EXPANDING ACCESS TO MEDICATIONS FOR OPIOID USE DISORDER IN THE CRIMINAL LEGAL SYSTEM BEYOND PRISONS AND JAILS

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ABSTRACT

Medications for Opioid Use Disorder (MOUD) are proven to save lives. Yet, too often, people who have contact with the criminal justice system are prohibited from accessing this lifesaving medical care. Such prohibitions on effective healthcare would be unimaginable if prison or probation officers were denying people with diabetes access to insulin. But because of the stigma facing people with opioid use disorder (OUD), MOUD is routinely denied. Recent litigation and policy efforts have increased access to MOUD in jails and prison. This Article argues that this litigation and policy strategy needs to be expanded throughout the criminal justice system, including to people under court supervision like probation and parole.

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INTRODUCTION

> *I'm going to give you a piece of advice when you come back here for sentencing. You're not going to be on methadone. That's a forbidden drug in this Court. So you better do everything you've got to do to get off it. When you come back here for sentencing, if you test positive for it, you're going to be going to prison, is that clear?*[1]
>
> *"You are not allowed to do Suboxone® and be on my supervision."*[2]

America is experiencing an unprecedented drug overdose crisis. Instead of mitigating the crisis, America's criminal justice system is exacerbating it by routinely denying access to basic, lifesaving healthcare: medications for opioid use disorder (MOUD). Several courts, in granting injunctions, have found that incarcerated people have a right to MOUD in jails and prisons under the Eighth and Fourteenth Amendments and the Americans with Disabilities Act (ADA).[3] The logic of these cases extends beyond just jails and prisons. Under the ADA, the criminal justice system is prohibited from blocking access to this life-saving healthcare from arrest through the end of supervision, including probation, parole, and drug courts. It is crucial that public defenders, the private defense bar, and civil rights litigators come together to advocate for access to this life-saving care. It is also incumbent upon judges, prosecutors, state legislatures, local elected officials, and law enforcement to recognize the medical necessity of this healthcare.

This Article explores how the criminal justice system's failure to treat substance use disorder as a disease that requires medical treatment has resulted in untold and wholly unnecessary death and misery. By explicitly banning necessary life-saving medications, the criminal justice system sets up individuals with substance use disorder for failure. Allowing unfettered access to evidence-based medical care—where decisions are based on medical necessity, not stigma-based punishment—is an opportunity for the criminal justice system to allow rehabilitation to take root.

First, I will discuss the current state of the overdose crisis and the crucial role that MOUD plays in saving and improving the lives of people with opioid use disorder. The Article then explores how, despite the overwhelming evidence, MOUD is often limited or outright banned in criminal justice settings, but that this is starting to change, thanks in part to coordinated litigation and legislative advocacy.

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1. State v. Porter, 2017-Ohio-7958, ¶ 5 (11th Dist.) (quoting a judge to a defendant in a pre-sentencing hearing).

2. Marisa Booty, Kathi Harp, Evan Batty, Hannah K. Knudsen, Michele Staton & Carrie B. Oser, *Barriers and Facilitators to the Use of Medication for Opioid Use Disorder Within the Criminal Justice System: Perspectives from Clinicians*, J. SUBSTANCE USE ADDICTION TREATMENT, June 2023, at 1, 9 (author manuscript) (quoting a probation or parole officer).

3. *See, e.g.*, P.G. v. Jefferson County, No. 5:21-CV-388, 2021 WL 4059409, at *5–6 (N.D.N.Y. Sept. 7, 2021); Smith v. Aroostook County, 376 F. Supp. 3d 146, 158–61 (D. Me. 2019); Pesce v. Coppinger, 355 F. Supp. 3d 35, 47–48 (D. Mass. 2018).

Part II of this Article discusses the various litigation tools that may expand access to MOUD throughout the criminal legal system.

I. THE CURRENT STATE OF THE OVERDOSE CRISIS

A. The Heavy Toll of Fatal Overdoses

America is in an overdose crisis. Between November 2023 and November 2024, over 80,000 Americans died of an overdose.[4]

This annual toll is both stunning and unacceptable. It is a relatively recent phenomenon that the number of overdose deaths is so high. The rate of drug overdoses has nearly quadrupled since 2002, spiking from 8.2 deaths per 100,000 people to 32.6 deaths per 100,000 people in 2022.[5] This spike is largely attributable to the rise of synthetic opiates like fentanyl in an increasingly unstable and unpredictable drug supply.[6] Drug overdoses in America kill more people than car accidents and gun violence combined.[7] These deaths disproportionately impact Native and Indigenous people and Black people, who die of overdose at a rate of 65.2 and 47.5 per 100,000, respectively, compared to 32.6 per 100,000 for the general population.[8] Many lives depend on implementing evidence-based policies that will reduce these unnecessary deaths.

B. MOUD is the Standard of Care for Opioid Use Disorder, Saves Lives, and is Underutilized

Medications for opioid use disorder (MOUD), in combination with clinically appropriate psychosocial services, is the standard of care for opioid use disorder (OUD).[9] In other words, MOUD is basic healthcare. MOUD currently consists of three FDA-approved medications: methadone, buprenorphine, and naltrexone.[10] The three medications are not interchangeable. Methadone is a full agonist medication, meaning that it stimulates the opioid receptors in the brain.[11] Buprenorphine is a partial agonist, partially stimulating the opioid receptor, while also acting as an

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4. *Provisional Drug Overdose Death Counts*, U.S. CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm (last visited Mar. 2, 2025).

5. MERIANNE R. SPENCER, MATTHEW F. GARNETT & ARIALDI M. MINIÑO, NAT'L CTR. FOR HEALTH STATS., DRUG OVERDOSE DEATHS IN THE UNITED STATES, 2002–2022, at 2 (2024), https://www.cdc.gov/nchs/data/databriefs/db491.pdf.

6. *Drug Overdose Deaths: Facts and Figures*, NAT'L INST. ON DRUG ABUSE, (Aug. 2024), https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates#Fig2.

7. *See All Injuries*, U.S. CTRS. FOR DISEASE CONTROL & PREVENTION, (Jul. 23, 2024), https://www.cdc.gov/nchs/fastats/injury.htm.

8. SPENCER ET AL., *supra* note 5, at 3.

9. NATIONAL PRACTICE GUIDELINE FOR THE TREATMENT OF OPIOID USE DISORDER, AM. SOC'Y. OF ADDICTION MED. 11 (2020), https://downloads.asam.org/sitefinity-production-blobs/docs/default-source/guidelines/npg-jam-supplement.pdf?sfvrsn=a00a52c2_4.

10. *See generally* NAT'L ACADS. OF SCIS., ENG'G, & MED., MEDICATIONS FOR OPIOID USE DISORDER SAVE LIVES (Michelle Mancher & Alan I. Lechner eds., 2019).

11. *Id.* at 34.

antagonist that blocks the stimulation of another receptor in the brain.[12] Naltrexone is an antagonist, which does not stimulate the opioid receptors, but blocks the receptors in the brain from being stimulated.[13]

The data shows that agonist MOUD saves lives. Of the three FDA-approved medications, there is much more evidence supporting the effectiveness of the agonist medications methadone and buprenorphine, compared to naltrexone.[14] Treatment with agonist MOUD is associated with a 50% decrease in mortality among people with opioid use disorder.[15] For people recently released from jails and prisons, providing MOUD was associated with a 75% decrease in all-cause mortality and an 85% decrease in overdose deaths in the first month after release.[16] In addition to saving lives, a review of the scientific literature found that agonist MOUD had the following benefits: "lower rates of other opioid use, improved social functioning, decreased injection drug use, reduced HIV transmission risk behaviors, reduced risk of HIV diagnosis, reduced risk of hepatitis C virus (HCV) infection, better quality of life compared to individuals with OUD not in treatment," and reduced rates of crime.[17] Behavioral interventions such as contingency management (which rewards adherence with a treatment plan), cognitive behavioral therapy, and structured family therapy have been shown to help support medication-based treatment for OUD.[18]

For too many people, MOUD are out of reach due to factors ranging from stigma, low insurance reimbursement, and cumbersome regulations.[19] Rates of treatment for substance use disorder are inadequate.[20] In 2022, only 25% of people with opioid use disorder received MOUD, and only 55% of people with OUD received any treatment at all for their disorder.[21] MOUD is basic healthcare for people with OUD, and needs to be more widely available.

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12. *Id.* at 35–36.

13. *Id.* at 37.

14. *See id.* at 38–39.

15. *Id.* at 39.

16. John Marsden et al., *Does Exposure to Opioid Substitution Treatment in Prison Reduce the Risk of Death After Release? A National Prospective Observational Study in England*, 112 ADDICTION 1408, 1408 (2017).

17. NAT'L ACADS. OF SCIS., ENG'G, & MED., *supra* note 10, at 39 (citations omitted).

18. *Id.* at 7, 48–49.

19. *See, e.g.*, Elinor Haider, *Barriers Limit Access to Medication for Opioid Use Disorder in Philadelphia*, PEW (Mar. 21, 2022), https://www.pewtrusts.org/en/research-and-analysis/reports/2022/03/barriers-limit-access-to-medication-for-opioid-use-disorder-in-philadelphia.

20. Treatment is not the only strategy to reduce overdose deaths. There must be robust investments in the entire continuum of care: prevention, harm reduction, treatment, and recovery. *See, e.g.*, OFF. OF NAT'L DRUG CONTROL POL'Y, NATIONAL DRUG CONTROL STRATEGY 3 (2024), https://bidenwhitehouse.archives.gov/wp-content/uploads/2024/05/2024-National-Drug-Control-Strategy.pdf.

21. Deborah Dowell, et al., *Treatment for Opioid Use Disorder: Population Estimates–United States, 2022*, 73 U.S. CTRS. FOR DISEASE CONTROL & PREVENTION MORBIDITY & MORTALITY WKLY. REP. 567, 568 (2024).

C. The Lethal Results of Denying Care to People with OUD in the Criminal Justice System

The criminal legal system has a disproportionately high concentration of people with opioid use disorder compared to the general public. Roughly fifteen percent of incarcerated people have OUD,[22] and approximately seventeen percent of people on probation and parole reported "opioid misuse" in the past year, which is about four times higher than the general population.[23] People who take MOUD under supervision are routinely denied access to their medications by criminal justice entities such as jails and prisons,[24] supervision authorities like probation and parole,[25] and drug courts.[26] These institutions frequently enact policies and practices that amount to bans on MOUD for people in their custody.[27] In jails and prisons, incarcerated people are at the mercy of the carceral healthcare system to receive these medications.[28] If a prison or jail does not allow access to MOUD, that is generally the end of the story. This forces those previously treated with medication to endure painful withdrawal symptoms, and puts them at a hugely increased risk of relapse, overdose, and death.[29] For people under court supervision, a urinalysis which shows the use of MOUD may lead to revocation of parole or probation, and land someone inside a carceral facility.[30]

Additionally, people who have an untreated opioid use disorder are routinely denied initiation of treatment including MOUD while incarcerated,[31] leaving them without basic medical care for opioid use disorder throughout their incarceration.

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22. *See* LAURA M. MARUSCHAK, TODD D. MINTON, & ZHEN ZENG, BUREAU OF JUST. STATS., U.S. DEP'T OF JUST., OPIOID USE DISORDER SCREENING AND TREATMENT IN LOCAL JAILS, 2019, at 2 (2023), https://bjs.ojp.gov/library/publications/opioid-use-disorder-screening-and-treatment-local-jails-2019.

23. Maria Morrison, Audrey Hang Hai, Yohita Shraddha Bandaru, Christopher P. Salas-Wright & Michael G. Vaughn, *Opioid Misuse and Associated Health Risks Among Adults on Probation and Parole: Prevalence and Correlates 2015-2020*, 59 SUBSTANCE USE & MISUSE 20, 20 (2023).

24. *See* Jennifer Logan, Joseph Longley, Regina LaBelle & Shelly Weizman, *Medication for Opioid Use Disorder in U.S. Jails and Prisons: Status Update*, QUICK TAKE (O'Neill Inst., Washington, D.C.), Mar. 2024, at 1 https://oneill.law.georgetown.edu/publications/moud-in-us-jails-and-prisons-status-update/.

25. *See, e.g.*, Jessica Reichert & Lily Gleicher, *Probation Clients' Barriers to Access and Use of Opioid Use Disorder Medications*, 7 HEALTH & JUST., no. 10, May 2019, at 1, https://link.springer.com/article/10.1186/s40352-019-0089-6; AKIN GUMP STRAUSS HAUER & FELD LLP, BLOOMBERG AM. HEALTH INITIATIVE, A LEGAL RIGHT TO ACCESS TO MEDICATIONS FOR THE TREATMENT OF OPIOID USE DISORDER IN THE CRIMINAL JUSTICE SYSTEM 4 (2018), https://americanhealth.jhu.edu/sites/default/files/website-media/resources/Initiative_Memo_Opioids_012319_0.pdf.

26. *See* SALLY FRIEDMAN & KATE WAGNER-GOLDSTEIN, LEGAL ACTION CTR., MAT IN DRUG COURTS: RECOMMENDED STRATEGIES 4 (2016), https://www.lac.org/resource/medication-assisted-treatment-in-drug-courts-recommended-strategies.

27. *See generally* Logan et al., *supra* note 24.

28. *See* Estelle v. Gamble, 429 U.S. 97, 103 (1976).

29. *See generally* Logan et al., *supra* note 24.

30. *See* Morrison et al., *supra* note 23, at 21.

31. *See* NORC AT THE UNIV. OF CHI, JCOIN'S NATIONAL SURVEY OF SUBSTANCE USE SERVICES IN JAILS 9-11 (2023) [hereinafter JCOIN National Survey], https://www.jcoinctc.org/wp-content/uploads/JCOIN-2022-Jail-Survey-MAT-Results_08.09.2023v2.pdf (showing the relatively low percentage of jails that offer MOUD to anyone with OUD who requests treatment).

It is extremely dangerous to prevent someone from accessing MOUD, particularly someone who is on probation, parole, or in a drug court program. People recently released from incarceration are dozens of times more likely to die of an overdose compared to the general population.[32] MOUD reduces a person with OUD's risk of dying by fifty percent.[33] Depriving people on probation, parole, or in drug courts who are in need of this medication therefore costs lives. Given these risks, MOUD access is especially important for people in the criminal justice system.

Probation and parole can serve as a juncture at which to refer people to treatment. Yet all too often, this opportunity is squandered. One study demonstrated that screening and referral to treatment during probation increased interest in medication treatment for OUD by an average of one point on a ten-point scale.[34] Here, it is important that probation and parole offices *refer* individuals to voluntary treatment, rather than *require* treatment.[35] Forced or required treatment raises a host of issues,[36] including civil liberties concerns such as ensuring that individuals have autonomy over what medications go in their body and allowing people who use drugs the agency to determine their own future.[37] Further, a systematic review of

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32. *See generally* Ingrid Binswanger, Marc F. Stern, Richard A. Deyo, Patrick J. Heagerty, Allen Cheadle, Joann G. Elmore & Thomas D. Koepsell, *Release from Prison – A High Risk of Death for Former Inmates*, 35 NEW ENG. J. MEDICINE 157 (2007).

33. NAT'L ACADS. OF SCIS., ENG'G, & MED., *supra* note 10, at 39 (citing studies).

34. Daniel J. Bromberg, Samy J. Galvez de Leon, Taylor Litz, Lyu Azbel, Amanda R. Liberman, Maxim Polonsky, Sergii Dvoriak, Nataliia Saichuk, Faye Taxman &Frederick L. Altice, *Aligning Public Health and Public Safety*, 3 PLOS GLOB. PUB. HEALTH, no. 11, Nov. 2023, at 1, 5, https://journals.plos.org/globalpublichealth/article?id=10.1371/journal.pgph.0002349.

35. *See, e.g.*, Barbara Andraka-Christou, Olivia Randall-Kosich, Matthew Golan, Rachel Totaram, Brendan Saloner, Adam J. Gordon & Bradley D. Stein, *A National Survey of State Laws Regarding Medications for Opioid Use Disorder in Problem-Solving Courts*, 10 HEALTH & JUST., no. 14, Mar. 2022, at 1, 7, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8969254/(observing that requiring treatment may be unethical); Carolyn Sufrin, Tali Ziv, Lauren Dayton, Carl Latkin & Camille Kramer, *"They Talked to Me like I Was Dirt Under Their Feet:" Treatment and Withdrawal Experiences of Incarcerated Pregnant People with Opioid Use Disorder in Four U.S. States*, 6 SSM - QUALITATIVE RSCH. IN HEALTH, no. 100453, Dec. 2024, at 1, 5–6, https://www.sciencedirect.com/science/article/pii/S2667321524000623. One incarcerated person, Rachel, "described the paradox of being judged for MOUD treatment in a jail that mandated methadone treatment for pregnant people":

> If you come in there off the street and find out you're pregnant and you're on heroin, they force you to get on methadone, and then they judge you for being on methadone after they force you to get on it, so it's just – it's just frustrating because, yeah, I was on methadone to kind of help my son and stay off of heroin, and they still made you feel kind of like you're – a terrible person because your baby is going to withdraw off of methadone.

Id.

36. DRUG POL'Y ALL., THE DRUG TREATMENT DEBATE: WHY ACCESSIBLE AND VOLUNTARY TREATMENT WINS OUT OVER FORCED 10 (2024), https://drugpolicy.org/wp-content/uploads/2024/09/TheDrugTreatmentDebate_10.30.24-Interactive.pdf.

37. *See* HANNAH-ALISE ROGERS, CONG. RSCH. SERV., R47571, INVOLUNTARY CIVIL COMMITMENT: FOURTEENTH AMENDMENT DUE PROCESS PROTECTIONS 6, 26–28 (2023) (discussing Due Process concerns with forced medical treatment).

studies regarding forced treatment found little evidence that such treatment is effective.[38]

D. Barriers to Treatment in Non-carceral Criminal Justice Settings

While difficult to quantify, there are many probation centers, parole offices, and drug courts throughout the country that have blanket prohibitions against the use of MOUD, or otherwise discriminate against individuals who use MOUD. These prohibitions have various sources. Some prohibitions, such as the one exemplified by the quotation at the beginning of this article, stem from the orders of a judge.[39] Some drug courts, as well as probation and parole offices, have restrictions on MOUD use written into their conditions of probation.[40] For others, it is an unwritten policy selectively enforced by individual probation and parole officers.[41]

Qualitative research has found that a probation officer's stigmatic beliefs—including the mistaken belief that methadone is substituting one addiction for another—is a barrier to MOUD access.[42] A study based on interviews with social service clinicians (SSCs) found that nearly half of surveyed SSCs cited probation and parole officers' negative attitudes towards MOUD as a barrier to MOUD for individuals on probation and parole.[43] In this study, SSCs reported that some officers would explicitly instruct people under their supervision not to use medication to treat their OUD while on probation.[44] Even when it wasn't flatly prohibited, the study found that some probation officers and SSCs themselves would discourage using MOUD, despite acknowledging that it was legally available to people on probation.[45] Another study showed that many probation staff receive little to no training about MOUD.[46]

Other reasons for lack of access to MOUD for individuals on probation include its often prohibitive cost and a lack of coordination between government agencies.[47]

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38. *See* Daniel Werb, *The Effectiveness of Compulsory Drug Treatment: A Systematic Review*, 28 INT'L J. DRUG POL'Y 1 (2016).

39. State v. Porter, 2017-Ohio-7958, ¶ 5 (11th Dist.).

40. *See, e.g.*, Press Release, U.S. Dep't of Just., U.S. Attorney's Office Settles Disability Discrimination Allegations with Massachusetts Parole Board (Dec. 17, 2021), https://www.justice.gov/usao-ma/pr/us-attorneys-office-settles-disability-discrimination-allegations-massachusetts-parole; Douglas B. Marlowe, David S. Theissb, Erika M. Ostlieb & John Carnevaleb, *Drug Court Utilization of Medications for Opioid Use Disorder in High Opioid Mortality Communities*, 141 J. SUBSTANCE ABUSE TREATMENT, no. 108850, Oct. 2022, at 1, 2, https://www.sciencedirect.com/science/article/pii/S0740547222001325?via%3Dihub.

41. *See* Reichert & Gleicher, *supra* note 25.

42. *See* Augustine Kang, Amelia Bailey, Siena Napoleon & Rosemarie Martin, *Contextualizing Medications for Opioid Use Disorder and Peer Support Service Provision in the Probation System with Implementation Science*, 24 BMC PUB. HEALTH, no. 658, Mar. 2024, at 1, 3, https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-024-18133-5.

43. Booty, et al., *supra* note 2, at 8–9.

44. *Id.*

45. *Id.*

46. *See* Reichert & Gleicher, *supra* note 25, at 6–7.

47. *See id.* at 8–9.

While it is necessary to root out illegal discrimination by probation and parole agencies,[48] a comprehensive policy solution—including ensuring coverage of MOUD and related services—is needed and cannot be achieved solely through litigation.[49]

E. Momentum for Policy Change

Prohibitions on MOUD access have been addressed in some jurisdictions. For example, some state legislatures passed laws in the last decade to require MOUD availability in drug court and other "problem solving" courts. Seven states have laws that prohibit these courts from discriminating against people who use MOUD.[50] However, other states have problematically allowed these courts to *require* participant's MOUD use, even where it is not medically necessary or where the individual wants to make an informed choice not to use MOUD.[51] Federal funding for drug court programs now requires these courts to permit participants to use all three forms of MOUD.[52]

II. LITIGATION AGAINST JAILS AND PRISONS FOR DENIAL OF MOUD

There is hope that litigation can help further turn the tides. Litigation against jails and prisons, in combination with federal, state, and local policy change, has sparked a sea change in the provision of MOUD in jails and prisons. As recently as 2018, experts estimated that only a handful of jails and prisons provided access to any form of MOUD.[53] Today, roughly twenty-two percent of local jails provide buprenorphine maintenance and sixteen percent provide methadone maintenance.[54] While these numbers are nowhere near as high as they need to be, these data represent hundreds of local jails starting these programs in just the last few years.[55]

However, even with access to MOUD, recently incarcerated individuals face a host of health-related challenges due to their incarceration.[56] There is a danger that bolstering MOUD access in the criminal justice system, while not ensuring easy access to care in the community, could create a misapprehension that incarcerating

48. *See infra* Part II.

49. *See infra* Part II.

50. Andraka-Christou et al., *supra* note 35, at 3.

51. *See id.* at 7.

52. *See* BUREAU OF JUST. ASSISTANCE, U.S. DEP'T OF JUST., BJA FY24 ADULT TREATMENT COURT PROGRAM 9 (2023) (on file with author).

53. Christine Vestal, *New Momentum for Addiction Treatment Behind Bars*, STATELINE (Apr. 4, 2018), https://stateline.org/2018/04/04/new-momentum-for-addiction-treatment-behind-bars/.

54. *See JCOIN National* Survey, *supra* note 31, at 7–10. This is based on multiplying two numbers provided in this study: the percentage of jails providing methadone/buprenorphine, and the percentage of jails providing methadone/buprenorphine maintenance to individuals who were on methadone or buprenorphine when booked.

55. ZHEN ZENG & TODD D. MINTON, BUREAU OF JUST. STATS., U.S. DEP'T OF JUST., CENSUS OF JAILS, 2005–2019 – STATISTICAL TABLES 47 (2021), https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/cj0519st.pdf (establishing that there are 3,116 jail facilities in 2,850 jail jurisdictions nationwide).

56. *See, e.g.*, *Understanding Mass Incarceration as a Public Health Issue*, UNC GILLINGS SCH. OF GLOB. PUB. HEALTH (Mar. 29, 2021), https://onlinemph.unc.edu/blog/mass-incarceration-public-health/(collecting public health outcomes of incarceration).

people with OUD is in their best interest.[57] That is why it is critical that policy advocates and litigators aim to reduce barriers to treatment in the community, in addition to criminal justice settings.[58] While much of the recent private litigation in this space has focused on expanding access to MOUD in jails and prisons, the ADA also provides protections for some people using MOUD in the community.

Several court decisions, and many more settlements,[59] have required jails and prisons to provide MOUD to incarcerated individuals. More damages cases are now being filed, suing jails and prisons for wrongful death and other injuries from the denial of MOUD to incarcerated individuals.[60]

The court cases have relied on two primary theories: (1) that denial of MOUD constitutes cruel and unusual punishment prohibited by the Eighth Amendment[61] or the Fourteenth Amendment for pretrial detainees;[62] and (2) that denial of MOUD amounts to disability discrimination in violation of the Americans with Disabilities Act[63] and the Rehabilitation Act.[64]

A. Eighth Amendment Law

The Eighth Amendment requires prison officials to ensure that incarcerated people receive adequate medical care.[65] Deliberate indifference to a serious medical need amounts to an Eighth Amendment violation.[66] The Due Process Clause of the Fourteenth Amendment applies to pretrial detainees and is at least as protective as the Eighth Amendment.[67] The Eighth Amendment has "(1) an objective prong that

57. *See, e.g.*, Emily Widra, *Addicted to Punishment: Jails and Prisons Punish Drug Use Far More Than They Treat It*, PRISON POL'Y INITIATIVE (Jan. 30, 2024), https://www.prisonpolicy.org/blog/2024/01/30/punishing-drug-use/.

58. *See* U.S. DEP'T OF JUST. C.R. DIV., THE AMERICANS WITH DISABILITIES ACT AND THE OPIOID CRISIS: COMBATING DISCRIMINATION AGAINST PEOPLE IN TREATMENT OR RECOVERY 2–5 (2022) [hereinafter THE ADA AND THE OPIOID CRISIS], https://archive.ada.gov/opioid_guidance.pdf (providing examples of violations of the ADA both in jails and prisons, and also in non-carceral settings such as skilled nursing facilities, hospitals and doctor's offices, municipal zoning, and employment).

59. ACLU, OVER-JAILED AND UN-TREATED: HOW THE FAILURE TO PROVIDE TREATMENT FOR SUBSTANCE USE IN PRISONS AND JAILS FUELS THE OVERDOSE EPIDEMIC 14 (2021), https://www.aclu.org/wp-content/uploads/publications/20210625-mat-prison_1.pdf.

60. *See, e.g.*, Taylor v. Wexford Health Sources, Inc., 737 F. Supp. 3d 357 (S.D.W. Va. 2024); Complaint, Wilson v. Fulton County., No. 9:24-cv-00261 (N.D.N.Y. Feb. 22, 2024).

61. *See* Farmer v. Brennan, 511 U.S. 825, 837 (1994) (holding that prison officials can violate the Eighth Amendment when they "know[] of and disregard[] an excessive risk to inmate health or safety").

62. *See* Bell v. Wolfish, 441 U.S. 520, 545 (1979) (explaining that pretrial detainees retain "at least those constitutional rights . . . enjoyed by convicted prisoners").

63. 42 U.S.C. § 12132.

64. 29 U.S.C. § 794.

65. *Farmer*, 511 U.S. at 832.

66. Helling v. McKinney, 509 U.S. 25, 32 (1993).

67. Pre-trial detainees may not permissibly be punished absent an adjudication of guilt, thus the Eighth Amendment's prohibition on cruel and unusual punishment does not apply. *See Wolfish*, 441 U.S. at 579. Instead, the Fourteenth Amendment provides equal or more protection. *See id.* at 545.

requires proof of a serious medical need, and (2) a subjective prong that mandates a showing of prison administrators' deliberate indifference to that need."[68]

Courts have found that OUD and opioid withdrawal—with their painful side effects and potentially deadly consequences—can both amount to serious medical needs.[69] Likewise, some courts are finding that blanket policies denying MOUD to incarcerated people, without any individualized assessment of medical need, can amount to deliberate indifference. For example, in the first case to hold that an incarcerated person likely has a right to access MOUD under the Eighth Amendment, the court held that the jail's "course of treatment ignores and contradicts his physician's recommendations" as a matter of "blanket policy."[70] While the Eighth Amendment's guarantee of constitutionally adequate healthcare only applies to health services for incarcerated individuals,[71] the same conduct violates the ADA and these cases are still relevant for people who are not incarcerated, but are facing barriers to their care because of government discrimination.

B. The Americans with Disabilities Act

Courts have also held that denial of MOUD in jails or prisons can amount to a violation of the ADA. Title II of the ADA, which applies to state and local government entities,[72] provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity."[73] A plaintiff must prove three elements to prevail in a Title II action: "(1) they have a disability; (2) they are otherwise qualified to receive the benefits of a public service, program, or activity; and (3) they were denied the benefits of such service, program, or activity, or otherwise discriminated against, on the basis of their disability."[74] Discrimination on the basis of disability can be shown by several methods, which include: intentional discrimination, disparate impact, failure to make reasonable modifications, failure to provide equally effective communication, and using methods of administration that have the effect of excluding people with disabilities from government programs.[75]

People with substance use disorders are people with disabilities.[76] However, "the term 'individual with a disability' does not include an individual who is

68. Kosilek v. Spencer, 774 F.3d 63, 82 (1st Cir. 2014).

69. *See, e.g.*, Foelker v. Outagamie County, 394 F.3d 510, 513 (7th Cir. 2005); P.G. v. Jefferson County, No. 5:21-CV-388, 2021 WL 4059409, at *5 (N.D.N.Y. Sept. 7, 2021); Pesce v. Coppinger, 355 F. Supp. 3d 35, 47 (D. Mass. 2018); Alvarado v. Westchester County, 22 F. Supp. 3d 208, 217 (S.D.N.Y. 2014).

70. *Pesce*, 355 F. Supp. 3d at 47–48.

71. *See* Estelle v. Gamble, 429 U.S. 97, 103–04 (1976).

72. Claims against the federal government or entities that receive federal funding should be brought under the Rehabilitation Act. 29 U.S.C. § 794.

73. 42 U.S.C. § 12132.

74. Nat'l Fed'n of the Blind v. Lamone, 813 F.3d 494, 502–03 (4th Cir. 2016).

75. *See* 28 C.F.R. § 35.130(b) (2025).

76. *Id.* §§ 35.108(b)(2), 36.105(b)(2).

currently engaging in the illegal use of drugs, when the covered entity acts on the basis of such use."[77] But the ADA explicitly protects people who are "participating in a supervised rehabilitation program and [are] no longer engaging in such use."[78] An individual who currently uses illegal drugs cannot "be denied health services, or services provided in connection with drug rehabilitation."[79] The ADA "expressly provides that health services and drug rehabilitation services, which would include . . . MOUD . . . cannot be denied based on current illegal drug use."[80] Therefore, people retain their protections under the ADA to access MOUD whether they are on probation, parole, or in drug courts.

Because of this, courts have found that denial of MOUD to incarcerated people can amount to an ADA violation. For example, in *Smith v. Aroostook County*, Brenda Smith, who had been in recovery for ten years, was at risk of losing access to her buprenorphine under a jail policy that prohibited MOUD except for pregnant people.[81] Despite requesting that the jail make a reasonable accommodation for her, Ms. Smith was told that she would have to come off of the medication when she arrived at the Aroostook County jail.[82] A district court judge found that the "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."[83] In the alternative, the court held that the defendants likely failed to make a reasonable accommodation by denying her access to her MOUD despite her requests to retain access to it.[84]

In addition to continuing to litigate against jails and prisons that fail to provide MOUD, litigators should also turn their attention to the rest of the criminal legal system—and indeed, the rest of society—to ensure that continuous MOUD access is available to everyone who needs it.

Today, MOUD is flatly prohibited for many individuals on probation and parole, as well as in some drug court programs.[85] While the Eighth Amendment right to health care does not extend to individuals who are not incarcerated, the ADA and the Rehabilitation Act provide legal recourse for those who are being denied access to their healthcare by the state or by public entities. Probation, parole, and drug courts are all programs, services, or activities of a government entity, which include "all of the operations of a department, agency, special purpose district, or other instrumentality of a State or of a local government."[86]

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77. 42 U.S.C. § 12210(a).
78. *Id.* § 12210(b)(2).
79. *Id.* § 12210(c).
80. Taylor v. Wexford Health Sources, Inc., 737 F. Supp. 3d 357, 375–76 (S.D.W. Va. 2024).
81. Smith v. Aroostook County, 376 F. Supp. 3d 146, 149–51 (D. Me. 2019).
82. *Id.* at 153.
83. *Id.* at 159–60.
84. *Id.* at 160–61.
85. *See* sources cited *supra* notes 25–26 and accompanying text.
86. 29 U.S.C. § 794(b)(1)(A) (Under the Rehabilitation Act, a "program or activity" includes "all of the operations of . . . a department, agency, special purpose district, or other instrumentality of a State or of a local

The United States Department of Justice (DOJ) issues guidance on combatting discrimination against people "in treatment or recovery."[87] The guidance reinforces that the ADA generally protects people with substance use disorder, unless they are currently illegally using drugs.[88] It provides examples of potential ADA violations—including denial of MOUD in a correctional setting,[89] a skilled nursing facility's refusal to admit someone taking MOUD,[90] discriminatory zoning restrictions against drug treatment facilities,[91] a doctor or hospital's refusal to treat someone with OUD,[92] and adverse employment actions against individuals taking MOUD.[93] The ADA thus provides a powerful legal tool for advocates representing people who use MOUD.

C. DOJ Enforcement Actions Against Probation, Parole, and Drug Court Entities that Discriminate Against People Who Use MOUD

The Department of Justice Civil Rights Division and U.S. Attorney's offices throughout the country have used their affirmative litigation authority to vindicate the rights of people with substance use disorder, including those in court supervision programs. DOJ's enforcement actions extend to a broader range of discriminatory conduct than the examples listed in their guidance,[94] including discrimination against people in drug courts and people under supervision on probation. The DOJ, in a letter of findings and conclusions in its case against the Unified Judicial System of Pennsylvania, found that the defendant violated the ADA "by denying [individuals] an equal opportunity to benefit from court services, programs, or activities—including probationary and treatment court supervision—because of their disability," namely substance use disorder.[95] The treatment courts were broader than just the drug court: according to the letter, veterans' courts and mental health courts both improperly denied individuals in their custody access to

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government"); 28 C.F.R. pt. 35 app. B (1991) ("[T]itle II applies to anything a public entity does."); Armstrong v. Wilson, 124 F.3d 1019, 1023 (9th Cir. 1997) (noting that the ADA is to be read in line with the Rehabilitation Act).

87. THE ADA AND THE OPIOID CRISIS, *supra* note 58, at 1.

88. *Id.* at 1.

89. *Id.* at 2.

90. *Id.*

91. *See id.* at 3.

92. *Id.* at 3–4.

93. *Id.* at 4–5.

94. The DOJ, for example, took action against the Indiana State Board of Nursing, which it found violated the ADA by prohibiting the use of MOUD for nurses in the Indiana State Nursing Assistance Program, a program for nurses in recovery for addiction. *Indiana State Board of Nursing*, U.S. DEP'T OF JUST., https://www.justice.gov/crt/case/indiana-state-board-nursing (Jan. 16, 2024). The settlement agreement between the DOJ and the nursing board requires the nursing board to allow nurses to continue their MOUD treatment "when the medication is prescribed by a licensed practitioner as part of a medically necessary treatment plan and incorporated into a recovery monitoring agreement." *Id.*

95. Letter from Rebecca B. Bond, Disability Rts. Div. Chief, U.S. Dep't of Just., to Robert J. Krandel, Legal Couns., Sup. Ct. of Pennsylvania 1–2 (Feb. 2, 2022), https://www.justice.gov/crt/case-document/file/1480031/dl.

MOUD.[96] One judge required all individuals under supervision—including probation, parole, and drug court—to be "completely clean" of "opiate based treatment medication."[97] The letter also cites other judges and treatment courts which limit or prohibit access to MOUD.[98] The parties settled, requiring the Administrative Office of Pennsylvania Courts to recommend and encourage all judicial districts in the commonwealth to adopt a policy that prohibits discrimination against people using MOUD, and requiring three specific defendant counties to adopt this policy.[99]

In 2022, the DOJ entered into a settlement agreement with the Massachusetts Trial Court, after allegations that the drug court prohibited participants from using methadone or buprenorphine, and instead required them to use naltrexone.[100] In Massachusetts, the drug court is a "form of heightened supervised probation."[101] The settlement agreement required the trial court system to implement a policy prohibiting drug court staff from interfering with a participant's MOUD in all twenty-five of its drug courts.[102]

D. Less Encouraging Efforts Outside of DOJ's Actions

Despite the clear language of the ADA, the guidance from the DOJ, and the DOJ's enforcement actions, compliance on the ground is uneven at best. This is, in part, because conditions of supervision are infrequently litigated. But private litigators and public defenders have taken some action to protect access to MOUD for people in drug courts, on probation, and on parole. In Ohio, for example, the Ohio Public Defender challenged a county probation office's restriction on the use of buprenorphine (Suboxone) all the way to the Ohio Supreme Court.[103] The Guernsey County adult probation department had a written policy that stated: "Suboxone will not be an approved medication. If you are currently prescribed Suboxone, you must see your physician to obtain a safe titration plan. You must be weaned off within 60 to 90 days."[104] The state intermediate appellate court held that, because Mr. Yontz had complied with this condition of his probation, the issue was moot and could not be challenged.[105] Mr. Yontz appealed, arguing that one is not required to violate the terms of their supervision in order to challenge them[106] and citing a long list of cases

96. *Id.* at 2 n.1.

97. *Id.* at 3.

98. *Id.* at 4–6.

99. Settlement Agreement at 6, United States v. Unified Jud. Sys. of Pa., No. 2:22-cv-00709-MSG (E.D. Pa. Feb. 1, 2024). The policy contemplated in the settlement agreement includes provisions that prohibit judges from even encouraging participants to choose one of the medications over another. *Id.* Ex. 1, at 1.

100. U.S. DEP'T OF JUST., SETTLEMENT AGREEMENT BETWEEN THE UNITED STATES AND THE MASSACHUSETTS TRIAL COURT para. 2 (2022), https://www.justice.gov/crt/case-document/file/1508451/dl.

101. *Id.* at para. 4.

102. *See id.* at paras. 11–13.

103. State v. Yontz, 169 Ohio St.3d 55, 2022-Ohio-2745, 201 N.E.3d 867, ¶¶ 8–10.

104. *Id.* ¶ 7, 201 N.E.3d at 869.

105. *Id.* ¶ 10, 201 N.E.3d at 870.

106. *Id.* ¶¶ 11–13, 201 N.E.3d at 870.

where courts had heard similar challenges.[107] The Ohio Supreme Court never considered this question because it made the much broader—and more worrisome—holding that the terms of his supervision were not a final, appealable order and thus could not be challenged upon appeal at all.[108] The court held that, because intervention-in-lieu-of-conviction supervision was a "special opportunity," not a right, a motion to modify the terms of this supervision could not affect a "substantial right."[109] This judicially created loophole appears to permit violations of the statutory and civil rights of people under supervision, so long as they agreed to a program like intervention in lieu of conviction. At minimum, it allows probation departments to strip some people on probation of lifesaving medication like Suboxone. The Ohio Supreme Court's conclusion is out of step with what many other courts have found.[110]

In another case in an Ohio state appellate court, a divided panel of judges held that a sentence was still valid, despite a judge's statement to the defendant at the plea hearing before sentencing that if he used legally dispensed methadone, he would go to prison.[111] As noted at the beginning of this Article, the judge threatened the defendant with prison time if he continued to use methadone.[112] The appellate court stated that the "inappropriateness" of the judge's statement "could not be understated" and that the trial court judge "lacked any justification" in forbidding methadone.[113] Nevertheless, the court held that the trial judge's comment on methadone was not the basis for the sentence ultimately imposed, and therefore the sentence was valid.[114]

In a Georgetown County, South Carolina drug court, a judge required a man to taper off of his buprenorphine within three weeks, or serve his entire sentence.[115] When he tried to taper off, he experienced seizures and he was placed back on buprenorphine by his doctor.[116] But because he was placed back on buprenorphine, he was required to serve the full seven years in prison.[117]

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107. Memorandum in Support of Jurisdiction of Appellant Vernon L. Yontz, II at 11–12, State v. Yontz, 169 Ohio St.3d 55, 2022-Ohio-2745, 201 N.E.3d 867 (No. 2021-0382).

108. *Yontz*, 2022-Ohio-2745, ¶¶ 16–17, 201 N.E.3d at 871.

109. *Id.* ¶ 19, 201 N.E.3d at 871–72.

110. *See e.g.*, United States v. Napulou, 593 F.3d 1041, 1045 (9th Cir. 2010) (holding supervised release condition prohibiting contact with anyone who had a misdemeanor conviction was unlawfully overbroad); United States v. Thompson, 777 F.3d 368, 376–77 (7th Cir. 2015) (invalidating association ban as vague); United States v. Bass, 121 F.3d 1218, 1223–25 (8th Cir. 1997) (condition banning alcohol use was unreasonable); United States v. Voda, 994 F.2d 149, 153–54 (5th Cir. 1993) (probation condition prohibiting firearm possession was unreasonable).

111. State v. Porter, 2017-Ohio-7958, ¶ 1 (11th Dist.).

112. *Id.* ¶ 5.

113. *Id.* ¶ 15.

114. *Id.* ¶ 16.

115. Sally Friedman & Melissa Trent, *Defense Lawyers and the Opioid Epidemic: Advocating for Addiction Medication*, THE CHAMPION, Aug. 2018, at 20, 22, https://www.lac.org/assets/files/Defense-Lawyers-Opiod-Epidemic-Champion-Aug-2018.pdf.

116. *Id.*

117. *Id.*

These opinions underscore the profound stakes of these cases. However, none of these opinions directly grappled with the ADA argument laid out in this paper and advanced successfully elsewhere by private litigators and the DOJ. As advocates continue to assert their justice-involved clients' rights under the ADA, there is an opportunity to make these dangerous practices a relic of the past.

CONCLUSION

These examples underscore the practical challenges that people with OUD face when trying to maintain or gain access to MOUD. A more concerted effort is needed in order to ensure that involvement in the criminal justice system is never a barrier to necessary healthcare, including MOUD.

We need public defenders, the defense bar, and civil rights organizations to take action on this topic and build upon the DOJ's victories. The Legal Action Center—who have been leaders for decades in this space—and the Brooklyn Defenders Service wrote an article about this topic, encouraging defense attorneys to challenge restrictions on their clients' MOUD access.[118] This Article includes suggestions and tools for litigators to use to challenge discriminatory barriers to MOUD.[119] These cases are life-saving and winnable. We have seen a sea change in the number of jails and prisons offering MOUD, thanks in large part to litigation victories using the Eighth and Fourteenth Amendments, as well as the ADA and the Rehabilitation Act. The ADA can be used to expand these victories to other corners of the criminal legal system, thus improving access across jurisdictions and stages of supervision. While these litigation victories make a major impact in the jurisdictions in which they are decided, more is needed for lasting change to take root.

We need leadership from judges, prosecutors, state legislatures, local elected officials, and law enforcement to ensure continuity and initiation of MOUD care in their jurisdictions. Resources exist to help supervision officials apply best practices to support individuals in their custody who have OUD.[120] State legislatures and local elected officials should follow the lead of the seven states who have explicitly codified protections for people taking MOUD while under some form of supervision.

MOUD access is low-hanging fruit for leaders in our communities who want to address the overdose crisis. But solving the problem will take so much more. While strategic litigation and targeted legislation can support better outcomes today, there is no existing legal or constitutional requirement to fully fund our addiction and mental health care systems. It will take legislation, funding, political will, and the eradication of stigma to actually solve the overdose crisis. This Article proposes one small, but significant, step towards that goal.

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118. *Id.* at 29–30.

119. *Id.*

120. *Community Supervision and MOUD Toolkit*, OPIOID RESPONSE NETWORK https://resources.opioidresponsenetwork.org/Education/CommunitySupervisionandMOUDToolkit.aspx (last visited Feb. 2, 2025).