

**THE CASE FOR OUD TREATMENT: WHY SOUTH CAROLINA’S
LEGISLATURE SHOULD REQUIRE THE STATE’S CORRECTIONAL
FACILITIES TO PROVIDE OPIOID AGONIST MEDICATIONS FOR
INDIVIDUALS IN THEIR CUSTODY WITH OPIOID USE DISORDER**

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I. INTRODUCTION

Since she was a teenager, Brianna Lynn Beland “struggled with opioid [dependency].”¹ She “attempted to get help for her addiction” by entering “a Suboxone treatment program under the care of a doctor and therapist.”² Unfortunately, Brianna was arrested for shoplifting colored pencils and received a \$1,000 fine.³ She missed her scheduled payments after the sudden death of her husband, resulting in her arrest and confinement in a correctional facility in Charleston County.⁴ During her initial booking and screening, Brianna informed the medical staff of her struggles with opioid dependency; however, the facility did not provide her access to her prescribed Suboxone.⁵ Therefore, Brianna started suffering from severe opioid withdrawal, which lasted throughout the four days of her confinement.⁶ On the fourth day, medical staff found Brianna unresponsive in her cell, surrounded by bloody vomit.⁷ The medical staff rushed Brianna to the hospital, where she was declared dead.⁸ The cause of death was determined to be complications of withdrawal from chronic opioid dependence.⁹

Brianna is just one of thousands of South Carolinians who struggle with opioid use disorder (OUD) while in the custody of correctional facilities.¹⁰ Situations like Brianna’s are avoidable with the availability of three FDA-approved medication-assisted treatment (MAT) medications that are proven to be successful for individuals with OUD.¹¹ The federal government has allocated funding for providing access to all three FDA-approved MAT medications in state and local correctional facilities, and a handful of states have successfully incorporated these medications into their correctional

1. Estate of Beland *ex rel.* Hayes v. Charleston Cnty. Sheriff’s Off., No. 1:20-3006-SAL-SVH, slip op. at 2 (D.S.C. Oct. 12, 2021).

2. *Breland*, slip op. at 2. Suboxone is the brand name for buprenorphine, which is one of three medications commonly used to treat opioid dependency. See Barbara Andraka-Christou, *Improving Drug Courts Through Medication-Assisted Treatment for Addiction*, 23 VA. J. SOC. POL’Y & L. 179, 188 (2016).

3. *Breland*, slip op. at 2.

4. *Id.* This Article uses “correctional facility” as a broader term to encompass both jails and prisons. *Correctional Facilities*, NAT’L INST. OF JUST., <https://nij.ojp.gov/topics/corrections/correctional-facilities> [<https://perma.cc/SK4R-5Q6T>].

5. See *Breland*, slip op. at 2–5.

6. *Id.* at 1.

7. *Id.* at 8.

8. *Id.* at 9.

9. *Id.*

10. *House Opioid Abuse Prevention Study Committee Public Hearing*, S.C. LEGISLATURE, at 17:26 (Aug. 16, 2017), <https://www.scstatehouse.gov/video/archives.php?KEY=7291> [<https://perma.cc/8UMF-QF4J>].

11. See discussion *infra* Section II.A.

healthcare services.¹² However, South Carolina's state and local correctional facilities lag behind in regards to properly treating inmates with OUD.¹³ South Carolina's state correctional facilities only offer a limited MAT program, and this program does not allow individuals with certain MAT prescriptions to access their medications while serving their sentences.¹⁴ Furthermore, only one of South Carolina's local correctional facilities has a treatment program.¹⁵

Recent trends in federal courts demonstrate that the practices of South Carolina's state and local correctional facilities could violate the Eighth Amendment and the Americans with Disabilities Act (ADA).¹⁶ Therefore, South Carolina needs to adopt legislation to expand its current use of MAT medications in its state correctional facilities and to require access to MAT medications in local correctional facilities, providing every individual with OUD in their custody with access to all three FDA-approved MAT medications.

Part II of this Note starts with a background of the opioid epidemic in the United States and the epidemic's connection to the criminal justice system. It then details how the federal government has acknowledged this problem and made efforts to expand access to MAT medications in both federal and state correctional facilities. Part III identifies recent trends in federal courts, suggesting correctional facilities that fail to provide inmates access to their prescribed opioid-agonist medications are likely violating the Eighth Amendment and the ADA. Additionally, Part III argues that even inmates without prescriptions may have viable claims under the Eighth Amendment in the future. Part IV then discusses the three states that have made the most progress in providing every inmate with OUD access to MAT medications and the key aspects of each state's program. Part V argues South Carolina's current approach to the use of MAT medications in state and local correctional facilities is problematic. It then argues that South Carolina should require all correctional facilities statewide to implement MAT programs that supply every individual with OUD in their custody with access to all three FDA-approved MAT medications, regardless of whether they were previously prescribed the medication. Finally, it insists on why this requirement should be enacted through legislative action and what this legislation should include.

12. See discussion *infra* Section II.B.

13. See discussion *infra* Section V.A. State correctional facilities are jails or prisons run by the South Carolina Department of Corrections. See S.C. CODE ANN. § 24-1-30 (2022). Local correctional facilities are jails or prisons run by county or municipal governments within a state. See S.C. CODE ANN. § 24-3-27(A) (2022).

14. See discussion *infra* Section V.A.

15. SHELLY WEIZMAN ET AL., O'NEILL INST. FOR NAT'L & GLOB. HEALTH L., A NATIONAL SNAPSHOT: ACCESS TO MEDICATIONS FOR OPIOID USE DISORDER IN U.S. JAILS AND PRISONS 18 (2021) (discussing access to MAT in every state).

16. See discussion *infra* Part III.

Part VI concludes by emphasizing the necessity for access to these medications in South Carolina's correctional facilities and the benefits that the state will receive in return.

II. BACKGROUND

A. *The Opioid Epidemic in Correctional Facilities*

Opioid dependency, or opioid use disorder (OUD), is a disease that damages the brain's reward system.¹⁷ This damage changes an individual's brain chemistry so that the brain functions normally only when opioids are in use.¹⁸ Therefore, individuals with OUD have a dependence on opioids and experience painful physical and mental withdrawal symptoms when opioids are not in their systems.¹⁹ OUD is a public health emergency in the United States, with approximately 2.1 million people dependent on opiate prescription pain killers and another 467,000 people dependent on heroin.²⁰ Unfortunately, OUD patients are at a high risk of overdose and death, and therefore, these startling addiction statistics are accompanied by equally startling fatality statistics.²¹ More than 564,000 people died from opioid-related overdoses between the years 1999 and 2020, marking the first time the United States' life expectancy declined since World War I.²² This epidemic

17. *Module 5: Assessing and Addressing Opioid Use Disorder (OUD)*, CTRS. FOR DISEASE CONTROL & PREVENTION [hereinafter *CDC Module*], <https://www.cdc.gov/drugoverdose/training/oud/accessible/index.html> [<https://perma.cc/8BNJ-JKA9>] (“OUD was previously classified as . . . Opioid Dependence . . .”); Thomas R. Kosten & Tony P. George, *The Neurobiology of Opioid Dependence: Implications for Treatment*, SCI. & PRAC. PERSPS., July 2002, at 13, 14.

18. See Kosten & George, *supra* note 17, at 14.

19. *Id.* at 15.

20. Julie Hirschfeld Davis, *Trump Declares Opioid Crisis a “Health Emergency” but Requests No Funds*, N.Y. TIMES (Oct. 26, 2017), <https://www.nytimes.com/2017/10/26/us/politics/trump-opioid-crisis.html> [<https://perma.cc/6AUJ-R3BR>]; Andra-Christou, *supra* note 2, at 181.

21. Jeremy Ledger, *Opioid Use Disorder*, YALE MED.: FACT SHEETS (Dec. 2020), <https://www.yalemedicine.org/conditions/opioid-use-disorder> [<https://perma.cc/PYJ8-LMAL>].

22. *Understanding the Opioid Overdose Epidemic*, CTRS. FOR DISEASE CONTROL & PREVENTION (June 1, 2022), <https://www.cdc.gov/opioids/basics/epidemic.html> [<https://perma.cc/UA2Y-XECU>]; Lenny Bernstein, *U.S. Life Expectancy Declines Again, a Dismal Trend Not Seen Since World War I*, WASH. POST (Nov. 28, 2018, 12:01 AM), https://www.washingtonpost.com/national/health-science/us-life-expectancy-declines-again-a-dismal-trend-not-seen-since-world-war-i/2018/11/28/ae58bc8c-f28c-11e8-bc79-68604ed88993_story.html [<https://perma.cc/ZX7Y-LA97>].

has not spared South Carolina. In 2020 alone, the state suffered 7,830 opioid-related overdose hospitalizations and 2,744 opioid-related deaths.²³

OUD affects individuals from all walks of life; yet individuals involved in the criminal justice system are disproportionately impacted by OUD because the lack of proper treatment in correctional facilities leaves these individuals especially susceptible to the negative effects of withdrawal and to a high risk of fatal overdose.²⁴ OUD is widespread in correctional facilities both nationwide and in South Carolina because those dependent on opioids are disproportionately involved in the criminal justice system.²⁵ People who use opioids are thirteen times more likely to be involved in the criminal justice system than non-opioid users.²⁶ Therefore, correctional facilities frequently house individuals suffering from OUD.²⁷ However, OUD remains untreated, or inadequately treated, in these facilities.²⁸ Correctional facilities typically force inmates with OUD to go through withdrawal as part of their treatment programs.²⁹ Withdrawal is a painful process that can result in death if

23. S.C. DEP'T ALCOHOL & OTHER DRUG ABUSE SERVS., PAIN KILLERS CAN BE JUST PLAIN KILLERS (2020), https://justplainkillers.com/wp-content/uploads/2022/03/daodas_11586_09_oert-fact-sheet-StateWide-2020_01.pdf [<https://perma.cc/NP47-XUFR>].

24. See Beth Schwartzapfel, *A Better Way to Treat Addiction in Jail*, MARSHALL PROJECT (Mar. 1, 2017, 10:00 PM), <https://www.themarshallproject.org/2017/03/01/a-better-way-to-treat-addiction-in-jail> [<https://perma.cc/5RHH-KW8Y>] (explaining that, two weeks after their release, inmates are 129 times more likely to die from an overdose than the general population because their tolerance goes down and cravings go up in prison); ACLU, OVERJAILED AND UN-TREATED: HOW THE FAILURE TO PROVIDE TREATMENT FOR SUBSTANCE USE IN PRISONS AND JAILS FUELS THE OVERDOSE EPIDEMIC 8 (2019).

25. ACLU, *supra* note 24, at 8 (“About a quarter of the prison and jail population has OUD.”); *By the Numbers: The SC Opioid Epidemic*, S.C. DEP'T ALCOHOL & OTHER DRUG ABUSE SERVS., <https://justplainkillers.com/data/embed/criminal-justice/> [<https://perma.cc/B385-U69W>] (discussing that, in 2020, 11.53% of South Carolina inmates indicated opioid use during screening); Matthias Pierce et al., *Insights Into the Link Between Drug Use and Criminality: Lifetime Offending of Criminally-Active Opiate Users*, 179 DRUG & ALCOHOL DEPENDENCE 309, 313–14 (2017).

26. Rhitu Chatterjee, *With More Opioid Use, People Are More Likely to Get Caught Up in the Justice System*, NAT'L PUB. RADIO (July 6, 2018, 2:28 PM), <https://www.npr.org/sections/health-shots/2018/07/06/626176621/with-more-opioid-use-people-are-more-likely-to-get-caught-up-in-the-justice-syst> [<https://perma.cc/QT4B-X79L>].

27. ACLU, *supra* note 24, at 8.

28. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., HHS PUB. NO. PEP19-MATUSECJS, USE OF MEDICATION-ASSISTED TREATMENT FOR OPIOID USE DISORDER IN CRIMINAL JUSTICE SETTING 5 (2019) [hereinafter SAMHSA].

29. The majority of correctional facilities treat OUD with naltrexone. Eric Westervelt, *County Jails Struggle with a New Role as America's Prime Centers for Opioid Detox*, NAT'L PUB. RADIO (Apr. 24, 2019, 5:05 AM), <https://www.npr.org/2019/04/24/716398909/county-jails-struggle-with-a-new-role-as-americas-prime-centers-for-opioid-detox> [<https://perma.cc/LNH5-FN3N>]. However, naltrexone requires patients to go through withdrawal before taking the medication. See Andraka-Christou, *supra* note 2, at 192.

symptoms are not properly treated.³⁰ Furthermore, withdrawal causes the body's opioid tolerance to lower, and thus a significantly smaller dose can be fatal if an inmate uses opioids again after release.³¹ Consequently, the formerly incarcerated are around thirty times more likely to die of an opioid overdose than the general population.³²

Treatments for OUD are readily available for correctional facilities to provide to affected inmates, yet few facilities offer the most effective medications for treating OUD.³³ Medication-assisted treatment (MAT) is the most effective treatment for OUD, and it has been shown to reduce opioid related deaths among the formally incarcerated by 80% to 85%.³⁴ MAT is “the use of medications in combination with counseling and behavioral therapies, which is effective in the treatment of opioid use disorders . . . and can help some people to sustain recovery.”³⁵ Currently, the FDA has approved three medications for treating OUD: methadone, buprenorphine, and naltrexone.³⁶ However, the majority of correctional facilities that have a MAT program only utilize naltrexone.³⁷

The reasoning behind the preference for naltrexone is that methadone and buprenorphine are both opioid agonists, meaning the medications are themselves opioids.³⁸ Similar to abusive opioids like heroin and fentanyl, methadone and buprenorphine are synthetic derivatives of the opium poppy.³⁹ Because of their chemical makeup, methadone and buprenorphine stimulate

30. ACLU, *supra* note 24, at 8.

31. *See id.* at 9.

32. SAMHSA, *supra* note 28, at 3.

33. *Id.* at 5.

34. Smith v. Aroostook County, 376 F. Supp. 3d 146, 150 (D. Me. 2019) (“One study of English correctional facilities found that treatment with buprenorphine or methadone was associated with an 80 to 85 percent reduction in post-release drug-related mortality.”).

35. *Information About Medication-Assisted Treatment (MAT)*, FDA (Feb. 14, 2019), <https://www.fda.gov/drugs/information-drug-class/information-about-medication-assisted-treatment-mat> [<https://perma.cc/Q82K-837D>].

36. *Id.* These medications are also referred to as medications for opioid use disorder (MOUD), but this article will use the term MAT. *Medications for Substance Use Disorders*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., <https://www.samhsa.gov/medications-substance-use-disorders> [<https://perma.cc/2HSX-Y3D3>].

37. SAMHSA, *supra* note 28, at 5; Westervelt, *supra* note 29.

38. Schwartzapfel, *supra* note 24 (“That causes many in law enforcement to question whether these treatments are ‘substituting’ one addiction for another.”); CTR. FOR ADDICTION & MENTAL HEALTH, MAKING THE CHOICE, MAKING IT WORK: TREATMENT FOR OPIOID ADDICTION, at ix (2nd ed. 2016); *Opioids*, LIVERTOX: CLINICAL & RSCH. INFO. ON DRUG-INDUCED LIVER INJ. 2 (Nov. 24, 2020), https://www.ncbi.nlm.nih.gov/books/NBK547864/pdf/Bookshelf_NBK547864.pdf [<https://perma.cc/6V3R-4QRZ>].

39. *Opioids*, *supra* note 38, at 1. The most commonly abused opioids are oxycodone, Vicodin, heroin, morphine, and fentanyl. *Commonly Abused Opioids in the US*, INSIGHT RECOVERY CTRS. (May 25, 2022), <https://www.insightrecoverycenters.com/rehab-blog/commonly-abused-opioids-in-the-us/> [<https://perma.cc/WB5K-CPLW>].

opioid receptors in the brain.⁴⁰ This stimulation reduces withdrawal symptoms and cravings because it acts on the same receptors that abusive opioids activate.⁴¹ However, unlike abusive opioids, these opioid agonists do not cause intoxication, euphoria, or sedation if delivered in the proper dosage, and they block these effects from occurring if an abusive opioid is taken.⁴² Therefore, opioid agonists are very effective for treating OUD because they alleviate withdrawal symptoms and allow affected individuals to function normally while satisfying their brains' dependency on opioids.⁴³ Yet, because these medications have similar qualities to abusive opioids, correctional facilities are wary of providing opioid agonists to inmates with OUD.⁴⁴

Correctional facilities are hesitant to permit inmates to begin or continue taking opioid agonists while detained because they fear that allowing access to these medications will lead to diversion and misuse.⁴⁵ Opioid agonists can produce a high if taken in large doses, and therefore, correctional facilities fear that inmates will store the opioid agonists to sell among the facilities' inmate population, leading to misuse.⁴⁶ This fear is not unfounded; nearly two-thirds of correctional facilities report nonprescribed use of buprenorphine, and around 20% report unauthorized concealment of buprenorphine.⁴⁷ Naltrexone, on the other hand, is an opioid antagonist and not an opioid.⁴⁸ The medication cannot cause intoxication and therefore does not have the potential of misuse and diversion.⁴⁹ However, opioid agonists can be provided without diversion and misuse through the implementation of proper safety protocols, and some correctional facilities have implemented the

40. See ACLU, *supra* note 24, at 7; SAMSHA, *supra* note 28, at 6–7.

41. See NAT'L INST. ON DRUG ABUSE, MEDICATIONS TO TREAT OPIOID USE DISORDER RESEARCH REPORT 3 (2021), <https://nida.nih.gov/download/21349/medications-to-treat-opioid-use-disorder-research-report.pdf> [<https://perma.cc/D6XG-NVQ7>].

42. SAMHSA, *supra* note 28, at 7.

43. Studies found opioid agonists are effective at reducing illicit opioid use and the risk of overdose. See ACLU, *supra* note 24, at 7–8.

44. See Schwartzapfel, *supra* note 24.

45. SAMHSA, *supra* note 28, at 10.

46. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., PUB. NO. PEP19-MAT-CORRECTIONS, MAT INSIDE CORRECTIONAL FACILITIES: ADDRESSING MEDICATION DIVERSION 1 (2019) (“MAT agonist medications used to treat opioid use disorder in correctional settings have contraband value because their nonmedical use by an individual can sometimes result in euphoria. In jails and prisons, some individuals receiving MAT may divert their prescribed medications to the black market within the facility. A common medication diversion technique is to avoid swallowing the medication and storing it on one's person or in a body cavity for later redistribution.”).

47. SAMHSA, *supra* note 28, at 10.

48. *Naltrexone*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (Jan. 25, 2023), <https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/naltrexone> [<https://perma.cc/Y5YH-4HNA>].

49. *Id.*; SAMHSA, *supra* note 28, at 6.

use of opioid agonists with minimal complications.⁵⁰ Unfortunately, a stigma still persists that providing these opioid agonists is simply “replacing one addictive drug for another” because these medications are themselves opioids and can be addictive if taken by individuals without OUD.⁵¹ Naltrexone does not have a similar stigma because it does not contain opioids, and thus it has no addictive tendencies.⁵² Therefore, naltrexone is more appealing to correctional facilities.⁵³

However, naltrexone’s effectiveness for treating OUD is limited because, unlike opioid agonists, the medication does not alleviate withdrawal symptoms.⁵⁴ The medication treats OUD by binding to the opioid receptors in the brain.⁵⁵ When the medication binds to opioid receptors, it prevents any opioid from producing rewarding effects, such as euphoria.⁵⁶ Therefore, naltrexone can prevent relapse among individuals with OUD because individuals using the medication are no longer able to get high from opioids.⁵⁷ However, because naltrexone is not an opioid, it does not alleviate withdrawal symptoms.⁵⁸ The medication does not stimulate the brain’s opioid receptors, and therefore, the brain’s dependency is no longer being satisfied by an opioid.⁵⁹ Without this stimulation, individuals with OUD will still suffer from withdrawal symptoms.⁶⁰ Furthermore, individuals with OUD must completely detox from opioids before taking naltrexone, meaning they must suffer through opioid withdrawal to even take the medication.⁶¹ The medication’s inability to alleviate withdrawal hinders its effectiveness because individuals with OUD are hesitant to go through a treatment program

50. See SAMHSA, *supra* note 28, at 50; NAT’L SHERIFFS’ ASS’N & NAT’L COMM’N ON CORR. HEALTH CARE, JAIL-BASED MEDICATION-ASSISTED TREATMENT: PROMISING PRACTICES, GUIDELINES, AND RESOURCES FOR THE FIELD 29 (2018), <https://www.sheriffs.org/publications/Jail-Based-MAT-PPG.pdf> [<https://perma.cc/ZPD3-WCQX>].

51. SAMHSA, *supra* note 28, at 10; see Schwartzapfel, *supra* note 24.

52. *Naltrexone*, *supra* note 48.

53. See SAMHSA, *supra* note 28, at 5–7; Westervelt, *supra* note 29; see also COMPREHENSIVE OPIOID, STIMULANT, AND SUBSTANCE ABUSE PROGRAM RES. CTR., IMPLEMENTING MAT IN JAILS—FOCUS ON NALTREXONE 2 (June 2021), https://www.cossapresources.org/Content/Documents/Articles/AHP_Naltrexone_June_2021.pdf [<https://perma.cc/T2WD-9ZTB>].

54. SAMHSA, *supra* note 28, at 7.

55. *Id.* at 6.

56. See Andraka-Christou, *supra* note 2, at 192–93.

57. *Id.*

58. SAMHSA, *supra* note 28, at 9.

59. NAT’L INST. ON DRUG ABUSE, *supra* note 41, at 4.

60. See SAMSHA, *supra* note 28, at 7, 18–19.

61. Individuals who take naltrexone with opioids in their system will experience “immediate and painful withdrawals.” See Andraka-Christou, *supra* note 2, at 192. Consequently, individuals must first completely detox before taking naltrexone, meaning they must go through withdrawal before taking the medication. See *id.*; see also SAMHSA, *supra* note 28, at 19.

that requires them to suffer from the negative effects of withdrawal.⁶² Thus, naltrexone programs have “poor medication compliance and high dropout rates.”⁶³ Consequently, most studies have found that opioid agonists are more effective than naltrexone at reducing illicit opioid use and the risk of overdose.⁶⁴ However, some studies found that naltrexone reduces cravings and can be effective for treating some patients.⁶⁵ Therefore, all three medications help treat inmates suffering from OUD, and every correctional facility should evolve to provide these medications to address inmates’ individual needs.⁶⁶

B. The Federal Government’s Approach to MAT in Correctional Facilities

Since 2016, the executive branch of the federal government, across multiple administrations, has acknowledged the critical role that MAT programs play in combating the opioid crisis, and has taken steps to provide inmates with greater access to MAT medications in both federal and state correctional facilities nationwide.⁶⁷ Regarding state correctional facilities, President Obama “signed into law two significant pieces of legislation to address the opioid epidemic: the Comprehensive Addiction and Recovery Act (CARA) and the Twenty-First Century Cures Act (The Cures Act).”⁶⁸ CARA allows the United States Attorney General to make grants to states for developing, implementing, or expanding MAT programs used or operated by

62. See ACLU, *supra* note 24, at 8, 20; NAT’L INST. ON DRUG ABUSE, *supra* note 41, at 7.

63. SAMHSA, *supra* note 28, at 20.

64. *Id.*; ACLU, *supra* note 24, at 8.

65. SAMHSA, *supra* note 28, at 7, 19; ACLU, *supra* note 24, at 8.

66. ACLU, *supra* note 24, at 8.

67. See generally BIPARTISAN POL’Y CTR., TRACKING FEDERAL FUNDING TO COMBAT THE OPIOID CRISIS (2019), <https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2019/03/Tracking-Federal-Funding-to-Combat-the-Opioid-Crisis.pdf> [<https://perma.cc/6F8J-YV2Y>] (tracking the application of federal funding toward, MAT and other opiate-related programs across several states following 2016 policy changes); CHRIS CHRISTIE ET AL., PRESIDENT’S COMM’N ON COMBATING DRUG ADDICTION & THE OPIOID CRISIS, FINAL REPORT 72–73 (2017), https://trumpwhitehouse.archives.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-15-2017.pdf [<https://perma.cc/V9XE-NQQW>] (discussing Trump Administration strategy to use MAT programs); see also OFF. OF NAT’L DRUG CONTROL POL’Y, EXEC. OFF. OF THE PRESIDENT, THE BIDEN-HARRIS ADMINISTRATION’S STATEMENT OF DRUG POLICY PRIORITIES FOR YEAR ONE 1 (2021), <https://www.whitehouse.gov/wp-content/uploads/2021/03/BidenHarris-Statement-of-Drug-Policy-Priorities-April-1.pdf> [<https://perma.cc/9NYY-7GF3>] (discussing Biden Administration strategy to reduce opioid overdoses).

68. BIPARTISAN POL’Y CTR., *supra* note 67, at 9.

the states' criminal justice agencies.⁶⁹ The Cures Act authorizes the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) to administer \$1 billion in funding for these grants.⁷⁰ The Trump Administration, in 2017, furthered the previous Administration's efforts by declaring the opioid epidemic a public health emergency and by forming the President's Commission on Combating Drug Addiction and the Opioid Crisis to lay out a policy plan to address the crisis.⁷¹ The commission's report echoed the importance of expanding access to MAT for inmates with OUD, and the Administration then added \$932 million in funding to SAMHSA's state grant program.⁷² The Biden Administration followed the lead of the previous two Administrations and announced in 2021 that, as part of its national policy on drug control, it would further expand access to MAT for inmates with OUD.⁷³ In accordance with this policy, the Administration added \$1.5 billion in funding for SAMHSA's state grant program.⁷⁴ This consistent, bipartisan effort from the federal government to expand access to MAT in state correctional facilities demonstrates the critical role that MAT programs play in combating OUD among the incarcerated population.

Furthermore, the federal government is not only using funding to expand access to MAT in state correctional facilities nationwide, but it is also implementing MAT programs that use all three FDA-approved medications in its federal prisons. The Federal Bureau of Prisons (BOP) previously had a policy denying most inmates access to opioid agonists while incarcerated in its facilities, including those who came in with prescriptions for such medications.⁷⁵ Correctional facilities often allow only pregnant inmates who

69. 34 U.S.C. § 10701(a)(5).

70. BIPARTISAN POL'Y CTR., *supra* note 67, at 9.

71. *Id.*

72. See CHRISTIE ET AL., *supra* note 67, at 72–73; Susan Morse, *Trump Administration Announces \$1.8 Billion in Funding to States to Combat Opioid Crisis*, HEALTHCARE FIN. (Sept. 4, 2019), <https://www.healthcarefinancenews.com/news/trump-administration-announces-18-billion-funding-states-combat-opioid-crisis> [https://perma.cc/KYG7-BJDT].

73. OFF. OF NAT'L DRUG CONTROL POL'Y, *supra* note 67, at 3.

74. Press Release, U.S. Dep't of Health & Hum. Servs., Biden Administration Announces \$1.5 Billion Funding Opportunity for State Opioid Response Grant Program (May 19, 2022) (on file with author), <https://www.hhs.gov/about/news/2022/05/19/biden-administration-announces-15-billion-funding-opportunity-state-opioid-response-grant-program.html> [https://perma.cc/LN2Q-GT6R].

75. See Press Release, ACLU of Wash., ACLU-WA Lawsuit Settled: Federal Prison System Agrees to Provide Medication-Assisted Treatment for Opioid Use Disorder (Dec. 11, 2019) (on file with author), <https://www.aclu.org/press-releases/aclu-wa-lawsuit-settled-federal-prison-system-agrees-provide-medication-assisted> [https://perma.cc/SVX8-KXNW] (discussing BOP's prior policy prohibiting treatment of inmates with opioid agonists); *DiPierro v. Hurwitz*, ACLU of MASS., <https://www.aclum.org/en/cases/dipierro-v-hurwitz>

come in on opioid agonist medications to continue using their medications because there is a significant possibility of miscarriage if they are denied their medications.⁷⁶ Yet, these pregnant inmates are not allowed to continue using opioid agonists after they give birth.⁷⁷ The BOP previously followed this concept and only allowed pregnant inmates, in addition to two other categories of inmates, to continue using prescribed opioid agonist while serving their sentences; and, like state facilities, the BOP would not allow these inmates to continue using these medications for the ongoing treatment of OUD.⁷⁸ However, litigation and legislative initiatives have caused the BOP to initiate programs that aim to provide any inmate with OUD access to all three FDA-approved MAT medications throughout their incarceration.⁷⁹

The BOP's previous policy started to change after President Trump signed the First Step Act (FSA) into law in 2018.⁸⁰ The FSA required the Director of the BOP to create "plans to expand access to evidence-based treatment for heroin and opioid abuse for prisoners, including access to medication-assisted treatment."⁸¹ However, into the latter half of 2019, the BOP continued to deny inmates with opioid agonist prescriptions access to their medications while serving their sentences.⁸² As a result, the American Civil Liberties Union (ACLU) initiated three lawsuits on behalf of inmates

[<https://perma.cc/7KXR-JPA2>]; FED. BUREAU OF PRISONS, OPIOID USE DISORDER: DIAGNOSIS, EVALUATION, AND TREATMENT 1 (2021), https://www.bop.gov/resources/pdfs/opioid_use_disorder_cg.pdf [<https://perma.cc/MYT3-42HS>] (detailing amended BOP policy allowing treatment of inmates with opioid agonists).

76. ACLU, *supra* note 24, at 15, 23.

77. See SAMHSA, *supra* note 28, at 48.

78. The other two categories of inmates that the BOP allowed to continue using prescribed opioid agonist were inmates needing pain management and inmates undergoing detox. See Sarah N. Lynch, *Woman with Opioid Addiction to Get Regular Methadone Treatment in Prison*, REUTERS (June 7, 2019, 10:22 PM), <https://www.reuters.com/article/us-usa-prisons-opioid-addiction/woman-with-opioid-addiction-to-get-regular-methadone-treatment-in-prison-idUSKCN1T903F> [<https://perma.cc/JYY3-9C47>].

79. See, e.g., *Crews v. Sawyer*, No. 19-2541-JWB, 2020 WL 1528502, at *2 (D. Kan. Mar. 31, 2020) ("The BOP's expansion of its MAT Program was, in part, to comply with the First Step Act."); see also First Step Act of 2018, Pub. L. No. 115-391, 132 Stat. 5194, 5244 (requiring BOP to develop and implement "plans to expand access to evidence-based treatment for heroin and opioid abuse for prisoners, including access to medication-assisted treatment in appropriate cases"); FED. BUREAU OF PRISONS, *supra* note 75, at 1, 6, 13.

80. NATHAN JAMES, CONG. RSCH. SERV., R45558, THE FIRST STEP ACT OF 2018: AN OVERVIEW 1 (2019); see also *Crews*, 2020 WL 1528502, at *2.

81. First Step Act of 2018, Pub. L. No. 115-391, 132 Stat. 5194, 5244.

82. See, e.g., *Crews*, 2020 WL 1528502, at *1 (denying treatment to inmate even after passage of FSA). But see, e.g., *Godsey v. Sawyer*, No. C19-1498 RSM, 2020 WL 2219291, at *2 (W.D. Wash. May 7, 2020) (accommodating inmate request for MAT assessment and treatment).

who were denied access to their prescribed opioid agonists under this policy.⁸³ These suits challenged the BOP's policy, and all resulted in settlement agreements where the BOP agreed to allow the plaintiffs to continue using their opioid agonist medications in federal prison.⁸⁴ These settlements suggest that the BOP believed its policy was insufficient and changes needed to be made.

Almost a month after settling its third case with the ACLU in September of 2019, the BOP issued the Medication Assisted Treatment for Opioid Use Disorder Interim Technical Guide, which provided guidance for expanding its MAT program to include all three FDA-approved MAT medications.⁸⁵ The BOP has continued, since 2019, to make strides in providing access to MAT for all inmates with OUD. As of 2021, BOP policy recommends that all federal "[i]nmates should be screened and assessed for OUD and treatment throughout their incarceration."⁸⁶ Moreover, this policy states that "there is no 'one size fits all' approach to OUD treatment."⁸⁷ All three FDA-approved medications should be available to inmates regardless of whether they were previously prescribed the medications, and BOP medical providers "should develop an individualized treatment plan for each patient based on that patient's needs, goals . . . and the patient's willingness to comply with the expectations of treatment with medications for OUD."⁸⁸ The BOP's efforts are ongoing because the BOP is still increasing its internal ability to prescribe buprenorphine.⁸⁹ Yet the BOP's efforts demonstrate an acknowledgement of the critical need for access to these medications in federal prisons, and therefore every correctional facility nationwide should take similar efforts to provide every inmate with OUD access to all three FDA-approved MAT medications.⁹⁰

83. See Press Release, ACLU of Wash., *supra* note 75; Settlement Agreement at 2, DiPierro v. Hurwitz, No. 1:19-cv-10495-WGY (D. Mass. 2019), https://www.aclum.org/sites/default/files/20190607_dipierro_settlement.pdf [<https://perma.cc/LT3F-U9PY>] (requiring BOP to administer methadone treatment to inmate); *Crews v. Sawyer*, ACLU OF KAN., <https://www.aclukansas.org/en/cases/crews-v-sawyer> [<https://perma.cc/VUP4-XT2R>].

84. See Press Release, ACLU of Wash., *supra* note 75.

85. See *Crews*, 2020 WL 1528502, at *2.

86. FED. BUREAU OF PRISONS, *supra* note 75, at 6.

87. *Id.* at 13.

88. See *id.* at 12–13.

89. U.S. DEP'T OF JUST., FIRST STEP ACT ANNUAL REPORT 45–46 (2022), <https://www.ojp.gov/first-step-act-annual-report-april-2022> [<https://perma.cc/9HXC-T7PH>] ("The BOP has worked to increase the number of BOP providers who have Drug Abuse Treatment Act (DATA) 2000 waivers that enable them to prescribe buprenorphine. Currently, the BOP has 143 prescribers with a DATA 2000 waiver.")

90. FED. BUREAU OF PRISONS, *supra* note 75, at 1 ("Current scientific evidence and trends in the treatment of OUD recognize that medications have a primary role and benefit that is independent of behavioral treatments. As an example, one large study found that treatment

III. THE JUDICIAL APPROACH TO MAT IN CORRECTIONAL FACILITIES

The recent federal policy initiatives expanding access to MAT for both federal and state inmates with OUD coincide with an emerging trend in federal courts around the country. Multiple federal courts have recently held state correctional facilities that either deny inmates with OUD their prescribed opioid agonists or fail to implement programs that provide these inmates access to their prescribed opioid agonists are likely in violation of both the Eighth Amendment and the Americans with Disabilities Act.⁹¹

A. *Eighth Amendment Claims*

Inmates with OUD have successfully asserted claims that correctional facilities' denial of access to prescribed opioid agonist medications violates the Eighth Amendment.⁹² Since the 1970s, courts have recognized inmates' constitutional right to adequate medical care under the Eighth Amendment.⁹³ The Supreme Court, in *Estelle v. Gamble*, held that the principles of the Eighth Amendment established an obligation for the government to provide medical care "for those whom it is punishing by incarceration" because a failure to do so would subject an inmate to torture.⁹⁴ Therefore, the Court concluded that a "deliberate indifference" to a serious medical need constitutes cruel and unusual punishment under the Eighth Amendment.⁹⁵ Importantly, the scope of what constitutes cruel and unusual punishment "is not static."⁹⁶ Courts must draw meaning from the "evolving standards of decency that mark the progress of a maturing society" to decide what actions are so unreasonable as to be

with methadone or buprenorphine following a non-fatal opioid overdose reduced subsequent opioid overdose deaths by 59%.").

91. *Pesce v. Coppinger*, 355 F. Supp. 3d 35, 47–48 (D. Mass. 2018) ("Because [Plaintiff] has alleged that [the facility's] policy 'ignore[s] treatment prescriptions given to Plaintiff by [his] doctors,' the Court concludes that, on the present record, [Plaintiff] is likely to succeed on the merits of his Eighth Amendment claim." (citing *Alexander v. Weiner*, 841 F. Supp. 2d 486, 493 (D. Mass. 2012))); *Smith v. Aroostook County*, 376 F. Supp. 3d 146, 160 (D. Me. 2019) (finding that a plaintiff was "likely to succeed on her ADA claim"); *DeVargas v. Bd. of Cnty. Comm'rs*, No. CIV 21-0271 RB/SCY, 2021 WL 4864478, at *5, *9 (D.N.M. Oct. 19, 2021) (finding "alleged facts sufficient to show an unconstitutional custom regarding the jail's failure to adequately treat detainees," thus violating the deceased's "Eighth and/or Fourteenth Amendment rights"); *P.G. v. Jefferson County*, No. 5:21-CV-388, slip op. at 5 (N.D.N.Y. Sept. 7, 2021) ("[R]efusal to guarantee access to methadone treatment likely violates the ADA.").

92. *See, e.g.*, Judgment at 1, *Pesce*, 355 F. Supp. 3d 35 (No. 18-11972-DJC) (granting inmate's preliminary injunction and over \$200,000 for attorney fees).

93. *See, e.g.*, *Estelle v. Gamble*, 429 U.S. 97, 102–03 (1976).

94. *Id.* at 103.

95. *Id.* at 104–05.

96. *See Trop v. Dulles*, 356 U.S. 86, 100–01 (1958) ("[T]he words of the Amendment are not precise, and . . . their scope is not static.").

cruel and unusual.⁹⁷ Over time, courts developed a two-part test for deliberate indifference claims under the Eighth Amendment, which contains both an objective and a subjective prong.⁹⁸ An inmate bringing a claim “must first show, objectively, that she had a serious medical condition,” and the inmate “must then show a prison official’s subjective indifference to that need.”⁹⁹

Inmates can show that opioid withdrawal satisfies the objective prong of the deliberate indifference test under Eighth Amendment challenges.¹⁰⁰ Under this prong, a medical need is serious if it has been diagnosed by a doctor as requiring treatment or is so obvious that “even a lay person would easily recognize the necessity for a doctor’s attention.”¹⁰¹ Alternatively, “a medical need is objectively serious if it ‘would result in further significant injury or an unnecessary and wanton infliction of pain if not treated.’”¹⁰² The current medical consensus is that “opioid withdrawal [] is a life-threatening condition stemming from [OUD].”¹⁰³ Modern courts have accepted this consensus and have held that opioid withdrawal satisfies the objective prong for Eighth Amendment violation claims.¹⁰⁴ Therefore, inmates with OUD can satisfy the objective prong of Eighth Amendment claims when correctional facilities force them to undergo withdrawal.¹⁰⁵

Under the subjective prong of the deliberate indifference test, inmates have properly alleged deliberate indifference when a correctional facility either denies or fails to provide them access to their opioid agonists prescribed prior to incarceration.¹⁰⁶ An inmate’s claim of deliberate indifference must show more than just mere negligence.¹⁰⁷ The inmate must demonstrate that a correctional facility “official kn[ew] of and disregard[ed] an excessive risk to

97. *Roper v. Simmons*, 543 U.S. 551, 561 (2005) (quoting *Trop*, 356 U.S. at 100–01).

98. *See, e.g.*, *Jackson v. Lightsey*, 775 F.3d 170, 178 (4th Cir. 2014).

99. *Estate of Beland ex rel. Hayes v. Charleston Cnty. Sheriff’s Off.*, No. 1:20-3006-SAL-SVH, slip op. at 13 (D.S.C. Oct. 12, 2021); *see also* *Farmer v. Brennan*, 511 U.S. 825, 837 (1994) (defining “deliberate indifference” as a subjective test).

100. *See, e.g.*, *Breland*, slip op. at 16–17.

101. *Iko v. Shreve*, 535 F.3d 225, 241 (4th Cir. 2008) (quoting *Henderson v. Sheahan*, 196 F.3d 839, 846 (7th Cir. 1999)).

102. *Formica v. Aylor*, 739 Fed. App’x 745, 755 (4th Cir. 2018) (quoting *Gayton v. McCoy*, 593 F.3d 610, 620 (7th Cir. 2010)).

103. Mansi Shah & Martin R. Huecker, *Opioid Withdrawal*, STATPEARLS (Sept. 9, 2022), <https://www.ncbi.nlm.nih.gov/books/NBK526012/> [<https://perma.cc/6ZZS-5YSH>] (“Opioid withdrawal is a life-threatening condition resulting from opioid dependence.”).

104. *See, e.g.*, *Sylvester v. City of Newark*, 120 Fed. App’x 419, 423 (3rd Cir. 2005).

105. *See Quintana v. Santa Fe Cnty. Bd. of Comm’rs*, 973 F.3d 1022, 1029 (10th Cir. 2020).

106. *See, e.g.*, *Pesce v. Coppinger*, 355 F. Supp. 3d 35, 48 (D. Mass. 2018); *DeVargas v. Bd. of Cnty. Comm’rs*, No. CIV 21-0271 RB/SCY, 2021 WL 4864478, at *9 (D.N.M. Oct. 19, 2021).

107. *Estelle v. Gamble*, 429 U.S. 97, 105–06 (1976).

inmate health or safety” to properly allege deliberate indifference.¹⁰⁸ In the context of inmates being denied opioid agonist medications, courts have held that inmates can satisfy this subjective prong under two different standards.¹⁰⁹ First, allegations that prison officials denied or delayed an inmate’s access to opioid agonists prescribed by medical professionals prior to incarceration can demonstrate a deliberate indifference.¹¹⁰ Second, broader allegations that prison officials failed to implement a MAT program that allowed for the continued use of opioid agonist medications for inmates prescribed prior to serving their sentences can also demonstrate a deliberate indifference.¹¹¹

Applying the first standard, the United States District Court for the District of Massachusetts held, in *Pesce v. Coppinger*, that a plaintiff, Pesce, would likely win on the merits of his Eighth Amendment claim when a county jail’s policy expressly denied Pesce access to his prescribed methadone.¹¹² Pesce suffered from OUD and was admitted into a treatment program in 2016, where his physician prescribed him methadone.¹¹³ Prior to his recovery, a court charged Pesce with driving under the influence of drugs, which resulted in about three years of probation.¹¹⁴ He violated his probation by driving with a suspended license and thus had to serve a sixty-day sentence in county jail.¹¹⁵ The county jail expressly prohibited methadone and required inmates to undergo medically supervised withdrawal.¹¹⁶ The jail would then administer naltrexone to inmates right before their release.¹¹⁷ Therefore, Pesce would not have been able to take his medication while serving his sentence.

Pesce’s attorney sent a letter to the sheriff and superintendent in charge of the county jail, requesting assurance that Pesce could continue his methadone treatment while incarcerated, but Pesce’s attorney did not receive a response.¹¹⁸ Therefore, Pesce filed suit against the county officials, alleging that their policy of denying access to methadone for the treatment of OUD violated the Eighth Amendment, and he sought injunctive relief requiring the county officials to provide access to his prescribed methadone.¹¹⁹

Under the objective prong of the Eighth Amendment deliberate indifference test, Pesce argued that he had a serious medical condition because withdrawal would cause him needless suffering and would threaten his long-

108. *Farmer v. Brennan*, 511 U.S. 825, 837 (1994).

109. *Pesce*, 355 F. Supp. 3d at 48.

110. *Id.*

111. *See DeVargas*, 2021 WL 4864478, at *9.

112. *Pesce*, 355 F. Supp. 3d at 48.

113. *Id.* at 40.

114. *Id.* at 41.

115. *Id.*

116. *Id.* at 42.

117. *Id.*

118. *Id.*

119. *Id.* at 39.

term recovery from OUD.¹²⁰ Pesce then argued that, under the subjective prong, the jail's refusal to continue his prescribed methadone constituted a deliberate indifference to his medical need.¹²¹ The court then examined, as required for granting injunctive relief, the likelihood of success for Pesce's Eighth Amendment claim.¹²² The court held that Pesce likely satisfied the objective prong because he demonstrated a serious medical need that would cause him further injury if he were denied his methadone treatment.¹²³ Furthermore, the court found that Pesce likely satisfied the subjective prong because he alleged the jail's policy denied and contradicted his physician's recommendations.¹²⁴ The court reasoned that the policy "ensured Pesce [would] be denied methadone despite his physician's recommendation" because naltrexone was not interchangeable with methadone for the treatment of OUD, and therefore, the prison officials were acting with deliberate indifference toward Pesce's serious medical condition by enforcing this policy.¹²⁵ Thus, the court held that Pesce would likely succeed on the merits of his Eighth Amendment claim, and granted injunctive relief after concluding that the additional injunctive relief elements were met.¹²⁶

Applying the second standard, the United States District Court for the District of New Mexico, in *DeVargas v. Board of County Commissioners*, denied the Board of County Commissioners of Santa Fe's (the Board) motion for summary judgment because the plaintiffs alleged facts sufficient to show a deliberate indifference in a county jail's failure to implement a MAT program that provided inmates access to their prescribed opioid agonists.¹²⁷ Carmela DeVargas was a drug user who suffered from OUD.¹²⁸ Before her incarceration, she sought treatment and was prescribed Suboxone.¹²⁹ Although she "was arrested for an alleged probation violation" and informed the jail that she suffered from OUD,¹³⁰ she did not receive access to Suboxone

120. *See id.* at 41, 47.

121. *Id.* at 47.

122. *Id.* at 39, 47.

123. *See id.* at 41, 47.

124. *See id.* at 48.

125. *See id.* Naltrexone and methadone differ because naltrexone does not alleviate withdrawal symptoms while methadone does. *See discussion supra* Section II.A.

126. *Pesce*, 355 F. Supp. 3d at 48–49. Injunctive relief requires the court to "consider (1) the movant's likelihood of success on the merits; (2) the likelihood of the movant suffering irreparable harm; (3) the balance of equities; and (4) whether granting the injunction is in the public interest." *Id.* at 39.

127. *See DeVargas v. Bd. of Cnty. Comm'rs*, No. CIV 21-0271 RB/SCY, 2021 WL 4864478, at *9 (D.N.M. Oct. 19, 2021).

128. *Id.* at *1.

129. *Id.* at *3. Suboxone is the brand name for buprenorphine. Andraka-Christou, *supra* note 2, at 188.

130. *DeVargas*, 2021 WL 4864478, at *1–*2.

because the county jail refused to implement a MAT program that provided opioid agonists.¹³¹ Without access to her prescribed Suboxone, DeVargas suffered serious withdrawal symptoms.¹³² The jail's medical staff first forcibly administered Narcan and subsequently prescribed her Librium, which is a drug commonly used for alcohol withdrawal but not approved for the treatment of opioid withdrawal.¹³³ Consequently, DeVargas continued to suffer from opioid withdrawal.¹³⁴ To alleviate her withdrawal symptoms, DeVargas obtained Suboxone illicitly.¹³⁵ Unfortunately, she developed an infection from either from the jail's unsanitary conditions or from the dirty needle used to administer the Suboxone, and she later died.¹³⁶

DeVargas's family sued the Board, alleging the Board was deliberately indifferent to DeVargas's medical needs by failing to implement a MAT program that provided DeVargas access to her prescribed Suboxone.¹³⁷ The family asserted the Board knew of the efficacy of MAT but refused to implement a program, despite the high number of inmates at the jail with OUD.¹³⁸ Furthermore, the family asserted the Board "knew or should have known that without a MAT program, inmates like DeVargas would suffer serious illness or death."¹³⁹ The Board attempted to show that MAT programs were not the standard for jails; however, the court held that the alleged facts were sufficient to show an Eighth Amendment violation regarding the jail's failure to implement a program that provided inmates with prescribed opioid agonists access their medications.¹⁴⁰ Thus, the court denied the Board's motion for summary judgment.¹⁴¹

These cases are just two of many cases where courts have found that inmates suffering from OUD sufficiently alleged facts to support Eighth Amendment claims against correctional facility officials.¹⁴² This line of cases

131. *Id.* at *1–2.

132. *Id.* at *3.

133. *Id.*

134. *Id.*

135. *Id.* at *4.

136. *Id.* at *5.

137. *Id.*

138. *Id.* at *9.

139. *Id.*

140. *Id.*

141. *Id.*

142. *See, e.g.,* Alvarado v. Westchester County, 22 F. Supp. 3d 208, 218–19 (S.D.N.Y. 2014); Quintana v. Santa Fe Cnty. Bd. of Comm'rs, 973 F.3d 1022, 1033, 1035 (10th Cir. 2020); Foster v. Maloney, 785 Fed. App'x 810, 818–19 (11th Cir. 2019). Some of the listed cases bring deliberate indifference claims under the Fourteenth Amendment rather than the Eighth Amendment. Courts evaluate the constitutionality of *pretrial* detainees' conditions under the Due Process Clause of the Fourteenth Amendment. *See* Bell v. Wolfish, 441 U.S. 520, 535, 537 n.16 (1979). Pretrial detainees can show a due process violation if they demonstrate a deliberate

suggests that inmates could bring viable claims in federal court alleging the Eighth Amendment is violated when correctional facilities either deny prescribed opioid agonists or fail to implement a MAT program that provides access to such prescribed medications. To avoid such a potential for deliberate indifference litigation, correctional facilities should consider implementing MAT programs that allow inmates with opioid agonist prescriptions to continue using such medications while incarcerated.

While most cases concerning Eighth Amendment claims for the denial of MAT involve inmates who were prescribed opioid agonists before incarceration,¹⁴³ inmates without prescriptions are not necessarily precluded from bringing claims under the Eighth Amendment. Inmates who abuse opioids have OUD regardless of whether they are officially diagnosed by a physician, and they will experience withdrawal symptoms while serving their sentences if they are cut off from access to opioids.¹⁴⁴ Under the objective prong of the Eighth Amendment analysis, withdrawal symptoms constitute a serious medical condition, even *without* being diagnosed as needing treatment, because the symptoms are obvious enough for a lay person to recognize the need for a physician's attention.¹⁴⁵ Thus, inmates who

indifference to serious medical needs within the meaning of *Estelle*. See *Martin v. Gentile*, 849 F.2d 863, 871 (4th Cir. 1988); see also *Strain v. Regalado*, 977 F.3d 984, 989 (10th Cir. 2020). Thus, the same test has been applied regardless of whether a plaintiff brought a deliberate indifference claim under the Eighth or Fourteenth Amendment. See, e.g., *Alvarado*, 22 F. Supp. 3d at 212 n.6. However, in the wake of the Supreme Court's decision in *Kingsley v. Hendrickson*, 576 U.S. 389 (2015), a recent circuit split has emerged. *Westmoreland v. Butler County*, 29 F.4th 721, 727 (6th Cir. 2022). The split is over whether *Kingsley's* holding—which applies only an objective analysis to pretrial detainees' Fourteenth Amendment claims involving the excessive use of force—also applies to deliberate indifference claims under the Fourteenth Amendment. *Kingsley*, 576 U.S. at 396–97; *Westmoreland*, 29 F.4th at 727. The Second, Sixth, Seventh, and Ninth Circuits held that *Kingsley* called for the “modification of the subjective component for pretrial detainees bringing Fourteenth Amendment deliberate-indifference claims.” *Westmoreland*, 29 F. 4th at 727. On the other hand, “the Fifth, Eighth, Tenth and Eleventh Circuits retained the subjective component for deliberate-indifference Fourteenth Amendment claims.” *Id.* The Fourth Circuit is the controlling authority over South Carolina's District Courts, and it still retains the subjective component for pretrial detainees' Fourteenth Amendment deliberate indifference claims. See *Tarashuk v. Givens*, 53 F.4th 154, 165–66 (4th Cir. 2022).

143. See, e.g., *Pesce v. Coppinger*, 355 F. Supp. 3d 35, 48 (D. Mass. 2018); *DeVargas*, 2021 WL 4864478, at *9.

144. Withdrawal in opioid-dependent individuals occurs when the individuals “reduce or suddenly stop taking opioids.” Stacy Mosel, *Opioid Withdrawal Symptoms, Timeline, and Detox Treatment*, AM. ADDICTION CTRS. (Oct. 21, 2022), <https://americanaddictioncenters.org/withdrawal-timelines-treatments/opiate> [https://perma.cc/3SXJ-3QDH].

145. See *Iko v. Shreve*, 535 F.3d 225, 241 (4th Cir. 2008) (“Beginning with the objective component, a ‘serious . . . medical need’ is ‘one that has been diagnosed by a physician as mandating treatment or one that is so obvious that even a lay person would easily recognize the necessity for a doctor’s attention.’” (quoting *Henderson v. Sheahan*, 196 F.3d 839, 846 (7th Cir.

experience withdrawal can show they had an objectively serious medical condition.

Yet, under the subjective prong, courts have been less willing to find deliberate indifference for inmates without prescriptions, likely because the denial of prescription medication more clearly indicates a prison official's conscious disregard of a risk to the inmates' health.¹⁴⁶ When an inmate has a pre-existing opioid agonist prescription, prison officials are made aware that the inmate has OUD and is undergoing treatment for the illness.¹⁴⁷ Accordingly, denying such medication constitutes deliberate indifference because the prison officials know that OUD poses a risk to the inmate's health and then disregard that risk by failing to provide this inmate the treatment prescribed to mitigate his OUD.¹⁴⁸ Thus, inmates without prescriptions may have a greater difficulty demonstrating the requisite awareness to support allegations of deliberate indifference.

However, inmates with OUD who are not prescribed opioid agonists could still allege deliberate indifference by arguing that forcing them to undergo withdrawal is in conscious disregard of a substantial risk to their health.¹⁴⁹ The modern scientific consensus is that "medically supervised withdrawal is usually not sufficient to produce long-term recovery" and that methadone and buprenorphine are the most effective methods for treating OUD.¹⁵⁰ Moreover, the federal government has acknowledged the need for state correctional facilities to provide inmates with OUD access to all three

1999))). The symptoms of opioid withdrawal are conspicuous and identifiable by a lay person. See Marc A. Schuckit, *Treatment of Opioid-Use Disorders*, 375 NEW ENG. J. MED. 357, 358–59 (2016) (explaining that withdrawal causes diarrhea, dilated pupils, pain, anxiety, fatigue and insomnia).

146. Compare, e.g., *Chamberlain v. Va. Dep't of Corr.*, No. 7:20-cv-00045, slip op. at 6 (W.D. Va. Sept. 28, 2020) (noting, in denying plaintiff's requested relief, "[m]ost significantly, . . . Chamberlain has not presented any medical testimony to support his assertion that he needs MAT to treat his OUD," and distinguishing his case from those in which a prescription constituted such proof), with *Alexander v. Weiner*, 841 F. Supp. 2d 486, 493–94 (D. Mass. 2012) ("[W]here Plaintiff has alleged that Defendants repeatedly ignored treatment prescriptions given to Plaintiff by her doctors, she has pled enough facts to satisfy the deliberate indifference standard for the purposes of a motion to dismiss.").

147. See *Pesce*, 355 F. Supp. 3d at 48 (finding that a prisoner sufficiently stated an Eighth Amendment violation by alleging that prison officials ignored his existing prescription for methadone treatment).

148. See *id.* ("Because *Pesce* has alleged that Defendants' policy 'ignore[s] treatment prescriptions given to Plaintiff by [his] doctors,' the Court concludes that, on the present record, *Pesce* is likely to succeed on the merits of his Eighth Amendment claim.") (alteration in original).

149. See *Farmer v. Brennan*, 511 U.S. 825, 842 (1994) ("[To demonstrate deliberate indifference,] it is enough that the official acted or failed to act despite his knowledge of a substantial risk of serious harm.").

150. Schuckit, *supra* note 145, at 358, 360.

FDA-approved medications.¹⁵¹ Correctional facilities that either deny or fail to provide access to opioid agonists to all inmates with OUD and force inmates to undergo withdrawal are then arguably on notice that their practices could subject inmates to a risk to their health. Thus, inmates who are not prescribed opioid agonists could still allege deliberate indifference by arguing that prison officials' practice of forced withdrawal was medically unacceptable for the inmates' circumstances and chosen in conscious disregard of a substantial risk to their health.

For example, *Alvarado*, a 2014 case from the Southern District of New York, suggests that courts are willing to find inmates' claims have merit in which they allege that prison officials' practice of forcing non-prescribed inmates with OUD to undergo withdrawal constitutes deliberate indifference.¹⁵² In that case, the plaintiffs were all heroin users prior to being taken into a county jail's custody.¹⁵³ While three of the plaintiffs participated in a methadone treatment program prior to incarceration, one—Susa—had not.¹⁵⁴ They were all denied access to methadone while serving their sentences and filed suit against the county, claiming the jail's medical staff's failure to supply them with methadone constituted a deliberate indifference to a serious medical need under the Eighth Amendment.¹⁵⁵

The court found that Susa plausibly alleged deliberate indifference to a serious medical need when the medical personal forced him to withdraw from heroin.¹⁵⁶ Susa asserted that the jail's medical staff was aware that he was undergoing opioid withdrawal, yet they refused to provide him with opioid agonist medications.¹⁵⁷ Moreover, Susa claimed the medical staff continued to deny him opioid agonists over the course of nine months when it was apparent that medically supervised withdrawal was not effective.¹⁵⁸ The court held that these facts plausibly alleged deliberate indifference because they demonstrated the jail's medical staff was "intentionally allow[ing] [the inmate] to suffer from the effects of his withdrawal."¹⁵⁹ Therefore, the court denied the county's motion to dismiss.¹⁶⁰

Alvarado does not conclusively show that courts will find deliberate indifference to a serious medical need when correctional facilities force non-

151. See discussion *supra* Section II.B.

152. *Alvarado v. Westchester County*, 22 F. Supp. 3d 208, 217 (S.D.N.Y. 2014) (denying defendants' motion to dismiss as to the plaintiffs' deliberate indifference claim against Westchester County Jail's medical staff).

153. *Id.* at 211.

154. *Id.*

155. *Id.* at 216.

156. *Id.* at 217.

157. *Id.*

158. *Id.*

159. *Id.* (quoting *Foelker v. Outagamie County*, 394 F.3d 510, 513 (7th Cir. 2005)).

160. *Id.* at 219.

prescribed inmates with OUD to undergo withdrawal. However, the court, by finding that Susa's claim overcame summary judgment, does suggest that courts are starting to take such claims seriously. Thus, future litigants could, under similar circumstances, survive dismissal and possibly prevail on their underlying claim. Therefore, correctional facilities should also provide access to opioid agonist medications for inmates without prescriptions because these inmates could possibly bring successful Eighth Amendment claims in the future.

B. ADA Claims

Inmates with OUD are also finding success in federal courts by claiming correctional facilities violated their rights under the Americans with Disabilities Act (ADA) when they were prescribed opioid agonist medications prior to incarceration and then denied access to those medications while serving their sentences.¹⁶¹ The ADA's purpose is to eliminate discrimination against people with disabilities and to make sure the "federal government plays a central role in enforcing the standards established" in the Act.¹⁶² An individual who files a claim for discrimination under the ADA can prevail if he shows:

(1) that [he] is a qualified individual with a disability; (2) that [he] was either excluded from participation in or denied the benefits of some public entity's services, programs, or activities or was otherwise discriminated against; and (3) that such exclusion, denial of benefits, or discrimination was by reason of the plaintiff's disability.¹⁶³

First, inmates with OUD can demonstrate that they are qualified individuals with a disability when they are prescribed opioid agonist medications. For individuals to qualify under the ADA, they must establish "(A) a physical or mental impairment that substantially limits one or more major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment."¹⁶⁴ Following a 2008

161. *See, e.g.*, *Smith v. Aroostook County*, 376 F. Supp. 3d 146, 160, 162 (D. Me. 2019) (finding inmate was likely to succeed on the merits of her ADA claim against correctional facility and therefore issuing a preliminary injunction to provide inmate access to prescribed opioid withdrawal treatment).

162. 42 U.S.C. § 12101(b).

163. *Gray v. Cumming*, 917 F.3d 1, 15 (1st Cir. 2019) (quoting *Buchanan v. Maine*, 469 F.3d 158, 170–71 (1st Cir. 2006)).

164. 42 U.S.C. § 12102(1)(A)–(C).

amendment, conditions such as OUD meet this criteria due to the impairment of major bodily functions, which are considered a major life activity.¹⁶⁵

However, simply satisfying one of these prongs is not enough for inmates with OUD to be qualified; the ADA has additional criteria that individuals with drug-abuse-related disabilities must meet.¹⁶⁶ The individuals must show that they are no longer engaged in illegal drug use and that they have either completed or are actively participating in a supervised rehabilitation program.¹⁶⁷ In the context of OUD, courts have held that individuals currently taking prescribed opioid agonists are qualified individuals with a disability under the ADA, provided they are no longer using illicit opioids.¹⁶⁸ Thus, inmates with OUD can establish they are qualified individuals with a disability under the ADA when they are prescribed opioid agonists and are not currently engaging in illegal drug use.

Second, inmates are denied the benefit of a public service when a correctional facility either denies or fails to provide access to prescribed opioid agonists. Inmates with OUD can bring suits against correctional facilities because they are considered “public entities” under the ADA.¹⁶⁹ Furthermore, correctional facility health care is a “service, program, or activity” that benefits the inmates, and the exclusion from participation in a correctional facility’s health care would be a denial of that benefit.¹⁷⁰ Therefore, a correctional facility’s denial or failure to provide prescribed inmates with OUD access to their opioid agonist medications excludes these inmates from the benefit of a public entity’s services.¹⁷¹

165. C.R. DIV., U.S. DEP’T OF JUST., *THE AMERICANS WITH DISABILITIES ACT AND THE OPIOID CRISIS: COMBATING DISCRIMINATION AGAINST PEOPLE IN TREATMENT OR RECOVERY 1–2* (2022) [hereinafter *THE ADA AND THE OPIOID CRISIS*], https://archive.ada.gov/opioid_guidance.pdf [<https://perma.cc/J7EZ-XE37>].

166. *See generally* 42 U.S.C. § 12114.

167. *Id.* § 12114(b).

168. *See Start, Inc. v. Baltimore County*, 295 F. Supp. 2d 569, 576–77 (D. Md. 2003) (“[T]here is no question that opiate addiction may qualify as an ‘impairment’ provided the addict is not currently using drugs”); *MX Grp., Inc. v. City of Covington*, 293 F.3d 326, 336, 339 (6th Cir. 2002) (“[W]e cannot agree . . . that in the context of a drug addiction impairment, merely because methadone has the intended effect of ameliorating the addiction, recovering drug addicts lose all protection under the ADA.”).

169. *Pa. Dept. of Corrs. v. Yeskey*, 524 U.S. 206, 210 (1998) (construing the scope of the ADA term “public entity” by stating that “[s]tate prisons fall squarely within the statutory definition of ‘public entity.’ . . .”).

170. *Kiman v. N.H. Dep’t of Corr.*, 451 F.3d 274, 286–87 (1st Cir. 2006) (“[A]ccess to prescription medications is part of a prison’s medical services and thus is one of the ‘services, programs, or activities’ covered by the ADA.” (quoting *United States v. Georgia*, 546 U.S. 151, 157 (2006))); *see also Yeskey*, 524 U.S. at 210.

171. Samuel Macomber, *The Right to Medication-Assisted Treatment in Jails and Prisons*, 51 U. MEM. L. REV. 963, 991 (2021).

Third, an inmate with OUD can demonstrate that a correctional facility's denial or failure to provide access to opioid agonist medications is discrimination by reason of their disability. To prove discrimination by reason of disability, the inmate must show either disparate treatment, disparate impact, or failure to provide a reasonable accommodation.¹⁷² Disparate treatment claims assert that the disability motivated the correctional facility's denial of treatment,¹⁷³ and disparate impact claims assert that a correctional facility's facially neutral policy disproportionately affects people with a disability.¹⁷⁴ Claims for failure to make a reasonable accommodation assert that a correctional facility refused to accommodate a disability where such an accommodation was necessary to provide "meaningful access to a public service."¹⁷⁵

In the context of OUD, inmates can show discrimination by reason of their OUD through any of the three discrimination theories. An inmate can show disparate treatment if a correctional facility expressly denies or fails to provide access to opioid agonists because inmates diagnosed with OUD are being denied medical care due to their disability.¹⁷⁶ Opioid agonists are specifically for the treatment of OUD, and therefore, a denial of access to these medications is blocking inmates specifically diagnosed with OUD from access to medical care.¹⁷⁷ Furthermore, an inmate on opioid agonist medications for OUD can show disparate impact when a correctional facility's neutral policy prevents access to these medications.¹⁷⁸ For example, a policy that bans the provisions of opioids would disproportionately impact inmates with OUD because inmates with opioid agonist prescriptions would be forced to stop using their medications to serve their sentences, while inmates with non-opioid prescriptions would not have to stop using their medications to serve their sentences.¹⁷⁹ Finally, an inmate could argue that a policy against the continuation of MAT is a failure to provide a reasonable accommodation to a public service because a denial of MAT deprives inmates with OUD their most effective form of treatment; and thus, they are denied meaningful access

172. *Quad Enters. Co., v. Town of Southold*, 369 Fed. App'x 202, 205 (2nd Cir. 2010) (quoting *Tsombanidis v. W. Haven Fire Dep't*, 352 F.3d 565, 573 (2d Cir. 2003)).

173. *Nunes v. Mass. Dep't of Corr.*, 766 F.3d 136, 144 (1st Cir. 2014).

174. *B.C. v. Mount Vernon Sch. Dist.*, 837 F.3d 152, 158 (2d Cir. 2016).

175. *Nunes*, 766 F.3d at 145 (quoting *Henrietta D. v. Bloomberg*, 331 F.3d 261, 276 (2d Cir. 2003)).

176. *Macomber*, *supra* note 171, at 992.

177. *Id.*

178. See Melissa Koppel, *Medication-Assisted Treatment: Statutory Schemes & Civil Rights Implications*, 27 *CARDOZO J. EQUAL RTS. & SOC. JUST.* 145, 161 (2020) ("If the prison has a policy of forbidding prescribed narcotics, the individual with OUD can dispute this by saying that failing to modify the policy would violate the ADA, as the prison is not providing 'reasonable accommodations.'").

179. *Id.*

to a correctional facility's health care services.¹⁸⁰ Therefore, inmates who are denied access to prescribed opioid agonist medications by correctional facilities can argue they were discriminated against by reason of their disability under the ADA.

For instance, a 2019 case heard by the United States District Court for the District of Maine, *Smith v. Aroostook County*, illustrates that inmates with OUD can successfully bring ADA claims against correctional facilities that fail to provide them access to their prescribed opioid agonist medications.¹⁸¹ Here, the plaintiff, Smith, was convicted of theft and sentenced to forty days in county jail.¹⁸² Prior to incarceration, Smith was an opioid abuser who was prescribed buprenorphine.¹⁸³ Smith's attorney reached out to the jail and asked whether Smith would be allowed to continue taking her prescribed buprenorphine.¹⁸⁴ However, the jail informed the attorney "that Ms. Smith would undergo withdrawal and her symptoms would be treated in accordance with the [j]ail's withdrawal protocol."¹⁸⁵ The jail's withdrawal protocol did not allow the use of MAT medications and instead provided medications to assist with withdrawal symptoms.¹⁸⁶ Therefore, Smith filed suit against the county and sheriff in charge of the jail, alleging the jail's refusal to provide access to her prescribed buprenorphine violated the ADA.¹⁸⁷ This suit sought a preliminary injunction that would require the jail to allow Smith to continue taking her medication while serving her sentence.¹⁸⁸ As part of the requirement for granting a preliminary injunction, the court had to determine whether Smith's ADA claim would likely succeed on its merits.¹⁸⁹ The court held Smith's ADA claim was likely to succeed on its merits under the disparate treatment and reasonable accommodation theories because the evidence supported an inference that the jail staff denied Smith's necessary medical treatment due to her OUD.¹⁹⁰

Under the disparate treatment theory, the court held that Smith was likely to succeed on the merits of her ADA claim because the general practice of denying prescribed MAT was "so unreasonable as to raise an inference that the [d]efendants denied the [p]laintiff's request because of her disability."¹⁹¹

180. *Smith v. Aroostook County*, 376 F. Supp. 3d 146, 160 (D. Me. 2019).

181. *Id.* at 158–62 (granting Smith's request for preliminary injunction after finding her ADA claim would likely succeed on the merits).

182. *Id.* at 153.

183. *Id.* at 149.

184. *Id.* at 153.

185. *Id.*

186. *Id.* at 152.

187. *Id.* at 149.

188. *Id.*

189. *Id.* at 158.

190. *See id.* at 158–61.

191. *Id.* at 159–60.

The court held the record raised this inference because the defendants denied Smith's request without considering her medical needs and without any justifying security concerns.¹⁹² The defendants argued "they generally disallow[ed] inmates from continuing MAT to prevent diversion of buprenorphine."¹⁹³ However, the defendants admitted to "a variety of ways in which the [j]ail could provide [] Smith's buprenorphine outside of the [j]ail," avoiding any diversion concerns with providing the medication.¹⁹⁴ Additionally, they once provided a pregnant woman MAT in the jail without any known problems and offered no reason why the same could not be done for Smith.¹⁹⁵ Therefore, the court held that this "unjustified denial" gave rise to an inference that the defendants denied Smith's request because of her disability, and thus, the court concluded that Smith was likely to succeed on the merits of her ADA claim under the disparate treatment theory.¹⁹⁶

Under the reasonable accommodation theory, the court held that Smith was likely to succeed on the merits of her ADA claim because she was being denied meaningful access to the jail's health care services, and her request was not unreasonable.¹⁹⁷ Smith made multiple requests to be exempted from the jail's practice of forced withdrawal, but the defendants denied these requests.¹⁹⁸ The court held that, without this accommodation, Smith would be denied the "only form of treatment shown" by her doctor to properly treat her disability,¹⁹⁹ and thus, she was excluded from "meaningful access" to the jail's health care services.²⁰⁰ Additionally, the court held Smith's accommodation was not unreasonable because the jail previously provided the same accommodation to a pregnant woman without issue, and, for the same reason, the defendants could not demonstrate that this accommodation would "fundamentally alter the nature" of the jail's health care services.²⁰¹ Therefore, the court concluded that Smith's suit would likely succeed on the merits of her ADA claim under the reasonable accommodation theory, and it granted Smith's motion for preliminary injunction after finding the other requirements for such an injunction were met.²⁰²

192. *Id.* at 159.

193. *Id.*

194. *Id.*

195. *Id.*

196. *Id.* at 160.

197. *Id.*

198. *Id.*

199. *Id.*

200. *Id.* (quoting *Nunes v. Mass. Dep't of Corr.*, 766 F.3d 136, 145 (1st Cir. 2014)). Often state and local correctional facilities allow pregnant women with OUD access to methadone but fail to provide such access to non-pregnant inmates. *See supra* Section II.B.

201. *Smith*, 376 F. Supp. 3d at 160–61 (quoting 28 C.F.R. § 35.130(b)(7)(i)(2018)).

202. *Id.* at 160–63.

Smith is just one of a growing list of cases that demonstrate inmates with OUD can arguably bring successful ADA violation claims by alleging that the denial of their prescribed opioid agonist medications is discrimination by reason of their OUD.²⁰³ These cases suggest that courts will likely find such a denial to be so unreasonable as to be discriminatory because of the prevalence of providing MAT to pregnant inmates and the ability to administer opioid agonists safely.²⁰⁴ Therefore, correctional facilities should provide inmates with OUD access to their prescribed opioid agonists, or they might find themselves facing ADA litigation.

Unfortunately, inmates with OUD who are not prescribed opioid agonists may not be able to bring claims under the ADA because the ADA is substantially limited for people with OUD.²⁰⁵ The ADA specifically prohibits inmates from receiving protection under the act if they are currently using illegal drugs and have not completed or are not actively in a treatment program.²⁰⁶ Therefore, ADA claims are mostly limited to inmates with MAT medication prescriptions because these prescriptions indicate that they are actively in a treatment program.²⁰⁷ Inmates with OUD seeking to bring Eighth Amendment claims are not limited in this way because they are not required to show that they have a prior prescription for MAT medication in order to argue that their Eighth Amendment rights have been violated.²⁰⁸ Therefore,

203. *See, e.g., Pesce v. Coppinger*, 355 F. Supp. 3d 35, 47 (D. Mass. 2018) (“Absent medical or individualized security considerations underlying the decision to deny access to medically necessary treatment, [the correctional facility’s] policy as applied to Pesce is either ‘arbitrary or capricious—as to imply that it was pretext for some discriminatory motive’ or ‘discriminatory on its face.’”); *P.G. v. Jefferson County*, No. 5:21-CV-388, 2021 WL 4059409, at *4–5 (N.D.N.Y. Sept. 7, 2021) (holding that a plaintiff sufficiently argued discrimination by reason of his OUD when a correctional facility unjustly denied the plaintiff his prescribed methadone).

204. *See Smith*, 376 F. Supp. 3d at 160–61 (finding a facility’s refusal to distribute methadone to a non-pregnant inmate would likely be unreasonable when the facility had previously distributed methadone to a pregnant inmate); *supra* notes 76–78 and accompanying text (discussing the provision of MAT to pregnant inmates); *Pesce*, 355 F. Supp. 3d at 46 (“[S]afely and securely administer[ing] prescription methadone . . . is a common practice in institutions across the United States”); NAT’L SHERIFFS’ ASS’N & NAT’L COMM’N ON CORR. HEALTH CARE, *supra* note 50, at 14–15, 17–18 (discussing the provision of MAT to pregnant inmates and appropriate diversion control measures).

205. The Department of Justice will enforce the ADA to protect people with OUD only if they are in or have completed a recovery program for OUD and are not engaging in illegal drug use. *See THE ADA AND THE OPIOID CRISIS*, *supra* note 165, at 1; *see also* 42 U.S.C. § 12114(a)–(b).

206. § 12114(a)–(b).

207. Koppel, *supra* note 178, at 161 (“All of the [ADA] cases thus far have fallen under the latter category: an individual who is in a rehabilitation program, but will soon be incarcerated and, therefore, denied the opportunity to continue his treatment.”); *see, e.g., Smith v. Aroostook County*, 376 F. Supp. 3d 146 (D. Me. 2019).

208. *See supra* Section III.A (discussing Eighth Amendment claims).

inmates with OUD who are not prescribed opioid agonist medications and who seek to pursue litigation against a correctional facility for not providing access to opioid agonists will have to utilize the Eighth Amendment and not the ADA.

IV. STATE APPROACHES

In response to the prevalence of OUD in state correctional facilities and the developing trends in access to MAT litigation, at least thirty-nine states, including South Carolina, have either initiated policies or enacted legislation to expand access to MAT medications in their correctional facilities.²⁰⁹ However, most of these programs are limited, and the vast majority only provide the opioid antagonist, naltrexone.²¹⁰ Consequently, few states provide opioid agonist medications to inmates with OUD, and inmates with OUD continue to suffer from withdrawal while incarcerated and continue to have a high risk of overdose after their release.²¹¹ Thus, most states' correctional facilities are probably not in compliance with the ADA and Eighth Amendment.²¹²

However, three states stand out for having made the most progress in providing access to MAT medications for every inmate with OUD: Rhode Island, Vermont, and New York.²¹³ These states' programs all ensure that their correctional facilities comply with the recent trends in ADA and Eighth Amendment litigation by allowing inmates with opioid agonist prescriptions to continue using their medications while incarcerated. Further, they protect every inmate with OUD from needless suffering by providing access to all three FDA-approved MAT medications, regardless of whether an inmate previously had a prescription for such medications.²¹⁴ However, Vermont and

209. Andrew Joseph, *One State Takes a Novel Approach to Opioid Addiction: Access to Treatment for All Inmates*, STAT (Aug. 3, 2017), <https://www.statnews.com/2017/08/03/opioid-treatment-prisons/> [<https://perma.cc/9GHN-9RYG>]; see also Koppel, *supra* note 178, at 155–58 (discussing increases in MAT access in Massachusetts, Pennsylvania, Washington, Rhode Island, and New York); WEIZMAN ET AL., *supra* note 15 (discussing access to MAT in each state's correctional facilities).

210. WEIZMAN ET AL., *supra* note 15, at 2; see also ACLU, *supra* note 24, at 5 (describing several shortcomings in MAT legislations and policies). Naltrexone is an opioid antagonist that does not alleviate withdrawal symptoms. See *supra* Section II.A.

211. WEIZMAN ET AL., *supra* note 15, at 1.

212. See *supra* Part III.

213. Joseph, *supra* note 209 (describing Rhode Island's expansion of MAT, including all three drugs used to treat addiction, to its entire prison population); VT. STAT. ANN. tit. 28, § 801(b) (2019) (expanding access to medication-assisted treatment in correctional facilities for inmates who "at any time" show symptoms of opioid use disorder); N.Y. CORRECT. LAW § 626 (McKinney 2020).

214. See sources cited *supra* note 213.

Rhode Island are smaller states with unified correctional systems, which may make their MAT program difficult for larger states to replicate.²¹⁵ On the other hand, New York is a larger state with a program specifically tailored toward its non-unified correctional system.²¹⁶ Thus, its program may be a more realistic model for other states' correctional systems.

A. *Rhode Island*

Rhode Island's MAT program ensures that its correctional facilities comply with the Eighth Amendment and the ADA by providing inmates with prescribed opioid agonist medications access to their medications while incarcerated.²¹⁷ Furthermore, it takes the additional step of providing every inmate with OUD access to all three FDA-approved MAT medications. In 2016, Rhode Island became the first state to do so when Governor Gina Raimondo created an overdose prevention taskforce.²¹⁸ This task force asked for a broad program that would offer MAT to inmates who came in with MAT prescriptions, to new inmates withdrawing from opiates, and to inmates with histories of addiction.²¹⁹ Rhode Island's Department of Corrections (RDOC), under an executive order, proceeded to launch the program, and the legislature added \$2 million to the state's 2017 budget to fund the program.²²⁰ Under this program, all inmates are screened and assessed for OUD, and those with OUD are given the option of treatment.²²¹ Inmates who opt to receive treatment have the option of choosing between the three FDA-approved MAT medications: methadone, buprenorphine and naltrexone.²²² Thus, Rhode Island's MAT program provides every inmate with OUD access to all three

215. See, e.g., Joseph, *supra* note 209 (describing the potential challenge in replicating successful MAT program changes from a small state's compact corrections system).

216. See WEIZMAN ET AL., *supra* note 15, at 15 (“[New York] has used federal funding through SOR grants and some state funding to support increased access to [MAT] in jails and prisons across the state.”); CORRECT. § 626.

217. See Joseph, *supra* note 209 (describing Rhode Island's decision to increase MAT access as meeting the “standard of care in the community”).

218. Erick Trickey, *How the Smallest State Is Defeating America's Biggest Addiction Crisis*, POLITICO (Aug. 25, 2018), <https://www.politico.com/magazine/story/2018/08/25/rhode-island-opioids-inmates-219594/> [<https://perma.cc/AB4J-8KR4>].

219. *Id.*

220. *Id.*; Andrea Hsu & Ari Shapiro, *Rhode Island Prisons Push to Get Inmates the Best Treatment for Opioid Addiction*, NAT'L PUB. RADIO (Nov. 19, 2018, 2:13 PM), <https://www.npr.org/sections/health-shots/2018/11/19/668340844/rhode-island-prisons-push-to-get-inmates-the-best-treatment-for-opioid-addiction> [<https://perma.cc/8YQD-SGT3>]; R.I. Exec. Order No. 17-07 (Jul. 17, 2017), <https://governor.ri.gov/executive-orders/executive-order-17-07> [<https://perma.cc/L7DF-TP9J>].

221. NAT'L SHERIFFS' ASS'N & NAT'L COMM'N ON CORR. HEALTH CARE, *supra* note 50, at 29; Joseph, *supra* note 209.

222. Joseph, *supra* note 209.

FDA-approved medications regardless of whether they were previously prescribed such medications prior to serving their sentences.

Rhode Island's program is a solid approach for other states to follow because it not only ensures compliance with the Eighth Amendment and the ADA, but it also protects every inmate with OUD from needless suffering and it saves lives. By screening every inmate for OUD and allowing all who screen positive for OUD to opt to receive treatment, Rhode Island's program helps prevent inmates with OUD from undergoing withdrawal while incarcerated. These inmates can choose to receive opioid agonists, like methadone and buprenorphine, which alleviate painful withdrawal symptoms.²²³ Additionally, allowing every inmate access to these medications reduces inmates' risk of fatal overdose, and Rhode Island has already seen benefits from this approach.²²⁴ After just one year of implementing this program, the overdose rate of recently released individuals dropped by 60%, and the overall number of fentanyl deaths dropped by 50%.²²⁵

However, the state has unique advantages that assist its program's implementation and success. First, it had tremendous political support for the program.²²⁶ The public supported the program, and the legislature approved funding for it with little opposition.²²⁷ Second, the state has a unified correctional facility, which means that the RDOC has control over all correctional facilities within its borders.²²⁸ Third, all of Rhode Island's correctional facilities are on the same campus.²²⁹ Therefore, Rhode Island, unlike many larger states, does not have county jails, which makes it easier to create a uniform MAT program.²³⁰ All of these advantages present challenges for larger states to replicate Rhode Island's program. However, providing access to all three FDA-approved to every inmate with OUD has produced beneficial results for the state of Rhode Island, and thus, every state should look toward this general concept as something to replicate.

223. *See supra* Section II.A; Joseph, *supra* note 209.

224. *See supra* Section II.A; SAMHSA, *supra* note 28, at 41.

225. SAMHSA, *supra* note 28, at 41.

226. Joseph, *supra* note 209.

227. Trickey, *supra* note 218.

228. Madelyn O'Kelley-Bangsberg, *Medication-Based Treatment for Substance Use Disorder in Correctional Facilities: Factors Influencing the Enactment of Legislation*, GEO. L.: O'NEILL INST. FOR NAT'L AND GLOB. HEALTH L. (Nov. 10, 2020), <https://oneill.law.georgetown.edu/medication-based-treatment-for-substance-use-disorder-in-correctional-facilities-factors-influencing-the-enactment-of-legislation/> [https://perma.cc/EU P7-8MXM].

229. Joseph, *supra* note 209.

230. *Id.*; O'Kelley-Bangsberg, *supra* note 228.

B. Vermont

Vermont's program is similar to Rhode Island's because it ensures that its correctional facilities comply with the Eighth Amendment and the ADA, and it protects all inmates with OUD from needless suffering.²³¹ Vermont's program, however, differs from Rhode Island's because legislative action implemented the program instead of an executive order.²³² In 2018, Vermont became the first state to pass a legislative act, Act 176, that required state correctional facilities to provide all three FDA-approved MAT medications to inmates with OUD.²³³ Under Act 176, Vermont's correctional facilities must allow inmates receiving MAT medications prior to their incarceration to continue using these medications while serving their sentences.²³⁴ Furthermore, the correctional facilities must screen every inmate for OUD and provide OUD positive inmates access to all three FDA-approved medications if they elect to partake in the treatment program.²³⁵ Therefore, the MAT program in Vermont's correctional facilities is a legislative action that provides every inmate with OUD access to all three FDA-approved MAT medications, regardless of whether they were previously prescribed such medication prior to serving their sentences.

Vermont's legislative approach to creating its MAT program is a solid example for other states to follow, but, like Rhode Island, Vermont has advantages that may make it difficult for other states to replicate Vermont's program. Vermont also has a unified prison system, and therefore, all its correctional facilities fall under the umbrella of the Vermont Department of

231. See *Opioid Use Disorder Treatment in Jails and Prisons: Medication Provided to Incarcerated Population Saves Lives*, PEW CHARITABLE TRS.: ISSUE BRIEFS 10 (Apr. 23, 2020) [hereinafter PEW ISSUE BRIEF], <https://www.pewtrusts.org/-/media/assets/2020/04/casemedicationassistedtreatmentjailsprisons.pdf> [https://perma.cc/KBX3-B6AF]. But see discussion *supra* Part III.

232. Compare PEW ISSUE BRIEF, *supra* note 231, at 10, with R.I. Exec. Order No. 17-07, at 1 (July 12, 2017) (citing R.I. Exec. Order No. 15-14 (Aug. 4, 2015)), <https://governor.ri.gov/sites/g/files/xkgbur236/files/2021-06/ExecOrder-17-07-07122017.pdf> [https://perma.cc/39Z6-HME6] (listing "Department of Corrections-based medication-assisted treatment access" as part of the Strategic Plan implemented by the Governor's Overdose Prevention and Intervention Task Force, pursuant to Executive Order 15-14).

233. Act of May 25, 2018, No. 176, 2018 Vt. Acts & Resolves 633 (codified as amended at VT. STAT. ANN. tit. 18, § 4750 (2018), VT. STAT. ANN. tit. 28, §§ 801–801b (2019)); see WEIZMAN ET AL., *supra* note 15, at 5–20.

234. Tit. 28, § 801b(a); ANNIE RAMNICEANU, VERMONT DEPARTMENT OF CORRECTIONS PEER REVIEW OF THE MEDICATION-ASSISTED TREATMENT POLICY AND PROCEDURES AND CLINICAL GUIDELINES INTERIM REPORT, at 2 (2019) <https://legislature.vermont.gov/Documents/2020/WorkGroups/Justice%20Oversight/Reports%20and%20Resources/W~Department%20of%20Corrections~Peer%20Review%20of%20Medication%20Assisted%20Treatment~11-12-2019.pdf> [https://perma.cc/U9FD-THFR].

235. Tit. 28, §§ 801(b)(2), 801b(a); see also RAMNICEANU, *supra* note 234, at 2–3, 12.

Corrections (VDOC).²³⁶ Consequently, Vermont's legislature only needed to pass legislation ordering the VDOC to implement a MAT program in its correctional facilities.²³⁷ Most states do not have unified prison systems, meaning their departments of corrections have authority only over state correctional facilities, while county or city governments have authority over local correctional facilities.²³⁸ Thus, most states' departments of corrections cannot implement MAT programs that bind local correctional facilities.²³⁹ This would require these state legislatures to take additional measures to implement MAT programs across all correctional facilities in the state. Accordingly, most states could not precisely replicate Vermont's legislative approach. The legislative approach, however, is beneficial for states whose executive branches do not have the authority to implement a program like MAT.²⁴⁰ Additionally, executive orders by governors can be overturned by future governors, and thus, states may want to solidify the implementation of MAT programs in correctional facilities by creating them through legislative action.²⁴¹ Vermont's MAT program is written into the state's code of laws, such that its Governor cannot abolish the program through an executive order.²⁴² Thus, other states should consider a legislative approach, like Vermont's, when creating MAT programs in their correctional facilities because legislative action prevents these program from being subjected to the opinions of their governors.

C. *New York*

New York, like Vermont, has a legislative act that ensures its correctional facilities comply with the Eighth Amendment and ADA and protects all inmates with OUD from needless suffering.²⁴³ But it differs from Vermont because its legislative act implements a MAT program in a non-unified prison

236. O'Kelley-Bangsberg, *supra* note 228; PEW ISSUE BRIEF, *supra* note 231, at 9.

237. Act of May 25, 2018.

238. See PEW ISSUE BRIEF, *supra* note 231 ("Six states . . . run a 'unified public safety system,' meaning that both the jails and prisons fall under state administration. . . . This contrasts with the majority of states, where state-run prisons are responsible for individuals serving sentences generally longer than a year, while jails run by counties or cities usually house individuals sentenced to a year or less, as well as individuals awaiting trial.").

239. See *id.*

240. See *infra* notes 293–294 and accompanying text.

241. See E. Lee Bernick & Charles W. Wiggins, *The Governor's Executive Order: An Unknown Power*, STATE & LOC. GOV'T REV. 3, 9 (1984) ("In analyzing the executive orders, we found that they were sometimes issued to make changes in already existing orders. Obviously, the most drastic change would be to repeal, rescind, or revoke a previous order.").

242. VT. STAT. ANN. tit. 28, §§ 801–801b (2019); see VT. CONST. ch. II, § 2.

243. Compare N.Y. CORRECT. LAW § 626 (McKinney Supp. 2022), with discussion *supra* Section III.

system.²⁴⁴ On October 7, 2021, Governor Kathy Hochul signed the MAT in Jails and Prisons Act, which requires the New York State Department of Corrections to establish a MAT program for state and county correctional facilities.²⁴⁵ Importantly, the act gave the State Commission of Corrections (SCC) the power to establish standards and guidelines for local correctional facilities equivalent to the program established in state correctional facilities.²⁴⁶ Under this program, state and county facilities must screen every inmate for OUD and offer all three FDA-approved MAT medications to inmates who are determined to have OUD.²⁴⁷ Thus, inmates with OUD are given access to MAT medications, regardless of whether they were prescribed the medications prior to their incarceration.²⁴⁸ In this way, New York's program resembles Vermont's because it was implemented through legislative action and provides every inmate with OUD access to all three FDA-approved MAT medications; yet, New York's program differs from both Vermont's and Rhode Island's because it is tailored to operate in a non-unified prison system.

New York's legislative approach to implementing its MAT program is more feasible for other states to replicate because it is designed for a non-unified prison system. New York's legislation gives its state correctional department the power to implement MAT programs that provide access to all three FDA-approved MAT medications across all correctional facilities within the state; however, local correctional facilities are also given flexibility in how they implement the operations of this program.²⁴⁹ They may either contract for third-party clinical services to operate the program or facilitate the program in-house.²⁵⁰ Flexibility is important for local correctional facilities because the impact of OUD varies between counties and municipalities, and a MAT program optimal for a correctional facility in an

244. See O'Kelley-Bangsberg, *supra* note 228.

245. Act of Oct. 7, 2021, ch. 432, 2021 N.Y. Laws 1293 (codified as amended at CORRECT. §§ 45(19), 626; N.Y. MENTAL HYG. LAW § 19.18-c (McKinney Supp. 2022)); see also Press Release, N.Y. State Governor, Governor Hochul Signs Legislation Package to Combat Opioid Crisis (Oct. 7, 2021) (on file with author), <https://www.governor.ny.gov/news/governor-hochul-signs-legislation-package-combat-opioid-crisis> [<https://perma.cc/4HS5-HZPM>]; WEIZMAN ET AL., *supra* note 15, at 16.

246. Act of Oct. 7, 2021 § 2, 2021 N.Y. Laws at 1294 (codified as amended at CORRECT. § 45(19)).

247. CORRECT. §§ 45(19), 626(2)(a); see also WEIZMAN ET AL., *supra* note 15, at 16.

248. See CORRECT. § 626(2)(a), (4).

249. *Id.* § 45(19); Press Release, N.Y. State Governor, Governor Hochul Announces \$5 Million in New Funding for Local Jails to Provide Substance Use Disorder Services to Incarcerated Individuals (Oct. 15, 2021) (on file with author), <https://www.governor.ny.gov/news/governor-hochul-announces-5-million-new-funding-local-jails-provide-substance-use-disorder> [<https://perma.cc/D5T8-APWJ>].

250. See Press Release, N.Y. State Governor, *supra* note 249.

area with high concentrations of OUD might not be as optimal for a correctional facility in a less concentrated area.²⁵¹ Because New York's program is relatively new, there are no concrete studies on the program's success. However, New York's program will likely have similar results to Rhode Island's program. Thus, New York's program is an ideal example for other states with non-unified prison systems for two reasons: first, it demonstrates how these states can require all correctional facilities within their borders to create MAT programs that provide every inmate with OUD access to all three FDA-approved medications; and second, it also shows how these states can afford local correctional facilities the flexibility to meet their specific needs.

V. THE PATH FORWARD FOR SOUTH CAROLINA

A. *South Carolina's Current Use of MAT in Its Correctional Facilities*

By denying inmate access to prescribed opioid agonist medications, South Carolina's current approach to MAT within correctional facilities likely does not comply with Eighth Amendment and ADA jurisprudence.²⁵² After receiving funding from the federal government's state grant program, the South Carolina Department of Corrections (SCDC) launched a MAT Program in 2021, hoping to prevent patients from re-entering the criminal justice system for drug-related offenses and to save the state money in the long run.²⁵³ Under this program, inmates are screened for OUD upon arrival, and those who are positive for OUD have the option of entering the MAT program.²⁵⁴ Additionally, inmates with histories of OUD who were booked prior to the implementation of this program can request to be placed into the MAT program.²⁵⁵ However, this program provides only naltrexone for inmates with OUD and does not provide access to opioid agonists like buprenorphine and

251. See Rebecca L. Haffajee et al., *Characteristics of US Counties with High Opioid Overdose Mortality and Low Capacity to Deliver Medications for Opioid Use Disorder*, JAMA NETWORK OPEN, June 28, 2019, at 4, <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2736933> [<https://perma.cc/5K73-GXGU>].

252. See WEIZMAN ET AL., *supra* note 15, at 3, 18.

253. S.C. DEP'T OF CORR., SCDC POLICIES/PROCEDURES, HS-19.16 MENTAL HEALTH SERVICES—MEDICATION ASSISTED TREATMENT PROGRAM DELIVERY PROTOCOL (2021), <https://www.doc.sc.gov/policy/HS-19-16.htm.pdf> [<https://perma.cc/DVV2-XFSG>]; see also Andrew Brown, *South Carolina Prisons Attempting Trial Run for New Opioid Treatment Drug*, POST & COURIER (Sept. 4, 2017), https://www.postandcourier.com/news/south-carolina-prisons-attempting-trial-run-for-new-opioid-treatment-drug/article_3b559298-8c1a-11e7-978d-174ab60d0b25.html [<https://perma.cc/FJP5-EUMK>].

254. S.C. DEP'T OF CORR., *supra* note 253, § 2.2.

255. *Id.*

methadone.²⁵⁶ Accordingly, inmates with prescriptions for opioid agonists will not have access to their medications while serving their sentences in state correctional facilities.²⁵⁷

South Carolina, like New York, does not have a unified correctional system, and therefore, local correctional facilities do not have to follow the policies of the SCDC.²⁵⁸ As a result, only Charleston County provides buprenorphine to its inmates with OUD, while other local correctional facilities lack any form of MAT.²⁵⁹ The lack of MAT in local correctional facilities is especially problematic because these facilities are more likely to hold individuals going through opioid withdrawal²⁶⁰ because they are the first stop for individuals after they are detained.²⁶¹ Upon detention, detainees attend bond hearings, usually within twenty-four hours of arrest.²⁶² Those who are denied bond must stay in the local correctional facility while awaiting adjudication or reconsideration of bond.²⁶³ Upon conviction, inmates who receive more than three months of jail time are moved to state correctional facilities, while those who receive three months or less stay in the local facility.²⁶⁴ Opioid withdrawal symptoms start eight to twelve hours after an inmate last uses an opioid and lasts for ten to fourteen days.²⁶⁵ An inmate's criminal adjudication is typically not concluded within fourteen days, so by the time they get to state prisons, they will likely no longer be going through withdrawal.²⁶⁶ Therefore, South Carolina's local correctional facilities are

256. *See id.* § 3; Naltrexone is an opioid antagonist; methadone and buprenorphine are opioid agonists. *See supra* Section II.A.

257. *See* HS-19.16. Based on a conversation the Author had with an SCDC employee who asked to remain unnamed, the SCDC does not utilize opioid agonists and does not permit inmates with existing prescriptions to continue using those medications while serving their sentences.

258. S.C. CODE ANN. § 24-3-27(A) (2007).

259. Charleston County began offering buprenorphine to inmates with OUD after the death of Brianna Beland. *See* Angie Jackson, *She Died of Opioid Withdrawal in SC Jail Custody. Family Wants Officials Held Accountable*, POST & COURIER (May 24, 2019), https://www.postandcourier.com/news/she-died-of-opioid-withdrawal-in-sc-jail-custody-family-wants-officials-held-accountable/article_0a31bd62-75e9-11e9-a8f7-476a32ace658.html [<https://perma.cc/2SFQ-SZHY>]; *see also* WEIZMAN ET AL., *supra* note 15, at 18.

260. *See supra* Section III.A.

261. *See* § 24-3-27(A).

262. *See* S.C. CODE ANN. § 17-15-10(A)–(B) (Supp. 2022); S.C. CODE ANN. § 22-5-510(B) (Supp. 2022).

263. *See* § 24-3-27(A); S.C. JUD. BRANCH, SOUTH CAROLINA BENCH BOOK FOR MAGISTRATES AND MUNICIPAL COURT JUDGES: CRIMINAL § E.4 <https://www.sccourts.org/summaryCourtBenchBook/PDF/Criminal.pdf> [<https://perma.cc/M9HM-2U6N>].

264. S.C. CODE ANN. § 24-3-20(A) (Supp. 2022).

265. Mosel, *supra* note 144.

266. *See* S.C. JUD. BRANCH, FREQUENTLY ASKED QUESTIONS (FAQS) IN SOUTH CAROLINA CRIMINAL COURT 3 (2011), <https://www.sccourts.org/selfhelp/>

highly exposed to potential Eighth Amendment litigation because they often house inmates going through opioid withdrawal yet fail to provide these inmates with access to opioid agonist medications.²⁶⁷

Thus, both state and local correctional facilities in South Carolina are arguably exposed to Eighth Amendment and ADA litigation because they fail to provide inmates with opioid agonist prescriptions access to their medications while they are incarcerated.²⁶⁸ Notably, a local correctional facility in Charleston County is already in the midst of Eighth Amendment litigation for a death that resulted from the jail's failure to provide an inmate her prescribed opioid agonist medication.²⁶⁹ Lawsuits like this one are likely to continue if South Carolina's current approach does not change.

B. South Carolina Must Provide MAT Medications to Every Inmate with OUD

South Carolina needs to require access to opioid agonists for inmates with prescriptions to protect its correctional facilities from potential litigation; however, South Carolina should also follow Rhode Island's, New York's, and Vermont's lead and require its correctional facilities to provide all three FDA-approved MAT medications to every inmate with OUD.²⁷⁰ This requirement will benefit South Carolina and its citizens in the long run by saving the state money through the reduction of overdose deaths and criminal recidivism, and by protecting its inmates from needless suffering and economic discrimination.

The cost of requiring correctional facilities to provide access to all three FDA-approved MAT medications for every inmate with OUD may tempt South Carolina to simply pursue the bare minimum and provide such medications only to inmates who come into custody with prescriptions. Implementing these MAT programs in correctional facilities statewide is not cheap; New York spent around \$8 million to implement MAT programs in its non-unified correctional system.²⁷¹ South Carolina is a relatively frugal state.²⁷² It requires the legislature to pass a balanced budget and limits

FAQGeneralSessions.pdf [<https://perma.cc/X3MJ-4B4D>] (stating that a defendant may spend up to forty-five days in jail before his first appearance in court).

267. See *supra* Section III.A.

268. See, e.g., Jackson, *supra* note 259.

269. Estate of Beland *ex rel.* Hayes v. Charleston Cnty. Sheriff's Off., No. 1:20-3006-SAL-SVH, slip op. at 1 (D.S.C. Oct. 12, 2021).

270. See *supra* Part IV.

271. See Press Release, N.Y. State Governor, *supra* note 249.

272. *State Fiscal Briefs: South Carolina*, URB. INST. (Sept. 2022), <https://www.urban.org/policy-centers/cross-center-initiatives/state-and-local-finance-initiative/projects/state-fiscal->

authorized debt.²⁷³ Therefore, South Carolina lawmakers would likely be hesitant to allocate the funding required to provide every inmate access to MAT medications, and they would want to supply only what is necessary to allow previously prescribed inmates access to their medications while incarcerated. However, the federal government provides ample amounts of funding through SAMHSA's state grant program, and South Carolina could use this grant money to help mitigate costs.²⁷⁴

In addition to mitigating costs through federal funding, providing MAT to every inmate with OUD could ultimately pay for itself by saving South Carolina money through the reduction of fatal overdoses. The CDC estimates that fatal opioid overdoses cost South Carolina millions of dollars in 2017.²⁷⁵ Methadone and buprenorphine significantly reduce the risk of overdose, and states have already seen the benefits of providing these medications to inmates.²⁷⁶ Rhode Island saw a 60% reduction in fatal overdoses among recently incarcerated individuals and a 50% decrease in deaths attributed to fentanyl in just one year after the introduction of its MAT program.²⁷⁷ Moreover, a recent study found that providing all three FDA-approved medications to individuals with OUD yields savings ranging from \$25,000 to \$105,000 per person.²⁷⁸ While the formerly incarcerated population certainly does not constitute the entire OUD makeup, reducing their overdose rates will ultimately save the state money.

Additionally, this requirement could also save South Carolina money by reducing criminal recidivism in the state. The provision of MAT medications to inmates with OUD has been shown to be a fruitful investment for states because it reduces costs associated with crime and the use of the criminal

briefs/south-carolina [<https://perma.cc/C6G7-CEM7>] (“South Carolina further limits spending with a budget rule based on personal income growth. The rule requires a special vote to override the limit. South Carolina also limits authorized debt and debt service.”).

273. *Id.*

274. *See supra* notes 73–74 and accompanying text.

275. Feijun Luo et al., *State-Level Economic Costs of Opioid Use Disorder and Fatal Opioid Overdose—United States, 2017*, 70 MORBIDITY & MORTALITY WKLY. REP. 541, 543 tbl.1 (2021) (finding that fatal opioid overdoses cost South Carolina approximately \$8,650 million dollars in 2017 alone).

276. *See supra* Sections II.A, IV.A. Maine saw a 60% reduction in overdose deaths after implementing a MAT program in its correctional facilities. Beth Schwartzapfel, *These Meds Prevent Overdoses. Few Federal Prisoners Are Getting Them.*, MARSHALL PROJECT (Aug. 10, 2021, 6:00 AM), <https://www.themarshallproject.org/2021/08/10/these-meds-prevent-overdoses-few-federal-prisoners-are-getting-them> [<https://perma.cc/SRHH-KW8Y>].

277. SAMHSA, *supra* note 28, at 41.

278. Michael Fairley et al., *Cost-Effectiveness of Treatments for Opioid Use Disorder*, JAMA PSYCHIATRY 767, 774 (2021) (“MAT was . . . associated with savings of approximately \$15,000 to \$90,000 in lifetime costs per person. Methadone and buprenorphine generated the largest savings and health benefits. Naltrexone is also a cost-effective choice that should be available to patients because many will decline methadone and buprenorphine.”).

justice system.²⁷⁹ Retention in methadone and buprenorphine treatment programs is often associated with lower rates of criminal activity, and correctional facilities have seen a reduction in recidivism after implementing such programs.²⁸⁰ For example, the Philadelphia Department of Prisons provided 459 inmates with OUD buprenorphine in 2018.²⁸¹ After these individuals were released from custody, only twenty-seven found themselves back in prison.²⁸² This group of inmates had a recidivism rate of 5%, which is striking when compared to the recidivism rate of nearly 50% in Philadelphia County.²⁸³ South Carolina has a relatively low criminal recidivism rate of 22%.²⁸⁴ Yet, there are still thirty-eight thousand people incarcerated in South Carolina, and the state spends around \$21,756 per year per inmate.²⁸⁵ Consequently, the state spends nearly \$800 million a year to house inmates. Therefore, a reduction in the state's current recidivism rate through the provision of all three FDA-approved MAT medications to inmates with OUD will benefit South Carolina because it will help reduce this massive amount of spending and ultimately save the state money.

South Carolina should pursue this requirement not only because of its cost-saving benefits but also because providing every inmate with access to all three FDA-approved MAT medications is the morally correct approach to take. Such a requirement would protect inmates with OUD from needless suffering because opioid agonists help prevent these inmates from going into withdrawal.²⁸⁶ Over 80% of individuals with OUD do not receive MAT.²⁸⁷ Therefore, merely requiring correctional facilities to provide MAT to inmates

279. SAMHSA'S GAINS CTR., *Realizing the Cost Savings and Public-Health Benefits of Medication-Assisted Treatment in Jails and Prisons*, POL'Y RSCH. ASSOCS. (Oct. 21, 2020), <https://www.prainc.com/gains-realizing-cost-savings-public-health-benefit-mat/> [<https://perma.cc/W2KL-BJG5>].

280. See SAMHSA, *supra* note 28, at 42, 44.

281. *Id.* at 44.

282. *Id.*

283. Compare *id.*, with Sarah Tirschwell, *Reduce Recidivism by Addressing Mental Health*, CORRECTIONAL NEWS (May 19, 2022), <https://correctionalnews.com/2022/05/19/reduce-recidivism-by-addressing-mental-health/> [<https://perma.cc/7ZYD-XTV7>].

284. Carrie Pettus & John Koufos, Opinion, *Commentary: Recidivism Rate Is Down in SC Prisons. These Strategies Work*, POST & COURIER (Sept. 17, 2021), https://www.postandcourier.com/opinion/commentary/commentary-recidivism-rate-is-down-in-sc-prisons-these-strategies-work/article_a0fcb8d6-1561-11ec-8c8d-b720d88aae87.html [<https://perma.cc/LGR8-4PWL>].

285. *South Carolina Profile*, PRISON POL'Y INITIATIVE, <https://www.prisonpolicy.org/profiles/SC.html> [<https://perma.cc/L8LF-AF3A>]; *Frequently Asked Questions (FAQS)*, S.C. DEP'T OF CORR., <https://www.doc.sc.gov/faqs.html> [<https://perma.cc/932T-DR88>].

286. See *supra* Section II.A.

287. Sarai Rodriguez, *Nearly 90% of Patients with Opioid Use Disorder Lack Medication Access*, PATIENT CARE ACCESS NEWS (Aug. 9, 2022), <https://patientengagementhit.com/news/nearly-90-of-patients-with-opioid-use-disorder-lack-medication-access> [<https://perma.cc/3PWX-D832>].

with prescriptions will leave a sizeable portion of inmates with OUD without treatment. These inmates will go into withdrawal within days of their arrest because they will no longer have opioids in their systems.²⁸⁸ Opioid agonists like methadone and buprenorphine are proven to prevent withdrawal symptoms, and these medications will be readily available in South Carolina correctional facilities if the state implements a system that shields its correctional facilities from potential Eighth Amendment and ADA litigation by providing all three MAT medications.²⁸⁹ To deny these medications to inmates when they are already in the hands of correctional facilities would be inhumane. South Carolina must provide every inmate access to all three FDA-approved MAT medications to protect inmates with OUD from needless suffering.

Additionally, this requirement is the morally correct approach to take because only permitting inmates with prior opioid agonist prescriptions to use these medications discriminates against the economically disadvantaged. Opioid agonist medications are expensive.²⁹⁰ Methadone treatments average around \$6,552 annually, and buprenorphine treatments average around \$5,980 annually.²⁹¹ Unfortunately, OUD disproportionately affects economically disadvantaged communities, and thus, many individuals with OUD are likely not able to afford treatment or have the insurance to help mitigate its costs.²⁹² Therefore, by allowing only inmates who were previously prescribed opioid agonist medications access to such treatments, correctional facilities are subjecting some individuals with OUD to needless suffering merely because these individuals are poor. To prevent such discrimination, South Carolina should allow every inmate with OUD access to all three FDA approved MAT medications.

C. *Implementing the Change*

Because the South Carolina Governor's powers are limited, the best approach for the state to follow when implementing a MAT program would be through legislative action.²⁹³ South Carolina's Constitution implicitly gives

288. Mosel, *supra* note 144.

289. *See supra* Part III.

290. NAT'L INST. ON DRUG ABUSE, NAT'L INSTS. OF HEALTH, MEDICATIONS TO TREAT OPIOID USE DISORDER RESEARCH REPORT 21 (2021), <https://nida.nih.gov/download/21349/medications-to-treat-opioid-use-disorder-research-report.pdf> [<https://perma.cc/C859-VG9V>].

291. *Id.*

292. Peter Grinspoon, *Poverty, Homelessness, and Social Stigma Make Addiction More Deadly*, HARV. HEALTH PUBL'G: HARV. HEALTH BLOG (Sept. 28, 2021), <https://www.health.harvard.edu/blog/poverty-homelessness-and-social-stigma-make-addiction-more-deadly-202109282602> [<https://perma.cc/SB5Z-BU7W>].

293. *See* 12 MARK R. ELAM ET AL., S.C. JURIS., GOVERNOR § 45 (2022).

its Governor the power to issue executive orders; yet, these orders must be vested in either constitutional or statutory authority.²⁹⁴ Neither the constitution nor statutory provisions grant the Governor the authority to require all correctional facilities in the state to provide MAT to inmates with OUD.²⁹⁵ Therefore, a MAT program in South Carolina's correctional facilities must be implemented through a legislative act.

The proposed act should draw from Vermont's and New York's legislative acts and amend South Carolina law to require both state and local correctional facilities to provide every inmate with OUD access to all three FDA-approved MAT medications while incarcerated.²⁹⁶ The most logical starting point would be adding this requirement to the statutes that dictate the powers of the SCDC because this department already has a MAT program in place, and it has experience with creating MAT policy.²⁹⁷ The legislature does not have the same intricate knowledge of prison programs as the SCDC does, so it should defer to the SCDC to detail the policy. S.C. Code Ann. § 24-1-130 provides that the director of the SCDC is responsible for the proper care and treatment of prisoners confined in state facilities.²⁹⁸ The act should amend this section and add provisions similar to Vermont's Vt. Stat. Ann. tit. 28, § 801(b)(1), (e)(1) and New York's N.Y. Correct. Law § 626(2)(a), (4).²⁹⁹

These provisions should require the director of the SCDC to establish a MAT program that provides all three FDA-approved MAT medications to inmates with OUD.³⁰⁰ Every incoming inmate must be screened for OUD and be given the option of treatment with one of these medications.³⁰¹ Additionally, inmates who come in with prescriptions for one of these medications must be allowed to continue taking their medication under the supervision of the correctional facility.³⁰² Importantly, this program must not be limited to include only inmates screened for OUD at intake.³⁰³ Inmates

294. *Id.*; see *Baddourah v. McMaster*, 433 S.C. 89, 114, 856 S.E.2d 561, 574 (2021); *Hodges v. Rainey* 341 S.C. 79, 85–86, 533 S.E.2d 578, 581 (2000).

295. See S.C. CONST. art. IV. South Carolina's laws regarding corrections only grant the Governor the power to appoint the directors of the SCDC, S.C. CODE ANN. § 24-1-40 (2007), to transfer and exchange offenders under treaty obligations, S.C. CODE ANN. § 24-1-145 (2007), to order local correctional facilities to transfer inmates sentenced to death to the custody of the SCDC, S.C. CODE ANN. § 24-3-520 (Supp. 2022), and to grant pardons, S.C. CODE ANN. § 24-21-910 (2007).

296. See *supra* Part IV.

297. See S.C. DEP'T OF CORR., *supra* note 253.

298. See S.C. CODE ANN. § 24-1-130 (2007).

299. VT. STAT. ANN. tit. 28, § 801(b)(1), (e)(1) (West 2018); N.Y. CORRECT. LAW § 626(2)(a), (4) (McKinney 2022).

300. See *supra* notes 233, 247 and accompanying text.

301. See *supra* notes 235, 247 and accompanying text.

302. See *supra* notes 234, 248 and accompanying text.

303. See *supra* notes 235, 248 and accompanying text.

may enter the program at any point during their incarceration.³⁰⁴ This additional requirement ensures that inmates with OUD who were incarcerated prior to the implementation of the program will have access to MAT medications. By adding similar provisions under the SCDC director's duty to provide proper care and treatment, the legislature will ensure that the director creates a MAT policy that provides every inmate with OUD in state correctional facilities has access to all three FDA-approved medications.

However, this proposed act must also ensure that local correctional facilities provide inmates with OUD access to MAT medications, and thus, the act should draw from New York's non-unified model.³⁰⁵ N.Y. Correct. Law § 45(19) (provides that the SCC has the power to establish MAT program standards and guidelines for local correctional facilities equivalent to the program established in state correctional facilities.³⁰⁶ South Carolina's act should draw from this provision to ensure its local correctional facilities implement MAT programs. Again, the SCDC's experience with creating a MAT program places the department in the best position to draft the new policy. Therefore, the legislature should amend South Carolina law to require the SCDC to create MAT standards and guidelines for local correctional facilities.

Current South Carolina law grants considerable deference to local correctional facilities in regards to providing health care services to inmates. S.C. Code Ann. § 24-5-80 simply states that the governing body of each county shall provide inmates access to medical care.³⁰⁷ The act should amend this section to require each governing body, under its duty to provide medical care, to follow the SCDC's standards for establishing MAT programs in its correctional facilities. However, like New York, the act should give local correctional facilities flexibility in how to implement the operations of this program.³⁰⁸ Local correctional facilities should be given flexibility in whether to use their own medical staff or to contract third-party providers for the provision of MAT medications.³⁰⁹ OUD affects South Carolina counties differently, and local correctional facilities with small OUD populations may prefer to use their own medical staff, while local correctional facilities with large OUD populations may prefer to seek outside help.³¹⁰ Ultimately, by allowing the SCDC to establish mandatory standards for local correctional facilities to follow while simultaneously granting local correctional facilities

304. *See supra* notes 235, 248 and accompanying text.

305. *See supra* Section IV.C.

306. N.Y. CORRECT. LAW § 45(19) (McKinney Supp. 2022).

307. S.C. CODE ANN. § 24-5-80 (Supp. 2022).

308. *See supra* Section IV.C.

309. *See supra* Section IV.C.

310. *See generally* Haffajee et al., *supra* note 251 (discussing county-level strategies to address the opioid crisis based on a jurisdiction's particular needs).

flexibility in operations, the proposed act will not only ensure that every correctional facility in the South Carolina implements MAT programs that provide every inmate with OUD access to all three FDA-approved medications but will also allow correctional facilities to create programs that meet their individual needs.

VI. CONCLUSION

The choice to provide every inmate with OUD access to all three FDA-approved MAT medications is expensive and controversial. Society often looks down upon criminal offenders and drug users, and this aversion possibly makes South Carolina lawmakers hesitant to enact legislation that would require a considerable expenditure of funding and resources for these individuals. However, if South Carolina truly wants to put an end to the damages inflicted by the opioid crisis, it must start by treating the most vulnerable population. Inmates are more likely than the general population to face the negative effects of OUD and should not be forced to suffer without treatment simply because they did not have the means to acquire treatment prior to their incarceration. By providing these individuals access to the medications necessary to treat their OUD, South Carolina will mitigate both the physical damages of OUD and the monetary damages the state incurs when it forces people with OUD to suffer without medication. Lastly, providing access to these medications will protect South Carolina's correctional facilities from litigation and will ultimately save the state money through the reduction of fatal overdoses and criminal recidivism. Therefore, South Carolina's legislature must act and pass legislation that would require all of its correctional facilities to provide access to all three FDA-approved MAT medications to every individual with OUD in their custody.