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Barring Methadone Behind Bars: How Prisons Err When Denying Methadone Treatment to Inmates with Opioid Use Disorder

Julia Durst

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**BARRING METHADONE BEHIND BARS: HOW PRISONS
ERR WHEN DENYING METHADONE TREATMENT TO
INMATES WITH OPIOID USE DISORDER**

Julia Durst[‡]

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I. INTRODUCTION

As the opioid epidemic continues to ravage the United States for a third decade,¹ communities look for new solutions. For the 200,000 heroin-addicted individuals who pass through correctional facilities each year, prison may be the opportunity for change.²

Incarceration pauses access to illicit drugs and presents a chance for intervention.³ For individuals with Opioid Use Disorder (“OUD”), the most effective treatment option involves opioid agonist medication, such as methadone or buprenorphine.⁴ Allowing inmates with OUD to receive these medications while incarcerated improves outcomes for the individual inmate and yields public health benefits by reducing costs associated with poor health, disease transmission, criminality, and recidivism.⁵ Despite these significant benefits to individuals and society, most prisons do not treat inmates’ OUD with methadone or buprenorphine.⁶

This Note examines why most of the United States’ prisons—including those in Minnesota—resist providing the most effective treatment for OUD. First, this Note will consider the public policy arguments for and against this treatment.⁷ To begin, OUD will be defined, and its prevalence among incarcerated individuals in the U.S. will be examined.⁸ Next, the best practices for treating OUD will be detailed, focusing on methadone.⁹ The discussion will then turn to the lack of availability of opioid agonist therapy within prisons.¹⁰ The rationale for limiting opioid agonist therapy in prisons will be considered, including fear of diversion within prison, the cost of providing care, philosophical opposition to utilizing medication when

¹ *Opioids: Understanding the Opioid Epidemic*, CTNS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/drugoverdose/epidemic/index.html#three-waves> [<https://perma.cc/CNL2-LLVB>]. The Centers for Disease Control and Prevention (“CDC”) identifies three waves of the opioid epidemic. *Id.* The first wave started in the 1990s, when overdose deaths involving prescription opioid pain medications rose, in conjunction with doctors prescribing these more frequently. *Id.* The second wave began in 2010, when overdose deaths involving heroin rapidly increased. *Id.* The third wave started in 2013, with a jump in overdose deaths involving synthetic opioids (especially illicitly manufactured fentanyl). *Id.*

² See Amy Boutwell, Ank Nijhawan, Nickolas Zaller & Josiah Rich, *Arrested on Heroin: A National Opportunity*, 3 J. OPIOID MGMT. 328 (Nov. 2007).

³ Christine Vestal, *New Momentum for Treatment Behind Bars*, PEW CHARITABLE TRUSTS (Apr. 4, 2018), <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/04/04/new-momentum-for-addiction-treatment-behind-bars> [<https://perma.cc/ZV33-HZWQ>].

⁴ See NAT’L ACADS. OF SCI., ENG’G, & MED., *MEDICATIONS FOR OPIOID USE DISORDER SAVE LIVES 19* (Alan I. Leshner & Michelle Mancher eds., 2019).

⁵ Boutwell, *supra* note 2.

⁶ *Id.*

⁷ See *infra* Section II.

⁸ *Id.*

⁹ See *infra* Section III.

¹⁰ See *infra* Section IV.

treating substance use disorders, and regulatory difficulties.¹¹ Each justification will be challenged.¹²

Next, this Note will explore the legal reasoning that supports allowing methadone treatment for OUD in prison, including the Eighth Amendment, the American Disabilities Act (“ADA”), and recent case law.¹³ Finally, this discussion will narrow its scope to Minnesota’s state prisons and consider the current practices of the Department of Corrections.¹⁴ After evaluation of current policy, this Note will offer recommendations for change.¹⁵

II. DEFINITION AND PREVALENCE OF OPIOID USE DISORDER

Opioids are “a class of drugs that include the illegal drug heroin, synthetic opioids such as fentanyl, and pain relievers available legally by prescription, such as oxycodone[,] . . . hydrocodone[,] . . . and many others.”¹⁶ Opioids work by attaching to cell receptors “found in the brain, spinal cord, and other areas of the body,” thus reducing the sending of pain messages, as well as the physical sensation of pain in the body.¹⁷ Opioids activate reward centers in the brain.¹⁸ They trigger the release of endorphins, which stymie one’s perception of pain and enhance one’s feelings of pleasure, “creating a temporary but powerful sense of well-being.”¹⁹ When an individual uses opioids over time, the body slows down its production of endorphins.²⁰ A dose of opioids produces a less intense euphoria than it used to.²¹ This experience of tolerance—needing more of the drug to feel the same effect—is part of what drives an opioid user to increase the amount of opioids consumed.²²

OUD is clinically diagnosed by physicians and other qualified medical professionals based on the criteria specified in the Diagnostic and Statistical

¹¹ See *infra* Section V.

¹² *Id.*

¹³ See *infra* Section VI.

¹⁴ See *infra* Section VII.

¹⁵ *Id.*

¹⁶ *Drug Topics: Opioids*, NAT’L INST. ON DRUG ABUSE, <https://www.drugabuse.gov/drug-topics/opioids> [https://perma.cc/VVQ8-6ADK].

¹⁷ *What Are Opioids?* WEBMD, <https://www.webmd.com/pain-management/opioids-opiates-explained#1> [https://perma.cc/M3R9-GWZE].

¹⁸ *How Opioid Addiction Occurs*, MAYOCLINIC (Feb. 16, 2018), <https://www.mayoclinic.org/diseases-conditions/prescription-drug-abuse/in-depth/how-opioid-addiction-occurs/art-20360372> [https://perma.cc/2BTA-IESD].

¹⁹ *Id.*

²⁰ *Id.*

²¹ *Id.*

²² *Id.*

Manual of Mental Disorders (“DSM-5”).²³ Physical dependence on opioids contributes to the risk of addiction and makes it particularly difficult for an individual to stop use.²⁴ When individuals are forced into withdrawal and experience a period of abstinence, their tolerance to opioids drops, and they are at an increased risk of overdose if they return to opioid use.²⁵ This vulnerability is commonly seen in people recently released from jail or prison.²⁶ North Carolina researchers reviewed fifteen years of records and discovered that in the “first two weeks after being released from prison, former inmates were [forty] times more likely to die of an opioid overdose than someone in the general population.”²⁷

The prevalence of OUD in the United States is staggering. Data from the 2016 National Survey on Drug Use and Health indicated more than 11.8 million people over age twelve misused opioids in the previous twelve months.²⁸ Among those, approximately 2.1 million people met the criteria for an OUD diagnosis.²⁹ With such widespread prevalence, opioid addiction has impacted society as a whole in the form of health care costs, criminal activity, homelessness, and increased numbers of children in foster care.³⁰ Infectious diseases like Hepatitis C and Human Immunodeficiency Virus (“HIV”) have had a resurgence due to the volume of intravenous opioid users.³¹ According to the Centers for Disease Control and Prevention (“CDC”), every day 136 people in the United States die from opioid overdose.³²

²³ AM. PSYCHIATRIC ASS’N, DIAGNOSTIC & STAT. MANUAL OF MENTAL DISORDERS 541 (5th ed. 2015). The eleven diagnostic criteria for OUD are: longer duration or larger amount of opioid use than intended, unsuccessful efforts to cut down or quit use, a great deal of time spent using or recovering from use, cravings, recurrent use causing failure to meet obligations at home/work/school, continued use despite interpersonal problems caused or worsened by use, important life activities given up or reduced due to use, use in physically dangerous situations, continued use despite knowing physical or psychological issues are worsened by it, tolerance, and withdrawal. *Id.* Two to three criteria occurring in a twelve-month period indicate mild OUD; four to five indicate moderate; and six or more indicate severe. *Id.*

²⁴ Shabbar Ranapurwala, Meghan Shanahan, Apostolos Alexandridis, Scott Proescholdbell, Rebecca Naumann, Daniel Edwards Jr. & Stephen Marshall, *Opioid Overdose Mortality Among Former North Carolina Inmates: 2000-2015*, AM. J. PUB. HEALTH (Aug. 8, 2018).

²⁵ *Id.*

²⁶ *Id.*

²⁷ *Id.*

²⁸ Rebecca Ahmsbrak, Jonaki Bose, Sarra Hedden, Rachel Lipari & Eunice Park-Lee, *Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health*, SUBSTANCE ABUSE & MENTAL HEALTH SERV. ADMIN. (2017), <https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.htm#sud7> [<https://perma.cc/FN5B-CADD>].

²⁹ *Id.*

³⁰ NAT’L ACADS. OF SCI., ENG’G, & MED., *supra* note 4, at 17.

³¹ *Id.* Intravenous refers to the “injecting” of drugs into the body’s bloodstream by inserting a needle into a vein. *Id.*

³² CTNS. FOR DISEASE CONTROL & PREVENTION, *supra* note 1.

III. BEST PRACTICES FOR TREATING OPIOID USE DISORDER

A. Opioid Agonist Therapy as Best Practice

A variety of evidence-based practices exist for treatment of substance use disorders.³³ Many of these approaches view addiction through a biopsychosocial framework, acknowledging addiction has biological influences, psychological factors, and social (environmental) determinants.³⁴ In response, treating addiction may require a biological strategy, a psychological strategy, and a social strategy.³⁵

Evidence-based biological treatment approaches include medication prescribed to reduce cravings and manage withdrawal symptoms.³⁶ Psychological approaches include cognitive-behavioral therapy, motivational enhancement, community reinforcement, and contingency management.³⁷ Evidence-based social approaches include therapeutic communities.³⁸

Because of the intense physical dependence and overdose risk inherent to opioid use, treatment involving medication statistically produces the best patient outcomes.³⁹ “The prescribed medication operates to normalize brain chemistry, block the euphoric effects of . . . opioids, relieve physiological cravings, and normalize body functions without the negative

³³ *Evidence-Based Approaches to Drug Addiction Treatment*, NAT'L INST. ON DRUG ABUSE, (June 3, 2020), <https://www.drugabuse.gov/download/675/principles-drug-addiction-treatment-research-based-guide-third-edition.pdf?v=74dad603627bab89b93193918330c223> [https://perma.cc/5RXG-UTF5].

³⁴ Nora Volkow, *What Does It Mean When We Call Addiction a Brain Disorder?*, NAT'L INST. ON DRUG ABUSE: NORA'S BLOG (Mar. 23, 2018), <https://www.drugabuse.gov/about-nida/noras-blog/2018/03/what-does-it-mean-when-we-call-addiction-brain-disorder> [https://perma.cc/XX78-TLJW].

³⁵ *See id.*

³⁶ Kaye Miller Temple, *What's MAT Got to Do with It? Medication-Assisted Treatment for Opioid Use Disorder in Rural America*, RURAL MONITOR (Mar. 21, 2018), <https://www.ruralhealthinfo.org/rural-monitor/medication-assisted-treatment/> [https://perma.cc/GTM4-SUMX].

³⁷ *Principles of Drug Addiction Treatment: A Research-Based Guide, Behavioral Therapies* NAT'L INST. ON DRUG ABUSE (Jan. 2018), <https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-therapies> [https://perma.cc/8WNA-4F2C].

³⁸ *See Therapeutic Communities Research Report: How is Treatment Provided in a Therapeutic Community?* NAT'L INST. ON DRUG ABUSE (July 2015), <https://www.drugabuse.gov/publications/research-reports/therapeutic-communities/how-treatment-provided-in-therapeutic-community> [https://perma.cc/TS76-F7S9].

³⁹ *Medications for Opioid Use Disorder Improve Patient Outcomes*, PEW CHARITABLE TRUSTS (Dec. 17, 2020), <https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2020/12/medications-for-opioid-use-disorder-improve-patient-outcomes#:~:text=The%20most%20effective%20treatments%20for,methadone%2C%20buprenorphine%2C%20and%20naltrexone> [https://perma.cc/H5QC-99Z6].

and euphoric effects of the substance used.”⁴⁰ Agonist therapy stabilizes the body from the highs and lows of euphoria and withdrawal, allowing a person to achieve some stability and no longer need to participate in the constant pursuit of opioids, or in activities to support their addiction.⁴¹

Decades of research demonstrate significantly decreased mortality, decreased overdoses, decreased intravenous drug use, and reduced incidence of infectious disease (e.g., HIV, Hepatitis C) in individuals on long-term agonist therapy.⁴² Individuals on agonist therapy show reduction of high-risk behaviors related to HIV transmission, and they experience improvement in social functioning and quality of life.⁴³ Notably, opioid agonist therapy—specifically, methadone—is associated with reduced levels of criminality for individuals with OUD.⁴⁴

The two primary forms of opioid agonist therapy are methadone and buprenorphine.⁴⁵ This paper will focus its discussion on methadone. Methadone is a Schedule II, long-lasting synthetic opioid used to treat OUD.⁴⁶ It works by diminishing opioid withdrawal symptoms and reducing the euphoric high one might feel by using an illicit, short-acting opioid (such as heroin) on top of it.⁴⁷ A nurse administers methadone daily to a patient as part of a federally-approved opioid treatment program (“OTP”), which provides counseling and ancillary health services in addition to medication, culminating in a “whole person,” individualized approach.⁴⁸ The duration of treatment varies per patient, but research indicates a patient should be on

⁴⁰ *Medication-Assisted Treatment*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (Sept. 16, 2021), <https://www.samhsa.gov/medication-assisted-treatment> [https://perma.cc/JHN8-LEVX].

⁴¹ *Id.*

⁴² NAT’L ACADS. OF SCI., ENG’G, & MED., *supra* note 4, at 33–34; Avril Taylor, Jennifer Champion & Alex Fleming, *The Role of Methadone Maintenance in Scottish Prisons: Prisoners’ Perspectives*, INST. FOR APPLIED SOC. & HEALTH RSCH. (Apr. 2006), http://www.sps.gov.uk/nmsruntime/saveasdialog.aspx?filename=sps_research_report_-_the_role_of_methadone_maintenance_in_scottish_prisons.doc [https://perma.cc/3SKW-FITL]. In Scotland, researchers observed a correlation between methadone maintenance therapy and reduction in criminality among males. *Id.* In England, patients of methadone programs had “significantly fewer convictions and cautions, and they spent significantly less time in prison than they had before the start of treatment.” *Id.*

⁴³ *Facing Addiction in America: The Surgeon General’s Report on Alcohol, Drugs, and Health*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN. (2016), <https://www.ncbi.nlm.nih.gov/books/NBK424859/> [https://perma.cc/2MFC-H5FW].

⁴⁴ See NAT’L ACADS. OF SCI., ENG’G, & MED., *supra* note 4.

⁴⁵ *Id.* at 19.

⁴⁶ *Id.* The United States Drug Enforcement Administration classifies drugs into five distinct schedules or categories based on the drug’s medical use and its potential for dependency or abuse. *Drug Scheduling*, U.S. DRUG ENFORCEMENT ADMIN., <https://www.dea.gov/drug-information/drug-scheduling> [https://perma.cc/987D-G6HS]. Schedule II is the second highest category. *Id.*

⁴⁷ *Id.*

⁴⁸ *Methadone*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., <https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/methadone> [https://perma.cc/JHN8-LEVX] (June 8, 2021).

methadone treatment for a minimum of one year.⁴⁹

Methadone has long been the favored treatment plan for pregnant women with OUD who are abusing illicit opioids during pregnancy, as it stabilizes opioid levels in both mother and baby, preventing medical problems associated with prenatal withdrawal.⁵⁰ Methadone has been the standard of care for pregnant women with OUD since 1998.⁵¹

B. Efficacy of Opioid Agonist Therapy in Prisons

Research on the effectiveness of opioid agonist therapy in prison has produced compelling results.

Yale School of Medicine conducted a study on the effects of continuing methadone treatment during incarceration.⁵² All 382 male participants were enrolled and participated in a methadone program prior to being incarcerated.⁵³ Once incarcerated, half continued on methadone; the other half did not.⁵⁴

Those who continued methadone during incarceration—thus avoiding forced opioid withdrawal—were approximately three times less likely to receive disciplinary tickets.⁵⁵ They were also thirty-two times more likely to visit a community-based methadone program within a day of release.⁵⁶ Those who maintained methadone treatment before, during, and after incarceration were five times less likely to be re-arrested for a felony and ten times less likely to be charged for a drug offense after release.⁵⁷

The few existing prison- or jail-based methadone programs in the United States report similar outcomes. Rhode Island Department of Corrections offers medication-assisted treatment, including methadone, to inmates in its jails and prisons.⁵⁸ In the first year of its program, Rhode Island saw the post-correctional overdose death rate drop by sixty-one percent,

⁴⁹ *Id.*

⁵⁰ *Treating Opioid Use Disorder During Pregnancy*, NAT'L INST. ON DRUG ABUSE (July 2017), <https://www.drugabuse.gov/publications/treating-opioid-use-disorder-during-pregnancy#:~:text=Methadone%20has%20been%20used%20to%20treat%20pregnant%20women,practice%20for%20opioid%20use%20disorder%20during%20pregnancy.%201> [<https://perma.cc/M8FU-SEDJ>] (citing recommendations made by the American College of Obstetricians and Gynecologists and the American Society of Addiction Medicine).

⁵¹ *Id.*

⁵² Christopher Gardner, *Yale Study: Methadone Treatment in Prison Improves Inmates' Behavior, Likelihood of Staying Clean Post-Release*, YALE SCH. MED. (Jan. 23, 2018), <https://medicine.yale.edu/news-article/16631/> [<https://perma.cc/G7Q8-29M9>].

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ Ronnie Cohen, *Pioneering Approach to Addiction in Rhode Island Jails Saves Lives*, REUTERS (Feb. 26, 2018), <https://www.reuters.com/article/us-health-addiction-prisoners/pioneering-approach-to-addiction-in-rhode-island-jails-saves-lives-idUSKCN1GA29V> [<https://perma.cc/CU46-UNWH>].

which contributed to an overall twelve percent drop in the overdose death rate statewide.⁵⁹

In New York City, Rikers Island jail also provides opioid agonist treatment to inmates.⁶⁰ A recent study of inmates with OUD at Rikers Island Jail showed that, after release:

[N]early nine out of ten inmates who were not medicated relapsed within a month, as opposed to just [two] out of [five] inmates who were on medication-assisted treatment. The difference to society between those two numbers—in terms of health outcomes, reduced crime, and improved employment stability—is huge.⁶¹

The public health benefits—reduced recidivism, reduced disease transmission, reduced overdoses and death—mark a clear benefit to communities. Notably, Canada, Australia, and all European Union member states have made methadone treatment available in their prisons.⁶² However, the United States lags behind.

IV. AVAILABILITY OF OPIOID AGONIST THERAPY IN U.S. PRISONS

With such compelling evidence of the efficacy of opioid agonist therapy, one would assume it is widespread and accessible during incarceration, particularly in light of the increased overdose risk inmates with OUD face following release from prison. Unfortunately, this is not the case.

In the United States, the Federal Bureau of Prisons, as a rule, does not permit methadone treatment for inmates, with the exception of pregnant

⁵⁹ *Id.*

⁶⁰ Megan McLemore, *Prisons Are Making America's Drug Problem Worse*, POLITICO (Mar. 11, 2015), <https://www.politico.com/magazine/story/2015/03/federal-bureau-of-prisons-medication-assisted-therapy-115998> [<https://perma.cc/6QRB-DV9F>].

⁶¹ *Id.*

⁶² Daniel D'Hotman, Jonathan Pugh & Thomas Douglas, *The Case Against Forced Methadone Detox in the U.S. Prisons*, 12 PUBLIC HEALTH ETHICS 89-93 (2019); see also Saman Zamani, Marziyeh Farnia, Saman Tavakoli, Mehran Gholizadeh, Mohammed Nazari, Ali-Akbar Seddighi, Hamidreza Setayesh, Parviz Afshar & Masahiro Kihara, *A Qualitative Inquiry into Methadone Maintenance Treatment for Opioid-Dependent Prisoners in Tehran, Iran*, INT. J. DRUG POLICY (May 2010), <https://doi.org/10.1016/j.drugpo.2009.03.001> [<https://perma.cc/9EEA-JMQB>]. “The rate of drug injecting in the prison unit was unanimously reported to have decreased drastically since introducing the [methadone] program.” *Id.* In addition to the health benefits, data showed that methadone treatment also had positive effects on the social status of the inmates’ families. *Id.* Even so, several barriers to expanding methadone services in prisons were identified, including staff shortages and stigma related to methadone. *Id.*

females with OUD.⁶³ Only a handful of local jails and a few state prisons allow methadone treatment.⁶⁴

Lack of access to methadone and other opioid agonist therapy in prison presents significant health risks to inmates with OUD—both immediately, as they face withdrawal, and long-term, as they contend with increased risk of blood-borne diseases, overdose, and death. When entering prison, an inmate with OUD may experience opioid withdrawal because he has used opioids illicitly up until incarceration, and thus is physically dependent on them.⁶⁵ Withdrawal can also occur when a person is receiving methadone treatment and consumes a daily amount of the prescribed medication to maintain physical stability and avoid withdrawal, then enters a prison where methadone is prohibited and abruptly stops receiving this daily medication.⁶⁶

Opioid withdrawal is extremely uncomfortable. Without a medically supervised taper, patients anecdotally report methadone to be the most difficult opioid to withdraw from because of its long-acting properties, which cause the body to metabolize it over an extended period of time.⁶⁷ Withdrawal symptoms include extreme cramping, nausea, diarrhea, vomiting, and sweating.⁶⁸ When an inmate experiences the vomiting and diarrhea associated with opioid withdrawal, it increases the likelihood of spreading disease among inmates in the prison.⁶⁹ The lack of appropriate withdrawal management in prisons is sometimes believed to result from a problematic philosophy held by some who work in corrections, that “painfully withdrawing from drugs in prison might deter individuals from

⁶³ Sarah N. Lynch, *Woman with Opioid Addiction to Get Regular Methadone Treatment in Prison*, REUTERS (June 7, 2019), <https://www.reuters.com/article/us-usa-prisons-opioid-addiction-idUSKCN1T903F> [<https://perma.cc/4CS4-WHEL>] (describing the Bureau of Prisons’ policy against methadone and how one woman successfully sued to get permission to continue methadone treatment in prison despite not being pregnant).

⁶⁴ McLemore, *supra* note 60.

⁶⁵ *Treatment of Opioid Use Disorder in Correctional Settings*, AM. SOC’Y OF ADDICTION MED. (July 15, 2020), <https://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2020/07/16/asam-public-policy-statement-on-treatment-of-opioid-use-disorder-in-correctional-settings> [<https://perma.cc/9TUX-WNQT>].

⁶⁶ Kate Wheeling, *A Case for Methadone in Our Jails*, PAC. STANDARD (May 3, 2017), <https://psmag.com/news/a-case-for-methadone-in-jails> [<https://perma.cc/8D3K-6GBW>].

⁶⁷ *Id.* A thirty-four-year-old woman described her withdrawal experience: “I was dying. When you’re on methadone for three years it stays in your bones. Being in jail without it just about kills you. I mean, the chills, the sweats, the cramps, the leg cramps, the muscle aches [. . .] I’d rather come off heroin than methadone any day.” *Id.*

⁶⁸ *Id.*

⁶⁹ *Id.*

using drugs.”⁷⁰ Research refutes that theory.⁷¹

V. PRISONS’ FLAWED RATIONALE FOR DENYING ACCESS TO METHADONE TREATMENT

Prisons provide several justifications for their refusal to offer methadone treatment: diversion within the prison, lack of funding for methadone programs, philosophical opposition to methadone, and struggles with the regulatory requirements associated with administering methadone.

A. Diversion Fears

Diversion occurs when a legally prescribed drug is obtained or used illegally.⁷² When a patient gives or sells their prescription drug to someone else, they divert the drugs.

Concern about diversion of methadone—or any narcotic medication—in a correctional setting is justified, as it poses a safety and medical risk. When a team of researchers and clinicians implemented methadone clinic services within a Rhode Island prison, correctional staff explicitly expressed such concerns.⁷³ Staff feared not only diversion, but the loss of control that diversion would represent.⁷⁴

Staff expressed concern about who would be eligible for initiating treatment. Correctional staff viewed methadone as something prized by inmates and saw the provision of methadone as a privilege and not something all inmates deserved. One officer

⁷⁰ *Id.* (detailing how painful withdrawal may result in medical problems and death, not deterrence and behavioral change). In Macomb County, Michigan, a thirty-two-year-old David Stojcevski died in his jail cell while under the watch of jail staff. *Id.* Stojcevski was jailed when he failed to pay a \$772 fine for careless driving. *Id.* “[Seventeen] days into a [thirty]-day sentence, he had lost [fifty] pounds. Too weak to stand up, he spent at least [forty-eight] hours on the floor of his cell before dying.” *Id.* His official cause of death was withdrawal. *Id.* Stojcevski had been in methadone treatment before he was jailed, and methadone was not provided during his incarceration. *Id.* Stojcevski’s family filed a wrongful death suit against Macomb County that claimed the defendants were “so deliberately indifferent to David’s mental health and medical needs that [they] . . . monitored, watched and observed David spend the final [ten] days of his life suffering” *Id.*

⁷¹ *Id.* The article highlights that a 2009 survey of opioid dependent adults in the *Journal of Psychoactive Drugs* found this problematic theory to be false. *Id.* The authors noted that “rather than avoiding heroin and other drugs while out in the community, many addicts simply resolve to try to avoid or minimize withdrawal during future incarceration episodes.” *Id.*

⁷² *Drug Diversion*, CTRS. FOR DISEASE CONTROL & PREVENTION (Nov. 26, 2019), <https://www.cdc.gov/injectionsafety/drugdiversion/index.html> [<https://perma.cc/C6G2-8Y46>].

⁷³ Michelle McKenzie, Amy Nunn, Nickolas Zaller, Alexander Bazazi & Josiah Rich, *Overcoming Obstacles to Implementing Methadone Maintenance Therapy for Prisoners: Implications for Policy and Practice*, 5 J. OPIOID MGMT. 219, 223 (2009).

⁷⁴ *Id.*

commented, “You really think this methadone project is going to work? You know, we don't like to give [the prisoners] *any* drugs. You know we even charge them for Tylenol, right?” Accustomed to controlling both rewards and punishments, and viewing methadone therapy as a reward, wardens saw distribution of methadone by medical staff as a threat to their control over inmates. Wardens felt uncomfortable about the potential diversion of methadone doses to inmates not in methadone treatment, both because of the possibility that an inmate's safety might be put at risk and because the “reward” of becoming intoxicated might be distributed without their control.⁷⁵

Correctional settings that provide methadone dosing develop clear protocols that, when combined with the liquid state of the medication, make diversion nearly impossible.⁷⁶ Methadone treatment programs provide patients with a liquid form of methadone.⁷⁷ The storage, dosage, and accounting of the medication are all strictly regulated by the federal government.⁷⁸

For example, the Franklin County Jail in Massachusetts has a practice that prevents diversion.⁷⁹ The nurse provides a liquid dose of methadone to the patients “as correctional officers stand watch. Every five minutes, [the nurse] checks each mouth with a flashlight. After three checks[,] the men are taken to a washroom to rinse their mouths, eat a Saltine cracker, rinse again, and wash their hands.”⁸⁰

The National Institutes of Health (“NIH”) drug abuse division asserts that diversion of methadone is rare in prison settings.⁸¹ The NIH states that attempts to divert methadone occur at a rate of one percent, but that strict dosing supervision can successfully prevent diversion.⁸²

While fears of diversion may prevent prisons from implementing methadone treatment, the data does not substantiate the concerns. With appropriate and achievable dosing supervision, diversion of methadone in

⁷⁵ *Id.*

⁷⁶ Deborah Becker, *Franklin County Jail Is the First Jail in the State That's Also a Licensed Methadone Treatment Provider*, WBUR (Nov. 12, 2019), <https://www.wbur.org/commonhealth/2019/11/12/franklin-county-jail-methadone> [https://perma.cc/REY8-UC9Y].

⁷⁷ *Methadose Oral Concentrate*, RXLIST (June 10, 2021), <https://www.rxlist.com/methadose-oral-concentrate-drug.htm#indications> [https://perma.cc/D4E9-M5TD] (describing the cherry-flavored or plain sugar-free liquid concentrate that nurses mix with water to create the dose of liquid methadone that patients orally consume daily when enrolled in a methadone treatment program).

⁷⁸ *Id.*

⁷⁹ *Id.*

⁸⁰ *Id.*

⁸¹ *Treating Opioid Addiction in Criminal Justice Settings*, NAT'L INST. ON DRUG ABUSE (Dec. 14, 2017), <https://www.drugabuse.gov/publications/treating-opioid-addiction-in-criminal-justice-settings> [https://perma.cc/8M78-NZUJ].

⁸² *Id.*

a prison setting is exceedingly rare.

B. Cost of Care

One often-cited barrier to providing methadone to prison inmates is the cost. Due to regulation, Medicaid funds typically cannot be used to cover a person's health care costs during incarceration.⁸³ Medicaid coverage must be paused or canceled when a person is incarcerated.⁸⁴ This means prisons incur the costs associated with inmate medical needs. In 2015, states spent \$8.1 billion on health care in correctional facilities.⁸⁵ The median expense was \$5,720 per inmate.⁸⁶ When inmates stay healthy, state budgets benefit.⁸⁷

To dispense methadone to prison inmates, a prison has two options: it can partner with a private local community-based OTP or create its own certified OTP within the prison. Opening an OTP is a rigorous process governed by the Code of Federal Regulations.⁸⁸ OTPs must be certified and accredited by the appropriate bodies, licensed in their state of operation, and registered with the Drug Enforcement Administration ("DEA").⁸⁹ The process of opening an OTP is complex and time-consuming, and maintaining compliance with regulations is equally challenging. In considering whether to contract or develop their own OTP, prisons must assess both the financial implications as well as the regulatory demands of each. Regardless of which route prisons take, grant funding is available to help finance the endeavor.

As the opioid crisis has swelled, so too have grant dollars for programs aimed at treatment and prevention. The federal government offers significant grant funding for the implementation and maintenance of treatment programs in local and state correctional facilities. Medication-assisted treatment, including methadone, is an approved cost under this

⁸³ Samantha Scotti, *Former Inmates Struggle if They Have No Health Coverage After Being Released*, STATE LEGS. MAGAZINE (Sept. 1, 2017), <https://www.ncsl.org/bookstore/state-legislatures-magazine/health-care-in-and-out-of-prisons.aspx> [https://perma.cc/YU6R-REAZ].

⁸⁴ *Id.*

⁸⁵ *Id.*

⁸⁶ *Id.*

⁸⁷ *Id.*

⁸⁸ *Certification of Opioid Treatment Programs (OTPs)*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (Oct. 7, 2020), <https://www.samhsa.gov/medication-assisted-treatment/become-accredited-opioid-treatment-program> [https://perma.cc/RJQ5-MZT2]. The Code of Federal Regulations includes a "system to certify and accredit OTPs, allowing them to administer and dispense [Food and Drug Administration ("FDA")] approved [medication-assisted treatment ("MAT")] medications. In addition, [OUD] patients receiving MAT medications must also receive counseling and other behavioral therapies to provide patients with a whole-person approach." *Id.* In addition to medication and counseling, OTPs are required to "provide counseling on the prevention of human autoimmune virus ("HIV"). [Substance Abuse and Mental Health Services Administration ("SAMHSA")] recommends OTPs also screen and educate high-risk patients on other infectious diseases." *Id.*

⁸⁹ *Id.*

grant program.⁹⁰ “All grants are awarded to State Administering Agencies (SAA) who must sub-grant these funds to correctional agencies across their state.”⁹¹

In addition, the U.S. Department of Justice (“DOJ”) provides grants under the Residential Substance Abuse Treatment for State Prisoners (“RSAT”) Program.⁹² Agencies that apply for RSAT funds must match twenty-five percent of the grant award.⁹³

Opioid-specific grant funding is widely available for programs inside and outside of incarcerated settings. The DOJ and the Department of Health and Human Services have several initiatives that offer grant opportunities: “the Comprehensive Opioid Abuse Site-based Program, the Opioid Affected Youth Initiative, the Rural Communities Opioid Response Program, SAMHSA’s Tribal Opioid Response Grants and the HEAL Initiative among others.”⁹⁴

When opening its OTP, Franklin County Jail in Massachusetts relied on a federal grant.⁹⁵ SAMHSA awarded Massachusetts a federal State Opioid Response Grant of \$35,879,685 to “support prevention, treatment, and recovery services.”⁹⁶ From that sum, Franklin County Jail received a \$500,000 grant to support the implementation of its methadone program.⁹⁷

For agencies that pursue them, funds exist to assist prisons in implementing and operating methadone treatment programs, demonstrating that cost is not a necessary barrier to offering such services.

C. Abstinence Theories of Recovery

Opioid agonist therapy entered the spotlight in new ways as the opioid epidemic continued, gaining attention from supporters and critics alike. While the science is undisputed and the positive results of methadone maintenance are well-documented, misconception and stigma persist.

In 2017, a national study showed the public had “low rates of awareness . . . about the evidence base for medications to treat OUD”⁹⁸ More than half the survey respondents believed there is no effective

⁹⁰ *Using Grants to Fund Inmate Healthcare*, CORRECTIONS1 (Dec. 19, 2018), <https://www.corrections1.com/issues-correctional-healthcare/articles/using-grants-to-fund-inmate-healthcare-qwmrfpC9tvZXgh6w/> [https://perma.cc/86KK-T9CA].

⁹¹ *Id.*

⁹² *Id.*

⁹³ *Id.*

⁹⁴ *Id.*

⁹⁵ Douglas Hook, *Six Months After Launching Massachusetts’ First In-House Methadone Clinic, Franklin County Jail Is Changing the Way Jails Look at Addiction*, MASS LIVE (Feb. 23, 2020), <https://www.masslive.com/news/2020/02/six-months-after-launching-massachusetts-first-in-house-methadone-clinic-franklin-county-jail-is-changing-the-way-jails-look-at-addiction.html> [https://perma.cc/Y8E9-RCSH].

⁹⁶ *Id.*

⁹⁷ *Id.*

⁹⁸ NAT’L ACADS. OF SCI., ENG’G, & MED., *supra* note 4, at 112.

treatment available for OUD.⁹⁹

Even among professionals, stigma and misconception persist. This can be dangerous when ill-informed criminal justice professionals are in the position of making life-changing treatment plan decisions for an individual with OUD.¹⁰⁰

[C]ritical treatment decisions often occur in the law enforcement and judicial systems rather than in medical settings. However, no policies are in place to require that the people making these decisions have received any education about evidence-based OUD treatment. Education and training about OUD for court officers could increase the uptake of medications to treat OUD. Probation and parole officers also need to be trained on medications used to treat people with OUD. Many prison medical directors limit treatment to abstinence-only or detoxification-only modalities for people with OUD in their prisons Implementing methadone treatment in correctional facilities can be logistically complicated and impeded by stigma toward the medication among management and staff; however, those challenges can and should be addressed¹⁰¹

The black-and-white thinking that permeates correctional settings does not easily comport with the methadone treatment model, which challenges individuals to reconsider what recovery from addiction means.¹⁰²

During the implementation of methadone services in a Rhode Island jail, the clinicians noted how many of the correctional staff believed drug addiction was a “moral failing” and should be punished, not treated.¹⁰³ The correctional staff viewed abstinence, without medication assistance like methadone, as the appropriate approach to overcoming addiction.¹⁰⁴

Abstinence is, of course, less difficult to maintain in a secure, controlled environment, like prison. Correctional staff may see inmates

⁹⁹ *Id.*

¹⁰⁰ *Id.*

¹⁰¹ *Id.* at 115-16.

¹⁰² See Alison Knopf, *Expanding OTPs into Corrections in Maryland*, ADDICTION TREATMENT FORUM (Apr. 7, 2019), <https://atforum.com/2019/04/expanding-otps-into-corrections-maryland/> [<https://perma.cc/R7EV-7QTJ>]. A Maryland bill proposed having an OTP in every jail in the state to offer methadone, buprenorphine, and naltrexone. *Id.* Some pointed out that the jails could offer naltrexone and buprenorphine without opening an OTP; methadone is the only one of the three medications that must be dispensed from an OTP. *Id.* However, methadone offers better relief of cravings and has a better rate of treatment retention than either of the other medications. *Id.* Major barriers were concern regarding the cost of the medications and operation of the OTPs, and major opposition from the jails. *Id.* The correctional staff asserted they “are corrections, people should be punished.” *Id.* Medical professionals point out the issue is medical treatment, not punishment. *Id.* “[I]t’s just like somebody with diabetes—they should get treatment.” *Id.* While addiction experts and doctors supported the bill, the jails themselves did not. *Id.*

¹⁰³ McKenzie et al., *supra* note 73.

¹⁰⁴ *Id.*

become healthier and improve in their level of functioning, and they assume this indicates the inmate is no longer addicted. “Once ‘clean,’ many believe that the legitimate approach in maintaining abstinence after leaving incarceration is will power [sic], avoiding negative influences, and finding support”¹⁰⁵ This assumption demonstrates a gross misunderstanding of the complex biopsychosocial nature of addiction and underestimates the difficulties an inmate faces after release.

Studies abroad have questioned why some nations, including the United States, resist implementation of prison methadone programs.¹⁰⁶ Some point to prison administrators’ discomfort with medicines used to treat addiction.¹⁰⁷ Other studies question the concept of treatment in prison, as prisons are not “therapeutic environments,” and it is unrealistic to expect emulating community-based programming to succeed in a prison-based setting.¹⁰⁸ Most importantly, “abstinence based approaches remain more popular than harm reduction ones in the cultural environment of penal institutions. This means that detox, rather than [methadone] maintenance, is the more common mode of methadone . . . in prisons.”¹⁰⁹

Prison administrators’ focus on maintaining a secure and drug-free facility is “often regarded as incongruent” with methadone treatment.¹¹⁰ Prison staff report difficulty reconciling the two objectives: making prisons drug-free, while also aiming to help those with drug problems via methadone treatment.¹¹¹

Despite the fact that methadone has been labeled the “gold standard” of care for OUD by the NIH, the stigma of methadone treatment is so great it impacts not just patients, but also the professionals who care for them.¹¹² This phenomenon earned the name “intervention stigma.”¹¹³ “Unlike ‘condition stigmas’ that mark individuals due to diagnosis, intervention stigma marks patients and health professionals due to involvement with a medical treatment or other form of intervention.”¹¹⁴

Addiction treatment professionals who work in methadone programs experience discrimination and prejudice from other professionals, “especially abstinent treatment professionals who disagree with the use of

¹⁰⁵ *Id.*

¹⁰⁶ Taylor, et al., *supra* note 42.

¹⁰⁷ *Id.*

¹⁰⁸ *Id.* at 19.

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ *Id.*

¹¹² Erin Fanning Madden, *Intervention Stigma: How Medication-Assisted Treatment Marginalizes Patients and Providers*, SOC. SCI. & MED. (July 2019), <https://www.sciencedirect.com/science/article/abs/pii/S0277953619302916?via%3Dihub> [<https://perma.cc/2VES-GAJB>].

¹¹³ *Id.*

¹¹⁴ *Id.*

medications to treat [OUD].”¹¹⁵ This discrimination may be rooted in stigma toward addiction generally or at methadone treatment in particular.¹¹⁶

The irony (and tragedy) is that this stigma targets a treatment model that has the best outcomes for OUD, and this stigma may then prevent patients—and programs—from pursuing methadone treatment.¹¹⁷ Prisons’ bias for abstinence-based recovery is not sufficient reason to deny OUD inmates access to methadone.

D. Regulatory Challenges

The regulatory requirements for methadone programs are considerable.¹¹⁸ When Franklin County Jail decided to apply to open a methadone program, the sheriff reported it took fifty-four weeks and a ninety-page application to complete the process.¹¹⁹ While jails or prisons can apply to open their own programs, like Franklin County did, some medical professionals advise against it. One physician in the correctional system notes, “There are some jails that have applied for methadone treatment program status. More power to them. I have not, nor will I do so. In my opinion, the headaches of such a program in my jails would far outweigh the benefits.”¹²⁰

The other option is to contract with a private methadone program in the community. In such an instance, counseling services are provided via telemedicine or on-site at the prison—whichever method federal regulators (or approved federal waivers) permit.¹²¹ The community program typically delivers pre-packaged methadone doses to the prison, or it creates a

¹¹⁵ *Id.*

¹¹⁶ *Id.*

¹¹⁷ See *After Years of Stigma, the Conversation Around Methadone Has Long Needed Change*, CARF INT’L (Feb. 5, 2019), <http://www.carf.org/OTP-methadone-blog/> [<https://perma.cc/2FK5-WMCD>]. “Methadone is one of the most widely studied substances in the United States and has been shown to be safe and effective when used as a component of holistic treatment for opioid use disorder.” *Id.* Despite this, stigma around methadone treatment persists. “The way we talk about methadone often does not communicate the treatment offerings and efficacy of Opioid Treatment Programs. It’s time we update public perceptions.” *Id.*

¹¹⁸ See Jeffrey Keller, *Methadone? In a Jail?* JAIL MED. (Sept. 18, 2012), <http://www.jailmedicine.com/methadone-in-a-jail/> [<https://perma.cc/JXP2-5BUQ>]. A licensed physician cannot independently prescribe methadone to treat a person’s addiction. *Id.* Methadone can only be prescribed through a licensed, accredited OTP which has met numerous rigorous guidelines set by SAMHSA, the DEA, a professional accreditation body (such as CARF or the Joint Commission), and state regulators. *Id.* Physicians can, however, prescribe methadone to treat chronic pain. If they prescribe it to treat addiction, they face discipline by the DEA for prescribing narcotics for addiction without the proper accreditation. *Id.*

¹¹⁹ Hook, *supra* note 95.

¹²⁰ Keller, *supra* note 118.

¹²¹ See Shannon Mace, Anne Siegler, KC Wu, Amanda Latimore & Heather Flynn, *Medication-Assisted Treatment for Opioid Use Disorder in Jails and Prisons: A Planning and Implementation Toolkit*, NAT’L COUNCIL FOR BEHAV. HEALTH & VITAL STRATEGIES 52–55 (2020).

medication unit within the prison to prepare and administer doses.¹²²

Whether administered through a medication unit, received from a private program and dispensed, or dispensed from a prison-owned and operated methadone program, the methadone must be meticulously accounted for and stored.¹²³ If it is being transported to the prison from a community-based clinic, only medical employees of the prison should accept the methadone.¹²⁴ It is transported in a locked container, and every transfer “must be accounted for on paper, similar to ‘chain-of-evidence’ documentation.”¹²⁵ The jail must store the methadone in a double-locked, secure area, as required for storage of Schedule II narcotics, per the DEA.¹²⁶

These regulatory requirements can be cumbersome and inconvenient but are not insurmountable in a prison setting. With appropriate policies and procedures in place, and with appropriate staff training to guide adherence, regulations on methadone should not be a barrier to providing methadone treatment in prison.

VI. THE LEGAL REASONING FOR METHADONE TREATMENT IN PRISON

When prison administrators actively refuse to consider the implementation of methadone treatment in prison, they expose themselves to risk of litigation for violating the rights of inmates. The following section explores why inmates are legally entitled to methadone treatment in prison and provides examples of successful litigation pursued with similar reasoning.

A. Violation of Inmates’ Rights

Prisons violate inmates’ rights in two ways when denying them access to methadone treatment. They violate the prohibition against cruel and unusual punishment as defined under the Eighth Amendment of the U.S. Constitution.¹²⁷ In addition, they violate Title II of the ADA, which protects

¹²² SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 88. A “medication unit” is a facility located in a geographically separate location, away from the licensed methadone program. *Id.* At the medication unit, staff employed by the methadone program can administer medication and collect samples for drug testing. *Id.* However, program admission and counseling services cannot be performed at a medication unit. *Id.* “Medication units must follow the same rules and guidelines as outlined by SAMHSA and the state in which they reside, and must apply and renew for certification.” *Id.* Medication units are thought to be helpful “for people living in rural areas with limited accessibility” to a primary methadone clinic. *Id.* “Even in major cities, medication units can be a valuable resource” to help improve patient access to a dosing location away from the primary clinic. *Id.*

¹²³ Keller, *supra* note 118.

¹²⁴ *Id.*

¹²⁵ *Id.*

¹²⁶ *Id.*

¹²⁷ U.S. CONST. amend. VIII.

individuals with disabilities, including inmates of state prisons, from enduring discrimination by public entities.¹²⁸

1. Eighth Amendment

The Eighth Amendment of the U.S. Constitution states that “[e]xcessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.”¹²⁹ Over time, the courts have considered and refined what qualifies as cruel and unusual punishment.

In *Estelle v. Gamble*, state prison inmate J.W. Gamble injured his back when a bale of cotton fell on him during a prison labor assignment.¹³⁰ For the three months following his injury, Gamble complained to prison staff about back and chest pain.¹³¹ He refused to work, causing prison staff to put him in administrative segregation.¹³² He received medical attention, though none sufficient to address his pain, and was ultimately treated for an irregular heartbeat.¹³³ Gamble sued, arguing that the prison committed medical malpractice by failing to provide him appropriate medical care and this amounted to cruel and unusual punishment.¹³⁴

The U.S. Supreme Court did not side with Gamble. It determined that the prison’s failure to provide Gamble appropriate care was a matter for medical judgment.¹³⁵ Though Gamble lost his case, the Court’s ruling served to establish a clear standard under the Eighth Amendment. The Court held that a violation of the Eighth Amendment occurs when the prison staff display “deliberate indifference to [the] serious medical needs of prisoners.”¹³⁶ Such conduct constitutes the “unnecessary and wanton infliction of pain,” which rises to the level of “cruel and unusual punishment” under the Eighth Amendment.¹³⁷

Estelle established the standard for a prison inmate to bring an Eighth Amendment claim for cruel and unusual punishment based on deficient medical care: the inmate must allege an objectively serious medical need and a prison official’s deliberate indifference to that need.¹³⁸

¹²⁸ 42 U.S.C. § 12132 (1990).

¹²⁹ U.S. CONST. amend. VIII.

¹³⁰ *Estelle v. Gamble*, 429 U.S. 97 (1976).

¹³¹ *Id.* at 101.

¹³² *Id.* at 100.

¹³³ *Id.* at 100–01.

¹³⁴ *Id.* at 101.

¹³⁵ *Id.* at 107.

¹³⁶ *Id.* at 104.

¹³⁷ *Id.*

¹³⁸ *Id.*; see also *Helling v. McKinney*, 509 U.S. 25 (1993). Going beyond what it established in *Estelle*, the Court in *Helling* ruled in favor of a Nevada prison inmate who shared a cell with a five-pack-a-day smoker and requested to be moved to an environment free of secondhand smoke. *Id.* Though the inmate did not have any specific medical condition and was not seeking medical treatment, the majority wrote that prison officials had “with deliberate indifference, exposed him to [levels of secondhand smoke] that pose an

A medical need may be deemed serious if failure to address it will lead to a serious risk of harm.¹³⁹ Deliberate indifference to the inmate's medical need occurs when the prison official realizes a substantial risk of serious harm to the inmate exists but the official disregards that risk.¹⁴⁰ Access to effective treatment for OUD is a serious medical need. With access to effective treatment, such as methadone, the inmate with OUD is at significantly lower risk of overdose.¹⁴¹ In addition, methadone treatment lowers risk of exposure to infectious diseases like HIV and Hepatitis C.¹⁴² And, methadone treatment prevents acute and post-acute withdrawal symptoms.¹⁴³

By not providing access to methadone treatment, prisons show deliberate indifference to inmates with OUD because of the risk of serious harm—withdrawal, infectious disease, overdose, and death.¹⁴⁴ Some may argue that the serious harm is too remote and not immediate enough for prisons to assume responsibility for providing this care. However, the U.S. Supreme Court held that a “remedy for unsafe conditions need not await a tragic event.”¹⁴⁵ Future harm incurred due to an inmate's current conditions is reviewable under the Eighth Amendment.¹⁴⁶

Courts observe that the constitutional minimum with respect to health care has increased over time as contemporary standards change.¹⁴⁷ Whereas denying inmates access to methadone treatment was not controversial in the past, the United States is now decades-deep into an opioid epidemic, and community standards and norms have evolved. The correctional system's policy on methadone is directly connected to many of the overdose deaths.¹⁴⁸

Deliberate indifference occurs when prisons offer less effective but more easily implemented treatment programs. In the case of OUD, counseling alone is far less effective than methadone combined with counseling.¹⁴⁹ Prisons that continue to refuse to offer methadone treatment to inmates with the serious medical need of effective treatment for OUD

unreasonable risk of serious damage to his future health,” thus his Eighth Amendment claim was valid. *Id.* at 35. To win his claim, the inmate would have to prove the risks of secondhand smoke and prove that it “violates contemporary standards of decency to expose *anyone* unwilling to such a risk . . . [He] must show that the risk of which he complains is not one that today's society chooses to tolerate.” *Id.* at 36.

¹³⁹ *Id.* at 33.

¹⁴⁰ *Estelle*, 429 U.S. at 104-05.

¹⁴¹ NAT'L ACADS. OF SCI., ENG'G, & MED., *supra* note 4, at 138-39.

¹⁴² *Id.*

¹⁴³ *Id.*

¹⁴⁴ *Id.*

¹⁴⁵ *Helling v. McKinney*, 509 U.S. 25, 33 (1993).

¹⁴⁶ *Id.*

¹⁴⁷ *Id.* at 32-33.

¹⁴⁸ *See Gardner*, *supra* note 52.

¹⁴⁹ NAT'L ACADS. OF SCI., ENG'G, & MED., *supra* note 4, at 17-18.

effectively exhibit deliberate indifference.

2. *Americans with Disabilities Act*

In addition to a constitutional rights violation, prison inmates with OUD who are denied methadone treatment may bring a valid claim under federal civil rights laws, including the ADA, and the Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments Act of 1978 (“Rehabilitation Act”).¹⁵⁰ The ADA and Rehabilitation Act share similar standards with regard to determining liability.¹⁵¹ Because of significant similarities between the laws with regard to disabilities, discussion here will focus on the ADA.

The ADA protects people with disabilities from discrimination.¹⁵² The ADA defines “disability” as a physical or mental impairment that substantially limits one or more major life activities.¹⁵³ Title II of the ADA states that “no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.”¹⁵⁴

Under the ADA, people with OUD are deemed individuals with a disability, provided they are not actively abusing drugs.¹⁵⁵ However, the law also says that “even current users can’t be denied health care.”¹⁵⁶ Much of how the ADA applies to these situations is up for interpretation and has yet to be determined by the courts. Regardless, inmates with OUD have a qualifying disability, and the prisons charged with their oversight and care are indeed responsible according to either the ADA or the Rehabilitation Act.

An inmate with OUD could file a claim under the ADA, employing either of two arguments: (1) that the prison provided disparate treatment, or (2) that the prison failed to provide reasonable accommodation or modification.

¹⁵⁰ Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments Act, 29 U.S.C. § 794 (1978).

¹⁵¹ See 42 U.S.C. § 12132 (1990); see also 29 U.S.C. § 794 (1978).

¹⁵² 42 U.S.C. § 12132 (1990).

¹⁵³ *Id.*

¹⁵⁴ *Id.*

¹⁵⁵ 42 U.S.C. § 12114(a); see also Beth Schwartzapfel, *How the Americans with Disabilities Act Could Change the Way the Nation’s Jails and Prisons Treat Addiction*, ABA J. (Feb. 8, 2019),

https://www.abajournal.com/news/article/how_the_ada_could_change_jails_prisons_addicti_on_treatment/ [https://perma.cc/7UHX-UWLY]. From the time of its inception, the ADA has included protection for individuals who are recovering from addictions to drugs or alcohol. “Yet until recently, the law was rarely invoked on behalf of prisoners taking methadone. . . . ‘It took this many people dying for people to do what they should have been doing all along,’ said Sally Friedman, an attorney with the Legal Action Center.” *Id.*

¹⁵⁶ *Id.*

a. Disparate Treatment

If the plaintiff argues the prison provided disparate treatment, he is claiming his disability actually motivated the defendant's conduct.¹⁵⁷ The plaintiff bears the initial burden to establish a prima facie case of discrimination.¹⁵⁸ The defendant then must respond by providing a legitimate, nondiscriminatory reason for their allegedly discriminatory conduct.¹⁵⁹ The burden then shifts back to the plaintiff, who must show the defendant's legitimate reason is actually just a pretext and not real.¹⁶⁰

Here, the inmate would need to show he was denied adequate treatment for his OUD by the prison, while other inmates in similar circumstances were not denied adequate treatment. For example, the inmate could show he was denied methadone treatment for his OUD, while other inmates received efficacious treatment and medications for their conditions.

In response, the prison may argue it has legitimate reasons for denying inmates access to methadone treatment, such as methadone being cost-prohibitive, or the facility having fears surrounding diversion of the drug. However, as discussed earlier, these reasons are not legitimate because feasible solutions exist.¹⁶¹ The lack of access to methadone treatment is in fact discriminatory, and prisons that deny inmates this care demonstrate disparate treatment of inmates with OUD.

b. Failure to Provide Reasonable Accommodations

Under the ADA, an inmate could claim the prison failed to provide reasonable accommodations for the inmate with OUD when the prison denied the inmate methadone treatment. The ADA requires public entities make reasonable modifications to their policies or rules when the modification is needed to provide meaningful access to a public service.¹⁶² Limitations to this exist, however, as the ADA states that the entity does not need to make modifications that would fundamentally alter the nature of the service or program.¹⁶³ Provision of methadone treatment does not fundamentally alter the nature of the prison, as its outcomes are well aligned with those of many prisons (rehabilitate inmates, decrease recidivism, address addiction, etc.).¹⁶⁴ By refusing to provide methadone treatment, the

¹⁵⁷ See *Raytheon Co. v. Hernandez*, 540 U.S. 44, 52-53 (2003).

¹⁵⁸ See *id.* at 49-52. Disparate treatment claims under the ADA and Rehabilitation Act are governed by the *McDonnell Douglas* burden-shifting analysis used to evaluate claims of discrimination under Title VII of the Civil Rights Act of 1964. *Id.*

¹⁵⁹ See *id.*

¹⁶⁰ See *id.*

¹⁶¹ See *supra* Part V.

¹⁶² 42 U.S.C. § 12132.

¹⁶³ *Id.*

¹⁶⁴ See NAT'L ACADS. OF SCI., ENG'G, & MED., *supra* note 5, at 138-39.

prison fails to make reasonable accommodations for inmates with OUD.

B. Successful Legal Actions

In the past five years, cases have emerged showing the Court's willingness to consider the application of the Eighth Amendment and ADA in determining access to methadone in prison. These results prompted broader conversation in the legal community.¹⁶⁵

1. Pesce v. Coppinger

In *Pesce*, a U.S. District Court in Massachusetts granted a preliminary injunction requiring a Massachusetts jail to provide inmate Geoffrey Pesce with methadone treatment during his incarceration.¹⁶⁶ At the time, Massachusetts did not have a practice of providing methadone treatment to inmates.¹⁶⁷

Plaintiff Pesce had a long history of OUD.¹⁶⁸ With the help of methadone treatment, he was in recovery from OUD since 2016.¹⁶⁹ In July 2018, he was charged with driving with a revoked license, which violated the terms of his probation.¹⁷⁰ Pesce would serve his resulting sentence in the Essex County House of Corrections.¹⁷¹ The facility did not provide or allow methadone treatment.¹⁷² Pesce requested the court order the jail to allow him to continue methadone treatment while incarcerated, describing it as a medically necessary treatment that would diminish his risk of overdose and death upon release.¹⁷³ He sued for an injunction that would allow him to continue his methadone treatment while incarcerated.¹⁷⁴

Pesce argued that the jail's policy against methadone treatment constituted cruel and unusual punishment in violation of the Eighth Amendment because it demonstrated deliberate indifference to his serious medical need.¹⁷⁵ The jail's policy denied him methadone treatment, repudiating his doctor's decision that methadone treatment was medically necessary to treat Pesce's OUD.¹⁷⁶

Pesce also asserted that the jail's policy against methadone treatment violated his rights under the ADA.¹⁷⁷ Pesce asserted he had a qualifying disability due to his OUD, and the jail's refusal to administer methadone deprived him of the benefit of health care programs and such conduct

¹⁶⁵ See Schwartzapfel, *supra* note 157.

¹⁶⁶ *Pesce v. Coppinger*, 355 F. Supp. 3d 35, 39 (D. Mass. 2018).

¹⁶⁷ *Id.* at 42.

¹⁶⁸ *Id.* at 40.

¹⁶⁹ *Id.* at 41.

¹⁷⁰ *Id.*

¹⁷¹ *Id.* at 41-42.

¹⁷² *Id.*

¹⁷³ *Id.*

¹⁷⁴ *Id.* at 43.

¹⁷⁵ *Id.* at 47-48.

¹⁷⁶ *Id.*

¹⁷⁷ *Id.* at 46.

constituted discrimination on the basis of his disability.¹⁷⁸

Pesce argued that he would suffer irreparable harm if his methadone treatment was stopped.¹⁷⁹ Before starting methadone, Pesce overdosed numerous times—at one point, three times within twenty-four hours.¹⁸⁰ His doctor described him as being very high risk for overdose or death upon his release from jail if he did not continue methadone treatment.¹⁸¹

The court ultimately determined that Pesce’s medical needs were of greater concern than any real or imagined security threats the jail would experience due to Pesce receiving methadone.¹⁸² While the court validated the prison’s need for safety and security, it recognized the safeguards in place—including staff observing Pesce consuming his dose and methadone’s liquid formulation—made diversion difficult.¹⁸³

The *Pesce* decision marked the first time a federal court in Massachusetts ruled in favor of providing methadone treatment to prison inmates. Shortly after the *Pesce* ruling, the U.S. Court of Appeals for the First Circuit affirmed a preliminary injunction ordering a Maine jail to provide an inmate opioid agonist therapy (buprenorphine) to treat OUD.¹⁸⁴ These decisions put pressure on Massachusetts prisons to allow inmates access to opioid agonist therapy, or to potentially face similar lawsuits.

2. *Kortlever v. Whatcom County*

As *Pesce* unfolded in Massachusetts, plaintiffs Gabriel Kortlever and

¹⁷⁸ *Id.*

¹⁷⁹ *Id.* at 48.

¹⁸⁰ *Id.*

¹⁸¹ *Id.*

¹⁸² *Id.* at 49.

¹⁸³ *Id.*

¹⁸⁴ *Smith v. Aroostook Cnty.*, 922 F.3d 41 (1st Cir. 2019). Plaintiff Brenda Smith was scheduled to serve forty days in the Aroostook County Jail. *Id.* at 41. The jail informed her that while incarcerated, she would not receive her twice-daily dose of buprenorphine, which was prescribed to treat her OUD. *Id.* at 41-42. Smith sued for injunctive relief. *Id.* at 42. The district court balanced potential harms with public interest and found in favor of Smith, thus issuing a preliminary injunction. *Id.* Upon appeal, the First Circuit held that the district court did not abuse its discretion in its assessment and balancing of the issues. *Id.* The First Circuit affirmed the district court’s grant of a preliminary injunction for Smith, compelling the jail to provide Smith with her prescribed buprenorphine while she was incarcerated. *Id.*

Sy Eubanks developed their case in Washington.¹⁸⁵ In *Kortlever*,¹⁸⁶ a group of inmates from Whatcom County Jail filed a class action civil rights lawsuit seeking access to methadone or buprenorphine for jail inmates with OUD.¹⁸⁷ The lawsuit alleged the Whatcom County Jail only provided medication-assisted treatment (“MAT”) like methadone or buprenorphine to pregnant females, while denying MAT to all male and non-pregnant female inmates with OUD.¹⁸⁸

Kortlever, assisted by the American Civil Liberties Union (“ACLU”) of Washington, argued this practice of providing MAT to only selected inmates violated the ADA.¹⁸⁹ He first pointed out that Whatcom County is in the midst of an opioid epidemic.¹⁹⁰ He went on to argue that OUD is a disability under the ADA, and MAT is a proven life-saving treatment for OUD.¹⁹¹ Kortlever stated that Whatcom County Jail has a policy and practice of denying MAT to non-pregnant inmates, even though the jail provides non-pregnant inmates with other clinically appropriate medications.¹⁹² Kortlever argued that he and other class members suffered serious and irreparable harm as a result of the jail’s policy of denying inmates with OUD access to MAT.¹⁹³ Despite the serious and irreparable harm, the jail refused to change its policy and practice regarding MAT.¹⁹⁴

The parties worked together for nearly a year and ultimately reached a settlement: Whatcom County agreed to provide MAT to inmates with OUD.¹⁹⁵ This included three options: treatment of opioid withdrawal, induction onto medication for maintenance as part of treatment, or continuing MAT the inmate established in the community prior to being

¹⁸⁵ *ACLU of Washington Lawsuit: Whatcom County Jail Violating ADA by Refusing Medication to People with Opioid Use Disorder*, ACLU-Wash. (June 7, 2018), <https://www.aclu-wa.org/news/aclu-washington-lawsuit-whatcom-county-jail-violating-ada-refusing-medication-people-opioid-use> [<https://perma.cc/KPE3-69XL>]. Plaintiff Sy Eubanks was a forty-six-year-old man with OUD who became addicted to opioids after receiving prescription painkillers following a surgery. *Id.* Eventually, he turned to heroin. *Id.* Eubanks had success with opioid agonist therapy, utilizing buprenorphine or methadone at different junctures. *Id.* Plaintiff Gabriel Kortlever was a twenty-four-year-old man with OUD who began using heroin at age sixteen. *Id.* His heroin use contributed to his eventual involvement with the criminal justice system. *Id.* He began opioid agonist therapy (buprenorphine) with the support of his family and probation officer, and found it effective. *Id.*

¹⁸⁶ *Kortlever, v. Whatcom Cty. Wash.*, No. 2:18-cv-00823, 2018 WL 8809158 (W.D. Wash. July 23, 2018).

¹⁸⁷ ACLU-WASH., *supra* note 185.

¹⁸⁸ Compl. at 1, *Kortlever v. Whatcom Cty. Wash.*, No. 2:18-cv-00823, 2018 WL 2763303 (W.D. Wash. June 6, 2018).

¹⁸⁹ *Id.* at 19.

¹⁹⁰ *Id.* at 5.

¹⁹¹ *Id.* at 8, 20–21.

¹⁹² *Id.* at 11.

¹⁹³ *Id.* at 13.

¹⁹⁴ *Id.* at 13–14.

¹⁹⁵ Settlement Agreement, *Kortlever v. Whatcom Cty. Wash.*, No. 2:18-cv-00823 (W.D. Wash. Apr. 29, 2019), ECF No. 35, [see https://www.aclu-wa.org/docs/settlement-agreement-1](https://www.aclu-wa.org/docs/settlement-agreement-1) [<https://perma.cc/NGW9-HC85>].

incarcerated.¹⁹⁶ In this settlement, Whatcom County agreed to offer only two MAT options: buprenorphine and naltrexone.¹⁹⁷ Whatcom County did not agree to provide inmates with methadone maintenance during incarceration.¹⁹⁸ To address needs of inmates who enter jail on methadone, this provision was included in the settlement agreement:

If the offender does not wish to transition from methadone to Suboxone, Subutex or Vivitrol, the Whatcom County Jail will make reasonable attempts for alternative arrangements to keep the offender on methadone. Alternative arrangements could include: transferring the offender to the Skagit County Jail upon approval of the offender and Skagit County; communication with prosecution and defense attorneys about the possibility of seeking in court a less restrictive alternative placement outside of the jail, or any other means for keeping the offender on methadone that is approved by the jail. If alternative arrangements cannot be made, clinically appropriate offenders will be offered the option of participating in MAT tapering.¹⁹⁹

Kortlever marks the first class action suit of its kind. With widespread lack of methadone treatment in U.S. jails and prisons, this case may not be the last of its kind.

VII. MINNESOTA PRISONS' APPROACH TO OPIOID AGONIST THERAPY

This Note examined the public policy rationale and legal argument for allowing methadone treatment in prisons and reviewed cases from the east and west coasts that helped spur change. This Note now turns its focus to the Midwest, examining how state prisons in Minnesota treat OUD and whether opportunity for improvement exists.

A. OUD Population and DOC Treatment Options

Like other states, Minnesota has endured the fatal consequences of the opioid epidemic—opioid overdoses have increased in Minnesota since 2000.²⁰⁰ Minnesota's overdose fatalities show significant racial disparities. In Minnesota, Native Americans are seven times more likely to die from a drug overdose as whites, and African Americans are twice as likely to die from a

¹⁹⁶ *Id.* at 6-8.

¹⁹⁷ *Id.* at 14-24.

¹⁹⁸ *Id.*

¹⁹⁹ *Id.* at 19.

²⁰⁰ *Opioids: Drug Overdose Dashboard*, MINN. DEPT. OF HEALTH, <https://www.health.state.mn.us/communities/opioids/opioid-dashboard/index.html> [https://perma.cc/H555-GFMX].

drug overdose as whites.²⁰¹

A similar disparity appears in the incarceration rates for drug offenses in Minnesota. “There is a stark racial disparity in incarceration rates for drug offenses, especially within the Native American and African American communities.”²⁰² By not appropriately treating OUD in the prison population, the criminal justice system contributes to racial health disparities and increased risk of recidivism, relapse, and death among Native Americans and African Americans.²⁰³

Approximately ninety percent of inmates in Minnesota state prisons have a substance use disorder diagnosis.²⁰⁴ The Minnesota Department of Corrections (“DOC”) provides substance use disorder treatment options during incarceration to all levels of offenders except those in maximum security.²⁰⁵ Each year, approximately 6,500 prison inmates are assessed as needing treatment for a substance use disorder.²⁰⁶ However, the DOC is currently funded to provide treatment to about 1,600 inmates each year.²⁰⁷

None of Minnesota’s DOC facilities currently offer methadone treatment for the duration of incarceration.²⁰⁸ Pregnant female inmates already maintained on methadone who enter a DOC facility are permitted to continue methadone until delivery of their baby.²⁰⁹ This policy exception is presumably in place to avoid putting the fetus at risk of withdrawal, which

²⁰¹ *Id.*

²⁰² *Opioids: Justice-Involved Populations*, MINN. DEPT. OF HEALTH, <https://www.health.state.mn.us/communities/opioids/mmresponse/justice.html> [<https://perma.cc/FZS2-6SYW>]. The Minnesota Department of Health’s State Opioid Oversight Project (“SOOP”) aims to focus on justice-involved populations during its prevention efforts. *Id.* This includes individuals who are in prison. *Id.* Notably, SOOP acknowledges the racial disparity in incarceration rates for drug offenses and posits these are “a product of structural racism, social determinants of health, intergenerational trauma, and other factors that disproportionately impact communities of color.” *Id.* Native Americans comprise 1.3% of Minnesota’s general population, yet Minnesota state prisons have between 7 and 22% Native American offenders. *Id.* African Americans make up 6.2% of Minnesota’s general population, yet Minnesota state prisons have between 15% and 46% African American offenders. *Id.*

²⁰³ *Id.*

²⁰⁴ *Fact Sheet: Substance Use Disorder Treatment Services in Prison*, MINN. DEPT. OF HEALTH (Dec. 2019), https://mn.gov/doc/assets/Substance%20Use%20Disorder%20Treatment_tcm1089-413914.pdf [<https://perma.cc/MG5Y-65QF>].

²⁰⁵ *Id.*

²⁰⁶ *Id.* The DOC reports that offenders can refuse treatment. *Id.* This may explain why, despite participants being incarcerated and thus unable to leave, the DOC’s residential treatment programs had only a 74.9% completion rate in 2018 and a 78.1% completion rate in 2019. *Id.* The treatment modality primarily offered to inmates who occupy one of the 1,051 “beds” in a residential program is that of a therapeutic community. *Id.*

²⁰⁷ *Id.*

²⁰⁸ E-mail from Nanette Larson, Dir. of Health Serv., Minn. Dept. of Corr., to author (Oct. 27, 2020, 11:31 AM) (on file with author) [hereinafter “Larson”].

²⁰⁹ *Id.*

would occur if the prison required pregnant inmates to taper.²¹⁰ Per current policy, males and non-pregnant females at DOC facilities do not have access to methadone treatment, or any other ongoing opioid agonist therapy.²¹¹

In select circumstances, the DOC offers inmates buprenorphine. If an inmate shows symptoms of opioid withdrawal, and is objectively assessed to have physical symptoms severe enough for clinical intervention, the inmate may receive buprenorphine.²¹² This administration of buprenorphine is solely for symptom relief—not as a maintenance medication. Rarely do inmates enter a DOC facility experiencing acute withdrawal that would qualify for buprenorphine, as most inmates complete their acute withdrawal while in jail awaiting sentencing or transfer to prison.²¹³

Aside from brief withdrawal management and pregnancy, the other circumstance in which the DOC may provide buprenorphine is upon an inmate's release from prison.²¹⁴ For inmates seeking methadone treatment, no option exists for starting medication before release. Instead, they re-enter the community at high risk for overdose due to not being stabilized on

²¹⁰ NAT'L INST. ON DRUG ABUSE, *supra* note 38 (discussing risks associated with a mother experiencing opioid withdrawal during pregnancy).

²¹¹ Larson, *supra* note 210. The DOC does not currently “offer Methadone to men and women during incarceration as a form of treatment. With that being said, if a female enters on methadone, and is pregnant[,] the treatment will be continued.” *Id.*

²¹² *Id.* The DOC uses the following buprenorphine guidelines:

At time of induction at intake, patients should have evidence of active opioid withdrawal based upon Clinical Opiate Withdrawal Scale (Score of 6-10 or higher) or be past acute withdrawal. Induction should generally occur at least 12 hours after the last dose of short acting opiates, including heroin, and 24 hours after long acting formulations. Patients previously taking illicit methadone should be at least 36 hours from last dose, but may need longer up to 72 hours. Intake: Patients in withdrawal (COWS >6-10) can start with 4-8mg SL of Buprenorphine; if still have COWS>6 in 30 mins, repeat the 4-8 mg. Patients who respond to the buprenorphine (target is 16 mg) COWS<6 should be able to remain at the intake facility and continue on 8-16 mg daily. Those who are not responding should be transferred to the ED for severe withdrawal.

If the patient requires adjuncts such as clonidine and ondansetron requiring 24 hour nursing, the patient should be transferred to the OPH-TCU (or hospital MCF-SHK).

Additional medications like ondansetron, hydroxyzine, and clonidine should be given to help with withdrawal symptoms in ALL patients, regardless of whether an individual is a candidate for buprenorphine.

For patients who have already been on buprenorphine in the community, but had a lapse in therapy of greater than 2 weeks, and are no longer showing symptoms/ signs of acute opiate withdrawal, higher doses may be initiated from above protocol given previous tolerance of medication.

Id.

²¹³ *Id.*

²¹⁴ *Id.*

opioid maintenance therapy prior to release. The DOC staff may assist an inmate with scheduling a post-release appointment at a community-based methadone clinic.²¹⁵

The DOC's treatment options consist of individual and group therapy and utilizing a structured curriculum in a therapeutic community setting.²¹⁶ For a person with OUD, this is simply not an effective treatment option.²¹⁷ Opioid agonist therapy (methadone, buprenorphine) is far more effective.²¹⁸

B. Recommendations for Change

Minnesota's DOC has a unique opportunity to pre-emptively address the disparate treatment it currently provides to prison inmates with OUD before inmates take legal action.²¹⁹ The DOC could do this by making methadone treatment available to prison inmates, either by contracting with a community-based treatment program, or by developing an OTP itself within the prison.²²⁰

If the DOC contracted with a community-based program, the DOC could delegate the clinical and medical work to professionals experienced in developing and running methadone clinics. The DOC could lease the program space within the prison or on the prison campus. The clinic and the DOC would be separate entities working in concert.²²¹ Alternatively, the DOC could establish methadone services by opening a clinic itself.²²² To do this, the DOC would benefit from working with an experienced consultant, as navigating the regulatory requirements of methadone programs can be

²¹⁵ *Id.*

²¹⁶ *Substance Abuse Program: Program Therapist*, MINN. DEPT. OF HEALTH, <https://mn.gov/doc/employment-opportunities/intern-opportunities/intern-positions/substance-abuse-program/> [<https://perma.cc/2J5V-PXLZ>].

Cognitive-Behavioral Therapy which assists clients with identifying, challenging, and replacing their thinking and beliefs that result in substance abuse and criminal behaviors. Treatment strategies include education, group therapy, reinforcement, modeling, rehearsal, and skill building. . . . Structured curriculum, written by MN DOC treatment providers in partnership with Hazelden Foundation, focuses on treatment readiness, criminal and addictive thinking, drug education, socialization, co-occurring disorders, relapse prevention, community reintegration, and victim impact. All components of treatment are designed to enhance a client's ability to maintain sobriety and conduct himself/herself in a pro-social, law-abiding manner.

Id.

²¹⁷ *See supra* Part III.A.

²¹⁸ NAT'L ACADS. OF SCI., ENG'G, & MED., *supra* note 4, at 35–39.

²¹⁹ *See* ACLU-WASH., *supra* note 185. Methadone treatment policies at Whatcom County Jail were not unlike those currently in place in the DOC. *Id.* The policies at Whatcom County Jail resulted in a class action lawsuit.

²²⁰ *See supra* Part V.D.

²²¹ *See CODAC at the RI Adult Correctional Institutions*, CODAC BEHAVIORAL HEALTHCARE, <https://codacinc.org/programs-services/ri-aci/> [<https://perma.cc/HHE3-Y49D>] (demonstrating how CODAC operates methadone clinics within Rhode Island County Jails).

²²² *See* Becker, *supra* note 76 (demonstrating how Franklin County Jail established its own jail-run methadone clinic).

challenging for the inexperienced.

The DOC has the opportunity to be a leader by approaching methadone from an evidence-based perspective and promoting induction and maintenance on methadone during incarceration. Studies show methadone maintenance should be ongoing throughout the duration of incarceration, not simply tapered off at the beginning of a prison sentence or started just prior to someone being released from prison.²²³

Minnesota policymakers also bear responsibility for advancing necessary change.²²⁴ “Policymakers should provide resources and introduce policy changes to help jails and prisons offer medication and counseling for OUD and help people transition to community-based care as they leave incarceration.”²²⁵ Policymakers can request data from state agencies that show the type of substance use issues in prison and illustrate where needs lie.²²⁶ Viewing the requested data will help policymakers understand which “regulatory and programmatic interventions are necessary and help estimate the needed funding to support jail- and prison-based treatment and re-entry services.”²²⁷ Once jails and prisons receive funding for new programming, policymakers should remain supportive throughout program implementation.²²⁸

²²³ Jeffrey A. Wickersham, Ruthanne Marcus, Adeeba Kamarluzaman, Muhammad Muhsin Zahari & Frederick L. Alice, *Implementing Methadone Maintenance Treatment in Prisons in Malaysia*, BULL. OF THE WORLD HEALTH ORG. 124–29 (2013), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3605007/> [<https://perma.cc/L8J3-WAEU>]. Prison-based methadone treatment has great potential for reducing HIV infection rates among prison inmates and the general population. *Id.* While implementing a prison-based methadone program is difficult, methadone continues to be the most efficacious medication available. *Id.* Other medications used to treat OUD, such as naltrexone and buprenorphine, show lower treatment adherence than methadone. *Id.* Study of Malaysia’s prison-based methadone program could prove useful for other countries that also struggle with high rates of OUD and HIV infection among prison inmates. *Id.*

Intervention should not focus on exclusively using methadone as an intervention just prior to an inmate’s release from prison. *Id.* Instead, methadone treatment “should be leveraged throughout the period of incarceration not only to ensure continuity of care for . . . participants, but also to ensure adequate methadone dosing before release from prison to avoid the risky injection of opioids within prison.” *Id.*

²²⁴ *Opioid Use Disorder Treatment in Jails and Prisons*, PEW CHARITABLE TRUSTS, (Apr. 23, 2020), <https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2020/04/opioid-use-disorder-treatment-in-jails-and-prisons> [<https://perma.cc/Y6DP-PPAW>].

²²⁵ *Id.*

²²⁶ *Id.*

²²⁷ *Id.* “It may also be necessary to fund integrated data systems that facilitate health information exchange and care continuity across settings.”

²²⁸ *Id.* Policymakers should:

expect prompt program implementation but be mindful that these facilities need time to develop the necessary medication and counseling program protocols, calculate demand for services, launch the program, and coordinate with other

If the DOC does not adapt its approach to OUD treatment, Minnesota may face legal action much like that seen in *Kortlever*.²²⁹ Similar to the Whatcom County Jail, the Minnesota DOC provides medication and healthcare to its inmates, but methadone treatment is reserved only for pregnant females with OUD. As demonstrated in *Kortlever*, this is disparate treatment under the ADA. The DOC has a responsibility to offer all inmates with OUD access to life-saving treatment.

VIII. CONCLUSION

Whether spurred forward by research initiatives or reluctantly thrust into progressive action by court injunctions, some states have had to reconsider their policies regarding methadone during incarceration. The policy reasons for doing so are persuasive—reduction in overdoses, deaths, disease transmission, and recidivism. The legal rationale holds as well, with plaintiffs filing valid claims under the ADA and Eighth Amendment. As the opioid epidemic continues, prisons are in a unique position to impact individuals and society by offering those with OUD methadone treatment during incarceration. The question remains whether they will.

agencies such as Medicaid and the state's substance use disorder . . . agency. Policymakers should request regular updates on persons served and the program's successes and challenges.

Id.

²²⁹ ACLU-WASH., *supra* note 185.