, N.Y. TIMES (Jan. 17, 2018), https://www.nytimes.com/2018/01/17/opinion/treating-opioid-addiction.html.

[69] U.S. DEP'T OF HEALTH & HUM. SERVS., *supra* note 50, at 4-22.

[70] Beletsky, *supra* note 7, at 364. The right dose can be difficult to calculate and requires trial and error, which is why it is "critical" to have all three MAT options available in prisons and jails. Lopez, *supra* note 5. When choosing the specific medication, providers have to consider the particular person's preference, history of opioid use, use of other substances, "co-occurring psychiatric or medical conditions," prior treatment history, and family history. U.S. DEP'T OF HEALTH & HUM. SERVS.: SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., USE OF MEDICATION-ASSISTED TREATMENT FOR OPIOID USE DISORDER IN CRIMINAL JUSTICE SETTINGS 1, 24 (2019) [hereinafter SAMHSA], https://store.samhsa.gov/sites/default/files/d7/priv/pep19-matusecjs.pdf.

[71] Beletsky, *supra* note 7, at 365.

[72] U.S. DEP'T OF HEALTH & HUM. SERVS., *supra* note 50, at 4-24. Rhode Island's prison data shows that "[N]altrexone is far and away the least popular" of the three medications offered, with four inmates choosing it in a six-month period while "180 took [M]ethadone and 119 took [B]uprenorphine." Lopez, *supra* note 5.

taking behavior" and, when opioid users have "psychological stress [or] co-morbid mental illnesses," enable the individual to stabilize "other medical and psychiatric diseases" that may otherwise hinder recovery.[73] It is far more complex and effective than merely substituting one drug for another—it gives an individual their life back.

The deep-rooted and often-cited justifications for denying MAT are simply untenable in the face of the scientific explanation of addiction. Like any other chronic disease, OUD requires comprehensive treatment, but the fact remains that criminalization of drug use and the corresponding limited reach of the Eighth Amendment and the ADA allow for the persistence of "unnecessary and discriminatory barriers to recovery."[74] MAT is undeniably an effective and crucial piece of recovery from OUD, and, as this Comment will show, it is constitutionally required.

B. Prison and Jail Policies Generally Prohibit MAT in Favor of Forced Withdrawal

Prisons and jails overwhelmingly favor withdrawal and detoxification as policy when a new inmate presents with OUD,[75] despite the fact that the standard of care is to provide and continue MAT.[76] Of five thousand prisons and jails, less than one percent allow MAT.[77] About two hundred jails provide Naltrexone to inmates close to or upon release[78] because it "blocks the effects of opioids" to prevent overdose.[79] Naltrexone, however, is only a short-term solution and does not consistently reduce cravings.[80] Though it can prevent an overdose death

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[73] Bruce & Schleifer, *supra* note 49.

[74] Schwartzapfel, *supra* note 22.

[75] Emily Mann, *Advocating for Access: How the Eighth Amendment and Americans with Disabilities Act Open a Pathway for Opioid-Addicted Inmates to Receive Medication-Assisted Treatment*, 29 ANNALS HEALTH L. ADVANCE DIRECTIVE 231, 240 (2020). Only Rhode Island currently provides Buprenorphine, Methadone, and Naltrexone to any inmate presenting with OUD. Christine Vestal, *New Momentum for Addiction Treatment Behind Bars*, PEW: STATELINE (Apr. 4, 2018), https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/04/04/new-momentum-for-addiction-treatment-behind-bars. As of 2018, thirty-five of the fifty states provide either no addiction medication in prisons and jails or only the less-effective Naltrexone right before release. *Id.*

[76] Motion for Class Certification at 10, Kortlever v. Whatcom County, No. 2:18-CV-00823 (W.D. Wash. July 13, 2018); *see also* Hilary Smith Connery, *Medication-Assisted Treatment of Opioid Use Disorder: Review of the Evidence and Future Directions*, 23 HARV. REV. PSYCHIATRY 63, 64 (2015) ("[M]ethadone maintenance remains the gold standard of care for OUD.").

[77] Mann, *supra* note 75.

[78] Vestal, *supra* note 75.

[79] Lopez, *supra* note 5.

[80] *Id.*

shortly after release, one dose before release will not put the individual in recovery, nor will it curb use while the individual is in custody.[81]

Most prisons and jails have a blanket policy prohibiting MAT[82] and only allow exceptions for pregnant inmates.[83] The best an inmate can hope for is that the withdrawal policy includes providing medication to address the physical symptoms, such as Imodium, Tylenol, or antihistamines for nausea.[84] Worse yet, some facilities practice "drug-free" detoxification in which the individual is not given any medication to help with withdrawal symptoms as a form of punishment to "motivate addicts to remain clean."[85] During a drug-free detoxification, an inmate's only comfort may be "a jug of water or juice during the period of acute withdrawal."[86] In the vast majority of situations, forced withdrawal is inevitable once an individual with OUD is booked into custody.[87]

Equally harmful post-release policies also do little to connect inmates with MAT upon release.[88] For example, an audit of the District of Columbia revealed it took thirty-three days, on average, "to connect [released inmates] to treatment options."[89] An individual is at the highest risk of overdose in the first fourteen days after reentry.[90]

Though policies within jails and prisons have improved in the last two years, this progress has been slow and piecemeal, happening mostly on a county-by-county or jail-by-jail basis.[91] While no doubt important, cases by and large require an "individualized assessment[s] of inmates' medical needs for MAT,"

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81 *Id.*

82 Beletsky et al., *supra* note 2, at 196.

83 Lopez, *supra* note 5.

84 Motion, *supra* note 76.

85 Mann, *supra* note 75.

86 Motion, *supra* note 76.

87 *Supra* note 75 and accompanying text.

88 SAMHSA, *supra* note 70, at 5 ("Less than half of state and federal prisons in 2009 referred inmates for [M]ethadone maintenance after release, and less than one-third provided referrals for [B]uprenorphine."). The statistics are even worse for someone with OUD on probation or parole: in 2014, less than five percent of people referred to OUD treatment received Methadone or Buprenorphine. *Id.* at 8.

89 Peter Jamison, *Many D.C. Drug Users Not Receiving Consistent Treatment After Arrests, Audit Shows*, WASH. POST. (Aug. 25, 2020, 4:15 PM), https://www.washingtonpost.com/local/many-dc-drug-users-not-receiving-consistent-treatment-after-arrests-audit-shows/2020/08/25/9854385a-e617-11ea-970a-64c73a1c2392_story.html.

90 Beletsky et al., *supra* note 2, at 152. In D.C., eight out of ten "victims of lethal drug overdoses" never made contact with the D.C. Department of Behavioral Health. Jamison, *supra* note 89.

91 *See, e.g.*, Settlement Agreement at 5, Kortlever v. Whatcom County, No. 2:18-CV-00823, 2018 WL 2763303 (W.D. Wash. Apr. 29, 2019) (requiring Whatcom County jails to allow continuation of MAT and provide it for people who are not on MAT when arrested).

which leaves ample discretion for prison officials to deny treatment.[92] This discretion may lead to an experience with treatment that is not evidence-based, leaving an inmate with a lower tolerance for opioids and thus, more vulnerable to overdose upon release.[93]

C. The Physical, Psychological, and Legal Effects of Withdrawal

Withdrawal occurs when a person with OUD reduces or completely stops taking opioids.[94] In the context of jails and prisons, it is considered forced withdrawal. Because Methadone and Buprenorphine are opioids, withdrawal occurs when an individual is forced off MAT as well.[95] Withdrawal has serious physical and psychological implications in the short term and the long term.[96] In the context of incarceration, the effects are exacerbated.[97]

Physically, individuals in withdrawal may experience "severe abdominal cramping, nausea, [diarrhea], . . . and convulsions."[98] For many people with OUD, "[w]ithdrawal is grueling and . . . a major reason for continued opioid use."[99] In her lawsuit against Aroostook County, Ms. Smith described her experience with forced withdrawal during a previous seven-day sentence as "the worst pain she has ever endured."[100] Another woman stated that her seven-day jail sentence and withdrawal was marked by dehydration because she did not have the "energy to go to the water fountain" and her insomnia was "made worse by the fluorescent lights that never turned off."[101] She relapsed within twenty-four hours of release.[102] Consequences can be even more detrimental for

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[92] *See* Smith v. Aroostook County, 376 F. Supp. 3d 146, 162 (D. Me. 2019) (order granting preliminary injunction) (holding that defendants failed to make individualized assessments of inmates' medical needs for MAT); Pesce v. Coppinger, 355 F. Supp. 3d 35, 47 (D. Mass 2018) ("[Defendants] have stood by the policy without any indication that they would consider Pesce's particular medical history and prescribed treatment in considering whether departure from such policy might be warranted.").

[93] Beletsky et al., *supra* note 7, at 378 (describing the use of 12-Step programs and the fact that they are not evidence-based treatment options).

[94] Leah K. Walker, *Opioid Withdrawal: Signs, Symptoms & Addiction Treatment*, AM. ADDICTION CTRS., https://americanaddictioncenters.org/withdrawal-timelines-treatments/opiate (Mar. 9, 2022).

[95] Bruce & Schleifer, *supra* note 49.

[96] *Id.* at 19.

[97] *Id.*

[98] *Id.*

[99] Lopez, *supra* note 5.

[100] Smith v. Aroostook County, 376 F. Supp. 3d 146, 150 (D. Me. 2019) (order granting preliminary injunction).

[101] Morgan Godvin, *I Thought Jail Would Help Me Get Clean. I Was Dead Wrong.*, THE MARSHALL PROJECT (Sept. 3, 2020, 10:00 PM), https://www.themarshallproject.org/2020/09/03/i-thought-jail-would-help-me-get-clean-i-was-dead-wrong.

[102] *Id.*

individuals with OUD who have co-morbidities or other mental health concerns.[103] Accidental death is a possible outcome of withdrawal in extreme cases or in cases where the withdrawal process is not properly monitored.[104] Given the substandard medical care in prisons and jails and the large volume of inmates, improperly monitored withdrawal may be the norm.[105]

Withdrawal can produce a host of psychological effects as well, including agitation, anxiety, or suicidal thoughts.[106] Coupled with the prison experience, which is marked by loneliness and a loss of autonomy, the risk of suicide increases for inmates.[107] These psychological effects can last up to thirty days and are shown to significantly contribute to relapse.[108] Additionally, some scholars argue that the psychological distress of opioid withdrawal while incarcerated may increase the risk of "self-incrimination, . . . victimization, and susceptibility to coercion" for the most susceptible individuals in the criminal justice system.[109]

In prison or jail, these effects continue even after withdrawal. When individuals withdraw in prison, many will seek out alternative ways to continue using opioids.[110] The first concern with this illicit use is overdose because withdrawal already reduces tolerance[111] and "sporadic" drug availability means individuals likely will not regain the same level of tolerance while in custody.[112]

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[103] Bruce & Schleifer, *supra* note 49, at 19 ("[Withdrawal] can have serious medical consequences for pregnant women and their [fetuses], immunocompromised people, and people suffering from comorbid medical disorders.").

[104] Mann, *supra* note 75.

[105] Madaline Pitkin died at age twenty-six in a jail in Oregon after she was arrested for heroin possession, had told jail officials she had ingested heroin before her arrest, and was placed on a withdrawal plan. Maxine Bernstein, *Record $10 Million Judgment Awarded in Washington County Jail Heroin Withdrawal Death*, THE OREGONIAN (Dec. 7, 2018), https://www.oregonlive.com/crime/2018/12/record-10-million-judgement-awarded-against-corizon-health-in-death-of-washington-county-jail-inmate.html ("Long before [Madaline Pitkin's] death in custody, administrators and policymakers . . . were well aware that medical care at [their] jail was subpar, understaffed[,] and those on staff were poorly trained . . . .").

[106] Mann, *supra* note 75.

[107] Bruce & Schleifer, *supra* note 49, at 19.

[108] Connery, *supra* note 76, at 71.

[109] Mann, *supra* note 75; *see also* Bruce & Schleifer, *supra* note 49, at 19 ("Physical and psychological symptoms attendant to withdrawal may impair capacity to make informed legal decisions, and heighten vulnerability to succumb to police pressure to admit to false charges or confess guilt . . . .").

[110] *Id.* ("Studies in prisons throughout the world have shown that many prisoners continue injection while incarcerated . . . .").

[111] U.S. DEP'T OF HEALTH & HUM. SERVS., *supra* note 50, at 4-13.

[112] *See supra* note 4 and accompanying text. Additionally, drug paraphernalia is limited in custody, which makes syringe sharing necessary and common without a reliable maintenance dose from MAT. Bruce & Schleifer, *supra* note 49, at 19. Unsafe practices in prisons and jails put opioid users at risk of HIV or hepatitis C and strain already "limited medical resources." *Id.*; Mann, *supra* note 75, at 240–41.

Inevitably, illicit use while in custody creates a corresponding "increase in black market demand for drugs," which runs directly counter to the oft-cited justification for banning MAT in jail—a desire to eliminate any risk of access to a drug supply for inmates.[113] By banning MAT, jails and prisons reinforce the exact problem they hope to avoid. The cycle continues and individuals with OUD are released, relapse, and are "back in jail within a month, then the month after that."[114]

Even supervised withdrawal is not considered adequate OUD treatment.[115] At most, withdrawal is considered stabilization, "a first step toward recovery" that is "most effective" with evidenced-based medicine.[116] However, studies show that fifty to seventy-five percent of individuals who undergo forced withdrawal do not receive subsequent treatment that would help them achieve long-term recovery.[117] More is needed to address the individual's brain chemistry and prevent relapse. In a three-state study, twenty-seven percent of people were readmitted within one year of completing withdrawal.[118] Simply put, not only is withdrawal painful and dangerous but it also does virtually nothing to start recovery without the addition of MAT.

II. LEGAL IMPLICATIONS: CASES CHALLENGING DENIAL OF MEDICATION-ASSISTED TREATMENT IN PRISON

Cases challenging prohibition of MAT in prisons and the cruel consequences discussed above are brought under the Eighth Amendment's prohibition on cruel and unusual punishment. An understanding of current Eighth Amendment jurisprudence is necessary for the alternative framework discussed and applied to post-release MAT in Part III. First, section A will discuss the Supreme Court's analyses in *Estelle v. Gamble* and *Farmer v. Brennan* to articulate the doctrinal test for cruel and unusual punishment under the Eighth Amendment. Next, section B will discuss *Pesce v. Coppinger* to explain both the application of the Eighth Amendment to MAT cases and to highlight the limitations of both Eighth Amendment jurisprudence and ADA claims in this context.

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113 Mann, *supra* note 75, at 240.

114 *See, e.g.*, Godvin, *supra* note 101 (describing her failed detoxification in jail and decision to "resign . . . to a life and death in heroin addiction" after selling her best friend the heroin that led to her overdose death); *see also* SAMHSA, *supra* note 70, at 27 ("Within [three] months of release from custody, [seventy-five percent] of formerly incarcerated individuals with an OUD relapse to opioid use, and approximately [forty to fifty percent] are arrested for a new crime within the first year."); *supra* notes 46–47.

115 U.S. DEP'T OF HEALTH & HUM. SERVS., *supra* note 50, at 4-12.

116 *Id.* at 4-13.

117 *Id.*

118 *Id.*

A. Eighth Amendment Jurisprudence: Estelle, Farmer, and the Test for Future Harm

In articulating the Eighth Amendment, the Supreme Court has stated that the Amendment protects people involved in the criminal justice system in three ways:

> First, it limits the kinds of punishment that can be imposed on those convicted of crimes . . . ; second, it proscribes punishment grossly disproportionate to the severity of the crime . . . ; and third, it imposes substantive limits on what can be made criminal and punished.[119]

Prison conditions generally, and medical care more specifically, may not breach the limit on cruel and unusual punishment under the Eighth Amendment.[120]

The duty to provide medical care in prisons historically developed at common law in recognition that once an individual is incarcerated and deprived of their liberty, they are unable to provide for their own medical care, and the state must do so instead.[121] Eventually, in the 1976 case *Estelle v. Gamble*, the Supreme Court extended the common law basis to create an affirmative duty by "drastically expand[ing] the scope of the Cruel and Unusual Punishment Clause" of the Eighth Amendment to apply to prison conditions.[122] *Farmer v. Brennan* expounded on the *Estelle* decision.[123] Today, these two cases primarily govern prison condition claims under the Eighth Amendment, including MAT cases.[124] However, the precise contours of the duty to provide medical care remain unclear, especially in the contexts of therapeutic treatment, the appropriate standard of care, and post-release MAT.[125]

The Supreme Court first considered prison conditions in *Estelle v. Gamble*. In *Estelle*, J.W. Gamble was working at a prison during his incarceration when a bale of cotton fell on him, resulting in three months of continuous back pain, during which he was seen by prison nurses and doctors on numerous

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[119] Ingraham v. Wright, 430 U.S. 651, 667 (1977) (citing Estelle v. Gamble, 429 U.S. 97, 97 (1976), Weems v. United States, 217 U.S. 349, 371–73 (1910); Robinson v. California, 370 U.S. 660 (1962)).

[120] Brenna Helppie-Schmieder, *Toxic Confinement: Can the Eighth Amendment Protect Prisoners from Human-Made Environmental Health Hazards?*, 110 NW. U. L. REV. 647, 653–54 (2016); *see infra* note 132 and accompanying text.

[121] Richard Siever, *HMOs Behind Bars: Constitutional Implications of Managed Health Care in the Prison System*, 58 VAND. L. REV. 1365, 1370 (2005) (discussing Spicer v. Williamson, 132 S.E. 291 (N.C. 1926)).

[122] Sara L. Rose, *"Cruel and Unusual Punishment" Need Not Be Cruel, Unusual, or Punishment*, 24 CAP. U. L. REV. 827, 828 (1995).

[123] *Id.* at 839–40.

[124] *Id.* at 857–58.

[125] Siever, *supra* note 122, at 1377.

occasions.[126] Each time, his only treatment was pain medication and some variation of an order to rest.[127] Eventually, his pain became so unbearable that Gamble faced disciplinary measures for refusing to work, and his circumstances forced him to file his original complaint.[128]

The extension of the Eighth Amendment in *Estelle* required recognition of both the history and tradition of prohibiting solely "'torture[s]' and other 'barbar[ous]' methods of punishment."[129] The Court explained that the Eighth Amendment "embodies 'broad and idealistic concepts of dignity, civilized standards, humanity, and decency.'"[130] Reconciling these two concepts, the Court reasoned that a failure to provide medical care may, at best, lead to pain and suffering without "any penological purpose" and, at worst, "produce physical 'torture or a lingering death.'"[131] Accordingly, the Court in *Estelle* held that prison conditions violate the Eighth Amendment prohibition on cruel and unusual punishment[132] when they "are incompatible with 'the evolving standards of decency . . . of a maturing society'"[133] or "involve the unnecessary and wanton infliction of pain."[134] Under *Estelle*, "the 'unnecessary and wanton infliction of pain' proscribed by the Eighth Amendment" occurs when a prison official or doctor acts with deliberate indifference to an inmate's serious medical needs.[135]

Importantly, the *Estelle* Court qualified the duty to provide medical care by declining to apply it to accidents and medical malpractice in the prison context,[136] implying that the deliberate indifference standard is only met when prison officials act intentionally.[137] The majority therefore articulated a

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126 Estelle v. Gamble, 429 U.S. 97, 98–99, 101 (1976).

127 *Id.* at 99–101.

128 *Id.* at 101.

129 *Id.* at 102 (alteration in original) (quoting Anthony F. Granucci, *Nor Cruel and Unusual Punishment Inflicted: The Original Meaning*, 57 CALIF. L. REV. 839, 842 (1969)).

130 *Id.* (quoting Jackson v. Bishop, 404 F.2d 571, 579 (8th Cir. 1968)).

131 *Id.* at 103.

132 *See* Ingraham v. Wright, 430 U.S. 651, 691 (1977) (citing *Estelle*, 429 U.S. at 97).

133 *Estelle*, 429 U.S. at 102 (quoting Trop v. Dulles, 356 U.S. 86, 100–01 (1958)).

134 *Id.* at 103 (quoting Gregg v. Georgia, 428 U.S. 153, 173 (1976)).

135 *Id.* at 104 (quoting *Gregg*, 428 U.S. at 173). The deliberate indifference standard encompasses the health and safety of inmates and has been considered broadly under the umbrella of "prison-conditions" cases, as opposed to a narrower category of medical care. *See* Farmer v. Brennan, 511 U.S. 825, 834 (1994) (citing Helling v. McKinney, 509 U.S. 25, 34 (1993)) (recognizing application of Eighth Amendment in instances of faulty electrical wiring and insufficient fire safety and rejecting proposition that Eighth Amendment only applies to deliberate indifference in the context of serious health problems).

136 *Estelle*, 429 U.S. at 105–06.

137 *But see id.* at 116–17 (Stevens, J., dissenting) ("By its repeated references to 'deliberate indifference' and the 'intentional' denial of adequate medical care, . . . the Court improperly attaches significance to the

subjective test that asks whether an official manifested indifference "in their response to the inmate's needs" or by "intentionally denying or delaying access to medical care."[138] Applying this test, the majority held that there was no violation of the Eighth Amendment because Gamble received medical attention seventeen times, and the crux of his complaint was that failing to provide an X-ray constituted insufficient medical treatment.[139]

In his dissent, Justice Stevens argued that a subjective analysis of individual motivation is inappropriate, and the test should instead turn on an objective analysis of the character of the punishment.[140] *Estelle* established the foundation for circuit courts to hold that prisons have an affirmative duty to protect inmates and their safety.[141] However, the Court did not clarify the definition or appropriate outer limits of the term "deliberate indifference," nor did it include an objective component.

Eighteen years later, in *Farmer v. Brennan*, the Court affirmed and clarified *Estelle*'s subjective test, added an objective component to the Eighth Amendment analysis, and clarified the definition of "deliberate indifference,"[142] which now governs MAT cases.[143] Dee Farmer, a transsexual inmate, brought suit against federal prison officials alleging violation of the Eighth Amendment after she was beaten and raped in her cell.[144] Farmer alleged an Eighth Amendment claim on the basis that prison officials knew, or should have known, that placing her in the general prison population would be dangerous to her

subjective motivation of the defendant as a criterion for determining whether cruel and unusual punishment has been inflicted. . . . However, whether the constitutional standard has been violated should turn on the character of the punishment rather than the motivation of the individual who inflicted it.").

138 *Id.* at 104–05.

139 *Id.* at 107.

140 *Id.* at 116 (Stevens, J., dissenting). Justice Stevens wrote that a subjective determination of what constitutes a cruel and unusual punishment is incorrect, and that regardless of whether the conditions in *Estelle* "were the product of design, negligence, or mere poverty, they were cruel and inhuman." *Id.* at 116–17.

141 Siever, *supra* note 122, at 1371 n.43; *see, e.g.*, Elliot v. Cheshire County, 940 F.2d 7, 10–11 (1st Cir. 1991) (establishing the duty of the jail to protect detainee from his suicidal tendencies, of which jail personnel were aware or should have been aware); Davis v. Zahradnick, 600 F.2d 458, 459–60 (4th Cir. 1979) (establishing the duty of the guard to protect prisoner from assault).

142 Courts of Appeals had inconsistently interpreted "deliberate indifference" to require anything from a subjective standard of recklessness to actual or constructive knowledge. *See* Farmer v. Brennan, 511 U.S. 825, 832 (1994).

143 Mann, *supra* note 75, at 234. The Court distinguished prison condition cases from excessive force cases in which inmates must prove officials "used force with 'a knowing willingness that [harm] occur.'" *Farmer*, 511 U.S. at 835–36 (quoting Hudson v. McMillian, 503 U.S. 1, 6–7 (1992)).

144 *Farmer*, 511 U.S. at 830–31.

because of her outwardly feminine characteristics and the "violent environment and history of inmate assaults" at the institution.[145]

The Court articulated a two-pronged test for an Eighth Amendment prison conditions claim that consists of both an objective and subjective component.[146] First, the objective prong requires proof that the deprivation is "sufficiently serious."[147] In a failure to prevent harm case, such as for failing to provide sufficient medical treatment for OUD, "the inmate must show that he is incarcerated under conditions posing a substantial risk of serious harm."[148] Importantly, the harm need not have occurred yet, nor must the substantial risk uniformly affect all inmates.[149] Eighth Amendment claims alleging future harm are permitted, and the objective prong of the *Farmer* test is satisfied by proving that (1) there is a likely risk of serious harm and (2) the serious harm is "so grave that it violates contemporary standards of decency to expose *anyone* unwillingly to such a risk."[150] A synthesis of cases in the Second, Eighth, and Ninth Circuits shows that to determine seriousness, courts consider "both the professional judgment of the medical community and . . . the potential that a given condition . . . will cause further harm."[151] Thus, the objective test can be undertaken in both a qualitative and quantitative manner. The future harm analysis is crucial for allegations of post-release overdose risks.

Second, the subjective prong established in *Estelle* requires that the inmate prove deliberate indifference.[152] The deliberate indifference prong is satisfied

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145 *Id.* at 831.

146 *Id.* at 834.

147 *Id.* An analysis of "sufficiently serious" is complicated by the fact that "[p]rison conditions may be 'restrictive and even harsh.'" *Id.* at 833. However, this does not mean that "prisoners can legally be made to suffer from treatable medical or mental health disorders as part of their sentence." David Lebowitz, *"Proper Subjects of Medical Treatment?" Addiction, Prison-Based Drug Treatment, and the Eighth Amendment*, 14 DEPAUL J. HEALTH CARE L. 271, 295 (2012).

148 *Farmer*, 511 U.S. at 834.

149 *Id.* at 845 (citing Helling v. McKinney, 509 U.S. 25, 33 (1993)). In *Helling v. McKinney*, William McKinney brought suit seeking injunctive relief on the basis that his exposure to environmental tobacco smoke in prison "posed an unreasonable risk of harm to his future health" in violation of the Eighth Amendment. *Helling*, 509 U.S. at 27–29. The Court equated the situation to more explicit examples of prison conditions, such as "exposed electrical wiring . . . [and] deficient firefighting measures" and held that an Eighth Amendment claim may be based on present or future harm since prison officials may not "ignore a condition of confinement that is sure or very likely to cause serious illness and needless suffering the next week or month or year." *Id.* at 33–34. The risky conditions created by the environmental tobacco smoke "required a remedy," even though the harm was not immediate and did not affect all prisoners. *Id.* at 33.

150 *Helling*, 509 U.S. at 36. The prisoner's risk of harm should be evaluated in light of the prison's most current policies. *Id.* This indicates there is room within the Eighth Amendment to consider a probable, yet uncertain, risk of overdose.

151 Lebowitz, *supra* note 148, at 296.

152 *Farmer*, 511 U.S. at 834.

when an official "knows of and disregards an excessive risk to inmate health or safety."[153] The Court upheld the subjective element of the test in *Estelle* because the Eighth Amendment prohibits cruel and unusual *punishment*, not "solely . . . the presence of objectively inhumane prison conditions"; therefore, the court must evaluate "a prison official's state of mind."[154] The subjective component makes it more difficult for an inmate to state an Eighth Amendment claim because prison officials can refute the claim by proving they were unaware of the risk or that they responded reasonably.[155]

Adding to an inmate's difficulty in stating a claim, *Farmer*'s subjective prong explicitly rejects constructive knowledge as a basis for liability under the Eighth Amendment.[156] Actual knowledge, on the other hand, is a question of fact for the jury, and the inmate may rely on circumstantial evidence.[157] Accordingly, an inmate's failure to give advance notice of the perceived harm to prison officials is not dispositive.[158] In the case of future harm where a petitioner seeks injunctive relief, deliberate indifference is "determined in light of the prison authorities' current attitudes and conduct."[159]

Thus, to succeed on an Eighth Amendment claim of future harm, such as the risk of overdose in a MAT case,[160] the petitioner must adequately show both that "prison officials, acting with deliberate indifference[,] exposed a prisoner to a sufficiently substantial [objective] 'risk of serious damage to his future health'"[161] such that his punishment is "grossly disproportionate to the severity of the crime."[162] Notably, the Supreme Court has diverged on what exactly constitutes "punishment," and whether a finding that a particular prison condition is punishment should turn on the subjective mental state of prison

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153 *Id.* at 837.

154 *Id.* at 838 (citing Wilson v. Seiter, 501 U.S. 294, 299–302 (1991)). *But see id.* at 858 (Stevens, J., concurring) ("I continue to believe that a state official may inflict cruel and unusual punishment without any improper subjective motivation . . . .").

155 *Id.* at 829, 844. *Farmer*'s dicta is even more deferential, suggesting that if a prison official "knew the underlying facts but believed . . . that the risk to which the facts gave rise was insubstantial or nonexistent," then a jury may choose not to infer knowledge of the risk on behalf of the official. *Id.* at 844.

156 *Id.* at 842.

157 *Id.* at 842–43. For example, the Court suggested that evidence showing that a substantial risk of inmate attacks was "longstanding, pervasive, well-documented, or expressly noted by prison officials in the past" was enough for the jury to find actual knowledge of the risk on behalf of the prison officials. *Id.* at 842.

158 *Id.* at 848.

159 *Id.* at 845 (citing Helling v. McKinney, 509 U.S. 25, 36 (1993)).

160 Beletsky et al., *supra* note 2, at 187–88.

161 *Farmer*, 511 U.S. at 843 (citing *Helling*, 509 U.S. at 35).

162 Ingraham v. Wright, 430 U.S. 651, 667 (1977) (citing Weems v. United States, 217 U.S. 349, 371–73 (1910)).

officials.[163] This disagreement is central to the difficulty of defining the outer bounds of an Eighth Amendment claim and determining when relief is appropriate.

Despite disagreement among the Court's Justices, the lower courts originally analyzed prison conditions under the Eighth Amendment, as Justice Brennan noted in his *Rhodes v. Chapman* concurrence, often finding "entire prison systems" unconstitutional.[164] Although the Court cautioned deference, Justice Brennan emphasized that "judicial intervention is *indispensable* if constitutional dictates . . . [and] considerations of basic humanity . . . are to be observed in the prisons."[165] Citing the horrendous conditions that lower courts have investigated and repudiated, Justice Brennan synthesized the analysis as one in which a court looks at the totality of the circumstances of a prison's conditions and evaluates them in terms of "contemporary standards of decency."[166] Ultimately, Justice Brennan concluded that conditions violate the Eighth Amendment when "the cumulative impact of the conditions of incarceration threatens the physical, mental, and emotional health and well-being of the inmates [and] creates a probability of recidivism and future incarceration."[167]

This cumulative impact analysis summarizes the sweeping effort of the lower courts to improve prison conditions, despite the Supreme Court's rigid interpretation of "punishment" and a subjective requirement for the Eighth Amendment.[168] In part, the more liberal approach taken by lower courts explains the difficulty in identifying the contours of the Eighth Amendment as it applies to prison conditions.[169] However, it simultaneously leaves open the possibility that lower courts may be more open to requiring prisons to provide MAT to

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163 *See supra* note 141 and accompanying text; *Farmer*, 511 U.S. at 851 (1994) (Blackmun, J., concurring) ("I agree with Justice Stevens that inhumane prison conditions violate the Eighth Amendment even if no prison official has an improper, subjective state of mind.").

164 Rhodes v. Chapman, 452 U.S. 337, 353 (1981) (Brennan, J., concurring in the judgment) (noting prisons or prison systems in twenty-four states have been found unconstitutional and stating that "[t]here is no reason of comity, judicial restraint, or recognition of expertise for courts to defer to negligent omissions of officials who lack the resources or motivation to operate prisons within limits of decency").

165 *Id.* at 349; *see id.* at 354 (Brennan, J., concurring in the judgment). This quote is taken out of context and is not meant to suggest a judicial usurpation of the legislative branch. Justice Brennan clarified that "[n]o one familiar with litigation in this area could suggest that the courts have been overeager to usurp the task of running prisons, which . . . is entrusted to . . . the 'legislature.'" *Id.* at 354 (citation omitted). Instead, Justice Brennan asserted that the abhorrent prison conditions brought to light in Eighth Amendment cases have "been thrust upon the judicial conscience." *Id*. (quoting Inmates of Suffolk Cnty. Jail v. Eisenstandt, 360 F. Supp. 676, 684 (D. Mass. 1973)).

166 *Id.* at 363–64 (citation omitted).

167 *Id.* at 364 (quoting Laaman v. Helgemoe, 437 F. Supp. 269, 323 (D.N.H. 1977)).

168 *Id.* at 363–64.

169 *See infra* Part II.B.

released inmates.[170] Though there has not been a Supreme Court case declaring a constitutional right to continue MAT in prison, federal district court decisions from 2018 and 2019 indicate a recent and growing acceptance for the argument that MAT must be provided in prison under the Eighth Amendment.[171] Before these district court cases, many scholars advocated for Eighth Amendment application to treatment of OUD in prisons.[172] Today, commentators advocate for extending the holding in *Pesce v. Coppinger* to inmates who want to opt in to MAT treatment when they initially enter the criminal justice system.[173] Despite more liberal treatment by the lower courts, as shown below, current Eighth Amendment jurisprudence still falls short of getting inmates the OUD treatment they need.

B. Pesce v. Coppinger *Indicates the Eighth Amendment Mandates the Provision of MAT*

Because advocates have only recently managed to secure MAT in prisons for certain inmates, a discussion of the limited case law is necessary. The reasoning in *Pesce v. Coppinger* and the alternative Eighth Amendment framework presented in Part III form the basis for extending Eighth Amendment claims to the post-release provision of MAT. Accordingly, this section discusses the recent district court case *Pesce v. Coppinger*, which granted injunctive relief for a man facing incarceration in a jail with an anti-MAT policy.[174] This section also details the growing recognition that prisons should both allow new inmates to continue their preexisting MAT use and offer it to inmates with OUD who have not previously been on medication. Finally, this section highlights the limitations of Eighth Amendment jurisprudence in the context of MAT, as well as the limitations the ADA imposes.

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[170] *See infra* Part II.B.

[171] CTR. FOR U.S. POL'Y, MAT FOR INCARCERATED INDIVIDUALS: CASE LAW UPDATE 1, 1–5 (2020), https://centerforuspolicy.org/wp-content/uploads/2020/01/MAT-for-Incarcerated-Individuals-Case-Law-Update.pdf.

[172] Beletsky et al., *supra* note 2, at 189.

[173] Mann, *supra* note 75, at 243 ("The hope is that the ADA protections continue to be construed and expanded in favor of inclusivity, granting access to addiction treatment for any inmate who desires to start on the road to recovery.").

[174] Pesce v. Coppinger, 355 F. Supp. 3d 35, 49 (D. Mass. 2018).

1. Analysis of Pesce v. Coppinger *and the Limitation of MAT Litigation Holdings*

In 2018,[175] Geoffrey Pesce brought suit seeking emergency injunctive relief against the Essex County House of Corrections in response to its policy that uniformly denies continuation of an inmate's MAT while they are in custody.[176] Pesce was arrested and charged with driving six miles over the speed limit with a revoked license while driving himself to receive Methadone treatment because he was desperate not to relapse.[177] The offense carries a "mandatory minimum sentence of [sixty] days' incarceration," during which Pesce would have to stop taking his MAT and subsequently suffer forced withdrawal.[178] The U.S. District Court of the District of Massachusetts considered Pesce's Eighth Amendment and ADA claims.[179] Although beyond the scope of this Comment, the court determined Pesce was "likely to succeed on the merits of his ADA claim" because the prison's withdrawal policy had been "documented . . . as ineffective."[180]

More importantly, the district court determined Pesce would likely prevail on his Eighth Amendment claim based on the objective and subjective prongs because his particular medical history showed the prison's treatment policy would most likely be ineffective for him, and because the prison directly ignored his doctor's treatment recommendation to continue with MAT.[181] First, the court concluded that Mr. Pesce satisfied the objective prong because his past failed

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[175] Similar holdings are not currently widespread in other circuits, but *Pesce* is nonetheless noteworthy given that as recently as 2012, "it [was] unlikely that any court in the status quo would hold an official liable for damages for failure to provide drug treatment, given the paucity of legal precedents supporting drug treatment as a constitutional right." Lebowitz, *supra* note 148, at 295 n.129. Today, the Eighth Amendment argument as it concerns MAT is gaining traction in federal courts in the states of Kansas, Massachusetts, and Washington. Mann, *supra* note 75, at 239 n.60 (citing four cases in which courts have granted continued access to MAT in prison for prisoners who had begun treatment before incarceration).

[176] Complaint, *supra* note 7, at 16.

[177] *Id.* at 3.

[178] *Id.* The policy in *Pesce* is illustrative of policies in many other prisons and jails. Mann, *supra* note 75, at 232. Here, MAT is not available to male inmates with OUD, regardless of whether they have a previous prescription before their arrest. *Id.* The only class of prisoners eligible to receive MAT are pregnant women. Pesce Complaint, *supra* note 7, at 8; *see also supra* note 63 and accompanying text.

[179] *Pesce*, 355 F. Supp. 3d at 47.

[180] *Id.*

[181] *Id.* at 47–48. Although *Pesce v. Coppinger* does not cite *Farmer v. Brennan* for the two-pronged test, the articulation and application is essentially the same as in *Farmer* in that the objective prong requires a sufficiently serious medical need and the subjective prong requires "intent or wanton disregard." *Id.* at 47 (citing Burrell v. Hampshire County, 307 F. 3d 1, 8 (1st Cir. 2002); Perry v. Roy, 782 F. 3d 73, 78 (1st Cir. 2015)). Although *Farmer* uses the term "deliberate indifference," the phrase "intent or wanton disregard" is applied the same way here. *See* Farmer v. Brennan, 511 U.S. 825, 829 (1994).

attempts at recovery without MAT proved the jail's prohibition of Methadone would deny him his "only adequate treatment."[182] The court reasoned that forcing Pesce into a detoxification treatment identical to his previous unsuccessful attempts would put him at a high risk of relapse.[183] In short, the court relied on the same reasoning to satisfy both the ADA claim and the objective prong of the Eighth Amendment test.[184]

Second, in the analysis of the deliberate indifference prong, the court noted that Pesce's doctor and others familiar with his medical needs recommended that he continue taking Methadone. In conclusion, the court stated that denying medical professionals' recommendations "may be sufficient to satisfy the deliberate indifference standard."[185] Although that was the extent of the deliberate indifference discussion, the court did seem to acknowledge the subjective knowledge requirement by indicating that prison officials knew of Pesce's doctor's recommendation but chose to actively ignore it.[186] This indicates that intent was still necessary for the holding. Additionally, the court cited Pesce's past attempts at treatment, numerous overdoses, and general overdose statistics to conclude that denying Methadone created a "reasonable likelihood of irreparable harm" for purposes of a preliminary injunction analysis.[187]

While a fairly straightforward case in terms of Eighth Amendment analysis, *Pesce* is novel in that it appears to be the first case to successfully prevail on an Eighth Amendment claim based on a prison's MAT withdrawal policy.[188] *Pesce* is also noteworthy because it has been a useful resource on which other advocates have based their legal arguments.[189] Further, with some changes to

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[182] *Pesce*, 355 F. Supp. 3d at 47.

[183] *Id.* at 45–46.

[184] *Id.* at 45.

[185] *Id.* at 48.

[186] *Id.* (citing Alexander v. Weiner, 841 F. Supp. 2d 486, 493 (D. Mass. 2012) for the proposition that "prison officials repeatedly ignor[ing] [a] physician's recommendations . . . establish[es] an Eighth Amendment violation").

[187] *Id.* The statistics the court cites in support of Pesce's claim of irreparable harm are noteworthy because they show that the court is willing to consider a statistical analysis. Additionally, they are exactly the kind of statistics useful in proving a case for post-release provision of MAT, such as the finding that "nearly [fifty percent] of all deaths among those released from incarceration were opioid-related." *Id.* Especially in the case of future harm, these statistics are invaluable and compelling to illustrate the severity of the problem and the role of incarceration.

[188] *See* ANITA MARTON & GABRIELLE DE LA GUÉRONNIÈRE, RECENT COURT ACTIONS IMPACTING THE SUBSTANCE USE DISORDER FIELD 1, 4 (2019), https://nasadad.org/wp-content/uploads/2019/06/6.6.19-Recent-Court-Actions-Impacting-SUD-Field.pdf (detailing five successful challenges to denial of MAT).

[189] *Id.* at 25.

Eighth Amendment jurisprudence, the same logic in *Pesce* also applies to MAT post-release.

2. *ADA Claims as an Alternative to the Eighth Amendment and Limitations of Eighth Amendment Jurisprudence in the MAT Context*

While *Pesce* has been a useful tool for advocates, other courts that have granted preliminary injunctions to petitioners have done so based on the ADA and have declined to consider the Eighth Amendment claims.[190] *Pesce* itself seems to blur the line between the two claims.[191] Without a change to Eighth Amendment jurisprudence and a provision of MAT post-release, people will continue to overdose and die.

ADA claims may be a less risky option for petitioners like Pesce, but, as discussed below, avoiding a more robust discussion of the Eighth Amendment means that holdings in MAT cases cannot positively impact inmates who do not qualify as disabled for purposes of ADA protection. The *Pesce* court may have been more willing to address the Eighth Amendment claim because in granting a preliminary injunction it only had to consider the "*likelihood* of success on the merits."[192] However, the more likely explanation for the petitioners' success is that because Pesce was taking MAT before he was incarcerated, he was classified as "in recovery," and thus protected by the ADA.[193] It is easy to see why a judge would rather apply the ADA, given the fairly logical conclusion that denying a "recovering" inmate's treatment plan runs counter to both the spirit and letter of the law.[194] Additionally, four other cases that alleged ADA and Eighth Amendment claims have all settled, which makes it difficult to determine precisely which legal arguments would have been successful,

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[190] *See* Smith v. Aroostook County, 376 F. Supp. 3d 146, 161 (D. Me. 2019) ("Because I find that the Plaintiff's ADA claim is likely to succeed . . . I do not address the Plaintiff's likelihood of success on her Eighth Amendment claim."), *aff'd*, 922 F.3d 41 (1st Cir. 2019); *see also What Is the Americans with Disabilities Act (ADA)?*, ADA NAT'L NETWORK, https://adata.org/learn-about-ada (May 2022) [hereinafter *What Is the ADA*] ("The ADA is a civil rights law that prohibits discrimination against individuals with disabilities in all areas of public life, including jobs, schools, transportation, and all public and private places that are open to the general public. The purpose of the law is to make sure that people with disabilities have the same rights and opportunities as everyone else.").

[191] *See supra* note 185 and accompanying text.

[192] *Pesce*, 355 F. Supp. 3d at 45 (emphasis added).

[193] Mann, *supra* note 75, at 236–37 ("Based on current interpretations, the Eighth Amendment alone is not enough to ensure that jails and prisons are required to provide access to MAT for recovering opioid addicts."). The ADA National Network states that "[t]he ADA protects a person in recovery who is no longer currently engaging in the illegal use of drugs." *What Is the ADA*, *supra* note 191. Additionally, according to the ADA National Network, a person "in recovery" has "ceased engaging in the illegal use of drugs" and is "either . . . in a supervised rehabilitation program; or has been successfully rehabilitated." *Id*.

[194] *See What Is the ADA*, *supra* note 191.

although each of the four petitioners was already prescribed and taking MAT before their lawsuits were filed.[195] The impact on Eighth Amendment jurisprudence appears minimal.

More problematic is that the cases with narrow holdings, as well as settlements, show the limits of the Eighth Amendment in the context of MAT—the cases do nothing more than provide immediate relief for a specific petitioner or class of petitioners, which makes policy changes, such as requiring MAT availability for all eligible inmates despite prior treatment, unlikely.[196] In other words, these narrow agreements are insufficient, are "not expected to change [prison] policy," and do not guarantee that "others [will not] endure the same . . . situations."[197] While the holdings may easily extend to similar plaintiffs, critics point out that uncertainty shrouds ADA claims deviating from the *Pesce* fact pattern.[198] Currently, it is uncertain whether, under the ADA, a prison would have to provide MAT for an inmate with a prescription who continues to use illegal drugs, or an inmate who clearly suffers from OUD, but did not have a prescription before incarceration.[199] Adding to the confusion, despite the ADA's limited protection,[200] "the law also says that even current users can't be denied health care."[201] Time spent litigating the meaning of the ADA ignores the real issue that, in the meantime, countless people in U.S. prisons and jails will face an almost insurmountably high risk of death, both

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195 Settlement Agreement at 2, Dipierro v. Hurwitz, C.A. No. 1:19-CV-10495-WGY (2019) (requiring defendants to administer Ms. DiPierro's Methadone treatment while she is incarcerated); *DOC Will Provide Doctor-Prescribed Medication to Prisoner with Opioid Use Disorder*, ACLU OF ME. (Sept. 28, 2019), https://www.aclumaine.org/en/press-releases/doc-will-provide-doctor-prescribed-medication-prisoner-opioid-use-disorder ("While the case [of Zachary Smith] did not reach a decision on the constitutional and ADA charges, the ACLU says the settlement will make it harder for other corrections facilities to argue that providing MAT to prisoners isn't possible."); Press Release, ACLU Washington, Whatcom County Jail to Provide Medications Necessary to Treat Opioid Addiction in Landmark Settlement Proposed in Civil Rights Lawsuit (Apr. 30, 2019) (available at https://www.aclu-wa.org/news/whatcom-county-jail-provide-medications-necessary-treat-opioid-addiction-landmark-settlement) (describing settlement agreement in class action requiring provision of MAT in Whatcom County Jail regardless of whether treatment began prior to incarceration and noting "facilities have begun to change their policies to provide MAT" for fear of "violating the ADA"); Sandra E. Garcia, *Kansas Inmate Will Be Allowed Opioid Addiction Drugs*, N.Y. TIMES (Sept. 11, 2019), https://www.nytimes.com/2019/09/11/us/kansas-aclu-inmate-opioids.html (detailing settlement for plaintiff Leaman Crews requiring Leavenworth federal penitentiary to provide his Buprenorphine and noting the settlement "appl[ies] narrowly to Mr. Crews's case").

196 The exception is the Whatcom County class action settlement agreement in which the county jail agreed to a complete overhaul of its MAT policies. *See supra* note 91.

197 Garcia, *supra* note 196.

198 Schwartzapfel, *supra* note 22.

199 *Id.*

200 *See supra* note 194 and accompanying text.

201 Schwartzapfel, *supra* note 22.

during and after incarceration.[202] This death toll could be significantly mitigated with a clearer holding based on the Eighth Amendment.[203]

Since *Pesce*, advocates have argued for an extension of its holding, such that "MAT could and should be granted to inmates in jails and prisons nationwide" if they elect OUD treatment.[204] Admittedly, although *Pesce* established the framework and increased the odds of a favorable ruling for MAT users in Eighth Amendment cases,[205] there is no acknowledged requirement for premium health care services.[206] Accordingly, "[c]ourts appear more inclined to dismiss claims where some service is provided."[207] As noted previously, however, thirty-five of the fifty states either do not provide MAT or limit services to the short-term Naltrexone shot upon release;[208] therefore, there is a dire need to expand access to MAT in a way that the current holdings cannot.

III. AN ALTERNATIVE FRAMEWORK FOR EIGHTH AMENDMENT JURISPRUDENCE: THE STATE'S CARCERAL BARGAIN AND A CORRESPONDING STRICT LIABILITY STANDARD

If prison conditions that result in death cannot be deemed unconstitutional without the help of a corresponding ADA claim, then the Eighth Amendment right is not fully realized under current jurisprudence.[209] Furthermore, the subjective analysis from *Farmer* misunderstands the nature and extent of the state's obligation under the Eighth Amendment and allows the state to inflict cruel and unusual punishment. First, section A discusses how Eighth Amendment jurisprudence is the cause of such limited MAT holdings and suggests an alternative framework centered on an objective, rather than

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202 *See supra* note 5 and accompanying text.

203 *See supra* note 9 and accompanying text.

204 Mann, *supra* note 75, at 234.

205 Schwartzapfel, *supra* note 22 ("So far these rulings have been narrow, pertaining only to the individuals who sued. But 'every time a prison or jail agrees that they're going to do this, it makes it harder for other prisons or jails to say it's impossible.'" (quoting Zachary Heiden, the ACLU attorney who worked on the suits in Maine)).

206 Beletsky et al., *supra* note 2, at 191.

207 *Id.* Given the prevalence of a preference for nonscientific treatment options in many states, such as abstinence treatment and 12-Step programs, it remains unclear how much deference a court will give to an "individualized determination" that one of these alternatives to MAT is suitable. *See* Beletsky, *supra* note 7, at 378 (analyzing spending under the 21st Century Cures Act and finding "states hardest-hit by overdose crisis . . . are using the most sizable portions of . . . funding" for non-evidence-based initiatives despite Act's intentions). Importantly, these "alternatives" are "not rooted in evidence of addressing identifiable overdose morbidity or mortality endpoints." *Id.* at 378, 381.

208 *See supra* note 7 and accompanying text.

209 This Comment does not suggest that such a holding is impossible under the current Eighth Amendment jurisprudence, only that case law shows that it is an unlikely outcome that courts are hesitant to reach.

subjective, analysis. Next, section B will discuss a heightened negligence standard for prison officials that asks whether a reasonable prison official would have known of the risk of harm. Knowledge is irrebuttably presumed for system-wide failures. Section C then applies this alternative framework to *Pesce*. Each analysis also outlines the claims and doctrinal tests in the context of future harm, since the deprivation of MAT and disruption of treatment necessarily creates the risk of overdose at an indeterminate point in the future, in addition to inmates' immediate suffering during withdrawal.[210] Section D discusses why intervening causation does not defeat the argument for mandating MAT post-release. Finally, section E distinguishes MAT from other rehabilitation services and clarifies that the Eighth Amendment should only be applied post-release when the cause of the harm is directly linked to a micro- or macro-level failure of the prison administration.

A. The State's Carceral Bargain Makes Prison Conditions Part of Eighth Amendment Punishment

Sharon Dolovich, Director of the UCLA Prison Law & Policy Program,[211] acknowledges the limited reach of current Eighth Amendment jurisprudence and attributes it to a misconception about the extent of the state's duty to inmates, as well as what exactly constitutes "punishment" under the Eighth Amendment.[212] This section first defines the state's "carceral bargain." It then details how prison conditions are always part of the state's bargain, and thus always constrained by the prohibition on cruel and unusual punishment.[213] Finally, this section critiques *Farmer*'s deliberate indifference standard and then presents an alternative framework—a heightened negligence standard with an irrebuttable presumption of prison officials' knowledge in certain situations.[214] While Dolovich's work focuses on claims for current inmates, the remainder of this Comment will extend heightened negligence to the post-incarceration provision of MAT.[215] If the Eighth Amendment is not applied to post-incarceration MAT, former inmates will continue to overdose at a staggering rate because of the unconstitutional lack of treatment.[216]

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[210] *See supra* notes 111–12 and accompanying text.

[211] *Sharon Dolovich*, UCLA L. (2021), https://law.ucla.edu/faculty/faculty-profiles/sharon-dolovich (last visited May 3, 2022) (Professor profile page).

[212] Sharon Dolovich, *Cruelty, Prison Conditions, and the Eighth Amendment*, 84 N.Y.U. L. REV. 881, 882–90 (2009).

[213] *See infra* notes 219, 228–29.

[214] *See infra* notes 232–46.

[215] *See infra* Part III.C.

[216] *See supra* notes 2–5.

As a matter of common law tradition, society's choice to punish people with incarceration "allows [it] to remove certain individuals from a shared public space," thereby making inmates "wholly dependent on the state . . . and deeply vulnerable."[217] The choice to incarcerate gives rise to a corresponding obligation: an affirmative, ongoing duty for the state to "maintain[] prisoners' physical and psychological integrity and well-being."[218] This ongoing obligation is "society's carceral bargain,"[219] which the Eighth Amendment's prohibition on cruel and unusual punishment makes "nonnegotiable"[220] so long as society punishes with incarceration.[221] Though inmates may justifiably endure deprivation, the state fails to fulfill its obligation and inflicts cruel and unusual punishment when, as in *Farmer*,[222] the prisoner suffers "serious harm" or a "substantial risk of serious harm."[223] Thus, the carceral bargain is a direct result of the decision to incarcerate and invariably operates in the background at any point in the criminal justice system.

The Eighth Amendment's prohibition of cruel and unusual punishment is "exclusively concerned" with *"state* punishment,"[224] which includes prison conditions by virtue of its administration.[225] State punishment can only be inflicted as "the result of a collective process" in which "state officials . . . derive their power from . . . linked institutions—the legislature, police, prosecutors, courts, and prisons."[226] This collective process results in state-sanctioned incarceration as a means of enforcing a judicially determined penalty, which prison officials, under state authority and legitimacy, then administer by "creat[ing] the conditions under which a prisoner will live."[227] These conditions,

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[217] Dolovich, *supra* note 212, at 892, 913.

[218] *Id.* at 921.

[219] It is a "bargain" because incarceration is a "public good" that "entails the investment of considerable resources." *Id.* at 923. Importantly, by connecting the carceral bargain directly to the Eighth Amendment, this definition resists the argument that the state's obligation is "simply a moral imperative," as opposed to a constitutional one. *Id.* at 914.

[220] *See supra* note 218 and accompanying text; *see also* Dolovich, *supra* note 212, at 923 (explaining that there is a "minimum cost that must be borne" by the state because of the choice to punish with incarceration).

[221] Dolovich, *supra* note 212, at 892.

[222] *See supra* note 147 and accompanying text.

[223] Dolovich, *supra* note 212, at 918. The length of the sentence "reflect[s] society's collective judgment as to the seriousness of the crime"; accordingly, prison officials cannot inflict additional punishment because of a "private judgment[] of moral desert." *Id.* at 920.

[224] *Id.* at 897.

[225] *Id.* at 898.

[226] *Id.* Importantly, to act on and fulfill its carceral bargain collectively, the state necessarily delegates "considerable power and discretion" to agencies and prison staff. *Id.* at 929. Accordingly, part of the state's carceral bargain is to ensure "any prison official[] . . . ha[s] the capacity and tendency to exercise their authority in ways consistent with the state's affirmative obligations to its prisoners." *Id*. at 930.

[227] *Id.* at 899.

and any treatment to which the prisoner is subject, are "the punishment the state has imposed" such that "the severity of the punishment ultimately depends on the conditions of confinement."[228] Therefore, whether an action is punishment is determined not by an intent to harm[229] but by "whether prisoners' suffering is traceable to state-created conditions of confinement."[230] By this logic, "*all* the conditions to which an offender is subjected at the hands of state officials . . . are appropriately open to Eighth Amendment scrutiny."[231]

Accordingly, under this more expansive interpretation of the Eighth Amendment,[232] *Farmer*'s actual knowledge requirement for a finding of deliberate indifference is "premised on a narrow, individualistic conception of punishment" inapposite to the state's carceral bargain.[233] A subjective standard of actual knowledge applied to the individual officers misunderstands both the Eighth Amendment and the state's carceral bargain. First, because the Eighth Amendment restricts state punishment, as explained above, a focus on the prison official's knowledge of the serious harm or substantial risk of serious harm misapplies the prohibition on cruel and unusual punishment to the individual and fails to recognize that they act on behalf of the state.[234] Second, and relatedly, because the state bears the carceral bargain while administering punishment through a complex array of delegation, the subjective standard ignores the fact that the duty to protect prisoners from serious harm is present at

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[228] *Id.* at 899, 913.

[229] *Id.* at 930 ("It is enough to show that the institution, through the combined actions of the various officials charged with its functioning, created a set of conditions—manifested most directly by the inflicting officer—that caused prisoners serious harm.").

[230] *Id.* at 897. Dolovich clarifies that the goals of punishment—"to chastise and deter"—are still present in this more expansive definition because incarceration is "judicially determined" to be the appropriate consequence of the crime. *Id.* at 899–900 (quoting Wilson v. Seiter, 501 U.S. 294, 300 (1991)).

[231] *Id.* at 899.

[232] Dolovich addresses and refutes two narrower interpretations of what constitutes punishment. *Id.* at 900. First, the "strictural view" completely rejects prison conditions as punishment and limits the term strictly to "the sentence imposed by 'judges or juries.'" *Id.* Not only is the view untenable, but it is also logically difficult to exclude all prison conditions from the term "punishment" when they are "a necessary feature of the penalty" once the prisoner is sentenced. *Id.* Additionally, the "governmentalist account" recognizes the state's ongoing obligation to prisoners but only classifies prison conditions as "punishment . . . when they arise from official action duly authorized by the state." *Id.* at 901–02. Like the strictural view, the governmentalist approach embraces an "inappropriately individualistic notion of punishment" that fails to "appreciate the state's responsibility for *all* official conduct that impacts prisoners." *Id.* at 902, 905. Instead, the appropriate analysis recognizes that society's choice to incarcerate results in delegation to a myriad of state agents, prison administrators, and correctional officers who only act "because the state has placed them in a position of authority and has given them considerable power to shape prisoners' conditions of confinement," regardless of whether those actions are state-authorized. *Id.* at 905.

[233] *Id.* at 897.

[234] *See supra* notes 224–28 and accompanying text.

every stage of punishment.[235] Prison conditions and prison officials' conduct cannot be separated from punishment, and thus are always governed by the affirmative carceral bargain on one hand, and the prohibitive Eighth Amendment, on the other.[236] The state's duty never goes away.[237]

Not only is *Farmer*'s subjective test problematic in terms of the Eighth Amendment and the carceral bargain, but it also gives prison officials a perverse incentive to completely shirk the portion of the carceral bargain delegated to them[238]—a micro-level failure.[239] Instead of recognizing prison officials' affirmative duties to "monitor, investigate, discover, and avert potential problems," the actual knowledge requirement creates an "episodic" duty that "[arises] only when [officials] happen to notice possible threats to prisoners' well-being."[240] In turn, officials are incentivized "*not* to be proactive [and] *not* to look."[241] The *Farmer* standard allows complicity within the entire criminal justice system and lets officials avoid liability so long as they can claim ignorance.[242] This is exactly the type of cruel and unusual punishment that should be barred by the state's carceral bargain.[243]

At the same time, willful ignorance on behalf of prison officials would not be possible without an institution that is complicit with, if not encouraging of, such behavior. Therefore, the state inflicts cruel and unusual punishment when, "in a structural sense," a prison system reflects indifference by design in that it "systematically subjects some subset of the population to needless and avoidable suffering."[244] Eighth Amendment violations on behalf of individual officers are possible because they are allowed by the state-created system. *Farmer*'s subjective test enables a failure of the carceral bargain on both the individual and state level and, in doing so, allows the continued infliction of cruel and unusual punishment.[245] Thus, an objective standard with an irrebuttable

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235 Dolovich, *supra* note 212, at 905. This duty applies to "*all* official conduct that impacts prisoners," regardless of whether that conduct is "beyond the scope of . . . delegation." *Id.*

236 *See supra* notes 224–28 and accompanying text.

237 Dolovich, *supra* note 212, at 903 ("State power, once delegated, cannot be so easily cabined.").

238 *Id.* at 945–46 ("The inadequacies of *Farmer*'s standard reverberate throughout the institution, encouraging officials at all levels to take insufficient steps to guard against serious harm.").

239 *Id.* at 946; *see infra* note 249 and accompanying text.

240 Dolovich, *supra* note 212, at 945.

241 *Id*.

242 *Id.* at 947.

243 *Id.*

244 *Id.* at 926.

245 *Id.* at 945–48. Though focusing on the state's responsibility, this framing does not conflict with the Eleventh Amendment's prohibition on "suits in federal courts against state governments in law [or] equity . . . by citizens of another state." *Id.* at 937 (quoting ERWIN CHEMERINSKY, CONSTITUTIONAL LAW: PRINCIPLES AND

presumption of constructive knowledge is necessary to fully encompass the scope of the bargain and remedy the inadequacies of current Eighth Amendment jurisprudence.[246]

Implementing this objective standard either via a heightened negligence standard or a modified strict liability standard could sufficiently bring prison conditions in compliance with the Eighth Amendment.[247] Although both standards are a compelling alternative, this Comment will discuss and apply the heightened negligence standard, both because it is a slightly more feasible alternative to current jurisprudence and because it illustrates the likelihood of success on a petitioner's MAT case under a more stringent burden than modified strict liability.

B. The Heightened Negligence Standard and Irrebuttable Presumption of Constructive Knowledge

The heightened negligence standard is an extrapolation of Justice Stevens's dissent in *Estelle v. Gamble* and asks "whether plaintiffs were subjected to a substantial risk of serious harm of which a reasonably attentive prison official would have known."[248] Implicit in Justice Stevens's dissent is "a different doctrinal approach" for claims of macro- and micro-level failures.[249] Macro-level failures occur because of "system-wide failures . . . through generally applicable conditions," whereas micro-level failures "arise from the conduct of individual prison officials toward individual prisoners."[250] For macro-level failure claims, "official knowledge of the risk ought to be '*irrebuttably presumed*'" because, where a substantial risk of harm exists at the macro-level, a designated prison official "will necessarily have been responsible for that aspect of the prison's operations" and thus, should have known about the harmful conditions.[251]

POLICIES 180 (3d ed. 2006)). Instead, allegations of cruel and unusual punishment can still be brought against the individual officer under Section 1983 of the Prison Litigation Reform Act. However, the distinction between macro- and micro-level failures still stands, despite the fact that an action is brought against the individual, not the state. While the action is "an allegation of institutional cruelty," it "happens to be manifested most immediately by the inflicting officer" who is necessary to carry out the state's punishment. *Id.* at 937–39.

246 *Id.* at 948.

247 *Id.* at 936.

248 *Id.* at 948.

249 *Id.* at 950. Because the MAT prison cases addressed in this Comment focus on MAT policies as a whole, this Comment will not detail the entire analysis of micro-level failures.

250 *Id.* at 946.

251 *Id.* at 950–52.

Justice Stevens's dissent in *Estelle v. Gamble* illustrates the distinction between micro- and macro-level analyses. In *Estelle*, J.W. Gamble, who suffered through three months of extreme back pain, was repeatedly given pain medication and ordered to rest without further examination of his condition.[252] The majority analyzed *Estelle* through a micro-level lens and rejected liability on the basis that none of Gamble's seventeen interactions with medical staff at the prison amounted to substantial harm.[253]

In contrast, Stevens's dissent implies that when seventeen interactions with prison officials fail to identify "an obvious need for remedial treatment," the harm is a result of "a connected set of macro-level failures in the operation of the prison's medical system."[254] In short, the individual is culpable for failing to fulfill that particular duty, but they could not be culpable without the simultaneous failure and culpability of the state—the creation of "such a plainly deficient system" with "too few staff members[,] . . . too many prisoners," incompetent officials, and inadequate facilities.[255] Here, constructive knowledge is appropriate because the state appoints officials precisely to implement a medical system within the prison. Therefore, that person "*should have known* about [the] conditions" and the corresponding serious harm or the risk of serious harm.[256] Additionally, courts should not analyze officials' alleged justification for the conduct because "serious physical or psychological harm is never justified."[257]

In practice, the analysis of what constitutes a substantial risk of serious harm stays the same. The main difference from *Farmer* is that by abandoning a subjective knowledge approach, courts are not required to ignore the systematic failings at work behind individual culpability. Instead, even if the individual officer is merely negligent, a big picture analysis centered on constructive knowledge allows a finding that the Eighth Amendment has been violated. Courts simply must find (1) a macro-level system failure that a prison official with delegated state power oversaw, and (2) a substantial risk of serious harm as a result of the failure.[258] Instead of inappropriately expanding the Eighth Amendment, heightened negligence merely recognizes that a state-centered

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252 *See supra* notes 127–29 and accompanying text.

253 Dolovich, *supra* note 212, at 950.

254 *Id.* at 950–51.

255 *Id.*

256 *Id.* at 952.

257 *Id.* at 957. Foreclosing an argument for justification is consistent with the preexisting *Farmer* test and, therefore, is nothing novel. *Id.*

258 *Id.* at 950–52.

analysis is more appropriate. Without such recognition of systematic failures of the state's carceral bargain, the Eighth Amendment's full purpose is not recognized.

Thus, an "irrebuttably presumed" constructive knowledge standard in the case of serious harm, or the risk of serious harm, addresses many of the Eighth Amendment shortcomings in the MAT context, discussed in the analysis of *Pesce v. Coppinger*.[259] Section C first applies heightened negligence and constructive knowledge to *Pesce v. Coppinger* to illustrate the feasibility and practicability of applying it to MAT cases. Second, the expanded definition of punishment and the facts in *Pesce v. Coppinger* are used to illustrate why extending the Eighth Amendment to the post-release provision of MAT is appropriate.

C. *The Framework in Practice: Applying Heightened Negligence to* Pesce v. Coppinger

This section applies the heightened negligence framework to the facts of *Pesce v. Coppinger* to illustrate how it allows for a broader holding focused on the prison system, instead of a narrow ADA-based holding that only protects prisoners previously prescribed MAT and not using any other illegal substance. First, this section will explain why the prison policy meets the state-centered definition of punishment. Next, this section will explain why the prison policy is a macro-level failure that warrants an irrebuttable presumption of constructive knowledge. Finally, this section will explore possible outcomes of a lawsuit brought under the new framework. Analyzing *Pesce v. Coppinger* is important because once MAT is discussed as a systematic, macro-level failure of prisons and jails, applying the framework to post-release provision of MAT is a natural extension based on the definition of punishment and use of constructive knowledge.

Punishment includes a prisoner's confinement or treatment that is "traceable to state-created conditions of confinement."[260] In *Pesce v. Coppinger*, the forced withdrawal policy is clearly state created because prison officials determined it was the best treatment for OUD in their facility.[261] Withdrawal is the only OUD

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[259] Dolovich, *supra* note 212, at 964.

[260] *Id.* at 897; *see supra* note 230 and accompanying text.

[261] Defendants Kevin F. Coppinger & Aaron Eastman's Memorandum of Law in Support of their Opposition to Plaintiff's Motion for Temporary Restraining Order & Preliminary Injunction at 5, Pesce v. Coppinger, 355 F. Supp. 3d 35 (D. Mass. 2018) (No. 18-CV-11972) [hereinafter Coppinger Memorandum]; *see supra* note 254 and accompanying text.

treatment that prison officials have approved, with a narrow exception for pregnant women.[262] Thus, the side effects of withdrawal that prisoners face—"severe abdominal cramping, nausea, [diarrhea], . . . convulsions,"[263] agitation, anxiety, and suicidal thoughts[264]—are unavoidable state-created conditions that are considered punishment.[265] The Eighth Amendment prohibits grossly disproportionate punishment.[266] Sentences cannot legitimately subject prisoners to the serious physical and psychological distress associated with withdrawal because it is cruel, disproportionate, and not judicially determined.[267] It violates the Eighth Amendment when withdrawal is an unavoidable part of a prisoner's confinement.[268]

Second, and most crucial to the analysis, the OUD policy in *Pesce v. Coppinger* is a macro-level failure of the prison administration that warrants an irrebuttable presumption of constructive knowledge.[269] Here, the OUD treatment policy is undeniably a feature of the prison's medical system, similar to *Estelle v. Gamble*.[270] Policies and features of the medical system are a macro-level failure because it would not be possible without state-created and sanctioned incompetency on behalf of medical officials in the prison who should have known their policies were dangerous to prisoners with OUD.[271] Although implemented by a few specific officials, an OUD policy so contrary to the standard of care would not be possible without state officials willfully ignoring modern science and medical advice in creating the medical system necessary to administer prison sentences.[272] Prison officials incorrectly categorized the recommendation of Pesce's doctor to continue his MAT as a "choice,"[273] when

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[262] There is a narrow exception for pregnant women. *See supra* note 179 and accompanying text.

[263] Bruce & Schleifer, *supra* note 49, at 19l; *see supra* note 110 and accompanying text.

[264] *See supra* note 106 and accompanying text.

[265] The fact that over-the-counter medication is provided for some physical side effects does not make the prisoners' experiences any less of a result of state-created conditions. Coppinger Memorandum, *supra* note 261, at 9.

[266] Ingraham v. Wright, 430 U.S. 651, 667 (1977) (citing Weems v. United States, 217 U.S. 349, 371–73 (1910)).

[267] *See supra* notes 224–27.

[268] *See* Dolovich, *supra* note 212, at 960 (undertaking a similar analysis about why prison rape is a state-created condition and illegitimate punishment).

[269] Even in the case of macro-level failures, a plaintiff will still have to sue individual officers to comply with the Eleventh Amendment and the Prison Litigation Reform Act. *See supra* note 245 and accompanying text.

[270] *See supra* notes 254–56 and accompanying text.

[271] *See supra* notes 244–46.

[272] Defendants base their policy on the belief that prisoners "return to the community . . . drug-free, and will not re-offend, thus reducing recidivism." Coppinger Memorandum, *supra* note 261. There is ample evidence to refute this reasoning. *See supra* Part I.A.

[273] Coppinger Memorandum, *supra* note 261, at 17.

in fact the standard of care is to continue MAT once started.[274] Based on the scientific evidence discussed in Part I,[275] it is clear that in creating their medical system, Defendants failed to adequately inform themselves of, or act on, the overwhelming scientific evidence in favor of MAT and opposed to withdrawal treatment. The result is a macro-level failure whereby any prisoner with OUD is subjected to physical and psychological harm and the risk of overdose. Accordingly, the irrebuttable presumption of constructive knowledge applies in *Pesce v. Coppinger*.

Importantly, under the presumption of constructive knowledge, the official's justification for the policy is not considered because "serious physical or psychological harm is never justified."[276] While judicial deference to official policies is still possible and appropriate under the heightened negligence analysis,[277] the original *Pesce* Order cites the feasibility and widespread use of a liquid form of MAT in prisons to prevent diversion to the general population, and generally dismisses the defendant's justification for prohibiting MAT.[278] Additionally, judicial deference is inappropriate here because of three things that make prisoners especially vulnerable to constitutional violations: (1) a failure to recognize their humanity, (2) their coinciding disenfranchisement, and (3) socially acceptable prejudice against them.[279] The particular vulnerability of prisoners is exacerbated when they have OUD because they are also subject to a widespread belief that OUD is the result of a moral failure and that MAT is just substituting one opioid for another.[280] While the defendants in *Pesce v. Coppinger* do not outright frame OUD as a moral failure, they do incorrectly label MAT as a dangerous continuation of addiction.[281] Thus, MAT for prisoners is one of the more compelling examples of the protections Dolovich's framework adds to Eighth Amendment jurisprudence because of the markedly intersectional experience of prisoners with OUD as members of two politically unpopular groups.[282]

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274 Motion, *supra* note 76.

275 *See supra* Part I.A.

276 Dolovich, *supra* note 212, at 957; *see supra* note 257 and accompanying text.

277 Dolovich, *supra* note 212, at 963, 974.

278 Pesce v. Coppinger, 355 F. Supp. 3d 35, 46 (D. Mass. 2018).

279 Dolovich, *supra* note 212, at 955, 975–76.

280 *See supra* Part I.A.

281 Coppinger Memorandum, *supra* note 260.

282 Dolovich, *supra* note 212, at 910, 974–77 ("[T]he judicial implementation of constitutional directives is often shaped by instrumental concerns divorced from, [or] at times even at odds with, the moral imperatives these directives embody—a phenomenon particularly evident when prisoners' constitutional rights are at issue.").

While cases like *Pesce* are no doubt important and noteworthy progress, current scholarship indicates that a wider, sweeping Eighth Amendment holding to protect prisoners who do not fit within the *Pesce* fact pattern may be difficult to come by for two reasons. First, lower courts' application of Eighth Amendment jurisprudence has proven to be inconsistent, and in some cases, they have even declined to apply *Farmer* and instead applied older cases.[283] Second, adding to the inconsistent application of the Eighth Amendment, the Supreme Court cases are also "highly deferential to prison administrators," but the deference accorded "varies with the jurisdiction and the particular court's standard."[284] Accordingly, while advocates may have a good idea of the array of legal arguments available to them because of *Pesce*, a standard as malleable as "deliberate indifference" means that success will vary, and access to life-saving medication is not guaranteed in any specific jurisdiction.

Potential holdings and solutions are much broader under heightened negligence because all prisoners with OUD should be protected by the holding, regardless of their ADA status and whether they previously used MAT. *Pesce* seemingly equates the Eighth Amendment and ADA arguments by finding both theories plausible because MAT was clearly the plaintiff's only successful treatment.[285] This resulted in very narrow precedent and uncertainty surrounding whether the holding had much impact on Eighth Amendment jurisprudence. Because the conditions and treatment resulting from the OUD policy constitute punishment and are never justified,[286] the limitations of the *Pesce* holding discussed above are irrelevant. Accordingly, there is greater opportunity to ensure prisoners who need MAT have access to it and are not subject to the cruel and unusual punishment of withdrawal.

Courts may be able to mandate more extensive access to MAT in line with the Eighth Amendment. A few jurisdictions have already shown it is possible to successfully and safely provide inmates with access to all three forms of MAT, while other states have legislation pending.[287] Because jails and prisons are

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283 Siever, *supra* note 122, at 1393.

284 Jessa Irene DeGroote, *Weighing the Eighth Amendment: Finding the Balance Between Treating and Mistreating Suicidal Prisoners*, 17 J. CONST. L. 259, 270 (2014); *see also* Dolovich, *supra* note 212, at 961 (describing "the strong tendency of the federal courts to defer to prison officials" and stating "[j]udicial deference to prison officials is perhaps the strongest theme to emerge from a historical survey of prisoners' rights litigation in the federal courts").

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

286 *See supra* note 257 and accompanying text.

287 Vestal, *supra* note 75. Jails and prisons can either become an accredited opioid treatment program or contract with a "community-based" opioid treatment program to provide MAT. Beletsky et al., *supra* note 2, at 200 n.255. Rhode Island provides Methadone, Buprenorphine, and Naltrexone to any prisoner who needs it at a

already required to conduct basic screening for substance use, a key piece of infrastructure is already in place for identifying prisoners who may benefit from MAT.[288] While it is important not to underestimate the cost and planning that go into implementing a MAT program in jails,[289] such factors do not justify continued violation of a prisoner's Eighth Amendment rights when the alternative is likely death by overdose. A prison policy that exclusively provides for withdrawal over MAT is not based on a difference of scientific and medical opinion, but rather whether the prison violates prisoners' Eighth Amendment rights. These violations must be rectified.

D. Post-Release MAT: Punishment and the Issue of Intervening Causation

The high risk of post-release overdose is a result of the state's failure to fulfill its carceral bargain at a macro-level, and the provision of post-release MAT is thus constitutionally required. Additionally, intervening causation is inappropriate because it ignores the science behind addiction and allows the state to avoid its carceral bargain. First, this section will discuss how the high risk of post-release overdose death is a result of official state action taken while the state has inmates in custody and is thus obligated to fulfill its carceral bargain. Second, this section will explain why the same reasoning from the *Pesce v. Coppinger* analysis applies, such that post-release overdoses are a macro-level failure. Finally, because the Eighth Amendment has not been interpreted to

cost of about $2 million per year, as of 2018, while Massachusetts and Connecticut are considering similar programs. Vestal, *supra* note 75. Additionally, the settlement agreement in *Kortlever v. Whatcom County* requires Whatcom County to provide MAT for all prisoners who require it, indicating it is a feasible solution for courts to reach. Press Release, ACLU Washington, *supra* note 196.

[288] U.S. DEP'T OF HEALTH & HUM. SERVS., SCREENING AND ASSESSMENT OF CO-OCCURRING DISORDERS IN THE JUSTICE SYSTEM 16 (2019).

[289] This Comment in no way suggests that implementing MAT programs in jails is a simple process. Instead, it emphasizes that despite the complexity, it is possible and in fact constitutionally necessary to do so. The National Academy for State Health Policy suggests that states consider state block grants, federal grant funds, group purchasing MAT (to receive lower rates), and participation in the federal 340B Drug Discount Program. Kitty Purrington & Chris Kukka, *States May Soon Have to Provide Medication-Assisted Treatment to Inmates, Here's How to Fund It*, NAT'L ACAD. FOR STATE HEALTH POL'Y (July 23, 2019), https://www.nashp.org/states-may-soon-have-to-provide-medication-assisted-treatment-to-inmates-heres-how-to-fund-it/. Although beyond the scope of this Comment, Medicaid presents another potential barrier or resource, depending on the state. *Id.* Specifically, in the instance of released prisoners, there are Medicaid waivers to cover reentry services and management, and states can consider changing their Medicaid rules to make it easier for released prisoners to resume Medicaid coverage and remain on MAT. *Id.* Kentucky will be the first state to treat OUD in prisons with Medicaid money. Jacqueline Pitts, *Kentucky Seeks to be First in the Nation to Treat Substance Use Disorder in Prisons Using Medicaid Dollars*, BOTTOM LINE NEWS (Nov. 16, 2020), https://kychamberbottomline.com/2020/11/16/kentucky-seeks-to-be-first-in-the-nation-to-treat-substance-use-disorder-in-prisons-using-medicaid-dollars/.

apply outside of prison,[290] this section addresses the issue of intervening causation and why it should not defeat the argument for mandating the provision of MAT to inmates post-release.[291]

First, releasing prisoners without continued access to MAT qualifies as treatment that is "traceable to state-created conditions of confinement" and therefore is punishment.[292] Research shows that "[i]nstitutional treatment alone . . . is rarely successful," and the best indicator of success is "whether participants experience a smooth transition to follow-up care . . . after release."[293] Without such services, "[w]ithin [three] months of release from custody, [seventy-five percent] of formerly incarcerated individuals with an OUD relapse to opioid use" and face an extremely high risk of death because of their reduced tolerance.[294] Although now outside the prison walls, a former inmate's low tolerance and risk of death are traceable to the state-created and sanctioned MAT policies discussed above.[295] Post-release policies are a matter of life or death.[296]

While MAT is not 100% successful, providing it post-release actually gives former inmates with OUD a fighting chance to recover.[297] If prisons do not provide MAT post-release, many former inmates will find it impossible to secure a dose within the first few days of their release because incarceration leads to issues with insurance and transportation.[298] Meanwhile, every day that former inmates suffering from OUD do not obtain MAT puts them at a greater risk of relapse and death.[299] Because the former inmate's conditions are clearly traceable to their time spent in prison, they essentially continue their punishment upon release via withdrawal or overdose. This is necessarily cruel and unusual punishment in violation of the Eighth Amendment.

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290 Ingraham v. Wright, 430 U.S. 651, 667–68 (1977).

291 Although a discussion of intervening causation seems slightly misplaced in the Eighth Amendment context, it is necessary to include here for two reasons. First, it is a compelling argument to say the Eighth Amendment stops at the prison gates, where the state and prison officials lose direct control over an inmate. Second, OUD is still blamed on the individual instead of seen as an illness.

292 Dolovich, *supra* note 212, at 897; *see supra* note 230 and accompanying text.

293 SAMHSA, *supra* note 70, at 27.

294 *Id.* at 3.

295 *See supra* notes 259–64 and accompanying text.

296 Beletsky et al., *supra* note 2, at 166.

297 SAMHSA, *see supra* note 70, at 41 (citing a 60.5% "decrease in the overdose death rate among those recently incarcerated" once a MAT program was implemented).

298 *Id.* at 57.

299 SAMHSA, *supra* note 70, at 26 (explaining that patients are generally on MAT for at least three years before their provider begins to scale back the amount they take).

Second, as in *Pesce v. Coppinger*, failing to provide MAT post-release is a macro-level failure of the state's carceral bargain because the decision is a part of the specific facility's release protocol.[300] State officials had to create a release protocol to administer prison sentences, and those same officials should have known that a policy that failed to provide MAT was dangerous to prisoners as a whole, as evidenced by the data.[301] State officials either failed to educate themselves on the standard of care or were indifferent to the dangers posed by their release policies.[302] Because the policy is a macro-level failure, constructive knowledge applies, but as shown throughout this Comment, the post-release overdose and death rates are well documented.[303]

Short of requiring rehabilitation, mandating the provision of post-release MAT simply requires that the state not abandon a person in the middle of a period of extreme medical vulnerability, brought on, in part, by their time in prison.[304] In other words, it requires the state to completely fulfill its carceral bargain instead of unconstitutionally renouncing it at the moment of release, when effects still emanate from the decision to incarcerate.[305] Otherwise, failing to address inmates' increased vulnerability upon release, leaving them to likely overdose within days, is unconstitutionally cruel and unusual punishment.[306]

Third, because of the misconstrued beliefs that OUD is a moral failure, and that MAT simply replaces one addiction with another, as well as the fact that the Eighth Amendment traditionally does not apply outside of prison,[307] a brief discussion of intervening causation is appropriate. An intervening causation argument against expanding the Eighth Amendment requires that the act was "(1) independent of the original . . . act; (2) adequate by itself to bring about the injury; and (3) not reasonably foreseeable."[308] Here, the first and second elements need not be discussed because overdose is foreseeable based on the science of OUD.

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300 *See supra* notes 268–74 and accompanying text.

301 *See supra* note 251 and accompanying text.

302 *See supra* note 256 and accompanying text.

303 *See generally* Introduction (explaining opioid death rates generally and post-release overdose rates specifically).

304 *See supra* notes 107–14 and accompanying text.

305 *Id.*; *see supra* notes 219–21 and accompanying text.

306 *See supra* note 5.

307 *But see* Ingraham v. Wright, 430 U.S. 651, 685–87 (1977) (White, J., dissenting) (arguing the Eighth Amendment is not only limited to criminal punishment but also applies when the purpose of a punishment goes beyond "those ordinarily associated with punishment, such as retribution, rehabilitation, or deterrence").

308 Beletsky et al., *supra* note 2, at 182.

An intervening causation argument ignores the fact that OUD is a chronic disease that rewires the brain.[309] Forced withdrawal results in intense cravings and the brain's natural and foreseeable response is to seek out more opioids to temporarily abate the cravings.[310] Further, prisons are on notice about inmates' OUD, and ignorance about OUD does not relieve officials of liability.[311] Because prisons and jails are required to conduct screening for OUD when booking the inmate,[312] prison officials "are informed about the risk factors for overdose post-release" of a particular inmate, and the third element is not met.[313] Here, protection of an individual's Eighth Amendment right should not be thwarted by society's harmful misconception of OUD.[314] Characterizing a former inmate's overdose as an intervening cause would also allow the state to shirk its carceral bargain by ignoring the fact that the state is in part responsible for the post-release circumstances.

Accordingly, the state is constitutionally obligated to provide MAT post-release. An inmate's vulnerability post-release is directly linked to state policies and actions that ignore the standard of care for OUD. These policies and actions directly decrease the likelihood that a former inmate will survive an overdose. Not only is this irresponsible and reckless but it is also contrary to the state's carceral bargain. Ignoring the post-release implications of prison MAT policies truncates the Eighth Amendment such that former inmates are deprived of their constitutionally guaranteed right to be free from cruel and unusual punishment.

E. The Slippery Slope Argument: Where to Draw the Line on Post-Release Application

Expanding the Eighth Amendment to apply post-release naturally begs the question of where to draw the line on its protections. The Eighth Amendment should be applied outside of prison only when the cause of the harm is directly linked to a micro- or macro-level failure of the prison administration.[315]

The argument for post-release MAT is distinguishable from other rehabilitation services for which there is no constitutional guarantee.[316] For

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309 *See supra* notes 58–59 and accompanying text.

310 *See supra* note 52 and accompanying text.

311 *See supra* notes 301–02 and accompanying text.

312 U.S. DEP'T OF HEALTH & HUM. SERVS., *supra* note 288.

313 Beletsky et al., *supra* note 2, at 182 ("[W]hen an intervening act is itself the foreseeable harm . . . a defendant who fails to guard against the act will not be relieved from liability when the act occurs.").

314 *See supra* notes 62–66 (describing the misconception that OUD is a moral failure instead of an illness).

315 Dolovich, *supra* note 212, at 946, 950; *see supra* notes 249–50.

316 JOEL DONAHUE, A GUIDE TO PRISON LITIGATION IN THE EIGHTH CIRCUIT 35 (2014), https://www.

example, another obstacle facing prisoners upon release is securing employment, as many places do not hire people with a criminal record.[317] Although job access can impact recidivism rates,[318] it does not directly lead to the same deadly results that failing to reconnect prisoners with MAT does.[319] Nor is post-release job access attributable to a macro-level failure because it is not related to prison conditions or policies in the same way that MAT is.[320] Because other rehabilitation services do not implicate the carceral bargain, there is no concern that the Eighth Amendment will suddenly apply to every aspect of a former inmate's life.

In conducting this analysis, courts could consider the extensive findings of correlation between prison policies and harm instructive, as they are in the MAT context.[321] As evidenced by *Pesce v. Coppinger*, courts are capable of considering—and willing to consider—statistics and science.[322] Additionally, as Justice Brennan pointed out in his concurrence in *Rhodes v. Chapman*, lower courts also engage in nuanced and meaningful evaluations of prison conditions similar to the analysis undertaken for post-release conditions.[323]

Further, the issue of intervening causation creates a natural limit to the Eighth Amendment outside of prisons and jails. MAT presents the strongest case for extending the Eighth Amendment because the fatal overdose rates associated

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aclunebraska.org/sites/default/files/field_documents/eighth20circuit20prison20conditions20article20vii20-20print20formatting.pdf.

317 Amanda Agan & Sonja Starr, *The Effect of Criminal Records on Access to Employment*, 107 AM. ECON. REV. 560, 563–64 (2017) ("[E]ven fairly minor felony records have large negative effects on employer callbacks . . . .").

318 *Id.* at 560.

319 *See supra* note 5 and accompanying text. Although a lack of job opportunities arguably results in suffering, cruel and unusual punishment still requires harm or a foreseeable risk of harm. *See supra* notes 229–30 and accompanying text; Dolovich, *supra* note 212, at 897, 899–900, 930. Examples of harm have been limited to physical or mental harm, not economic harm. *Id.* at 915–16, 921, 956. There is no indication that adopting heightened negligence will force courts to include harms beyond those that are physical or mental.

320 *See* Dolovich, *supra* note 212, at 897, 899 (discussing prison conditions created by prison officials); Coppinger Memorandum, *supra* note 261, at 5, 9 (summarizing the MAT process in a prison); Pesce v. Coppinger, 355 F. Supp. 3d 35, 45 (D. Mass. 2018) (discussing a prison's failure to provide methadone treatment to prisoners with opioid addiction); Beletsky et al., *supra* note 2, at 157 (describing withdrawal experience without treatment); Mann, *supra* note 75, at 240–41 (describing policies and reasons prisons choose not to implement MAT); Bruce & Schleifer, *supra* note 49, at 19 (discussing the human rights aspect of providing MAT to prisoners); *supra* notes 299–303 and accompanying text. *See generally* U.S. DEP'T OF HEALTH & HUM. SERVS., *supra* note 50, at 1-4 to 1-14 (describing substance use and the societal costs).

321 Beletsky et al., *supra* note 2, at 166; Trickey, *supra* note 23.

322 *See supra* notes 183, 188 and accompanying text; *Pesce*, 355 F. Supp. 3d at 47; MARTON & DE LA GUÉRONNIÈRE, *supra* note 189, at 24–25.

323 Rhodes v. Chapman, 452 U.S. 337, 363–64 (1981) (Brennan, J., concurring in the judgment); *see supra* notes 168–171; *supra* Part II.B.

with prison policies are so clearly established by and emanate directly from prison and jails' actions.[324] In the case of job access, on the other hand, the employer is primarily concerned with the conviction, not the applicant's prison time.[325] The applicant could have been sentenced to community service or house arrest, but the employer would still focus on the conviction that resulted from the individual committing a crime.[326] Here, the conviction meets all the elements of intervening causation: it is independent of the prison time, it is adequate by itself to decrease employment opportunities, and it is not reasonably foreseeable to prison officials because it necessarily happened before the prison sentence began.[327] It has no direct relationship to prison policies. Unavoidable overdose upon release, however, is cruel and unusual punishment.[328] The prisoner cannot avoid it once sentenced, and it is therefore a prison condition.[329]

This example illustrates the feasibility of ending Eighth Amendment protection once intervening causation is established. While there is not a bright-line rule, the analysis is straightforward, and causation is already familiar to courts. Intervening causation is established once it is clear that a micro- or macro-level failure did not lead to the harm. Thus, although requiring post-release MAT under the Eighth Amendment is novel, it is clearly workable if courts employ the well-established concept of causation in the context of micro- and macro-level failures.[330] Because causation is a relatively workable concept, applying it to the Eighth Amendment may actually lead to more uniformity among the lower courts.[331]

IV. MONEY AND LIVES SAVED: PUBLIC POLICY CONSIDERATIONS

The societal and individual benefits associated with MAT are impressive.[332] Methadone and Buprenorphine result in "as much as $58 savings for every dollar

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[324] *See supra* Part I; Beletsky & Goulka, *supra* note 5; Lopez, *supra* note 5.

[325] Agan & Starr, *supra* note 317, at 561.

[326] *Id.* at 560.

[327] Beletsky et al., *supra* note 2, at 182 (outlining the three elements necessary for intervening causation).

[328] *See supra* Part III.C.

[329] Dolovich, *supra* note 212, at 899–900, 905, 913, 930; *see supra* notes 227–31.

[330] Dolovich, *supra* note 212, at 954 ("True, the line between micro- and macro-level failures . . . will not always be so easily drawn . . . [b]ut such indeterminacy is an insufficient reason to reject this approach.").

[331] *See* Siever, *supra* note 122, at 1393 (describing *Estelle* as establishing certain standards by which to evaluate Eighth Amendment cases); DeGroote, *supra* note 284, at 267, 269 (discussing the unpredictable results in cases that require proving deliberate indifference on the part of prison officials); *supra* notes 282–83 and accompanying text (discussing the inconsistent application of the Eighth Amendment by lower courts).

[332] Relevant to this section, MAT is a form of harm reduction, which aims to reduce harm to an individual when they engage in risky behavior—in this case, using opioids. THE PLAYBOOK, IMPLEMENTING A HARM REDUCTION APPROACH TO MEDICATIONS FOR ADDICTION TREATMENT IN OUTPATIENT SETTINGS 1 (2020),

spent."[333] More importantly, these same drugs also "slash[] OUD patient risk of overdose mortality" by fifty to eighty percent.[334] This section will highlight the promising statistics on the effectiveness of MAT, with a specific focus on Rhode Island's program.[335]

This section focuses on the effectiveness of MAT generally and the benefits of providing MAT to inmates. There is limited data on the cost-effectiveness of MAT post-release.[336] However, the money and lives saved because of MAT administered in prison is highest when services continue after an inmate's release, a potentially unstable and stressful time period during which relapse may be appealing.[337] Dr. Josiah Rich, co-director of Rhode Island's Center for Prisoner Health and Human Rights, says that following up with former inmates by "helping them stay on insurance, and letting them use the same clinic they used in prison" is key to a MAT program's success.[338] Continuity of services is so important because a disruption in MAT after prison may make it impossible to "successfully resume . . . treatment" and lead to the "loss of opioid tolerance" that MAT in prison is supposed to avoid in the first place.[339] Not only is it

https://www.bettercareplaybook.org/sites/default/files/2020-06/Camden%20MAT%20Play_062320_final.pdf.

333 Beletsky, *supra* note 7, at 365.

334 *Id.*

335 This is a public health model of harm reduction that focuses on reducing "overall . . . social harm," which includes reducing lost wages, taxes, and government expenditures to compensate for the negative externalities. Hoss, *supra* note 41, at 829; Harold Pollack, *Moral, Prudential, and Political Arguments About Harm Reduction*, 35 CONTEMP. DRUG PROBS. 211, 216 (2008). Alternatively, the human rights model advocates for harm reduction on the premise that "drug users are deserving of the health care, safety, and freedoms of other members of the public." Hoss, *supra* note 41, at 829. While this model is beyond the scope of this Comment, it is important for proponents of MAT to embrace for two reasons.

First, opponents of MAT continue to argue against MAT on a moral basis, while proponents tend to focus on economic and scientific rationale. Instead, a more effective pro-MAT moral response that proponents have failed to capitalize on is a focus on people like Mr. Pesce and Ms. Smith. Beletsky, *supra* note 7, at 367; Lopez, *supra* note 5; Pollack, *supra* note 334, at 213 ("The public health community has stumbled in its efforts to sidestep the moral and cultural politics of harm reduction . . . ."); Memorandum, *supra* note 11; Complaint, *supra* note 7, at 14; Smith v. Aroostook County, 376 F. Supp. 3d 146, 149–50 (D. Me. 2019); *see supra* notes 11–17.

Second, a moral argument is not misplaced within the Eighth Amendment context. As the Court held in *Estelle*, cruel and unusual punishment is "incompatible with 'the evolving standards of decency . . . of a maturing society.'" Estelle v. Gamble, 429 U.S. 97, 102 (1976) (quoting Trop v. Dulles, 356 U.S. 86, 101–02 (1958)). Accordingly, there is room for an argument about what is morally right and wrong within the Eighth Amendment, as this is surely part of any maturing society. A moral argument is a necessary response to MAT opponents.

336 SAMHSA, *supra* note 70, at 22.

337 Lopez, *supra* note 5. Providing MAT post release may be even more complicated than providing MAT to inmates, but Maryland is leading the way with new legislation requiring facilities to "provide follow-up treatment and care coordination after release." Purrington & Kukka, *supra* note 289.

338 Lopez, *supra* note 5.

339 Pesce v. Coppinger, 355 F. Supp. 3d 35, 41 (D. Mass. 2018); *see also* SAMHSA, *supra* note 70, at 22

constitutionally required to provide services post release,[340] but it is also most cost effective to help former inmates stay in recovery for the long term, as shown by the figures discussed below. Accordingly, this section applies to both MAT provided in prison and post-release.

A review of thirty studies on the cost-effectiveness of MAT show that, despite "higher outpatient or prescription costs," all three types of MAT are "associated with lower total health care costs" by about fifty percent.[341] All three types are also cost-effective "relative to no pharmacotherapy" or only behavioral therapy, like withdrawal or 12-Step programs.[342] As of 2018, MAT was estimated to cost about "$4,700 annually per person,"[343] as compared to the $24,000 cost of incarcerating *one* person annually.[344] The money saved upfront is impressive, but the long-term societal costs saved are staggering—the potential to recover $25.6 billion in workplace productivity, $25 billion in health care costs, and $5.1 billion in criminal justice costs per year.[345]

Rhode Island's MAT program started in 2016 and provides all three forms of MAT to prisoners, regardless of whether it was previously prescribed.[346] The program costs about $2 million per year and saw a sixty-one percent decrease in fatalities within the first six months.[347] But "lives saved" does not just refer to fatalities, it also refers to inmates regaining independence and relationships, and becoming productive members of society.[348] Further, MAT is also associated

("Any protective effects that might be achieved from prison or jail-based treatment appear to degrade quickly if [MAT] [is] not delivered continuously in the community.").

340 *See supra* Part III.D.

341 SEAN MURPHY, DAN POLSKY, ZACHARY MEISEL & JULIA MITCHELL, SHOW ME THE MONEY: ECONOMIC EVALUATIONS OF OPIOID USE DISORDER INTERVENTIONS 1, 3 (2016).

342 *Id.* at 3–4.

343 SAMHSA, *supra* note 70, at 7. This is just an estimate for the actual medication. Best practice is to provide patients with other services, such as therapy and a support system, which would add to the total cost but is still well below the cost to care for an inmate for a year. *See* CRIME RSCH. GRP., VERMONT RESULTS FIRST: INVENTORY AND BENEFIT-COST ANALYSIS FOR THE DEPARTMENT OF HEALTH/DIVISION OF ALCOHOL AND DRUG ABUSE PROGRAM'S MEDICATION ASSISTED TREATMENT FOR OPIOID USE DISORDER (HUB AND SPOKE) (2017), https://blueprintforhealth.vermont.gov/sites/bfh/files/VT%20Results%20First%20Inventory%20and%20Benefit-Cost%20Analysis%20for%20the%20Hub%20and%20Spoke%20Model%202017.pdf (describing the use of specialty substance abuse treatment facilities ("Hubs") and general medical offices ("Spokes") as part of a system of opioid treatment using a whole-patient approach).

344 SAMHSA, *supra* note 70, at 7.

345 Howard G. Birnbaum, Alan G. White, Matt Schiller, Tracy Waldman, Jody M. Cleveland & Carly L. Roland, *Societal Costs of Prescription Opioid Abuse, Dependence, and Misuse in the United States*, 12 PAIN MED. 657, 661 (2011).

346 Trickey, *supra* note 23.

347 *Id.*

348 Memorandum, *supra* note 11; Complaint, *supra* note 7, at 14; Smith v. Aroostook County, 376 F. Supp. 3d 146, 149–50 (D. Me. 2019); *see supra* notes 11–17 and accompanying text (detailing Pesce's story).

with a decrease in sexually transmitted diseases, crime victimization, and the involvement of Child Protective Services, which, generally speaking, are positive developments.[349] One former inmate calls MAT "a godsend" and the reason "[his] daughter finally can trust [him] again."[350] MAT not only saves states money by "reduc[ing] criminal activity, arrests, [and] probation revocations and re-incarcerations"[351]; the people receiving MAT retake their lives as well.[352]

Thus, MAT is financially beneficial as well because it can reduce spending on both incarceration and the opioid crisis in the long term.[353] Although the financial savings pale in comparison to lives saved, this is an effective starting point and common ground for MAT advocates and opponents.

CONCLUSION

It is clear that in jails and prisons across the country, inmates suffer cruel and unusual punishment because of anti-MAT policies. Worse yet, the state continues to subject inmates to cruel and unusual punishment by refusing to provide MAT once they are released. This Comment argues that without MAT both in prison and post-release, prisons and jails are violating the Eighth Amendment. In effect, inmates have been informally sentenced to withdrawal and eventual overdose. As it stands, the current Eighth Amendment jurisprudence, coupled with a pervasive misunderstanding of MAT and OUD, does not give full effect to inmates' Eighth Amendment rights and cannot remedy the paucity of MAT for inmates. Relying on the ADA to effectuate inmates' right to MAT is insufficient and inappropriately undermines the magnitude of the constitutional right to be free from cruel and unusual punishment.

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349 SAMHSA, *supra* note 70, at 4, 21, 23; Pamela Petersen-Baston, *Methods of Engaging Family Courts and Child Protective Services Through Opioid Treatment Programs and DATA 2000 Practices*, *in* INCREASING ACCESS TO MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION IN DRUG COURTS AND CORRECTIONAL FACILITIES AND WORKING EFFECTIVELY WITH FAMILY COURTS AND CHILD PROTECTIVE SERVICES 1, 26 (2016).

350 Trickey, *supra* note 23.

351 Purrington & Kukka, *supra* note 289; *see* Beletsky, *supra* note 7, at 364; Lopez, *supra* note 5 ("[M]any inmates are in prison *because* of their drug use; for example, about 39 percent of people in state prison for property offenses said that they committed their crimes to get drugs . . . .").

352 Memorandum, *supra* note 11 (detailing Mr. Pesce's newfound economic independence and role in his son's life); *see also* Hoss, *supra* note 41, at 829 ("A human rights model for harm reduction justifies these strategies because drug users are deserving of the health care, safety, and freedoms of other members of the public . . . .").

353 *See generally* Birnbaum et al., *supra* note 345 (describing a study on the estimated $55.7 billion economic cost of opioid abuse and addiction).

As society evolves, so too does the standard of decency that defines the minimum protections afforded by the Eighth Amendment. Today, this standard, as defined by science and ethics, includes MAT for inmates. In its current state, Eighth Amendment jurisprudence fails both to recognize these evolving standards of decency and to hold the state accountable for its carceral bargain. This failure, coupled with the decades long opioid crisis, is a perfect storm that has resulted in countless lives lost. It is therefore imperative that courts adopt a heightened negligence standard and a micro- and macro-level harm analysis for Eighth Amendment cases. This framework will hold the state accountable and prevent more senseless overdose deaths upon release to combat the relentless opioid crisis.

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