

How the Failure to Provide Treatment for Substance Use  
in Prisons and Jails Fuels the Overdose Epidemic

# Over-Jailed and Un-Treated



**ACLU**

How the Failure to Provide Treatment for Substance Use  
in Prisons and Jails Fuels the Overdose Epidemic

# Over-Jailed and Un-Treated

**ACLU**

© 2021 AMERICAN CIVIL LIBERTIES UNION

Cover Photo © Shutterstock/kittirat roekburi

# Contents

Executive Summary.....	4
Why Jails and Prisons Must Provide MAT.....	6
What’s at Stake: The Stories of People Who Have Been Denied MAT While Incarcerated.....	6
MAT Is the Standard of Care for Opioid Use Disorder.....	7
Denying MAT to Incarcerated People Has Deadly Consequences.....	8
Consensus on Providing MAT Is Growing Among Corrections Officials, Prosecutors, and the Federal Government.....	9
MAT Can Be Safely and Effectively Administered in Jails and Prisons.....	10
Providing MAT in Corrections Facilities Is Affordable.....	10
Providing MAT Is Not Swapping One Addiction for Another.....	11
What Is Driving Reform?.....	12
Lawsuits.....	12
Shifting Landscape.....	14
Actions Taken by Local, State, and Federal Lawmakers, Organizers, Correctional Officials, and Policymakers.....	16
The Limitations of Current Reform Efforts.....	20
Naltrexone-only Programs/Programs That Don’t Offer All Three Medications at the Proper Dosage.....	20
Unreasonable Delays in Treatment.....	21
Unnecessary Restrictions on Participation.....	21
Use of MAT Program to Justify Further Incarceration.....	22
What Real Reform Looks Like: Recommendations for Policy and Practice.....	23
Ensure MAT Is Available to Everyone for Whom It Is Clinically Indicated ...	23
Push for Both Maintenance and Induction of MAT.....	23
Collect Data on Provision of MAT and Its Benefits.....	23
Connect to Community Care.....	24
Strategies to Advocate for MAT in Jails and Prisons.....	25
Create a Media and Advocacy Strategy Responsive to Your State.....	25
Reach Out to Local Corrections Officials/Decision Makers and Offer to Collaborate.....	25
Share Evidence From Other States/Localities.....	25
Refer to the science and the data.....	26
Conclusion.....	27
Endnotes.....	28

# Executive Summary

This report focuses on an ongoing crisis in many of America's jails and prisons: the near total denial of medication for addiction treatment (MAT) for people with opioid use disorder (OUD). Despite a crisis of overdose deaths, which have spiked further in the wake of COVID-19, many jails and prisons are ignoring a vital public health tool that is proven to curb the deadly effects of the opioid epidemic.

MAT is basic healthcare for individuals with OUD. There are three MAT medications approved by the Food and Drug Administration (FDA): methadone, buprenorphine, and naltrexone.<sup>1</sup> Methadone and buprenorphine are proven to be effective, while the evidence supporting the effectiveness of naltrexone is more limited.<sup>2</sup> In far too many jails and prisons around the country, none of these medications are available to incarcerated people with OUD, or only naltrexone is available. OUD is common in jails and prisons, affecting nearly a quarter of the incarcerated population.<sup>3</sup> This denial of treatment leaves people with OUD at a much higher risk of relapse and overdose upon release from incarceration.<sup>4</sup>

MAT is a practical solution to this problem. MAT reduces the risk of death from any cause by 85%, and the risk of death from an overdose by 75% in the weeks following release.<sup>5</sup> As discussed herein, there is a growing consensus among policy makers, medical professionals, and corrections officials that MAT is appropriate for incarcerated people with OUD. And many of the jails and prisons that have implemented MAT programs report that it is affordable and can be safely administered.

There is a quickly growing contingent of jails and prisons that are providing MAT. A number of factors

are driving this expansion of MAT in jails and prisons. First, courts have recently found that denial of MAT to people with OUD likely violates the Eighth Amendment's ban on cruel and unusual punishment, and also likely amounts to disability discrimination under the Americans with Disabilities Act. Second, as the opioid epidemic has wreaked havoc in communities

---

**MAT reduces the risk of death from any cause by 85%, and the risk of death from an overdose by 75% in the weeks following release.**

---

over the past decade, there has been growing consensus that OUD should be treated as a disease rather than criminalized. This change is thanks in large part to activists, MAT providers, and people directly impacted by the opioid epidemic sharing their stories. Finally, some state, local, and federal actors have taken proactive steps to require access to MAT in jails and prisons. Together, these changes have built significant momentum toward ensuring that all incarcerated people with OUD have access to MAT.

While this growing momentum is exciting, not all reform efforts have lived up to their promise. Advocates should be mindful of several common loopholes in MAT legislation and policies:

- Some programs try to pass themselves off as comprehensive MAT programs but offer only one or two of the three FDA-approved MAT medications. Others require that dosages of MAT be so low that they are clinically ineffective. Incarcerated people should have meaningful access to whichever of the three MAT medications is medically appropriate for them at a clinically appropriate dosage.



Photo © AP/Ted S. Warren

- Some programs don't allow MAT for the entire time a person is incarcerated. Some only provide MAT for a few weeks before forcibly tapering an individual off of their treatment plan. Some jails and prisons offer MAT only to people with, for example, six months left on their sentence. This sort of program ignores the fact that OUD needs to be treated the entire time that someone is incarcerated, especially since there were more than 900 overdose deaths in jail between 2000–2013.<sup>6</sup> Denying MAT to an individual for any time while they are incarcerated leaves them at a significantly higher risk of relapse, overdose, and death. An effective MAT program should offer the

appropriate medication for the length of time that is clinically appropriate for that patient, without time restrictions not rooted in medical necessity.

- Some jails and prisons offer MAT only to people who were already on it before being incarcerated, and not to people who have OUD and have a clinical need for MAT but have not accessed it in their communities. MAT should be available to every incarcerated person for whom it is clinically appropriate, regardless of whether they have been on it previously. It is also important that jails and prisons engage in prerelease planning to connect incarcerated people to community care upon release, so that formerly incarcerated people can continue their treatment without interruption.
- Some MAT programs threaten to kick individuals off their MAT for disciplinary reasons, such as a disciplinary write-up, a failed drug test, or even missing a therapy appointment. This sort of punitive approach would be unthinkable in any other medical context. No one would take someone with diabetes off their insulin if they were written up, and if they did, it would be plainly unconstitutional. MAT should remain available to everyone who needs it, just like any other medication.
- Some judges and prosecutors have used MAT programs in jails and prisons as a reason to incarcerate people, rather than keep them in the community. No one should be going to jail or prison in order to get treatment. Treatment is most successful in the community, where people have access to their support systems. However, when jail or prison time is unavoidable, it is essential that treatment not be interrupted.

# Why Jails and Prisons Must Provide MAT

## What's at Stake: The Stories of People Who Have Been Denied MAT While Incarcerated

The opioid epidemic is ravaging communities across the nation. On average, 130 Americans die every day from an opioid overdose.<sup>7</sup> In 2019, 49,860 people died of opioid overdose.<sup>8</sup> These deaths cut across all racial groups, but were especially concentrated among non-Hispanic white people (19.4 deaths per 100,000 people); non-Hispanic American Indian/Alaska Native people (15.7 deaths per 100,000 people); and non-Hispanic Black people (12.9 deaths per 100,000 people).<sup>9</sup> And as COVID-19 wears on and people are more isolated from support systems, have less access to treatment, and are less likely to be employed, the opioid epidemic is getting even worse.<sup>10</sup>

In the era of mass incarceration, jails and prisons are unfortunately on the frontlines of this public health crisis, yet many correctional institutions are not providing even the most basic medical care for opioid use disorder. Denying medication for addiction treatment to incarcerated people with opioid use disorder is bad for everybody — from the people directly impacted to the corrections officials who are charged with keeping their institutions safe. And the impact is far-reaching. About a quarter of the prison and jail population in the United States has OUD.<sup>11</sup> Instead of fighting the opioid epidemic, American jails and prisons are *fueling* it by forcing thousands of people off their medications for addiction treatment<sup>12</sup> like methadone and buprenorphine. Not only does this lead to brutal withdrawal symptoms, it also makes it far more likely that incarcerated people will relapse and experience

an overdose either while incarcerated or upon release. Over 10% of jail deaths are attributed to drug or alcohol intoxication, compared to just 4% of jail deaths in 2000.<sup>13</sup> Denying MAT to incarcerated people also increases the chances that these individuals will get re-arrested.

Take the story of Brenda Smith,<sup>14</sup> for example. Ms. Smith was sentenced to 40 days in a county jail for taking \$40 that someone else had left behind at the Walmart self-checkout. Despite having been in recovery for 10 years, she was at risk of losing her access to medication just because she had to serve time in jail. For 10 years, Ms. Smith had been on buprenorphine (one of the three FDA-approved medications for treatment of OUD), which she described as making her feel “normal.” In those 10 years, she had regained custody of her children and secured a job and housing. She was a success story. But the jail refused to allow

---

About a quarter of the prison and jail population in the U.S. has opioid use disorder.

---

her to stay on buprenorphine, despite the fact that it had been crucial to her success. This was not based on any medical rationale, but rather based solely on the decision of a jail administrator with no medical training. Indeed, this sort of nonmedical blanket

policy underscores the stigma that people with OUD face. Ms. Smith knew the high stakes of being denied her medication – she had a cellmate from a previous incarceration in a local jail who overdosed and died shortly after her release from jail after being denied her medication.

Similarly, with the help of methadone, Geoffrey Pesce<sup>15</sup> had been in recovery from opioid use disorder for two years when he faced jail time for a probation violation related to driving on a suspended license. While addicted to opioids, Mr. Pesce had lost custody of his son, his home, and his job. Mr. Pesce had tried both buprenorphine and naltrexone, two FDA-approved medications for opioid use disorder. Neither medication had worked for him. It was only methadone, a third FDA-approved medication for opioid use disorder, that had helped him achieve recovery. Since being on methadone, he had been able to work as a machinist and spend time with his son. His incarceration threatened his access to the only medication that had ever helped him manage his opioid use disorder – methadone.

Fortunately for both Ms. Smith and Mr. Pesce, the ACLU was able to intervene. In two lawsuits, federal courts in Maine and Massachusetts required county jails to provide them their medication for addiction treatment.

But thousands of other incarcerated people are being denied their medication for addiction treatment every day that they are in jail or prison, making it far more likely that they will overdose while they are incarcerated or upon their release, or that they will end up back in jail or prison (see Section II.c below). The lack of medication for addiction treatment also creates a powerful demand for opioids inside of jails and prisons, making jails and prisons more dangerous. For too many, there is no time to wait for another lawsuit. Providing medication for addiction treatment to incarcerated people is a matter of life and death. And lives are wasted when legislators and corrections officials fail to provide medication for addiction treatment.

The good news is that the tide is starting to turn. Litigation brought by the ACLU and our partners in

places like Illinois, Kansas, Massachusetts, Maine, and Washington have successfully expanded access to medication for addiction treatment in both local jails and state and federal prisons. Additionally, promising legislative and executive action has led to expansion of medication for addiction treatment in places like Maryland, Michigan, Pennsylvania, Rhode Island, and Vermont. Finally, grant programs sponsored by the federal government, state governments, and private foundations have created resources to expand MAT programs in correctional settings. All told, medication for addiction treatment is available in three times as many facilities as it was just two years ago.<sup>16</sup>

**But the fight is not over. All three forms of medication for addiction treatment must be available to everyone in jails and prisons for whom it is clinically appropriate – in the dosage and duration determined in consultation with qualified medical providers.**

## MAT Is the Standard of Care for Opioid Use Disorder

MAT is the standard of care for treating people with opioid use disorder. Three medications are FDA-approved: methadone, buprenorphine, and naltrexone.<sup>17</sup>

Buprenorphine and methadone both help prevent withdrawal symptoms and cravings by activating the opioid receptors. They are known as opioid agonists.<sup>18</sup> These medications do not get a patient “high,” but rather create a steady state where a patient feels normal again, after having their brain chemistry rewired by addiction.<sup>19</sup>

Naltrexone, an opioid antagonist, helps reduce cravings by blocking the receptors in the brain, but does not prevent withdrawal, and it requires that a patient not use any opiates for over a week before starting.<sup>20</sup> A shot of Vivitrol, which is a large dose of naltrexone, can stave off cravings for up to one month.<sup>21</sup> However, this medication can only be used after a

person has completely gone through withdrawal. They must also get another shot at the end of the month, or they will have a lower tolerance for opioids and will be at a higher risk of overdose and death.<sup>22</sup>

Buprenorphine and methadone significantly reduce the risk of an opioid overdose, while the risk of an opioid overdose during treatment with an opioid antagonist like naltrexone was not significantly different than the risk to a person receiving no treatment at all.<sup>23</sup> However, naltrexone is effective for some patients, especially those who voluntarily choose not to be on methadone or buprenorphine. It is important that all three FDA-approved medications be available, as different medications are appropriate for different patients based on their individual medical needs, as determined by themselves and their doctor.

Additionally, all three medications should be available for the length of time that a doctor prescribes. For many people, MAT can be appropriate for years or even a lifetime, like many other medications for chronic diseases, like insulin for diabetes or ACE inhibitors for high blood pressure.<sup>24</sup>

## Denying MAT to Incarcerated People Has Deadly Consequences

The opioid epidemic is especially concentrated in America's jails and prisons. About a quarter of the prison and jail population has OUD.<sup>25</sup> This is not an accident, given that we have harshly criminalized drug use and possession through the war on drugs. The availability of MAT inside of a jail or prison should never be a reason to incarcerate someone, but rather is a harm reduction tool to better serve people who are incarcerated.

This concentration of people with OUD means that, without access to MAT agonists, a sizeable chunk of the jail and prison population will experience the brutal symptoms associated with opioid withdrawal. Acute

withdrawal symptoms include insomnia, hot and cold sweats, muscle aches and pains, cramping, nausea, vomiting, and diarrhea.<sup>26</sup> These symptoms can last for one to four weeks.<sup>27</sup> Post-acute withdrawal symptoms include mood swings and disturbed sleep and can last up to two years.<sup>28</sup> Not only is this suffering painful, it is entirely medically unnecessary. MAT could prevent most or all of the withdrawal symptoms.<sup>29</sup>



Photo © Shutterstock/PureRaiancePhoto

Providing MAT for people in jails and prisons is lifesaving. Withdrawal can lead to death if symptoms are not properly managed or if the individual has another serious disease, which is common in jails and prisons.<sup>30</sup> Especially in the context of a corrections setting, intentionally ignoring a medical condition that can lead to mood swings is dangerous, because suicide is a leading cause of death in correctional facilities.<sup>31</sup> Even after acute and post-acute withdrawal, MAT remains critically important to people while they are incarcerated, because MAT makes it less likely that they will die of an overdose while they are still incarcerated.<sup>32</sup> The risk of unnatural death (including overdose, suicide, and other preventable causes) was 87% lower for incarcerated people on MAT compared to incarcerated people with OUD not on MAT.<sup>33</sup> Indeed, over 10% of jail deaths are attributed to drug or alcohol intoxication, compared to just 4% of jail deaths in 2000.<sup>34</sup> This underscores that MAT is not only necessary for people being released back into



the community, but for incarcerated people during the course of their incarceration.

The risk of overdose upon release from jail or prison is enormous when incarcerated people with OUD are not treated with MAT. In the first two weeks after release from a correctional institution, formerly incarcerated people are far more likely to die of a fatal heroin overdose than the general population. One study found that they were 129 times more likely to die of an overdose,<sup>35</sup> while another study found that they were 56 times more likely to die of an overdose.<sup>36</sup> This spike is unsurprising, given that formerly incarcerated people will have lower tolerance for opioids after being forcibly withdrawn from their lifesaving medication. Providing MAT during incarceration makes it far less likely that someone will experience an overdose upon release. A study shows an 85% decrease in overdose deaths and a 75% decrease in all-cause mortality in the first four weeks after release for people who were maintained on MAT in a corrections setting.<sup>37</sup> That is, people who are forced off of their MAT are seven times as likely to die of an overdose. Since there is a significant risk of relapse, overdose, and death during incarceration, in

---

The risk of overdose, suicide, and other preventable causes was 87% lower for incarcerated people on MAT compared to incarcerated people with OUD not on MAT.

---

addition to these risks upon release from incarceration, it is extremely important that individuals receive MAT throughout their entire incarceration, and not just in the days and weeks before release.

## Consensus on Providing MAT Is Growing Among Corrections Officials, Prosecutors, and the Federal Government

The number of jails and prisons providing MAT has tripled over the past three years.<sup>38</sup> In a 2018 report, the National Sheriffs' Association and the National Commission on Correctional Health Care (NCCHC) explain that "correctional withdrawal alone actually increases the chances the person will overdose following community release due to loss of opioid tolerance" and recommend "[f]or this reason, all individuals with OUD should be considered for MAT" while incarcerated.<sup>39</sup> The American Society of Addiction Medicine, the leading professional society in the country on addiction medicine, also recommends treatment with MAT for people with OUD in the criminal justice system.<sup>40</sup> Additionally, the Substance Abuse and Mental Health Services Administration states that "making treatment available to criminal justice populations" is one of the "remaining challenges" in fighting the opioid epidemic.<sup>41</sup>

The federal government has encouraged expanding access to MAT in jails and prisons. In 2017, the President's Commission on Combating Drug Addiction and the Opioid Crisis, led by Gov. Chris Christie, recommended providing MAT for pretrial detainees.<sup>42</sup> Additionally, the Trump administration identified "increasing the availability of MAT for incarcerated individuals" as a priority initiative.<sup>43</sup> Joe Biden's presidential campaign called for "the public health and criminal justice systems to provide evidence-based substance use disorder treatment, including MAT, for people during their incarceration and after their release."<sup>44</sup> And the Biden Administration identified

“expanding access to evidence-based treatment for incarcerated individuals” as a priority for their first year in office.<sup>45</sup>

Momentum for MAT is also growing elsewhere in the federal government. The U.S. Department of Justice recently concluded that denial of MAT to incarcerated people in a New Jersey county jail amounted to an Eighth Amendment violation.<sup>46</sup> Some U.S. Attorneys also support expanding access to MAT. The U.S. Attorney for Massachusetts investigated several county correctional facilities and the Massachusetts Department of Corrections for failing to provide MAT to incarcerated people who have OUD, stating that “all individuals in treatment for OUD, regardless of whether they are inmates or detainees, are already protected by the ADA, and the DOC has existing obligations to accommodate this disability.”<sup>47</sup> In New York, the U.S. Attorney for the Southern District wrote a letter to the state Attorney General stating that “MAT is a safe and widely accepted strategy for treating opioid disorders,” with “broad support among medical and substance use experts.”<sup>48</sup> The letter went on to instruct that “the Sullivan (County) family court and Sullivan (County) surrogate’s court should ensure that their policies and practices with respect to individuals participating in MAT ... are consistent with ADA requirements.”<sup>49</sup>

## MAT Can Be Safely and Effectively Administered in Jails and Prisons

A common objection is that MAT cannot be administered safely in a correctional setting.<sup>50</sup> The reality is that *refusing* to administer MAT makes facilities less safe. When left untreated, people with opioid use disorder have unmet medical needs. Without access to MAT, incarcerated people are more likely to find ways to self-medicate, which could include illicitly getting medications like methadone and buprenorphine or illegal drugs like heroin or fentanyl inside the facility.

This is not a character flaw or moral failing, but rather a symptom of OUD itself.

The reality on the ground is that many facilities around the country are now safely administering MAT. For example, Dr. Ruth Potee, the medical director of the Franklin County House of Correction (a rural jail in Massachusetts that has a robust MAT program), testified to the common-sense safety precautions taken in her facility: “Buprenorphine and all controlled substances are stored in locked cabinets with controlled access. The supply is subject to a ‘count’ with every shift change, along with needles, syringes and scalpels. To prevent patients from ‘cheeking’ or diverting pills, inmates receive their medication in a crushed form, their mouths are inspected before and after administration, and they are required to eat a cracker and drink a glass of water after receiving their medication.”<sup>51</sup> Additionally, she testified that since implementation of the MAT program in the Franklin County House of Correction, they have seen a decrease in disciplinary issues and illegal drug use.<sup>52</sup> MAT has also been successfully implemented in many facilities throughout the country, as detailed in this report.

## Providing MAT in Corrections Facilities Is Affordable

Another common objection to providing MAT in jail or prison is concern about the cost.<sup>53</sup> This concern is misplaced. MAT is basic medical care for OUD, and jails and prisons have a constitutional obligation to provide adequate medical care, regardless of the cost. Moreover, provision of MAT – besides being the right thing to do and required by law – is not particularly costly, and the savings may be enormous. There has been significant federal investment in combating the opioid epidemic. For example, the federal government made over \$3 billion in State Opioid Response funding available in 2019 and 2020.<sup>54</sup> There may be appetite for even more funding. Last Congress saw bipartisan legislation introduced that would create a federal grant program administered by the U.S. Department of Justice aimed

at expanding MAT in jails and prisons around the country.<sup>55</sup>

Even without state or federal funding, the costs of providing this lifesaving medicine are far from prohibitive. Sheriff Craig Apple in Albany County, New York, set up a MAT program with all three medications serving 110 participants.<sup>56</sup> The total program operational costs for the first six months was \$30,202 — *roughly \$275 per person served* — with startup costs of \$15,555.<sup>57</sup>

But even this cost estimate may be high, as it does not consider the savings that taxpayers will realize from providing lifesaving medication to individuals caught in the opioid epidemic. A study in California, outside of the prison context, found that providing treatment saves approximately \$17,550 per person treated over six months, compared to forcing detoxification.<sup>58</sup> The savings are realized in lower crime and less money spent on policing and incarceration.

We have every reason to believe the same cost savings would be realized across the country. First, providing MAT leaves these individuals in a better position to maintain a job, keep a roof over their heads, and care for their families upon release. According to a survey by the Bureau of Justice Statistics, nearly four in 10 property crimes, such as burglary, are motivated by a desire to get money for drugs.<sup>59</sup> Additionally, with a significant dip in overdoses upon release for people who were on MAT during their incarceration, there will be less of a burden on limited community healthcare resources. Providing treatment for people with opioid use disorder will not only help those individuals, it will make communities safer and reduce losses to criminal activity.

Second, people receiving MAT are less likely to end up back in jail.<sup>60</sup> This saves tax dollars, as the average annual cost of incarcerating an individual is over \$33,000.<sup>61</sup> Rather than paying to house and supervise an incarcerated person for behavior related to opioid use disorder, people who receive treatment can help support themselves and their families, contribute to their communities, and flourish outside of prison walls.

---

A California study, outside of the prison context, found that providing treatment saves approximately \$17,550 per person treated over six months, compared to forcing detoxification.

---

## Providing MAT Is Not Swapping One Addiction For Another

Yet another common objection is that people on MAT are simply swapping one addiction for another.<sup>62</sup> But this view is rooted in stigma, not science or fact. MAT does not get an individual “high.” Instead, it returns people with OUD to a steady state where they once again feel normal.<sup>63</sup> While some individuals may be on MAT for years or a lifetime, that does not mean that they are “addicted” to MAT. Rather, they need a medication that enables them to live healthy and productive lives in the face of a disease that has permanently altered their brain chemistry. This is quite similar to treatment for other chronic diseases, like providing insulin for many years or a lifetime to treat diabetes.

# What Is Driving Reform?

There are several factors that are driving reform across the nation. Among them are successful lawsuits against jails and prisons, vindicating the constitutional and civil rights of incarcerated people with OUD. The robust medical and scientific consensus around the appropriateness of MAT makes the case for providing MAT in jails and prisons much stronger. And, finally, faced with the devastation caused by the opioid epidemic, leaders across the country are taking steps to expand access to MAT through legislation, regulation, and private grant funding.

## Lawsuits

Around the country, courts have started to recognize that providing MAT in jails and prisons is not only good policy, but that it is legally required under the Rehabilitation Act, the Americans with Disabilities Act, and the Eighth Amendment.

### **Denying MAT Is Discrimination Based on a Disability, Which Violates the Americans with Disabilities Act**

Denying MAT to an individual with OUD is discrimination based upon a recognized disability. Title II of the Americans with Disabilities Act prohibits jails and prisons from discriminating against a qualified individual with a disability on the basis of that disability.<sup>64</sup> Federal regulations state that a drug addiction that substantially impairs one or more life activities is a recognized disability under the

Americans with Disabilities Act.<sup>65</sup> Public entities are prohibited from “deny[ing] health services, or services provided in connection with drug rehabilitation, to an individual on the basis of that individual’s current illegal use of drugs, if the individual is otherwise entitled to such services.”<sup>66</sup>

The ADA was crucial in both the *Smith*<sup>67</sup> and *Pesce*<sup>68</sup> cases brought by the ACLU of Maine and the ACLU of Massachusetts, respectively (discussed above). In *Smith*, the court found that “[t]he Defendants’ out of hand, unjustified denial of the Plaintiff’s request for her prescribed, necessary medication – and the general practice that precipitated that denial – is so unreasonable as to raise an inference that the Defendants denied the Plaintiff’s request because of her disability.”<sup>69</sup> The court also characterized the jail’s attitude toward incarcerated people with OUD as “apathetic.”<sup>70</sup> The court required the jail to provide Ms. Smith with buprenorphine, as prescribed by her doctor.<sup>71</sup> The jail appealed this decision and it was affirmed by the First Circuit.<sup>72</sup>

In *Pesce*, the court took notice of the fact that, in the past, Mr. Pesce had attempted to use both buprenorphine and naltrexone, but had been unsuccessful.<sup>73</sup> Methadone was the medication that helped him achieve recovery for two years.<sup>74</sup> The court focused on the jail’s refusal to do an individualized medical assessment of Mr. Pesce to determine his medical needs,<sup>75</sup> instead requiring “Pesce to participate in a treatment program that bears strong resemblance to the methods that failed Pesce.”<sup>76</sup> The court found that the jail’s reliance on a blanket policy denying methadone treatment based on a security rationale, not a medical rationale, violated the ADA.<sup>77</sup>



### Denying MAT Violates the Constitutional Prohibition on Cruel and Unusual Punishment

There is a right to medical care under the Eighth Amendment for incarcerated people and under the Fourteenth Amendment for pretrial detainees.<sup>78</sup> The Eighth Amendment prohibits cruel and unusual punishment.<sup>79</sup>

In *Pesce*, the court ruled on the Eighth Amendment claim. Similar to the court's analysis on the ADA claim, the court found that ignoring Mr. Pesce's physician's clinical judgment on providing him his prescribed methadone made it likely that Mr. Pesce could prove that they violated his constitutional right to adequate medical care.<sup>80</sup>

Before *Pesce*, other cases vindicated the right to access methadone, treatment for methadone withdrawal, and other related conditions in prison and jail. While *Pesce* and *Smith* are unique in their focus on a lack of treatment for opioid use disorder, most of the following cases focus on a lack of treatment for withdrawal symptoms. These cases demonstrate the well-established constitutional guarantee of medical care for incarcerated people in the context of drug treatment.

*Cudnik v. Kreiger*, a case from the 1970s, found that pretrial detainees already on methadone in the community had a right to methadone while detained.<sup>81</sup> The sheriff had made a categorical ban on methadone in the prison, similar to the bans in *Pesce* and *Smith*,

that provided no room for individualized medical judgments.<sup>82</sup> The court determined that pretrial detainees had an interest in continuing methadone treatment.<sup>83</sup> It found that there was no security risk in administering methadone in the facility that could not be properly managed, especially given the fact that it had been administered safely at other facilities in the metropolitan area.<sup>84</sup>

In *Alvarado v. Westchester County*,<sup>85</sup> the court found that where prison officials misled incarcerated people about the availability of a methadone program, the incarcerated people had plausibly alleged a constitutional violation.<sup>86</sup>

In *Foelker v. Outagamie County*,<sup>87</sup> the court found that a reasonable jury could conclude that the jail nurse and social worker violated Foelker's constitutional rights by denying him access to methadone.<sup>88</sup>

In *Strain v. Sandham*,<sup>89</sup> the court found that cutting off an incarcerated person's methadone "cold turkey" after several years of methadone treatment at another prison could amount to a constitutional violation.<sup>90</sup> The court said a constitutional violation could be found where prison officials "deliberately ignore the express orders of a prisoner's prior physician for reasons unrelated to the medical needs of the prisoner."<sup>91</sup>

In *Anderson v. Benton County*,<sup>92</sup> the court found that a reasonable jury could believe a plaintiff's expert, who claimed that a reasonable medical professional would know that immediate cessation of methadone would cause severe withdrawal symptoms.<sup>93</sup>

In *Gonzalez v. Cecil County, Maryland*,<sup>94</sup> the court found that the administration of blood pressure medication and an over-the-counter stomach remedy to someone experiencing heroin withdrawal were not enough to dismiss the case. The incarcerated person eventually died of complications from heroin withdrawal.<sup>95</sup>

In *Quatroy v. Jefferson Parish Sheriff's Office*,<sup>96</sup> the court found that jail employees knew of an individual's methadone use and knew he would go through withdrawal without it, and yet they failed to treat him, ultimately leading to his death.<sup>97</sup> The court therefore

denied the Sheriff's Office's motion to dismiss the lawsuit.

### Settlements/Positive Resolutions to Cases

In addition to the cases in Maine and Massachusetts that went to a final ruling before the court, other jails and prisons have entered into the following settlements and resolutions to cases.

#### ***Finnigan v. Mendrick***<sup>98</sup>

In *Finnigan*, the DuPage County Jail represented to the court that they were strongly considering giving the plaintiff, Christine Finnigan, her methadone, as long as it was clinically indicated. Given this representation, the court found that the case was not yet ripe for adjudication. Soon thereafter, the jail gave Ms. Finnigan her methadone upon arrival to the jail. She was the first non-pregnant person in five years to receive methadone at the DuPage County Jail.

#### **Settlement, *Sclafani v. Mici***<sup>99</sup>

Three plaintiffs sued the Massachusetts Department of Corrections. The Department settled the case, agreeing to provide the plaintiffs buprenorphine throughout the course of their incarceration.

#### **Settlement, *Godsey v. Sawyer***<sup>100</sup>

The ACLU of Washington sued the federal Bureau of Prisons. It resulted in a settlement granting Melissa Godsey access to buprenorphine while in prison at FCI Dublin.

#### **Settlement, *Crews v. Sawyer***<sup>101</sup>

The ACLU of Kansas brought a suit against the federal Bureau of Prisons that resulted in a settlement granting Leaman Crews access to methadone while in federal prison in Leavenworth.

#### **Settlement, *DiPierro v. Hurwitz***<sup>102</sup>

The ACLU of Massachusetts sued the federal Bureau of Prisons. In a final settlement agreement, the prison agreed to provide Stephanie DiPierro with her methadone treatment throughout the duration of her incarceration.

#### **Settlement, *Smith v. Fitzpatrick***<sup>103</sup>

The ACLU of Maine settled with the Maine Department of Corrections, which allowed Zachary Smith to receive MAT while incarcerated.

#### **Settlement, *Kortlever v. Whatcom County***<sup>104</sup>

A class of pretrial detainees sued Whatcom County. This settlement broke new ground by not only securing MAT maintenance for incarcerated people who were already receiving MAT, but also securing MAT induction for incarcerated people with OUD who were otherwise untreated in the community. The settlement agreement also limited the use of medically assisted withdrawal: "The taper must be optional for the inmate provided they fit the clinical parameters for participation, and not at the expense of their ability to participate in MAT maintenance or induction."<sup>105</sup> Further, the agreement stipulated that there be no requirement to have behavioral health treatment in order to receive MAT, though MAT patients would have the same access to behavioral health treatment as all other people incarcerated in Whatcom County.<sup>106</sup> There was also an agreement to extensively advertise the MAT program within the prison.<sup>107</sup>

## Shifting Landscape

### **The Medical Consensus of MAT as the Standard of Care**

Medical consensus about the efficacy of MAT has contributed to the growing momentum for providing MAT in jails and prisons. MAT is the standard of care for people with opioid use disorder.<sup>108</sup> With a much richer scientific literature around the efficacy of MAT, it is now easier to make the case that jails and prisons that deny MAT to people with OUD are violating their civil and constitutional rights. In order to demonstrate deliberate indifference on the part of prison and jail medical staff for purposes of the Eighth Amendment, it is important to show that treating OUD with something other than MAT falls outside of the reasonable standard of care and is medically

unacceptable. Credentialed, experienced, and qualified medical experts can testify to the scientific literature that establishes MAT as lifesaving medical care. As discussed above, this literature includes a study that found a 75% decrease in all-cause mortality among incarcerated people receiving MAT and another study that found that upon release, incarcerated people who did not receive MAT were 129 times more likely to die of an overdose.

Just as people who have other chronic diseases like diabetes or heart disease are entitled to be adequately treated for their conditions in jail and prison, people with opioid use disorder have a right to be adequately

---

With richer science around the efficacy of MAT, it is easier to make the case that jails and prisons that deny MAT to people with OUD are violating their civil and constitutional rights.

---

treated. This right to care includes avoiding harms that do not risk immediate injury, but increase the risk of injury over time. For example, depriving an incarcerated person of their blood-thinning medication likely will not cause a stroke on Day 1. But depriving someone of blood-thinning medication dramatically increases the risk of a stroke or heart attack, and potentially death, over the longer term. Likewise — even setting aside the suffering inherent in withdrawal

— depriving someone of MAT dramatically increases their risk of catastrophic events such as relapse and overdose, up to and including death.

### The Deadly Toll of the Opioid Epidemic

The sheer human cost of the opioid epidemic has contributed to the shift in MAT policies in jails and prisons. Public awareness of the effect that opioids have on individuals has greatly increased in the wake of the opioid epidemic. Opioids were responsible for 49,860 overdose deaths in the United States in 2019.<sup>109</sup> 2020 was a record year for drug overdoses, with dramatic increases during the COVID-19 pandemic.<sup>110</sup>

Directly impacted people deserve credit for the shift in public support for treatment for OUD. Nearly anyone whose life has been touched by the opioid epidemic has a compelling story. Many of the impacted people will personally know someone who has overdosed or have overdosed themselves. Some risk factors for OUD include genetic predisposition and childhood trauma, and the details of these stories are often harrowing.<sup>111</sup> The legal papers in nearly all of the cases had long descriptions about the excruciating pain that the plaintiffs went through as a result of being denied their medicine and their success while on MAT. In *Finnigan*, Ms. Finnigan bravely talked about losing three of her four siblings in their twenties to heroin overdoses.<sup>112</sup> The *Smith* and *Pesce* decisions both described how MAT allowed Ms. Smith and Mr. Pesce be better parents, hold down a job and housing, and contribute more to society.

### A MAT Program Can Be Safely Implemented in Jails and Prisons

As more jails and prisons implement MAT programs, it is more and more difficult for jail administrators to argue that providing MAT is a practical impossibility. Many correctional facilities already provide MAT to pregnant people in their custody.<sup>113</sup> The National Sheriffs' Association and the NCCHC both support providing MAT in jails and prisons.<sup>114</sup> Additionally, the National Council for Behavioral Health released

a toolkit for how to implement a MAT program in jail and prison.<sup>115</sup> Contrary to corrections administrators' fears, Jennifer Clarke, medical director for the Rhode Island Department of Corrections, stated that the black market for drugs in prison "dried up" when MAT was made available to people with OUD.<sup>116</sup>

## Actions Taken by Local, State, and Federal Lawmakers, Organizers, Correctional Officials, and Policymakers

There has also been change thanks to the leadership of local, state, and federal lawmakers, organizers, corrections officials, and policymakers. While there has been significant expansion in access to MAT since the recent federal court decisions in Massachusetts and Maine, far too many jails and prisons still unconstitutionally deny MAT for people with OUD.

The job won't be done until all three forms of MAT are available to all incarcerated people for whom it is clinically indicated, at the dosage and for the length of time that it is clinically indicated. Leaders at all levels of government are taking steps toward reform.

### Federal Legislation and Policy

Last Congress, Sen. Ed Markey (D-MA) and Sen. Lisa Murkowski (R-AK) introduced the Community Re-Entry through Addiction Treatment to Enhance (CREATE) Opportunities Act, bipartisan legislation that would create a grant program within the Department of Justice for state and local governments to provide MAT in jails and prisons.<sup>117</sup> The legislation was reintroduced in the House by Reps. Annie Kuster (D-NH), Lisa Blunt Rochester (D-DE), Mike Turner (R-OH), and Jackie Walorski (R-IN).<sup>118</sup> The legislation would require grantees to provide at least two of the three FDA-approved MAT medications, meaning that at least one opioid agonist (methadone or buprenorphine) would need to be available.<sup>119</sup>

Additionally, the federal Bureau of Prisons (BOP), one of the largest prison systems in the country, issued Interim Technical Guidance in 2019 that allows all three forms of MAT in all of its facilities.<sup>120</sup> The interim guidance allows both MAT maintenance and MAT induction, meaning that anyone at the BOP, regardless of whether they were on MAT while in the community, could get access to treatment. There is still a long way to go in the BOP. The guidance states that approximately 10% of the BOP population would be eligible for MAT. However, a GAO report indicates that only six people in the BOP have been provided with opioid agonists like methadone and buprenorphine.<sup>121</sup> This is still a significant first step toward a robust MAT program in federal prisons across the entire country.

### State Legislation and Policy

This section will discuss different approaches states have taken in expanding MAT through legislation and regulations.

#### Rhode Island – Leadership of the Governor

The Rhode Island Department of Corrections, which has a unified jail and prison system, has been a trailblazer on the issue of MAT in corrections settings. The state's governor's office was the driving force behind a \$2 million appropriation for MAT in the budget for 2016, including all three forms of MAT.<sup>122</sup> The Rhode Island program has had an enormous amount of success in decreasing opioid related deaths in jails and in the state more generally. After implementing the program, Rhode Island saw a 60.5% drop in overdose deaths amongst incarcerated people and a 12.3% drop in overdose deaths statewide.<sup>123</sup> They have also been leaders in educating facilities across the country on how to implement MAT programs.<sup>124</sup>

#### Vermont – Legislation Mandating MAT

In 2018, the Vermont legislature passed legislation that dramatically increased access to MAT for incarcerated Vermonters. Like Rhode Island, Vermont also has a unified jail and prison system.



While the legislation has been successful in expanding MAT, there were some bumps in the drafting and implementation of the legislation. The legislation only requires MAT if it is “medically necessary.”<sup>125</sup> This was the primary ambiguity in the legislation that allowed the Vermont system to deny MAT to some people who would greatly benefit from MAT. We would suggest that states modeling their legislation on Vermont simply require that MAT be “clinically indicated,” rather than “medically necessary.”

Still, in order to combat this ambiguity, the legislature included language in the “legislative intent” section of the bill that clarified what “medically necessary” means. “It is the intent of the General Assembly that medication-assisted treatment offered at or facilitated by a correctional facility is a medically necessary component of treatment for inmates with opioid use disorder.”<sup>126</sup> Further, the legislature defined the term “medically necessary.” Medically necessary “describes health care services that are appropriate in terms of type, amount, frequency, level, setting, and duration to the individual’s diagnosis or condition, are informed by generally accepted medical or scientific evidence, and are consistent with generally accepted practice parameters. Such services shall be informed by the unique needs of each individual and each presenting situation, and shall include a determination that a service is needed to achieve proper growth and development or to prevent the onset or worsening of a health condition.”<sup>127</sup>

The Vermont law requires timely screening for substance use disorders upon admission to a corrections facility. “Within 24 hours after admission to a correctional facility, each inmate shall be screened for substance use disorders as part of the initial and ongoing substance use screening and assessment process. This process includes screening and assessment for opioid use disorders.”<sup>128</sup>

Section 801(e)(1) of the Vermont legislation explicitly names buprenorphine and methadone as medications that incarcerated people “shall be entitled to continue” pending an evaluation by a medical professional. Section 801(e)(2) provides that the Department of Corrections can defer provision of the medication if it is not “medically necessary” to continue the medication at

the time.<sup>129</sup> Section 801(e)(3) provides that the medical professional must give a reason for the discontinuance and that reason must be provided both orally and in writing to the incarcerated person and must be a “specific explanation ... with notice of the right to have his or her community-based prescriber notified of the decision.”<sup>130</sup>

Section 801b(b)(1) provides for induction, in addition to maintenance. This means incarcerated people who were not on MAT in the community can be started on MAT while incarcerated, if it is clinically appropriate. The incarcerated person “may elect to commence buprenorphine-specific MAT if it is deemed medically necessary by a provider authorized to prescribe buprenorphine.”<sup>131</sup> The legislation also allows the incarcerated person to switch from buprenorphine to methadone if it is deemed medically necessary by the provider and the incarcerated person elects to do so.<sup>132</sup> The legislation requires the DOC to coordinate with community providers to ensure continuity of care.<sup>133</sup>

The legislation explicitly prohibits a private cause of action, meaning individuals don’t have a right to sue to enforce the statute.<sup>134</sup>

While implementation of this legislation has improved, there were many challenges at the beginning of the process. The act went into effect on July 1, 2018. According to an article written in September 2018, most incarcerated people who were not on MAT in the community, but were clinically appropriate for MAT, did not receive MAT treatment until 30 days before their release date.<sup>135</sup> As of the article’s publication, only 52 of 549 requests for induction onto MAT had been approved.<sup>136</sup> One hundred and ninety-two incarcerated people who had MAT prescriptions in the community were able to stay on MAT.<sup>137</sup>

However, implementation has dramatically improved. By January 2019, 543 of the 1,750 people incarcerated by the Vermont DOC were receiving MAT;<sup>138</sup> 1,700 incarcerated people had been assessed for MAT since July 1, 2018; and more than 1,000 incarcerated people had received MAT.<sup>139</sup> While this is a significant improvement, there were still reports on the ground of some delays in treatment, inadequate coordination

of care upon release, and dosages of buprenorphine at lower than a therapeutic dose.

### **Maryland – Legislation Expanding MAT in County and Local Jails, but Not State Prisons**

In 2019, Maryland enacted legislation expanding access to MAT.<sup>140</sup> The law requires local jails to implement MAT programs for everyone for whom it is clinically indicated. It requires MAT for pregnant people in both state prisons and local jails “as soon as practicable.”<sup>141</sup> The legislation was scheduled to take effect in phases.

The MAT program created by the legislation went into effect in Howard, Montgomery, Prince George’s, and St. Mary’s counties on January 1, 2020. It will go into effect in six other counties on October 1, 2021. MAT will be required in all local jails by January 2023. The law does not apply to state prisons.<sup>142</sup>

The law requires facilities to screen each incarcerated person to determine if MAT is appropriate. There is no timeline set for this screening, other than for pregnant people, who must be screened “as soon as practicable.” This law allows for both maintenance of individuals who were on MAT in the community and induction onto MAT for individuals who were not on MAT in the community. Each local facility must offer at least one form of all three FDA-approved MAT medications. The program is funded by the state.<sup>143</sup>

The law also requires annual reporting to the legislature on the number of people diagnosed with OUD, the cost of treatment, and the number of incarcerated people receiving treatment, among other data.<sup>144</sup>

Some counties have been providing MAT to people with OUD for years. Anne Arundel County, for example, has had a jail-based methadone program since 2012.<sup>145</sup>

### **New York – Proposed Legislation Has Unique Promise**

A proposed bill in New York passed both chambers of the New York legislature in 2021 and awaits action from the Governor.<sup>146</sup> The legislation would establish MAT programs in state correctional facilities and county jails. It requires correctional facilities to participate

in reentry planning to ensure continuity of care upon release. The law would also require an annual report about the effectiveness of the program. The New York legislation is especially promising because it does not allow facilities to deny participation based upon a positive drug screening or a disciplinary report, foresight that has been uncommon in legislation thus far. As discussed elsewhere in the report, denial of MAT on the basis of a disciplinary report or other nonmedical reason is commonplace in jails and prisons.

### **Michigan – Promises of MAT in State Prisons by Gov. Whitmer, Following a “National Trend”**

In 2019, Michigan Gov. Gretchen Whitmer announced a plan to expand MAT in prisons across Michigan.<sup>147</sup> The *Detroit Free Press* reported that “Michigan is joining the national trend of offering medication-assisted treatment (MAT) to prison inmates.”<sup>148</sup> They also reported that all three FDA-approved medications would be offered. The state wants to have MAT in all state prisons by 2023.

### **New Hampshire – Administrative and Legislative Changes Expand Access to MAT in State Prisons and Local Jails**

Reporting in June 2019 indicated that the New Hampshire Department of Corrections was following the lead of Rhode Island in implementing a MAT program.<sup>149</sup> The program includes buprenorphine.<sup>150</sup> The expansion of MAT started at the Northern New Hampshire Correctional Facility in Berlin, New Hampshire.<sup>151</sup> Now all prisons provide MAT. The program is funded by the State Opioid Response (SOR) grant.<sup>152</sup> Legislation passed in 2020 requires county jails to provide MAT to all incarcerated people with OUD.<sup>153</sup>

### **Other Legislation and Policy Changes**

The Delaware State Senate unanimously passed a non-binding resolution that directed the Department of Correction to provide MAT to “all persons with opioid use disorder in any Delaware correctional facility.”<sup>154</sup> It also states that the Delaware DOC “should develop a strategic plan ... to adequately provide all of the forms of medication in all facilities by 2021.” In July 2019, the Delaware DOC announced that it would expand access

to MAT to all jails and prisons in its unified system, and that MAT would be available to individuals held pretrial and postconviction.<sup>155</sup> Additionally, it stated that MAT would be available to anyone who was on MAT in the community and to anyone not on MAT in the community for whom it is clinically indicated.

New Jersey funded a \$7.8 million grant to county jails to start MAT programs in 2020.<sup>156</sup>

North Carolina Gov. Roy Cooper announced that part of a \$6.5 million grant the state received from the DOJ's Bureau of Justice Assistance will go to expanding MAT in correctional facilities.<sup>157</sup> Kody Kinsley, the chief deputy secretary for health for the Department of Health and Human Services, said that there would "hopefully" be 15 jail-based treatment programs in the state by next year.<sup>158</sup>

While the Ohio legislature appropriated money for MAT in county jails, unfortunately, Gov. Mike DeWine line item vetoed a \$4.5 million allocation in the state budget for MAT in county jails.<sup>159</sup>

In 2019, the Oklahoma legislature appropriated \$500,000 for a MAT pilot program in Oklahoma county jails.<sup>160</sup> The legislation does not name which FDA-approved medications must be used.

In January 2018, Pennsylvania Gov. Tom Wolf directed the prison system to provide all three FDA-approved forms of MAT. On June 1, 2019, MAT maintenance became available to anyone in the state prison system who was already on MAT in the community or in a county jail.<sup>161</sup>

In February 2021, the Maine Department of Corrections expanded access to MAT to incarcerated people.<sup>162</sup> Previously, only people with six months remaining on their sentence were able to be on MAT. However, the policy change will allow all people, regardless of sentence length, to be on MAT.

Effective reform is not limited to the state level. The New York City administrative code requires that correctional health services "establish a program for the treatment of substance abuse through the use of medication assisted treatment, including the

administration of methadone, buprenorphine, and naltrexone."<sup>163</sup>

# The Limitations of Current Reform Efforts

This section of the report focuses on the current policies in place in states and localities across the country. We discuss common problems that we see in MAT policies and provide suggestions for what needs to be present in a robust MAT program. Disturbingly, many jails and prisons try to pass off patently inadequate medical care as a comprehensive MAT program.

## Naltrexone-only Programs/ Programs That Don't Offer All Three Medications at the Proper Dosage

Some jails and prisons<sup>164</sup> will try to pass off a program that offers only some of the three FDA-approved medications as a comprehensive MAT program. The most problematic version of this is when only naltrexone is offered to incarcerated people. Unlike buprenorphine and methadone, naltrexone is not an opioid agonist and it only reduces cravings for opioids. An opioid agonist activates the opioid receptors in the brain, thus staving off withdrawal symptoms. An opioid antagonist, like naltrexone, blocks the receptors from being stimulated but does not prevent withdrawal symptoms. Further, in order to be on naltrexone, one must not have taken any opiates for several days, meaning that going through often brutal withdrawal symptoms is mandatory in order to be treated with naltrexone. The research around the benefits of

naltrexone is not nearly as robust as the research around the benefits of opioid agonists like methadone and buprenorphine. Naltrexone is not an adequate alternative to a robust MAT program.<sup>165</sup>

A medically appropriate policy will make all three FDA-approved MAT medications available. The aim should be to keep people on the medications that work for them and give them maximum flexibility. Indeed, some patients will have only one medication that has worked for them. For example, some patients may have tried buprenorphine and/or naltrexone and still struggled with their OUD, but methadone succeeds at returning them to a steady state.

Some jails and prisons will limit the number of times that MAT is administered in a week or lower the dosage that is administered to levels that are below what is clinically indicated for an individual.<sup>166</sup> Many methadone clinics are closed on Sundays, and some



Photo © AP/Carla K. Johnson

jails refuse to provide treatment inside the facility on Sunday. This is unacceptable. Jails and prisons that have a MAT program need to administer it in such a way that the individuals receiving MAT receive dosages that will actually treat their OUD. Policies should guarantee that individuals will receive their prescribed MAT at the dosages and frequency prescribed by their doctor.

## Unreasonable Delays in Treatment

Some programs offer induction on to MAT only as people near release (e.g., 90 days before release).<sup>167</sup> This approach is inadequate. Leaving OUD untreated for days, months, or even years leaves the person at a much higher risk of overdose, death, and brutal withdrawal symptoms while still incarcerated. Individuals are much more likely to seek out illicit opiates if their OUD is not treated with MAT. An effective MAT program is

---

Leaving OUD untreated for days, months, or even years leaves the person at a much higher risk of overdose, death, and brutal withdrawal symptoms while still incarcerated.

---

not only about maximizing the chance of survival upon reentry, but also survival while incarcerated.

Even if a program does not have a formal delay in providing MAT, MAT needs to be available immediately or on the same day that someone with an active prescription comes in. If they do not already have an opioid treatment program (OTP) authorized to prescribe MAT, the jail or prison needs to coordinate with a local OTP to get an individual with OUD access to care. For induction, individuals should be screened for OUD within 24 hours of admission to the facility and then put on the appropriate MAT the same day. Without sufficient coordination and timeliness, incarcerated people are left at an increased risk of relapse, overdose, and death.

## Unnecessary Restrictions on Participation

As with any medical condition, the only restriction on access to MAT in jails and prisons should be whether MAT is clinically indicated, as determined by a medical professional and the patient. Corrections officials should not get in the way of doctors making medical judgments about what is best for the patients they are seeing. However, in some policies, we see this type of nonmedical interference manifest in a number of ways.

One of the most common ways this is done is by threatening to kick people off MAT if they attempt to give it to someone to whom it is not prescribed (called “diversion”) or if they are caught with “contraband” (anything an incarcerated person isn’t permitted to have).<sup>168</sup> Additionally, failed drug screens should not be used to kick people off of their treatment, as OUD recovery involves cycles of relapse. In any other medical context, it would be nonsensical to deny medication for a disciplinary issue. If a person has diabetes and gets in trouble for any reason in jail, it would not be a valid punishment to deny them insulin. There are effective ways to prevent diversion without threatening to take away people’s lifesaving medication.

Another unnecessary limitation is only making MAT available to people who were already on it in the community.<sup>169</sup> MAT is necessary medical care for many people with OUD, regardless of whether they were on it in the community or not.

Other policies require individuals to go to therapy in order to continue receiving their medication.<sup>170</sup> While there is no doubt that therapy should be available and can be highly beneficial to people that are receiving MAT, *requiring* therapy creates a loophole that allows prison officials to arbitrarily deny people the MAT they need. There are many reasons that people may not be able to go to therapy while in jail or prison, yet would still greatly benefit from MAT. Examples include lockdowns and count, where incarcerated people cannot move through the facility to get to their appointment. These events are often unpredictable and may interfere with their ability to regularly attend therapy. Others are not able to get into therapy because of long waitlists for the programs. Additionally, some incarcerated people may have had traumatizing or negative experiences with therapy and it may simply not be beneficial for them. This one-size-fits-all solution leaves too many people who need MAT out.

Finally, some policies restrict people from using MAT based on the type of offense for which they were convicted or accused.<sup>171</sup> For example, if they were convicted or accused of a nonviolent offense, they may be eligible for a MAT program, but if they were convicted or accused of a violent offense, they would not be eligible. Withholding medical care based on the type of offense that a person is convicted or accused of is unconstitutional. No one would offer insulin only to people who were convicted or accused of a nonviolent offense. All incarcerated people are entitled to healthcare that meets the standard of care.

## Use of MAT Program to Justify Further Incarceration

Some people in the criminal justice system, like judges and prosecutors, have used a MAT program to justify longer sentences or time in jail.<sup>172</sup> MAT programs are a harm reduction tool that makes time spent in jail or prison less damaging, but should never justify incarceration itself. People with substance use disorders do best when they have access to their support systems, jobs, families, and communities.

# What Real Reform Looks Like: Recommendations for Policy and Practice

## Ensure MAT Is Available to Everyone for Whom It Is Clinically Indicated

Many groups are denied access to MAT. The group that most commonly receives MAT in a jail or prison are pregnant people who already have a prescription for MAT in the community at the time of their incarceration. This is often justified by the fact that there is a significantly greater chance of miscarriage if a pregnant person who needs MAT is denied it. It is certainly important that MAT is available for pregnant people; however, MAT needs to be made available to everyone for whom it is clinically indicated, regardless of whether they are pregnant. If an institution provides MAT to pregnant people, it undermines the credibility of claims that it is simply impossible to administer MAT in the facility.

Even so, there are still some facilities that deny MAT to pregnant people. Even more common is providing MAT to pregnant people, and then immediately withdrawing them from MAT upon delivery. The NCCHC has recommended MAT maintenance for pregnant people for years.<sup>173</sup>

Additionally, incarcerated people will sometimes be denied MAT just because they are, for example, an immigrant detainee or a federal incarcerated person being housed in a county or state facility. Any incarcerated individual, regardless of their custody status, should be eligible to receive MAT.

## Push for Both Maintenance and Induction of MAT

MAT should be made available both to people who were already on MAT in the community (referred to as MAT maintenance) and to people for whom it is clinically indicated, but were not on MAT in the community (referred to as MAT induction). If a medical provider diagnoses someone in jail or prison with OUD, they should have access to appropriate treatment regardless of whether they were diagnosed and treated previously in the community. It is especially important to ensure that those who are induced on MAT while incarcerated are connected to care in the community upon release (as discussed below).

## Collect Data on Provision of MAT and Its Benefits

A good MAT policy should require extensive data collection about the program, including, at minimum, reporting regarding the number of people initiated on MAT, the number continued from a community provider, the number of people on each medication, recidivism rates, and community overdose rates. This will allow tracking of the efficacy of MAT in correctional facilities and give a better understanding of the benefits of implementing a MAT program. Additionally, this data will be in the public record and can be used to hold facilities accountable when they claim to offer MAT but are in practice denying it (as discussed above). Utah is

collecting data on OUD in jails and prisons to further study the issue before deciding whether to provide MAT in their corrections settings.<sup>174</sup>

## Connect to Community Care

A good MAT policy will require jails and prisons to connect incarcerated people to continued care in the community to which they are returning. Jails and prisons should be required to ensure that all incarcerated people on MAT will not have a disruption in their care upon release.



# Strategies to Advocate for MAT in Jails and Prisons

## Create a Media and Advocacy Strategy Responsive to Your State

Local advocates know their states best. Build a diverse coalition of advocates and craft a strategy for how to move expansion of MAT in corrections settings forward. This coalition might include impacted people, community organizers, medical professionals, treatment professionals, and experts from local medical schools, among other advocates. Potential approaches could include litigation, legislation, or working with state and local executives and corrections officials to push policy change forward. We hope that Sections III and IV of this report can be useful in crafting legislation that ensures that MAT programs provide *everyone* who is incarcerated with MAT for the length of time and at the dosage clinically indicated.

In some states and localities, it may make sense to lead a very vocal campaign, with lots of press, op-eds, rallies, lobby days, and community engagement. In other places, it may make sense to make change more quietly, through a line item in the state budget or through funding from a state or federal grant program. In yet other places, litigation may be necessary to get the attention of local officials.

## Reach Out to Local Corrections Officials/Decision Makers and Offer to Collaborate

Offer to work with corrections officials and decision makers and offer to collaborate to create a policy that would be acceptable. As more jails and prisons start implementing these policies, more corrections officials are demonstrating openness to implementing a MAT program. Refer them to available resources about implementing MAT programs.<sup>175</sup> These resources will address the common objections made by corrections officials, such as concerns about the risk of diversion.

Another common objection from corrections officials is cost. However, these concerns are misplaced – implementing MAT is affordable and in fact saves money for taxpayers in the long run.<sup>176</sup> Additionally, advocates should focus on promoting cost-saving and cost-shifting measures, such as federal legislation that would allow Medicaid to cover individuals in jail pretrial detention<sup>177</sup> and a federal grant program specifically for expanding MAT in jails and prisons.<sup>178</sup>

## Share Evidence From Other States/Localities

Talk about the results from other localities that have implemented MAT programs. For example, in Rhode Island, officials saw a statewide reduction in overdose deaths of 12.3% after implementing the MAT program,

and a 60.5% decrease in mortality rates amongst incarcerated people.<sup>179</sup> And a study in California estimated that enrolling people in an opioid agonist treatment program saved \$17,550 compared to forced detoxification, when considering the decrease that they saw in crime.<sup>180</sup>

## Refer to the Science and the Data

There is a wealth of data supporting the use of MAT in jails and prisons. It is the community standard of care and therefore required in jails and prisons. An especially good resource is *Medications for Opioid Use Disorder Save Lives*, a consensus study report of the National Academies of Sciences, Engineering, and Medicine.<sup>181</sup>

# Conclusion

With lots of talk about combatting the opioid epidemic, it is past time for action based on the evidence. Providing MAT to incarcerated people will save lives, make our communities safer, and leave formerly incarcerated people in a better position to successfully re-enter the community upon their release. Incarcerated people have a right to basic healthcare. It is time that jails and prisons stop getting in the way of patients having their MAT. Legislators, policy makers, and corrections officials need to provide meaningful access to MAT for everyone in their care for whom it is clinically indicated.



Photo © AP/Carla K. Johnson

# Endnotes

- 1 Buprenorphine is often administered under the brand name Suboxone, which is a combination of buprenorphine and naloxone. Naltrexone is often administered in a large, injectable dose under the brand name Vivitrol. Throughout this report, we will refer to these medications by their generic name.
- 2 Declaration of Dr. Richard Rosenthal, P.G. v. Jefferson County, No. 5:21-cv-00388, Dkt. 14-8 at Par. 32.
- 3 Christine Vestal, “New Momentum for Addiction Treatment Behind Bars,” *Stateline* (April 4, 2018), <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/04/04/new-momentum-for-addiction-treatment-behind-bars>.
- 4 Ingrid A. Binswanger, Marc F. Stern, Richard A. Deyo, Patrick J. Heagerty, Allen Cheadle, Joann G. Elmore, and Thomas D. Koepsell, “Release From Prison – A High Risk of Death for Former Inmates,” *New England Journal of Medicine* 356, no. 5 (January 2007), <https://doi.org/10.1056/nejmsa064115>.
- 5 John Marsden, Garry Stillwell, Hayley Jones, Alisha Cooper, Brian Eastwood, Michael Farrell, Tim Lowden, Nino Maddalena, Chris Metcalfe, Jenny Shaw, and Matthew Hickman, “Does Exposure to Opioid Substitution Treatment in Prison Reduce the Risk of Death After Release? A National Prospective Observational Study in England,” *Addiction* 112, no. 8 (2017): 1408–18, <https://www.ncbi.nlm.nih.gov/pubmed/28160345>.
- 6 Margaret Noonan, Harley Rohloff, and Scott Ginder, *Mortality in Local Jails and State Prisons, 2000-2013* (BJS, August 2015), <https://www.bjs.gov/content/pub/pdf/mlj013st.pdf>.
- 7 “Understanding the Epidemic,” Centers for Disease Control and Prevention, last updated March 17, 2021, <https://www.cdc.gov/drugoverdose/epidemic/index.html>.
- 8 “Drug Overdose Deaths,” Centers for Disease Control and Prevention, last updated March 3, 2021, <https://www.cdc.gov/drugoverdose/data/statedeaths.html>.
- 9 Lawrence Scholl, Puja Seth, Mbazazi Kariisa, Nana Wilson, and Grant Baldwin, “Drug and Opioid-Involved Overdose Deaths, United States 2013-2017,” *Morbidity and Mortality Weekly Report* 67 (January 2019): 1419-1427, <http://dx.doi.org/10.15585/mmwr.mm675152e1>.
- 10 Abby Goodnough, “Overdose Deaths Have Surged During the Pandemic, C.D.C. Data Shows,” *New York Times* (April 14, 2021), <https://www.nytimes.com/2021/04/14/health/overdose-deaths-fentanyl-opioids-coronaviru-pandemic.html>.
- 11 Christine Vestal, “New Momentum for Addiction Treatment Behind Bars,” *Stateline* (April 4, 2018), <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/04/04/new-momentum-for-addiction-treatment-behind-bars>.
- 12 The terms “medication for addiction treatment” or “medication for opioid use disorder” (MOUD) are preferred in the substance use treatment community. Using these phrases, rather than “medication-assisted treatment,” is also helpful in emphasizing the medical necessity of the treatment. “Medications for addiction treatment” emphasizes the importance of the medication in treatment for opioid use disorder. Studies show medication is the main driver of treatment. See Laura Amato, Silvia Minozzi, Marina Davoli, and Simona Vecchi, “Psychosocial Combined With Agonist Maintenance Treatments Versus Agonist Maintenance Treatments Alone for Treatment of Opioid Dependence,” *Cochrane Database of Systematic Reviews* (October 2011), <https://doi.org/10.1002/14651858.cd004147.pub4>.
- 13 E. Ann Carson and Mary P. Cowhig, *Mortality in Local Jails, 2000-2016 – Statistical Tables* (BJS, February 2020), <https://www.bjs.gov/content/pub/pdf/mlj0016st.pdf>.
- 14 *Smith v. Aroostook Cty.*, 376 F. Supp. 3d 146, 149 (D. Me. 2019), *aff’d*, 922 F.3d 41 (1st Cir. 2019).
- 15 *Pesce v Coppinger*, 355 F.Supp.3d 35 (D. Mass 2018).
- 16 Christine Vestal, “This State Has Figured Out How to Treat Drug-Addicted Inmates,” *Stateline* (February 26, 2020), <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2020/02/26/this-state-has-figured-out-how-to-treat-drug-addicted-inmates>.
- 17 “MAT Medications, Counseling, and Related Conditions,” Substance Abuse and Mental Health Services Administration, last updated August 19, 2020, <https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions#medications-used-in-mat>.
- 18 *Id.*
- 19 *Id.*
- 20 *Id.*
- 21 “Naltrexone,” Substance Abuse and Mental Health Services Administration, last updated September 15, 2019, <https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/naltrexone>.
- 22 Declaration of Dr. Richard Rosenthal, P.G. v. Jefferson County, No. 5:21-cv-00388, Dkt. 14-8 at Par. 32.
- 23 Jake R. Morgan, Bruce R. Schackman, Zoe M. Weinstein, Alexander Y. Walley, and Benjamin P. Linas, “Overdose Following Initiation of Naltrexone and Buprenorphine Medication Treatment for Opioid Use Disorder in a United States Commercially Insured Cohort,” *Drug and Alcohol Dependence* 200 (July 2019), <https://doi.org/10.1016/j.drugalcdep.2019.02.031>.
- 24 Substance Abuse and Mental Health Services Administration, *Medications for Opioid Use Disorder for Healthcare and Addiction Professionals, Policymakers, Patients, and Families, A Treatment Improvement Protocol TIP 63* (2020), [https://store.samhsa.gov/sites/default/files/SAMHSA\\_Digital\\_Download/PEP20-02-01-006\\_508.pdf](https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-006_508.pdf).
- 25 Christine Vestal, “New Momentum for Addiction Treatment Behind Bars,” *Stateline* (April 4, 2018), <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/04/04/new-momentum-for-addiction-treatment-behind-bars>.
- 26 “Opioids: Addiction, Withdrawal and Recovery,” Addictions and Recovery, last updated April 13, 2021, <https://www.addictionsandrecovery.org/opioid-opiate-recovery.htm>.
- 27 *Id.*
- 28 *Id.*
- 29 “MAT Medications, Counseling, and Related Conditions,” Substance Abuse and Mental Health Services Administration, last updated August 19, 2020, <https://www.samhsa.gov/medication-assisted-treatment/treatment>.
- 30 Shane Darke, Sarah Larney, and Michael Farrell, “Yes, People Can Die From Opiate Withdrawal,” *Addiction* 112, no. 2 (February 2017), <https://doi.org/10.1111/add.13512>.
- 31 Margaret E. Noonan, *Mortality in Local Jails, 2000-2014 – Statistical Tables* (BJS, December 2016), <https://www.bjs.gov/index.cfm?ty=pbdetail&iid=5865>.
- 32 Margaret E. Noonan, *Mortality in Local Jails, 2000-2014 – Statistical Tables* (BJS, December 2016), <https://www.bjs.gov/index.cfm?ty=pbdetail&iid=5865>.
- 33 Sarah Larney, Natasa Gisev, Michael Farrell, Timothy Dobbins, Lucinda Burns, Amy Gibson, Jo Kimber, and Louisa Degenhardt, “Opioid Substitution Therapy as a Strategy to Reduce Deaths in Prison: Retrospective Cohort Study,” *BMJ Open* 4, no. 4 (April 2014): 1-8, <https://bmjopen.bmj.com/content/4/4/e004666>.
- 34 E. Ann Carson and Mary P. Cowhig, *Mortality in Local Jails, 2000-2016 – Statistical Tables* (BJS, February 2020), <https://www.bjs.gov/content/pub/pdf/mlj0016st.pdf>.

- 35 Ingrid A. Binswanger, Marc F. Stern, Richard A. Deyo, Patrick J. Heagerty, Allen Cheadle, Joann G. Elmore, and Thomas D. Koepsell, "Release From Prison – A High Risk of Death for Former Inmates," *New England Journal of Medicine* 356, no. 5 (January 2007), <https://doi.org/10.1056/nejmsa064115>.
- 36 Massachusetts Department of Public Health, *Data Brief: An Assessment of Opioid-Related Deaths in Massachusetts 2013-2014* (September 2016), <https://www.mass.gov/doc/data-brief-chapter-55-opioid-overdose-study-september-2016/download>.
- 37 John Marsden, Garry Stillwell, Hayley Jones, Alisha Cooper, Brian Eastwood, Michael Farrell, Tim Lowden, Nino Maddalena, Chris Metcalfe, Jenny Shaw, and Matthew Hickman, "Does Exposure to Opioid Substitution Treatment in Prison Reduce the Risk of Death After Release? A National Prospective Observational Study in England," *Addiction* 112, no. 8 (2017): 1408–18, <https://www.ncbi.nlm.nih.gov/pubmed/28160345>.
- 38 Christine Vestal, "This State Has Figured Out How to Treat Drug-Addicted Inmates," *Stateline* (February 26, 2020), <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2020/02/26/this-state-has-figured-out-how-to-treat-drug-addicted-inmates>.
- 39 National Sheriffs' Association and National Commission on Correctional Health Care, *Jail-Based Medication-Assisted Treatment: Promising Practices, Guideline, and Resources for the Field* (October 2018), <https://www.ncchc.org/filebin/Resources/Jail-Based-MAT-PPG-web.pdf>.
- 40 American Society of Addiction Medicine, *The National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use* (June 2015), <https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=24>
- 41 Substance Abuse and Mental Health Services Administration, *Medications for Opioid Use Disorder for Healthcare and Addiction Professionals, Policymakers, Patients, and Families, A Treatment Improvement Protocol TIP 63* (2020), [https://store.samhsa.gov/sites/default/files/SAMHSA\\_Digital\\_Download/PEP20-02-01-006\\_508.pdf](https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-006_508.pdf).
- 42 Chris Christie, *The President's Commission on Combating Drug Addiction and the Opioid Crisis Final Report* (November 2017), [https://trumpwhitehouse.archives.gov/sites/whitehouse.gov/files/images/Final\\_Report\\_Draft\\_11-15-2017.pdf](https://trumpwhitehouse.archives.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-15-2017.pdf).
- 43 Office of National Drug Control Strategy, *National Drug Control Strategy* (January 2019), <https://www.opioidlibrary.org/wp-content/uploads/2020/01/Nat-DrugControlStrategy2019.pdf>.
- 44 "The Biden Plan to End the Opioid Crisis," Joe Biden for President (2020), <https://joebiden.com/opioidcrisis/>.
- 45 Office of National Drug Control Policy, "The Biden-Harris Administration's Statement of Drug Policy Priorities for Year One" (April 1, 2021), <https://www.whitehouse.gov/wp-content/uploads/2021/03/BidenHarris-Statement-of-Drug-Policy-Priorities-April-1.pdf>.
- 46 United States Department of Justice Civil Rights Division, *Investigation of the Cumberland County Jail* (January 14, 2021), <https://www.justice.gov/opa/press-release/file/1354646/download>.
- 47 Letter from Andrew E. Lelling, United States Attorney, to David Solet, General Counsel, Executive Office of Public Safety and Security and Jesse Caplan, General Counsel, Executive Office of Health and Human Services, (March 16, 2018); *see also* Letter from Andrew E. Lelling, United States Attorney for the District of Massachusetts to Sheriff Kevin F. Coppinger (Essex County) (Dec. 4, 2018).
- 48 Letter from the Department of Justice, United States Attorney for the Southern District of New York to New York State Office of the Attorney General regarding Medication-Assisted Treatment and the ADA (October 3, 2017), <https://lac.org/wp-content/uploads/2018/02/DOJ-SDNY-ltr-to-OCA-10.3.17.pdf>.
- 49 Letter from the Department of Justice, United States Attorney for the Southern District of New York to New York State Office of the Attorney General regarding Medication-Assisted Treatment and the ADA (October 3, 2017), <https://lac.org/wp-content/uploads/2018/02/DOJ-SDNY-ltr-to-OCA-10.3.17.pdf>.
- 50 Jessica Pishko, "The Repurposing of the American Jail," *The Atlantic* (November 19, 2019), <https://www.theatlantic.com/politics/archive/2019/11/going-jail-substance-abuse-treatment/602206/>.
- 51 Potee Declaration, DiPierro v. Hurtwitz, No. 1:19-cv-10495-LTS at 9 (D. Mass. Mar. 15, 2019).
- 52 Potee Declaration, DiPierro v. Hurtwitz, No. 1:19-cv-10495-LTS at 10 (D. Mass. Mar. 15, 2019).
- 53 Renee Fox, "ACLU Wants to Hear From Inmates Denied Opioid Treatment," *The Vindicator* (January 14, 2020), <https://www.vindy.com/news/local-news/2020/01/aclu-wants-to-hear-from-inmates-denied-opioid-treatment/>.
- 54 Substance Abuse and Mental Health Services Administration, "HHS Releases \$1.5 Billion to States, Tribes to Combat Opioid Crisis" (August 27, 2020), <https://www.samhsa.gov/newsroom/press-announcements/202008270530>.
- 55 The Reforming and Expanding Access to Treatment Act, H.R. 2511, 116th Cong. § 1 (2019).
- 56 Regina LaBelle and Shelly Weizman, *Applying the Evidence: Legal and Policy Strategies to Address Opioid Use Disorder in Criminal Justice and Child Welfare Systems* (O'Neill Institute for National and Global Health Law, October 2019), <https://oneill.law.georgetown.edu/wp-content/uploads/Applying-the-Evidence-Report-1.pdf>.
- 57 *Id.*
- 58 Emanuel Krebs, Darren Urada, Elizabeth Evans, David Huang, Yih-Ing Hser, and Bohdan Noysk, "The Costs of Crime During and After Publicly Funded Treatment for Opioid Use Disorders: A Population-level Study for the State of California," *Addiction* 112, no. 5 (May 2017): 838–851, <https://www.ncbi.nlm.nih.gov/pubmed/27981691>.
- 59 Jennifer Bronson, Jessica Stroop, Stephanie Zimmer, and Marcus Berzofsky, *Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates, 2007-2009* (BJS, June 2017), <https://www.bjs.gov/content/pub/pdf/dudaspi0709.pdf>.
- 60 Advocates for Human Potential, Inc., *Promising Practice Guidelines for Medication Assisted Treatment for Justice Involved Populations* (2017).
- 61 Chris Mai and Ram Subramanian, *The Price of Prisons: Examining State Spending Trends, 2010–2015*, <https://www.vera.org/publications/price-of-prisons-2015-state-spending-trends/>.
- 62 John Keilman, "Giving Addicted Inmates Opioid Meds Behind Bars Can Reduce Overdose Deaths. Why Don't More Jails Use Them?," *Chicago Tribune* (July 6, 2018), <https://www.chicagotribune.com/news/ct-met-jail-inmates-opioid-addiction-20180703-story.html>.
- 63 "MAT Medications, Counseling, and Related Conditions," Substance Abuse and Mental Health Services Administration, last updated August 19, 2020, <https://www.samhsa.gov/medication-assisted-treatment/treatment>.
- 64 *Pennsylvania Department of Corrections v. Yeskey*, 524 U.S. 206, 208 (1998).
- 65 28 C.F.R. § 35.108 (2010).
- 66 28 CFR 35.131(b)(1).
- 67 *Smith v. Aroostook Cty.*, 376 F. Supp. 3d 146, 149 (D. Me. 2019), *aff'd*, 922 F.3d 41 (1st Cir. 2019).
- 68 *Pesce v Coppinger*, 355 F.Supp.3d 35 (D. Mass 2018).
- 69 *Id.* at 159.
- 70 *Id.* at 160.

- 71 *Id.* at 162.
- 72 *Smith v. Aroostook Cty.*, 922 F.3d 41 (1st Cir. 2019).
- 73 *Pesce*, 355 F.Supp.3d at 40.
- 74 *Id.*
- 75 *Id.*
- 76 *Id.*
- 77 *Id.* at 46.
- 78 Protections for pretrial detainees under the Fourteenth Amendment are at least as expansive as those for convicted incarcerated people under the Eighth Amendment. *Bell v. Wolfish*, 441 U.S. 520, 545 (1979).
- 79 U.S. Const. Amend. VIII.
- 80 *Pesce*, 355 F.Supp.3d at 48.
- 81 *Cudnik v. Kreiger*, 392 F.Supp. 305 (N.D. Ohio 1974).
- 82 *Id.* at 308.
- 83 *Id.* at 312.
- 84 *Id.* at 312.
- 85 *Alvarado v. Westchester County*, 22 F.Supp.3d 208 (S.D.N.Y. 2014).
- 86 *Id.* at 217.
- 87 *Foelker v Outagamie County*, 394 F.3d 510 (7th Cir. 2005).
- 88 *Id.* at 512.
- 89 *Strain v. Sandham*, No. CIV S05-0474GEBGGHP, 2009 WL 172898, at \*6 (E.D. Cal. Jan. 23, 2009), report and recommendation adopted, No. 2:05CV0474GEBGGH-P, 2009 WL 500728 (E.D. Cal. Feb. 26, 2009).
- 90 *Id.* at \*6.
- 91 *Id.* (quoting *Hamilton v. Endell*, 981 F.2d 1062, 1066 (9th Cir.1992)).
- 92 *Anderson v. Benton Cty.*, No. 03-806-TC, 2004 WL 2110690 (D. Or. Sept. 21, 2004).
- 93 *Id.*
- 94 *Gonzalez v. Cecil County Maryland*, 221 F.Supp.2d 611 (D. Md. 2002).
- 95 *Id.* at 616.
- 96 *Quatrov v Jefferson Parish Sheriff's Office*, Nos. 04-451, 04-1425, 2009 WL 1380196 (E.D. La. 2009).
- 97 *Id.* at \*11.
- 98 *Finnigan v. Mendrick*, No. 21-cv-00341, Dkt. 71 (N.D. Ill. Feb. 26, 2021).
- 99 *Sclafani v. Mici*, No. 19-12550-LTS (D. Mass Feb. 27, 2020).
- 100 *Godsey v. Sawyer*, No. 2:19-cv-01498 (W.D. Wash. Dec. 3, 2019).
- 101 *Crews v. Sawyer*, No. 19-cv-2541 (D. Kan. Sept. 11, 2019).
- 102 *DiPierro v. Hurwitz*, No. 1:19-cv-10495-WGY (D. Mass June 7, 2019).
- 103 *Smith v. Fitzpatrick*, No. 1:18-cv-00288-NT, (D. Me. Sept. 28, 2018).
- 104 *Kortlever v. Whatcom County*, No. 2:18-cv-00823-JLR (W.D. Wash Apr. 29, 2019).
- 105 *Id.* at ¶ 5.2a.
- 106 *Id.* at ¶ 5.8.
- 107 *Id.* at ¶ 5.9.
- 108 Barbara DiPietro, Julia Zur, and Jennifer Tolbert, *Addressing the Opioid Crisis: Medication-Assisted Treatment at Health Care for the Homeless Programs* (The Henry J. Kaiser Family Foundation, April 2019), <https://www.kff.org/report-section/addressing-the-opioid-crisis-medication-assisted-treatment-at-health-care-for-the-homeless-programs-issue-brief/>.
- 109 “Drug Overdose Deaths,” Centers for Disease Control and Prevention, last updated March 3, 2021, <https://www.cdc.gov/drugoverdose/data/statedeaths.html>.
- 110 Abby Goodnough, “Overdose Deaths Have Surged During the Pandemic, C.D.C. Data Shows,” *New York Times* (April 14, 2021), <https://www.nytimes.com/2021/04/14/health/overdose-deaths-fentanyl-opioids-coronaviruses-pandemic.html>.
- 111 Shao-Cheng Wang, Yuan-Chuan Chen, Chun-Hung Lee, Ching-Ming Cheng, “Opioid Addiction, Genetic Susceptibility, and Medical Treatments: A Review,” *International Journal of Molecular Sciences* 20 (September 2019), <https://doi.org/10.3390/ijms20174294>; Eli Somer, “Trauma, Dissociation, and Opiate Use Disorder,” *Current Addiction Reports* 6 (January 2019): 15–20, <https://doi.org/10.1007/s40429-019-0236-0>.
- 112 CITATION
- 113 Mary Peeler, Kevin Fiscella, Mishka Terplan, and Carolyn Sufirin, “Best Practices for Pregnant Incarcerated Women With Opioid Use Disorder,” *Journal of Correctional Health Care* 25, no. 1 (January 2019): 4–14, <https://doi.org/10.1177/1078345818819855>.
- 114 National Sheriffs’ Association & National Commission on Correctional Health Care, *Jail-Based Medication-Assisted Treatment* (October 2018), <https://www.ncchc.org/filebin/Resources/Jail-Based-MAT-PPG-web.pdf>.
- 115 Vital Strategies and National Council for Behavioral Health, *Medication-Assisted Treatment for Opioid Use Disorder in Jails and Prisons: A Planning and Implementation Toolkit* (January 2020), [https://www.thenationalcouncil.org/wp-content/uploads/2020/09/MAT\\_in\\_Jails\\_Prisons\\_Toolkit\\_Final\\_12\\_Feb\\_20.pdf?dof=375ateTbd56](https://www.thenationalcouncil.org/wp-content/uploads/2020/09/MAT_in_Jails_Prisons_Toolkit_Final_12_Feb_20.pdf?dof=375ateTbd56).
- 116 Christine Vestal, “This State Has Figured Out How to Treat Drug-Addicted Inmates,” *Stateline* (February 26, 2020), <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2020/02/26/this-state-has-figured-out-how-to-treat-drug-addicted-inmates>.
- 117 Office of Sen. Lisa Murkowski, “Senators Markey and Murkowski Introduce Legislation to Support Access to Opioid Use Disorder Treatment in Correctional Facilities” (June 28, 2019), <https://www.murkowski.senate.gov/press/release/senators-markey-and-murkowski-introduce-legislation-to-support-access-to-opioid-use-disorder-treatment-in-correctional-facilities>.
- 118 H.R. 3496, 116th Cong. (2019).
- 119 *Id.*
- 120 United States Bureau of Prisons, Medication Assisted Treatment for Opioid Use Disorder Interim Technical Guidance (February 2019).
- 121 U.S. Government Accountability Office, *Improved Planning Would Help BOP Evaluate and Manage Its Portfolio of Drug Education and Treatment Programs*, GAO-20-423 (May 2020), <https://www.gao.gov/products/gao-20-423>.
- 122 Rhode Island Budget, *Agency Analyses, FY 2016*, <http://webserver.rilin.state.ri.us/housefinance/ba/2016/fy%202017%20bae%20%20section%20iii%20agency%20analyses.pdf>.
- 123 Traci C. Green, Jennifer Clarke, Lauren Brinkley-Rubinstein, Brandon D.L. Marshall, Nicole Alexander-Scott, Rebecca Boss, and Josiah D. Rich, “Postincarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System,” *JAMA Psychiatry* 75, no. 4 (April 2018): 405–407, <https://doi.org/10.1001/jamapsychiatry.2017.4614>.



files/documents/Biennial%20Report%20Archive/2017-2019%20Biennium%20Report\_links.pdf.

- 170 California Department of Corrections and Rehabilitation, "Integrated Substance Use Disorder Treatment," In Service Training Slideshow at Slide 21.
- 171 West Virginia Department of Homeland Security, "W.Va. Regional Jail Starts Inpatient Treatment Pilot" (February 21, 2019), <https://dmaps.wv.gov/News-Announcements/Pages/WV-regional-jail-starts-inpatient-treatment-pilot.aspx>.
- 172 Karen Bota, "Ionia Man Kicks Heroin Habit, But Gets Prison for Meth," *The Daily News* (November 27, 2019), <https://thedailynews.cc/articles/ionia-man-kicks-heroin-habit-but-gets-prison-for-meth/>.
- 173 National Commission on Correctional Health Care, *Standards for Health Services in Jails* (2014).
- 174 Utah Code 17-22-32.
- 175 National Sheriffs' Association and National Commission on Correctional Health Care, *Jail-Based Medication-Assisted Treatment: Promising Practices, Guideline, and Resources for the Field* (October 2018), <https://www.ncchc.org/filebin/Resources/Jail-Based-MAT-PPG-web.pdf>; Vital Strategies and National Council for Behavioral Health, *Medication-Assisted Treatment for Opioid Use Disorder in Jails and Prisons: A Planning and Implementation Toolkit* (January 2020), [https://www.thenationalcouncil.org/wp-content/uploads/2020/09/MAT\\_in\\_Jails\\_Prisons\\_Toolkit\\_Final\\_12\\_Feb\\_20.pdf?dof=375ateTbd56](https://www.thenationalcouncil.org/wp-content/uploads/2020/09/MAT_in_Jails_Prisons_Toolkit_Final_12_Feb_20.pdf?dof=375ateTbd56).
- 176 Kitty Purington and Chris Kukka, "States May Soon Have to Provide Medication-Assisted Treatment to Inmates, Here's How to Fund It," National Academy for State Health Policy (July 23, 2019), <https://nashp.org/states-may-soon-have-to-provide-medication-assisted-treatment-to-inmates-heres-how-to-fund-it/>; Regina LaBelle and Shelly Weizman, *Applying the Evidence: Legal and Policy Strategies to Address Opioid Use Disorder in Criminal Justice and Child Welfare Systems* (O'Neill Institute for National and Global Health Law, October 2019), <https://oneill.law.georgetown.edu/wp-content/uploads/Applying-the-Evidence-Report-1.pdf>.
- 177 Office of Sen. Ed Markey, "Senators Markey, Merkley, Brown, and Durbin Introduce Legislation to Protect Medicaid Access for Those Who Cannot Afford Bail" (October 17, 2019), <https://www.markey.senate.gov/news/press-releases/senators-markey-merkley-brown-and-durbin-introduce-legislation-to-protect-medicaid-access-for-those-who-cannot-afford-bail>.
- 178 Office of Rep. Mike Turner, "Turner Reintroduces Bipartisan Legislation to Treat Opioid Addiction" (May 2, 2019), <https://turner.house.gov/media-center/press-releases/turner-reintroduces-bipartisan-legislation-to-treat-opioid-addiction>.
- 179 Traci C. Green, Jennifer Clarke, Lauren Brinkley-Rubinstein, Brandon D.L. Marshall, Nicole Alexander-Scott, Rebecca Boss, and Josiah D. Rich, "Postincarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System," *JAMA Psychiatry* 75, no. 4 (April 2018): 405–407, <https://doi.org/10.1001/jamapsychiatry.2017.4614>.
- 180 Emanuel Krebs, Darren Urada, Elizabeth Evans, David Huang, Yih-Ing Hser, and Bohdan Noysk, "The Costs of Crime During and After Publicly Funded Treatment for Opioid Use Disorders: A Population-level Study for the State of California," *Addiction* 112, no. 5 (May 2017): 838–851, <https://www.ncbi.nlm.nih.gov/pubmed/27981691>.
- 181 The National Academies of Sciences, Engineering, and Medicine, *Medications for Opioid Use Disorder Save Lives* (Washington, D.C.: The National Academies Press 2019), <https://www.nap.edu/catalog/25310/medications-for-opioid-use-disorder-save-lives>.