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Fatal Re-Entry: Legal and Programmatic Opportunities to Curb Opioid Overdose Among Individuals Newly Released from Incarceration

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Introduction

The United States is in the midst of a public health crisis: Every year, well over 24,000 Americans die from opioid overdose.\(^2\) This staggering death toll is equivalent to a weekly jumbo jet crash. After a decade of rapid growth, overdose caused by prescription opioids and heroin now tops the accidental death rankings, beating out automobile accidents, AIDS, and other high-profile killers.\(^3\)

Overdose does not discriminate, cutting across all geographic, economic, and racial divides. But some groups are especially vulnerable.\(^4\) This article is dedicated to one such group: individuals re-entering the community from correctional settings. In the immediate two weeks after release, people in this group are almost 130 times more likely to die of an overdose than the general population.\(^5\)

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\(^2\) CJ Arlotta, *Deaths Involving Opioids, Heroin Continue to Rise, Report Shows*, Forbes (Jan. 16, 2015), http://www.forbes.com/sites/cjarlotta/2015/01/16/deaths-involving-opioids-heroin-continue-to-rise-report-shows/ (estimating the overall 2013 number of drug overdose deaths at 43,982); *see also* Ctrs. For Disease Control and Prevention, *Prescription Drug Overdose in the United States: Fact Sheet* (2014), available at http://www.cdc.gov/homeandrecreationalsafety/overdose/facts.html [hereinafter CDC 2014]; *see also* Rose A. Rudd et al., *Increases in Heroin Overdose Deaths — 28 States, 2010 to 2012*, 63 MMWR 849 (2014), at Table 1 (estimating the number of 2012 heroin overdose fatalities for 18 states (56% coverage of the US population) at 3,635. Extrapolating from this datapoint, the national number of heroin overdose deaths is approximately equal to the number for the 18 covered states divided by the proportion of the U.S. population covered, or 3,635/.56 = 6,491. To account for the theoretical possibility of systematically lower rates of overdose in states not covered as compared by states covered in the cited study, it may be prudent to reduce this crude national estimate by 20%, resulting in a conservative estimate of approximately 5,193 fatalities). (The 2012 estimate for total opioid overdose deaths—including both heroin and OPR—is thus derived by combining the national OPR estimate of 16,007 with the crude fatal heroin overdose estimate of 5,193 to arrive at a 21,200 estimate).

\(^3\) See CDC 2014, *supra* note 2 (“Drug overdose was the leading cause of injury death in 2012. Among people 25 to 64 years old, drug overdose caused more deaths than motor vehicle traffic crashes.”).


\(^5\) *see, e.g.*, Ingrid A. Binswanger et al., *Mortality After Prison Release: Opioid Overdose And Other Causes of Death, Risk Factors, And Time Trends From 1999 To 2009*, 159(9) Annals Internal Med. 592, 592–93 (2013) [hereinafter Binswanger et al. 2013] (noting that in the state of Washington, 8.3% of all opioid overdose fatalities during the study period were attributable to those recently released
The United States leads the world in both the absolute number as well as the percentage of incarcerated individuals.\(^6\) Taken together, the rising levels of drug misuse in our society, chronic underfunding of community substance abuse and mental health services, and the increased risk of criminal justice involvement among those affected by substance use and mental health disorders translates to a correctional population disproportionately affected by these issues.\(^7\) Correctional institutions act as the de-facto mental health care system in this country,\(^8\) but only a fraction of those who struggle with mental health problems are able to receive adequate care behind bars.\(^9\) In the particular case of substance use disorders, upwards of 80% of incarcerated individuals are estimated to require treatment, but

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\(^{8}\) See Bridget M. Kuehn, Criminal Justice Becomes Front Line for Mental Health Care, 311 JAMA 1953, 1953 (2014).

only a small percentage receive any help at all; access to adequate, evidence-based substance abuse services is downright dismal.\(^{10}\)

As a result, most incarcerated individuals with substance use disorders re-enter the community without having received appropriate treatment and support while in custody. Reintegrating into society from jail or prison can be chaotic and stressful. During this time, individuals struggle to secure work, health care, a safe place to sleep, and many other elements of social and economic support.\(^{11}\) This can lead to self-medication and relapse of pre-existing substance abuse.\(^{12}\)

Tragedy results when mass incarceration meets our society’s failure to adequately treat substance abuse and mental health problems. In the days and months immediately following release from prisons and jails, thousands of lives are lost to fatal overdoses.\(^{13}\) The most acute overdose risk is concentrated in the first two weeks after

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\(^{10}\) Nat’l Inst. on Drug Abuse, Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide 13 (2012), available at http://www.drugabuse.gov/sites/default/files/txcriminaljustice_0.pdf; see also Elizabeth L.C. Merrall et al., Meta-analysis of Drug-related Deaths Soon After Release from Prison. 105(9) Addiction 1545, 1549 (2010) (stating variation in availability of drug treatment programs inside as well as outside prison); see also Kathryn M. Nowotny, Race/Ethnic Disparities in the Utilization of Treatment for Drug Dependent Inmates in U.S. State Correctional Facilities, 40 Addictive Behaviors 148, 150 (2015) (noting that, of all covered individuals in prison who were diagnosed with substance use disorder using DSM IV criteria, “[f]orty six percent of whites report having received some kind of treatment compared to 43 percent of blacks and 33 percent of Latinos” (p-value omitted) and “of those who received treatment, self-help groups are the most commonly reported with 83 percent receiving that form of treatment, Detox (27%) and drug maintenance programs (35%) are the least reported”).


\(^{12}\) Id. at 7.

\(^{13}\) There were over 21,000 opioid overdose deaths in the United States in 2012. See CDC 2014 and Rudd, supra note 2. Though national figures are not available, over 8% of all overdose deaths in Washington were estimated to be among recently-released individuals. See Binswanger et al. 2013, supra note 5, at 592–93. In fact, overdose is just one of the potentially life-threatening health issues that afflicts individuals upon re-entry. See, e.g., Emily A. Wang, et al., A High Risk of Hospitalization Following Release from Correctional Facilities in Medicare Beneficiaries: A Retrospective Matched Cohort Study, 2002 to 2010, 173(17) JAMA Internal Med. 1621, 1621–23 (2013).
release.\textsuperscript{14} Overdose often results when newly-released individuals resume drug use after a period of abstinence basing their intake on pre-incarceration doses, when they use drugs from unfamiliar sources and of unknown strength, or as a result of mixing multiple substances.

It is easy to cast post-incarceration substance use—and consequent overdose—as the re-entering individual’s character weakness or a propensity towards reckless behavior. Nevertheless, modern addiction science reframes such relapse as a foreseeable consequence of the chronic nature of substance use disorders.\textsuperscript{15} This scientific evidence also provides clear guidance on how most of the resulting fatalities can be prevented.\textsuperscript{16} This article considers the creation of fatal overdose risk among formerly incarcerated individuals as an unacceptable collateral harm emanating from criminal justice involvement.

In order to address this largely overlooked public health problem, we explore a range of legal channels that can help persuade the state (broadly construed) to address a risk to which it substantially contributes. We consider a number of doctrinal approaches, guided by the belief that spending time behind bars must not translate to a death sentence for so many Americans. Whether as a part of possible legal actions or an action agenda on its own right, we present a number of programmatic interventions and policy reforms that may alleviate this crisis. Our analysis also highlights the potential role of the Affordable Care Act (ACA) in facilitating overdose prevention

\textsuperscript{14} See Binswanger et al. 2007, supra note 5, at 157, 160–61; Binswanger et al. 2012, supra note 11, at 1; Traci Green et al., Staying Alive on the Outside: Opioid Overdose Prevention and Response for People Leaving Prison, abstract available at https://apha.confex.com/apha/140am/webprogram/Paper271542.html (forthcoming); Farrell & Marsden, supra note 5, at 254; Merrall, supra note 10, at 1549; Clarissa S. Krisnky et al., Drugs, Detention, and Death: A Study of the Mortality of Recently Released Prisoners, 30(1) AM. J. FORENSIC MED. \& PATHOLOGY 6, 6–9 (2009). Additionally, overlapping risk factors, such as an increasingly older and aging prison population, can exacerbate the risk of overdose post-release. See Human Rights Watch, Old Behind Bars: The Aging Prison Population in the United States (January 2012), at 6, available at http://www.hrw.org/sites/default/files/reports/usprisons0112webcover_0_0.pdf (calculating that, between 2007 and 2010, the number of sentenced federal and state prisoners aged 65 or older grew an astonishing 94 times faster than the total sentenced prisoner population).


\textsuperscript{16} See id.
before, during and post-incarceration. This agenda is especially timely given the current move by federal and state governments towards releasing large numbers of individuals incarcerated on drug-related charges to ease prison over-crowding or as a result of legal reforms, pardons, or exonerations.17

In Section I, we provide an overview of the opioid overdose epidemic and the special vulnerability among criminal justice-involved individuals. In Section II, we examine the scientific evidence on prevention measures that should be, but are currently rarely deployed to address this vulnerability. In Section III, we explore various legal theories that could be invoked in efforts to motivate government actors to take a greater responsibility for preventing post-incarceration overdose deaths. In Section IV, we cover additional mechanisms to motivate institutional change. We conclude by outlining a policy and programmatic agenda for reducing the vulnerability of criminal justice-involved individuals to opioid overdose.

I. Background

Since the 1980s, the number of Americans behind bars has risen significantly. In 2011, there were approximately seven million Americans under the supervision of the correctional system, with more than twelve million cycling in and out of jails.18 Much of this surge is attributed to the “War on Drugs,” as well as to the sharp defunding and dismantling of publicly-financed mental health and substance use treatment resources.19

The mass incarceration paradigm is defined by gross racial and economic disparities. In 2010, roughly half of individuals sentenced to state prisons for drug-related crimes were African American\(^20\) despite comprising only about 13% of the population of the United States.\(^21\) Evidence that African Americans are not any more likely to misuse drugs or engage in drug-related crimes than whites underscores the gross and systemic injustice of these disparities.\(^22\)

The War on Drugs has had little impact on the rate of drug abuse in the United States. In fact, after decades of steady growth, opioid abuse (including both prescription analgesics and illicit opioids like heroin) is at an all-time high.\(^23\) As of 2011, approximately 145 out of every 10,000 Americans in the general population were nonmedical users of opioid pain relievers and 9 to 16 out of every 10,000 Americans were users of heroin.\(^24\) Based on sporadic testing anywhere from 5-15% of US arrestees have detectable blood levels of opioids at the time of detention, and over three percent report having used heroin within the past seven days.\(^25\) There is also evidence that
at least 200,000 heroin users are estimated to pass through the correctional system each year.\textsuperscript{26} The overall rate of arrestees who may misuse opioids, but do not have them in their system at the time of arrest is unknown.

A significant number of individuals with opioid dependency are under custody in criminal justice institutions. In fact, at least 200,000 heroin users are estimated to pass through the correctional system each year.\textsuperscript{27} Put another way, upwards of 85% of the incarcerated population either meet the clinical criteria for substance abuse or addiction, have histories of substance abuse, were under the influence of alcohol or other drugs at the time of their crime, committed their offense to obtain drugs, were incarcerated for an alcohol or drug law violation, or shared some combination of these characteristics.\textsuperscript{28} Accordingly, inmates are at a much higher risk of substance abuse than the general public. Moreover, drug use does not necessarily abate upon incarceration.\textsuperscript{29} The sporadic availability and usage of drugs within jail and prison walls is well documented,\textsuperscript{30} as are the in-custody overdoses that result.

\textsuperscript{26} McKenzie et al, supra note 19, at 2.
\textsuperscript{27} McKenzie et al, supra note 19, at 2.
\textsuperscript{28} Nat’l Ctr. for Addiction and Substance Abuse at Columbia Univ. (“CASA”), Behind Bars II: Substance Abuse and America’s Prison Population (Feb. 2010) at i (Feb. 2010).
\textsuperscript{30} The 1998 Annual Study of Jails, which examined 36,215 drug test results from inmates in a representative sample of 820 jail jurisdictions, found that 10% of samples tested positive for drugs. Doris James Wilson, Drug Use, Testing, And Treatment In Local Jails (2000), available at http://www.bjs.gov/content/pub/pdf/duttj.pdf. In 2003, a report by the Justice Department’s Office of the Inspector General stated that the Bureau of Prisons was falling short in efforts to address a “continuing problem with inmate drug use and drug smuggling in almost every institution.” See Crary, supra note 29. In a
Criminal justice institutions such as jails, prisons, detention centers, and mandated drug-treatment programs vary widely with respect to the populations served, lengths of stay, and services available. For most incarcerated individuals with addiction issues, time behind bars does not present an opportunity to receive comprehensive, evidence-based substance abuse treatment and counseling. Rather, treatment services are generally absent, and overdose prevention services are virtually non-existent.

Without appropriate care, undergoing severe opioid withdrawal in jail or prison is an extremely distressing health condition. At times, withdrawal is accompanied by profuse vomiting, diarrhea, and hostile, even violent behavior. Unmediated withdrawal is potentially life-threatening. It also creates a danger of self-harm or harm to others.

Additionally, incarceration settings present their own stressors and trauma, including pervasive physical and sexual abuse. As a result, most re-enter the community untreated and often traumatized, without so much as the basic knowledge of the risk factors associated

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31 See Nowotny, supra note 10 and accompanying text. See also Chandler et al., supra note 9.

32 Id.; Josiah D. Rich et al., Attitudes and Practices Regarding the Use of Methadone in US State and Federal Prisons, 82 J. Of Urb. Health 411, 411 (2005); see also Carmen E. Albizu-Garcia et al., Characteristics of Inmates Witnessing Overdoses Events in Prison: Implications for Prevention in the Correctional Setting, 6 Harm Reduction J. 1, 7 (2009) (stating that drug overdose events are frequently witnessed which requires prompt interventions to reduce drug related harm within the correctional system).


34 See, e.g., Cecil Brace v. Massachusetts, 673 F. Supp. 2d 36 (D. Mass. 2009) (a wrongful death lawsuit where failure to provide appropriate care for an incarcerated individual in withdrawal was alleged to have caused death).


with post-release overdose or the tools by which they might be able to save their own life or the lives of other similarly-situated individuals.\textsuperscript{37}

When recently released individuals return to substance use, they face several physical and psychological factors that elevate overdose risk. Although incarcerated individuals still have access to drugs while incarcerated, that access is limited compared to community settings.\textsuperscript{38} Therefore, after spending time in jail or prison, a person’s tolerance decreases drastically. As a result, what was a normal dose for an individual prior to incarceration could suddenly be enough to kill him or her.\textsuperscript{39} Lowered tolerance can also be exacerbated by use of more than one drug at a time.\textsuperscript{40} Combining alcohol with an opioid, for instance, can increase the propensity of opioids to suppress breathing.\textsuperscript{41} In fact, the risk of death doubles with every illicit drug consumed in combination with opioids.\textsuperscript{42}

Opioid dependence is within the constellation of factors that have been found to impede successful reintegration. Other factors include physical or sexual abuse, homelessness and unemployment.\textsuperscript{43} These characteristics can trigger relapse and contribute to an elevated risk of overdose.\textsuperscript{44} Indeed, formerly incarcerated individuals have cited overdose as a result of self-medication to escape the multiple stressors created by the struggle to reintegrate into society.\textsuperscript{45}

Criminal justice institutions are well aware of the post-release substance misuse relapse and overdose risk among those in their custody, both as a general matter and in many individual cases.\textsuperscript{46}

\begin{footnotes}
\item[37] Green et al., supra note 14.
\item[38] Binswanger et al. 2012, supra note 11, at 5.
\item[39] McKenzie et al., supra note 19, at 7.
\item[40] World Health Org 2014, supra note 5, at 10–11.
\item[41] Id.
\item[42] Id.
\item[44] Binswanger et al. 2012, supra note 11, at 7.
\item[45] Id.
\end{footnotes}
These institutions are also optimally situated to provide targeted services to incarcerated individuals to facilitate recovery and prevent their death upon release. Although many structural and systemic changes are needed to comprehensively address the multiple issues facing newly-released individuals, the distinct harm of fatal overdose can be mitigated relatively easily. As we detail below, properly targeted evidence-based services such as drug treatment, overdose education, and fatality prevention training can be provided directly to incarcerated individuals—in some instances, with minimal cost and effort.47

The current reality is that very few correctional institutions take these straightforward prevention measures. The reasons behind this system-wide failure are varied. For instance, access to treatment while in custody as well as bridges to care for re-entering individuals are complicated by an entire constellation of factors.48 Many policymakers and correctional officials do not view medication assisted treatment (MAT)—the only kind of drug treatment proven to reduce overdose risk—as appropriate for custodial settings.49 Moreover, direct overdose prevention education and training may be seen as running counter to encouraging those re-entering the community to abstain from drug use.50 Lastly, given that providing health care services already constitutes the largest and the fastest-rising component of correctional spending, the cost of additional programming is likely also a barrier.

A broader structural explanation for the lack of action on the part of correctional institutions is that people who populate prisons and jails represent some of the most disenfranchised members of our

49 See infra notes 55-79 and accompanying text.
In practice, those most affected by criminal justice policies are least able to shape them. These individuals often lack access to political, economic, and social capital to affect reform and marshal public resources. The issue of opioid overdose in this population vividly demonstrates how such disempowerment may translate to perpetuating avoidable public health harms.

Current sentencing reform, expansion of clemency, and court decrees mandating the easing of prison over-crowding will lead to an expansion in the number of newly released individuals. Those convicted of drug offenses have faced disparities in prison sentencing, so the federal and some state governments have made efforts to restore a sense of fairness to a greater number of people with drug law violations. A growing number of state-level initiatives parallel the U.S. Justice Department’s expansion of the criteria for clemency to potentially thousands of inmates. Unless adequate risk reduction steps are taken, these—otherwise positive—reforms can put thousands of individuals at risk of fatal overdose.

Overdose among the recently released is a public health issue that affects not only the specific individual, but also their families, friends, and the community at large. The criminal justice system

51 See Michelle Alexander, The New Jim Crow: Mass Incarceration in the Age of Colorblindness (2012); see also Becky Pettit, Invisible Men: Mass Incarceration and the Myth of Black Progress (2012) (detailing the systematic disengagement of incarcerated populations, particularly populations of color, from mainstream services, employment, and even being included in census and other socio-demographic data).

52 See, e.g., Lisa Kerber, Texas Department of Criminal Justice State Jail Division, Substance Abuse Among Female State Jail Inmates (1998), http://www.utexas.edu/research/cswr/gcattc/documents/female_inmates1998.pdf (last visited August 2, 2014) (A 1998 survey conducted on female state inmates in Texas found that forty-two percent of female inmates with a history of substance abuse had an annual family income of less than $10,000 at time of entry. Sixty-five percent of individuals with a history of substance abuse did not graduate from high school.).


54 Id.

has an obligation to make inmates’ community reintegration as safe as possible. With the availability of evidence-based tools to reduce the elevated risk of overdose faced by the newly released, it behooves us, as a society, to demand these simple measures to become standard.

II. Proven Prevention Measures Exist, but Are Not Utilized

A set of evidence-based interventions have been shown to address substance abuse relapse and associated overdose death risk in the days and weeks after release from incarceration.

A. Medication-Assisted Treatment

MAT, otherwise known as opioid substitution treatment, refers to the use of medications to treat opioid dependence. The U.S. Food and Drug Administration has approved three medications for use in treating opioid dependence: methadone, naltrexone, and buprenorphine. These medications are typically used in combination with counseling and behavioral therapies. Based on extensive research, these regiments have been found to be safe, effective and cost-effective across social, geographic, and other settings and diverse populations.

Providing MAT during incarceration and connecting patients to appropriate treatment immediately following release significantly reduces substance use relapse and overdose deaths among re-entering individuals. One illustrative study following people who were incarcerated and participated in prison-based methadone treatment found that post release, seventeen individuals among those who did not maintain MAT participation died from overdose during the four-year follow-up period; in contrast, none of those who maintained


In another randomized trial, there were no overdose deaths for patients assigned to counseling and referral to a methadone program or counseling and methadone while incarcerated, while four such deaths occurred to those participants assigned to counseling only during the twelve-month follow-up period. Research estimates that MAT participation confers inmates with a fourteen-fold risk reduction in overdose mortality after release.

Access to effective drug treatment during incarceration also carries a range of additional positive benefits for both the incarcerated individual as well as other stakeholders. Broader research is needed

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In another randomized trial, there were no overdose deaths for MAT participation confers inmates with a fourteen-fold risk reduction in overdose mortality after release. Sixty-one patients assigned to counseling and referral to a methadone program during the twelve-month follow-up period. Thierry Favrod-Coune et al., (2008); Carmen E. Albizu-García et al., (2008); Timothy W. Kinlock et al., (2012); Robert Heimer et al., (2007). Methadone maintenance treatment during incarceration has been proven to reduce crime and recidivism. Methadone Maintenance in Prison: Evaluation of a Pilot Program supra note 59, at 277–85; Victor Tomasino et al., A Randomized Clinical Trial of Methadone Maintenance for Prisoners: 3-Month Postrelease Outcomes. "Isoniazid for Tuberculosis Prevention in Injection Drug Users," Robert Nowotny, supra note 10, at 1–38. Given the high prevalence of substance use disorder, including opioid dependence among individuals booked into U.S. prisons or jails, initiating MAT behind bars and linking re-entering patients to community-based treatment services should be a widespread, 


62 See Nowotny, supra note 10 and accompanying text.
64 Lars Møller et al., Interventions to Address HIV in Prison: Drug Dependence Treatment World Health Org. (2007).
65 Id.
66 McKenzie et al., supra note 19, at 2; see also Nowotny, supra note 10 and accompanying text.
standard practice.\footnote{67} Shockingly—and inexplicably—this is far from reality, as MAT availability to opioid dependent individuals in incarceration settings is almost entirely lacking.\footnote{68} In a national survey of forty respondent state prison medical directors (having jurisdiction over 88\% of the of U.S. state and federal prisoners), \textit{none} offered methadone treatment to incarcerated individuals other than pregnant women.\footnote{69} These results are consistent with a U.S. Department of Justice report, which found that less than 0.5\% of state and federally incarcerated individuals receive any MAT.\footnote{70} Another survey reported that only 0.2\% of people in prison and jail have access to MAT.\footnote{71} Further, a study of state medical directors found that over 85\% of state prison systems did not provide any buprenorphine access.\footnote{72}

Even in the small number of instances where some access exists, no data are available to assess what circumstances trigger such access and whether medication is provided only for detoxification, or for maintenance, as is recommended.\footnote{73} Fragmented evidence suggests that, where available, medication-assisted detoxification (MAD) and treatment in correction settings is often inadequate and not based on established best practices.\footnote{74} A national study covering 245 U.S. jails found that only 12\% of the incarcerated population that reported being a MAT patient at the time of arrest received any continuation

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\footnote{67} Bennett W. Fletcher \textit{et al.}, \textit{Nat'l Inst. on Drug Abuse, Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide} (2014), \textit{available at} http://www.drugabuse.gov/sites/default/files/txcriminaljustice_0.pdf (last visited Aug. 4, 2014) (stating, e.g., “Medications are an important part of treatment for many drug abusing offenders. Medicines such as methadone, buprenorphine, and extended-release naltrexone have been shown to reduce heroin use and should be made available to individuals who could benefit from them”); \textit{id.} at 5.

\footnote{68} Hannah K. Knudsen \textit{et al.}, \textit{Adoption and Implementation of Medications in Addiction Treatment Programs}, 5 J. Addiction Med. 21, 21–27 (2011).

\footnote{69} Rich \textit{et al.}, \textit{supra} note 32, at 413; \textit{see also} R. Heimer \textit{et al.}, \textit{supra} note 62, at 123 (“In the U.S., no domestic prison currently provides methadone maintenance for sentenced inmates”).

\footnote{70} Mumola \& Karberg, \textit{supra} note 43, at 9.

\footnote{71} Nat'l Ctr. on Addict. \& Subt. Abuse, Colum. Univ., \textit{Behind Bars II: Substance Abuse and America’s Prison Population} 2–4 (2010).


\footnote{73} \textit{Id.}

\footnote{74} \textit{See generally} Rich \textit{et al.}, \textit{supra} note 48, at 464–65.
It is unclear to what extent the access cited by the researchers constituted true MAT as opposed to MAD. Illustrating the outrageous paucity of treatment, only one jail program in the United States is known for providing comprehensive MAT behind bars—Rikers Island Jail’s Key Extended Entry Program (KEEP). KEEP performs approximately 18,000 detoxifications and 4,000 admissions for methadone treatment per year, resulting in a battery of public health, criminal justice, and economic benefits.

Whether or not MAT or MAD is supplied by correctional institutions, re-entering individuals are rarely bridged to appropriate care in the community. A national survey of jail administrators found that less than 10% reported referring opioid-dependent individuals incarcerated in jails to methadone programs upon their release. Linking treatment during incarceration with robust treatment and support services post-release in the community should be standard for overdose prevention as well as a number of other public health and public safety reasons.

Jails and prisons are not the only correctional settings in which individuals under criminal justice control are denied access to proven drug treatment. Despite endorsement by the National Association of Drug Court Professionals, many—and perhaps most—drug courts currently prohibit evidence-based treatment and other maintenance

76 Id.
77 Tomasino et al., supra note 61, at 14.
78 Rich et al., supra note 32, at 413.
therapies because of an ideological preference for abstinence.\textsuperscript{79} Overdose deaths are directly linked to these policies.\textsuperscript{80}

MAT in the incarceration settings, when continued during post-release is both effective and cost-effective. If widely adopted, it is likely to result in sharp decreases in overdose risk, especially when coupled with education and naloxone prescription elements we discuss next.

B. Overdose Education and Naloxone Access Pre-Release

Naloxone hydrochloride is a fast-acting medication that, when administered during an overdose, blocks the effects of opioids on the brain and restores breathing.\textsuperscript{81} This antagonist has no potential for abuse; side effects are rare.\textsuperscript{82} Since it was first introduced in the

\textsuperscript{79} Colleen O’Donnell & Marcia Trick, Nat’l Ass’n of State Alcohol and Drug AbuseDirs., Methadone Maintenance Treatment and the Criminal Justice System (2006); California Drug Courts Denying Methadone, CSAM News Q. Newsletter (Cal. Soc’y of Addiction Med., S.F., Cal.), Winter 2002. With new rules announced to tie federal drug court funding to policies permitting MAT, these bans may at last change. See Substance Abuse and Mental Health Services Administration (SAHMSA), Grants to Expand Substance Abuse Treatment Capacity in Adult and Family Drug Courts, (2015) http://www.samhsa.gov/grants/grant-announcements/ti-15-002 (last visited March 9, 2015) (conditioning federal funding as follows: “Applicants must affirm...that the treatment drug court(s) for which funds are sought will not: 1) deny any appropriate and eligible client for the treatment drug court access to the program because of their use of FDA-approved MAT medications (e.g., methadone, injectable naltrexone, noninjectable naltrexone, disulfiram, acamprosate calcium, buprenorphine, etc.) that is in accordance with an appropriately authorized [physician’s prescription]; and 2) mandate that a drug court client no longer use MAT as part of the conditions of the drug court if such a mandate is inconsistent with a physician’s recommendation or prescription. If an application does not include the Statement of Assurance affirming these conditions, the application will be screened out and will not be reviewed”).

\textsuperscript{80} Peggy Fulton Hora, Trading One Addiction for Another?, 2(4) J. Maint. Addictions 71, 73–74 (2005) (describing the case of Brad Moore, a Nevada County drug court client, who died of a heroin overdose on December 15, 1999, shortly after being ordered by the drug court judge supervising him to withdraw from his methadone program and become entirely “drug-free”).


\textsuperscript{82} See Burris et al., supra note 81, at 287; see generally Leo Beletsky et al., Prevention of Fatal Opioid Overdose, 308(18) J. AM. MED. ASS’N 1863, 1863–64 (2012).
early 1970s, “naloxone has been used safely and effectively for over forty years in ambulances and emergency rooms across the country.”\textsuperscript{83} Increasingly, naloxone is also available by prescription from a physician, through pharmacies working under collaborative practice agreements, and is distributed by community-based programs offering opioid overdose prevention services.\textsuperscript{84} Naloxone distribution and education is a highly effective means of reducing overdose deaths.\textsuperscript{85} According to the CDC, programs that have distributed naloxone to drug users, their family members, friends, and others who are likely to witness an overdose have logged at least 10,000 overdose reversals,\textsuperscript{86} slashing overdose rates for entire participating communities.\textsuperscript{87}

Despite the staggering and disproportionate toll of overdose on newly-released individuals, only a handful of programs in jails and prisons are distributing naloxone to inmates before they re-enter the community.\textsuperscript{88} Given the small number and modest scale of these interventions, data evaluating their effectiveness is sparse. Initial results are highly promising, however. As of June 2011, Scotland’s National Naloxone Program has distributed ‘take-home’ naloxone kits to all incarcerated individuals at risk of opioid related overdose upon release from prison.\textsuperscript{89} The naloxone rescue kit is stored with the prisoner’s personal belongings, until the individual collects them upon release.\textsuperscript{90} In 2013, a significant decrease in the percentage of

\begin{thebibliography}{99}
\bibitem{83} Drug Policy Alliance, supra note 81, at 1.
\bibitem{85} See Burris et al., supra note 81, at 277, 287.
\bibitem{86} Ctrs. For Disease Control and Prevention, Community-Based Opioid Overdose Prevention Programs Providing Naloxone – United States, 2010 (2012), available at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6106a1.htm.
\bibitem{88} See Green et al., supra note 47, at 4–6; see also infra notes 88-106 and accompanying text.
\bibitem{90} Id.
\end{thebibliography}
opioid related deaths occurring within four weeks of prison release was observed (4.7%) compared to the 2006-10 baseline rate (9.8%).

Though in the early stages of evaluation, the naloxone investigation (N-ALIVE) randomized trial in the United Kingdom involves assigning 56,000 incarcerated individuals to either receive a take-home supply of emergency naloxone upon release in conjunction with overdose education or to education alone. Amongst the control group of 28,000 eligible ex-prisoners that receive naloxone, researchers expect to detect a 30% reduction in overdose deaths—from the anticipated 140 deaths during the first four weeks of release down to a lower level of just under 100 deaths.

In view of this evidence, incorporation of overdose education, program referral, and naloxone distribution prior to release is a feasible and inexpensive intervention available to significantly reduce opioid overdose mortality risk among newly-released individuals. Especially given the paucity of treatment available behind bars, overdose education and naloxone access may in many jurisdictions represent the only opioid overdose intervention realistically available for this population. Nevertheless, at the time of writing, only a small number of programs in the United States—including those in New York’s Erie County, New Mexico, San Francisco, Seattle, and Rhode Island—offer naloxone to incarcerated individuals upon release.

As just one example, the goals of the San Francisco County Jail Naloxone Pilot are to: 1) educate incarcerated individuals

91 Id. at 3.
93 Id.
95 The SF County Jail naloxone pilot is a collaboration between: 1) The Drug Overdose Prevention and Education (DOPE) Project, a program of the Harm Reduction Coalition with funding and support from the San Francisco Department of Public Health; 2) Jail Health Services (JHS), LHEAP Program (Linkage to Health Education and Prevention) with funding and support from the San Francisco Department of Public Health; and 3) Re-Entry Pod at CJ2, a program overseen by the San Francisco Adult Probation Department.
about to re-enter the community about the high risk of overdose; 2) offer the option of obtaining a naloxone kit in their property when they are released; 3) integrate overdose prevention into the wider array of services for substance using adults, including substance abuse treatment, STD testing, and linkage to care; and 4) decrease overdose mortality among people leaving jail and re-entering the community. The naloxone is provided by a community organization (dispensed via standing order from the San Francisco Department of Public Health) and jail staff are trained by the organization to provide overdose prevention education. Incarcerated individuals in participating housing units are visited monthly by trained staff and are called to participate within one month of their release date. At that time, participants watch an informational video on overdose risk following release and can then opt to receive naloxone. If he opts in, the prisoner meets with staff one-on-one to go over any questions, practice with a naloxone demonstration, and complete paperwork. A naloxone kit is then placed in the incarcerated individuals’ property. Though not screened for overdose risk, of the 101 participants who have been eligible to receive naloxone thus far, an overwhelming majority (65%) opted to receive a kit. It remains to be seen how many overdoses are reversed as a result of the pilot but, at the very least, it provides an opportunity for overdose education and access to naloxone that otherwise would not exist.

A number of programs provide overdose prevention education to incarcerated individuals in the United States without the accompanying naloxone distribution. Prevention Point Pittsburgh’s (PPP) Overdose Prevention Project, for example, has offered one-hour training sessions for people who are incarcerated at the Allegheny County Jail in Allegheny County, Pennsylvania since 2003. The

97 S.F. County Jail Naloxone Pilot PowerPoint Presentation (on file with author).
98 Id.
99 Id. at 7.
100 Id.
101 Id.
102 Id. at 8.
sessions are run by trainers from a local syringe exchange program and cover overdose risks, prevention, and instruction on rescue breathing. Trainers provide literature on other issues like Hepatitis C and HIV, as well as information about cocaine and opioid overdose. The trainings have been overwhelmingly well received, and many visitors at the city’s syringe exchange program have said that they learned about its services from the “jail trainings.” In addition to serving as a model for overdose education in jail, PPP also provides a means of linking people who were formerly incarcerated to public health prevention organizations upon release—something that is understood to be a major gap in the re-entry process.

Overdose prevention and naloxone distribution programs in jails and prisons provide incarcerated individuals with critical information such as their unique risk of overdose following release, how to recognize and respond to an overdose, and where to access naloxone if it is not provided by the program. Although evaluation of the US program impact is still preliminary, taken in concert with international data, evidence suggests that such initiatives will help save lives.

C. Overdose Prevention as Part of Comprehensive Re-Entry Support

Increasing access to MAT within incarceration settings and post-release, and overdose prevention services and education represent narrowly targeted interventions that are critical to reducing overdose risk among newly-released individuals. Given the multiple and complex challenges that characterize community reintegration, these interventions must be incorporated into a broader set of efforts to provide social support and services to this population.

The days and weeks following release can be chaotic, disorienting, and highly stressful. Inadequate social support, disrupted networks, strained financial resources, and lack of access to healthcare coverage and medical and mental healthcare all contribute to the elevated risk of overdose. Relapse after release

104 Id. at 33.
105 Id.
106 Id. at 32.
107 See, e.g., Rich et al., supra note 48, at 462–64.
109 Id.; see also Rich et al., supra note 48, at 465–66.
is particularly heightened by exposure and access to illicit substances in the environment to which recently released individuals return.110

Federal and state statutes and regulations bar those with criminal records from taking residence in public and subsidized housing.111 Although a substantial proportion of individuals will reside with family, friends, or in their own home on the first night of release,112 many have no other choice but to enter a shelter or “halfway house.”113 These institutions are often located in neighborhoods with a high concentration of illicit substance users, and may themselves house a population that is at higher risk of having substance use disorders.114 Many of these institutions, however, have stringent policies regarding drug use, including curfews and prohibition of MAT enrollment in some cases.115 Partly because it is difficult to secure beds in institutions designed to facilitate reentry, homelessness is a common fate for many formerly incarcerated.116

Criminal justice involved individuals are also at an elevated risk of unemployment. Lack of education and economic opportunity is both a cause and effect of incarceration.117 Securing employment after serving a criminal conviction is especially difficult because most employers screen out applicants with a history of criminal justice involvement.118

113 Id. at 19.
114 See Binswanger et al. 2012, supra note 11, at 4.
116 This is especially true of individuals listed on sex offender registries. See Joseph Goldstein, Housing Restrictions Keep Sex Offenders in Prison Beyond Release Dates, N.Y. TIMES, Aug. 21, 2014, at A18.
118 Current efforts to outlaw this practice known as “ban the box” have been making some inroads, although this practice remains pervasive. See generally, Ban the Box, NAT’L EMPL. LAW PROJECT (2014), http://www.nelp.org/page/-/SCLP/Ban-the-Box.Current.pdf?nocdn=1.
Health care and other services that the individual may have received while behind bars are often times disrupted or terminated once the individual reenters society. Although access to evidence-based drug treatment in correctional settings is lacking, correctional custodians are constitutionally mandated to provide—and pay for—adequate medical and psychiatric care to all incarcerated persons. Upon re-entry, however, such care is usually interrupted because of several factors, including failure to effectively link newly released individuals to community-based services, lack of options for accessible providers, and suspension of health insurance benefits. Some of these gaps inevitably result from the need to attend to other, more urgent life priorities, like housing and employment.

Given the complicated and unsupported landscape to which many formerly incarcerated individuals return, specialized housing programs can serve as a supportive environment, providing a bridge to treatment, as well as comprehensive overdose prevention education and naloxone access programs. While initiatives providing structural support and case management are successful among former incarcerated individuals in reducing the risk of substance use relapse, access to such services is rare.

III. Motivating State Actors to Address Overdose Risk: Legal Options

In view of the highly-foreseeable risk of overdose among newly-released inmates, how can the legal system be used to motivate correctional settings to adopt simple and cost-effective risk reduction strategies? The authors did not find any case law directly addressing the question of whether state actors or institutions can be held liable for the overdose of a formerly incarcerated individual during the critical post-release period. To inform an analysis of potential claims, we turned to analogous case law concerning patients or incarcerated individuals who have brought tort claims of negligence or wrongful death against medical professionals, medical facilities, and state actors. Many courts hold mental health professionals liable for a patient’s

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120 See Binswanger et al. 2012, supra note 11, at 6.
self-harm or harm of a third party after the patient’s release from professional care or institutional control, if that harm was reasonably foreseeable.\textsuperscript{121} Though the cases are very fact-specific, courts have found that a duty of care attaches to a health care professional or state institution to prevent foreseeable harm by their patients or dependents, even post-release.\textsuperscript{122}

As described above, prisons are acting as de-facto mental health care and custodial institutions in the U.S.\textsuperscript{123} Yet, several formidable hurdles exist to the use of tort liability to hold health professionals and state officials accountable for the heightened overdose risk to incarcerated individuals upon release, including questions of causation and immunity for state actors. The following sections provide a general overview of the main principles of and challenges to holding state officials and health institutions accountable for harm that occurs to a patient\textsuperscript{124} in the days and weeks after their discharge.

This section lays out a number of factors that a practitioner could consider in building a case under tort law for formerly incarcerated overdose victims, as well as the major obstacles that could be encountered in such suits. The subsequent section explores the types of claims that individuals could bring while still incarcerated, including constitutional and statutory claims at the federal and state level. These sections aim to highlight elements that may constitute the strongest case addressing post-release overdose harm, while also acknowledging the serious limitations to litigating this issue in the courts.

A. Common Law Tort Claims

1. Duty of Care: Imposing Liability on Custodians for Patients Post-Release

To establish a claim for negligence, a plaintiff must meet four elements: (1) a duty requiring the defendant to conform to a certain standard of care; (2) a failure on the defendant’s part to meet

\begin{itemize}
  \item \textsuperscript{121} See infra notes 123-153 and accompanying text.
  \item \textsuperscript{122} See infra notes 130-154 and accompanying text.
  \item \textsuperscript{123} See Kuehn, supra note 8; see also supra notes 27-54 and accompanying text.
  \item \textsuperscript{124} The authors primarily looked at cases of post-discharge harm to a third party by a patient or formerly incarcerated person because they present analogous scenarios; the cases are therefore distinguishable from accidental or intentional overdose death where no third party harm occurs.
\end{itemize}
that standard; (3) a reasonably close causal connection between the
conduct and the resulting injury; and (4) actual injury.\textsuperscript{125} Generally,
the first issue a plaintiff bringing a negligence claim will encounter
is that of whether a duty of care attaches under the circumstances.

One established predicate to liability in tort law is the existence
of a “special relationship” between two parties, which imposes a duty
of care on a party.\textsuperscript{126} A “special relationship” includes that of a mental
health professional to his/her patient or a custodian, such as a prison
official to a prisoner.\textsuperscript{127} The duty of care may require one person to
take affirmative action to avoid foreseeable harm to the other, or to
warn a third party of foreseeable harm.

The duty to warn was expounded by the California Supreme
Court in \textit{Tarasoff v. Regents of the University of California}, a seminal case
holding that a special relationship existed between a psychotherapist
and an outpatient; this imposed a duty on the health professional
to act reasonably to protect foreseeable victims from harm by the
patient.\textsuperscript{128} In \textit{Tarasoff}, the victim’s parents brought a wrongful death
claim against the defendant’s therapist, who was employed at a
university hospital, as well as the campus police and the university
itself. Because the defendant confided in the therapist his intention
to kill Tatiana Tarasoff, the court held that the therapist had a duty to
warn the victim of the impending danger and that a claim for breach
of this duty could be brought against the medical professional and
the university as his employer.\textsuperscript{129} The court stated: “When a therapist
determines, or pursuant to the standards of his profession should

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\textbf{126} \textit{Restatement (Third) of Torts: Phys. & Emot. Harm} § 41(a) (2012);
\textit{see} Mark A. Sessums \& Robert S. Swaine, \textit{Halfway Houses and Mental Health
\textbf{129} \textit{Id.} at 347–48. However, the court still barred the plaintiffs’ claims on immunity
grounds. The court held that California law protected public entities and
their employees from liability for “‘any injury resulting from determining in
accordance with any applicable enactment … whether to confine a person for
mental illness.’” \textit{Id.} at 351. The court also held that the campus officers were
entitled to immunity under a California law that declared, “‘the professional
person in charge of the facility providing 72-hour treatment and evaluation, his
designee, and the peace officer responsible for the detainment of the person
shall not be held civilly or criminally liable for any action by a person released
at or before the end of 72 hours.’” \textit{Id.} at 353 (italics omitted).
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determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger.”\(^{130}\) Although the holding focused on a duty to warn third parties, the holding was later interpreted to also cover the duty to engage in other affirmative steps to protect potential victims when particular harm is foreseeable.\(^{131}\)

**Tarasoff** and other case law have been integrated in the Restatement (Third) of Torts, which underscores the duty of health care professionals and their employers to protect patients under their care, as well as their foreseeable victims.\(^{132}\) In the context of residential facilities, the special relationship between the institution and its patient creates an obligation for the facilities “to perform their duties such that the residents are not injured and those injured by negligent actions or inactions have recourse through an action for damages and a trial by jury.”\(^{133}\)

While there is no need for a patient to be “committed” or under the direct control of the health professional or facility for liability to attach,\(^{134}\) the “mere fact of residency in a facility” at some point in time is not necessarily sufficient to establish a duty of care upon discharge.\(^{135}\) In addition, whether the duty of care requires

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130 *Id.* at 340. Four years after this ruling, in *Thompson v. County of Alameda*, the court clarified that this duty to act only attaches to the “foreseeable and identifiable” victims of the health professional’s patient. 614 P.2d 728, 734 (Cal. 1980).


132 *Restatement (Third) of Torts: Phys. & Emot. Harm* § 41 cmt. (g) (2012) (“a health-care professional can pursue, and may have a statutory obligation to seek, involuntary commitment of patients who are dangerous to themselves or others”).

133 Sessums & Swaine, *supra* note 126, at 93–94.

134 *See, e.g.*, Nova Univ., Inc., v. Wagner, 491 So. 2d 1116, 1118 (Fla. 1986) (“We merely hold that a facility in the business of taking charge of persons likely to harm others has an ordinary duty to exercise reasonable care in its operation to avoid foreseeable attacks by its charges upon third persons. If reasonable care is exercised, there can be no liability. The alternative, the exercise of no care or unreasonable lack of care, subjects the facility to liability”). Sessums & Swaine note that “[t]his is especially true when one who voluntarily assumes such a responsibility creates a grossly negligent policy, such as precluding the use by residents of prescribed antidepressants, and this policy causes a death.” Sessums & Swaine, *supra* note 126, at 93.

a medical professional to take action to hospitalize, commit, or otherwise “order” an outpatient to comply with treatment is very much a function of the facts of a case and the foreseeability of harm. For example, a Florida court has held that a psychiatrist had no duty to involuntarily hospitalize a patient and was not negligently liable for the patient’s attempted suicide.\footnote{See Paddock v. Chacko, 522 So.2d 410, 411-12, 414-15 (Fla. Dist. Ct. App.1988). In this case, the psychiatrist did recommend hospitalization, but the recommendation was not followed by the plaintiff’s father.} However, a Nebraska court, relying on Tarasoff, found the relationship between a psychotherapist and his voluntary outpatient sufficient to impose an affirmative duty on the therapist to control the conduct of his patient for the protection of himself or those persons foreseeably endangered by the patient. \footnote{See Lipari v. Sears, Roebuck & Co., 497 F.Supp. 185, 191, 193 (D. Neb. 1980) (third-party negligence claim brought against U.S. after a Veterans Administration outpatient shot and killed a woman in a crowded dining room).} The Vermont Supreme Court broadly stated that “[w]hether or not there is actual control over an outpatient in a mental health clinic setting similar to that exercised over institutionalized patients, the relationship between a clinical therapist and his or her patient ‘is sufficient to create a duty to exercise reasonable care to protect a potential victim of another’s conduct.’” \footnote{Peck v. Counseling Serv. of Addison Cnty., Inc., 499 A.2d 422, 425 (Vt. 1985) (quoting Tarasoff, 551 P.2d 334, 334 (Cal. 1976)); see 2 AM. JUR. PROOF OF FACTS 3d 327 Psychotherapist’s Liability For Failure To Protect Third Person (originally published in 1988; updated April 2014).} In the context of post-incarceration overdoses, it is necessary to review how the existence of a special relationship and the accompanying duty of care apply to a recently released individual’s foreseeable injury. \footnote{See Peck, supra note 138.} Given the reality that incarceration settings serve as the nation’s largest mental health care and commitment system, a documented history of self-harm and mental health
problems known to custodians can be sufficient to impose a duty of reasonable care for that patient-prisoner.\textsuperscript{141} Perhaps most importantly, courts have applied liability for negligence to medical professionals in the case of outpatient death by overdose.\textsuperscript{142}

Liability under tort law can apply to public entities, such as local governments, that take on mental health care, treatment, or custody functions (barring immunity claims, which are discussed below). A New York court recently found that where a county engages in the function of providing psychiatric care, it is held to the same duty of care as private institutions.\textsuperscript{143} Further, the court held that though the county’s duty may be more limited because the patient in the case was a voluntary outpatient, “[t]he county nonetheless was bound to properly monitor [the outpatient] and take whatever reasonable steps were available to prevent her from harming others.”\textsuperscript{144} One scholar makes the case for this logic to apply to self-harm as well, noting that “[c]ourts frequently distinguish a duty to provide a generally safe environment from a duty to prevent a foreseeably dangerous individual’s attacks. In the matter of self-inflicted injury, courts should do the same.”\textsuperscript{145}

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health treatment in prisons and jails than in hospitals or treatment centers. In fact, the three largest inpatient psychiatric facilities in the country are jails: Los Angeles County Jail, Rikers Island Jail in New York City and Cook County Jail in Illinois”.
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\textsuperscript{141} Tatsch-Corbin v. Feathers, 561 F.Supp. 2d 538 (W.D. Pa. 2008).
\textsuperscript{142} See Kockelman v. Segal, 61 Cal. Rptr. 2d 552 (Ct. App. 1998) (finding that a psychiatrist owed a duty of care to an outpatient he was treating for depression and who committed suicide by overdose after 17 months of treatment).
\textsuperscript{144} Id. at 666; see also Christiansen v. City of Tulsa, 332 F.3d 1270, 1280 (10th Cir. 2003) (holding that a government’s failure to protect individual against harm caused by intervening factors generally does not violate due process, except when a special relationship exists, e.g., “when the state assumes control over an individual sufficient to trigger an affirmative duty to provide protection to that individual,” or under the “danger creation” exception, which holds that a government “may also be liable for an individual’s safety if it created the danger that harmed the individual” (internal citations omitted) (internal quotations omitted)).
\textsuperscript{145} Peter F. Lake, Still Waiting: The Slow Evolution of the Law in Light of the Ongoing Student Suicide Crisis, 34 J.C. & U.L. 253, 268 (2008) (proposing that the basic duty of care should apply in equal measure to a wider institutional context, such as universities; “courts should be careful to extrapolate from individual prevention intervention situations to general environmental intervention situations.... Although [an] individual heroin overdose was not foreseeable, self-inflicted injury by drugs, alcohol, or otherwise can be foreseen”).
Given that most incarcerated individuals typically go through some form of a health assessment during the intake or booking process, a court may find that a correctional institution has a duty of care after an individual overdose becomes foreseeable as a result of this screening. This is especially true if the individual exhibits or attests to symptoms or prior diagnosis of substance use disorder or other risk factors for post-release overdose. This duty may be heightened by other factors, including results of drug testing, continued non-medical drug use behind bars, or the prevalence of opioid analgesic prescription by the correctional health care system.

Nevertheless, according to the established public duty doctrine, public institutions have a different duty than that imposed on private entities, rooted in the public services and balancing of interests that public entities undertake, as well as “the discretionary nature of the functions of planning and allocation of resources.” One important case on the duty of public entities is *Riss v. City of New York*, which dealt with the question of municipal tort liability after Linda Riss sued the City of New York for failing to respond to her requests for police protection from an abusive former boyfriend who ultimately hired an attacker to maim her. Over a strong dissent, the court shielded the city from liability by finding no duty to provide police protection; however, the majority still found “quite distinguishable” those cases where “police authorities undertake responsibilities to particular members of the public and expose them, without adequate protection, to the risks which then materialize into actual losses.” Later cases recognized such an exception in cases of special relationships or the

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146 *See supra* note 46 and accompanying text.
147 Dram shop liability theory could help boost claims based on provision of prescription medication or failure to stop non-medical drug use behind bars. *See*, e.g., Michael E. Bronfin, “Gram Shop” Liability: Holding Drug Dealers Civilly Liable for Injuries to Third Parties and Underage Purchasers, 1994 U. CHI. LEGAL F. 345, 353–61 (1994) (using dram shop liability theory to propose a statute holding drug dealers civilly liable to innocent victim third parties and underage purchasers for injury arising from the dealer’s sale of drugs; the author excludes adult drug users from the protection of this statute because dram shop law has often barred the recovery of intoxicated bar patrons that injure themselves, but the author notes that at least one court has “observed that drug addicts do not voluntarily purchase drugs and thus are not responsible for their injuries”).
148 *Pratt v. Robinson*, 349 N.E.2d 849, 855 (N.Y. 1976); for an overview of the public duty doctrine, *see* COOLEY ON TORTS § 300 at 385 (4th ed.).
150 *Id.* at 583 (citing Schuster v. City of New York, 5 N.Y.2d 75 (1958)).
assumption of a duty plus a victim’s reliance on that duty.\textsuperscript{151} Although New York has outlined a very narrow and limited public duty rule,\textsuperscript{152} other jurisdictions such as New Jersey and Louisiana more liberally apply a reasonable duty of care to public entities in cases where the negligent action is a ministerial, non-discretionary task.\textsuperscript{153} This holds true even when there is no special relationship but simply a state-created danger from which a victim’s harm arose.\textsuperscript{154} The Supreme Court of New Hampshire has gone so far as to discard the “special duty/special relationship test” and public duty rule to determine municipal liability, finding it an impermissible abrogation of common law municipal immunity, and instead adhering to traditional elements of negligence law, citing various other jurisdictions that have done the same.\textsuperscript{155}

The fact that many formerly incarcerated individuals remain under parole or other forms of community supervision can strengthen a finding of a duty of care because the state maintains formal control over many aspects of the individual’s behavior post-release, including whether or not the parolee or probationer can access MAT in the

\textsuperscript{151} These principles can be seen in 911 caller cases like De Long v. County of Erie, 457 N.E.2d 717 (N.Y. 1983) (finding an assumption of a duty to respond with due care to a victim’s call for help when a 911 operator assured the victim that help would be sent “right away”) and Merced v. City of New York, 551 N.E.2d 589 (N.Y. 1990) (assumption of duty of care and reliance by the 911 caller is required to establish the custodial relationship). See also Muthukumarana v. Montgomery County, 805 A.2d 372 (Md. 2002) (the person at risk, rather than a third party, must have a special relationship with the governmental actor).

\textsuperscript{152} See Michael G. Bersani, The “Governmental Function Immunity” Defense in Personal Injury Cases in the Post-McLean World, N.Y. St. B.J., June 2013, at 37 (discussing McLean v. City of N.Y., 12 N.Y.3d 194 (2009), which held that “discretionary municipal acts may never be a basis for liability, while ministerial municipal acts may support liability only where a special duty is found.” Id. at 202. (emphasis added)).

\textsuperscript{153} See Reis v. Del. River Port Auth., 2008 WL 425522 (N.J.App. 2008) (city could be held liable for 911 dispatcher’s negligence in failing to carry out the required “ministerial function” of entering information on victim’s abduction and victim was subsequently murdered). Further explanation of ministerial duties versus discretionary actions is found in the governmental immunity section below.

\textsuperscript{154} See Persilver v. La. Dept. of Transp., 592 So. 2d 1344, 1347 n.2 (La. Ct. App. 1991) (finding old public duty jurisprudence legislatively overruled by a state immunity statute and deciding the issue of the duty owed to the intoxicated and later injured motorist under “the traditional risk-duty analysis”).

\textsuperscript{155} Doucette v. Town of Bristol, 635 A.2d 1387, 1390–91 (N.H. 1993).
community. In addition to this control, the correctional system is also best-situated to intervene with risk-reduction measures through the community supervision framework. In other words, the state continues to play an active, quasi-custodial role after the discharge of a prisoner and may directly influence his or her overdose risk as a result of its policies, which strengthens its duty to prevent foreseeable harm. To the extent that post-release drug use may be tied to drug use during incarceration (either in issuing opioid analgesics for medical use or preventing non-medical opioid use), dram shop liability theory may also strengthen such a claim.

Finally, a key element for determining liability in negligence is the customary standard of care against which a professional or institution is held. Since the kinds of programs that can prevent overdoses post-release are not currently the community standard, it will be challenging to hold institutions liable under a theory of negligence. Some form of malfeasance on the part of the correctional institution – for instance, where an institution or its officers (e.g. guards) facilitates drug use in the prison that later results in the overdose may support the imposition of a duty of care because the institution’s actions or omissions actively caused the harm.

2. Challenges of Causation and Intervening Illegal Conduct

Establishing the causal link between the acts (or omissions) of a medical professional or custodial institution and the post-release death of a patient or formerly incarcerated person is also subject to challenges. Generally, a plaintiff must prove that it would be “more probable than not” that the harm was the result of the caregiver’s negligence, rather than a “preexisting condition.” To establish a

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156 See Glaze & Park, infra note 18; see also Jason Cherkis and Ryan Grim, Kentucky Sued In Federal Court Over Drug Treatment Practices, HUFFINGTON POST, http://www.huffingtonpost.com/2015/03/10/kentucky-sued_n_6842772.html?utm_hp_ref=tw (last accessed March 11, 2015) (Explaining that KY is among the states that ban the use of MAT for certain classes of individuals under community supervision—a policy rationale rooted in an “abstinence” model of substance use treatment).

157 See, e.g., Bronfin, supra note 147.

158 See Bersani, infra note 152, at 41 n.37.

159 Dickhoff ex rel. Dickhoff v. Green, 836 N.W.2d 321, 333 (Minn. 2013), reh’g denied (Sept. 9, 2013) (“Under traditional principles of tort causation, a plaintiff is required to prove that it is ‘more probable than not’ that the harm resulted
causal connection, the law generally requires a “reasonable degree of medical certainty” or “reasonable probability” – i.e., more than “guesswork or speculation” – that the breach of the duty of care more likely than not was the cause of the patient’s injury. In addition, an individual who is the immediate cause of his injury may be intervening conduct sufficient to break the chain of causation.

Aside from linking the harm to the institutional actor, the likelihood of the event does not necessarily place that risk within the scope of duty of a medical professional or institutional custodian. For example, a Louisiana court found that a hospital’s release of a schizophrenic patient with his car keys was not the proximate cause of an accident 48 hours later resulting in the death of a third party. The release of the patient with his keys was “too remote in the chain of causation” because the hospital could not know that the outpatient would subsequently “intoxicate himself, get in his car, drive recklessly and cause the death of the victim.” In other words, the “probability of a possibility” is not sufficient to show that the discharge of a patient fell below a customary standard of care.

Additionally, medical professionals and institutional actors can use the affirmative defenses of intervening illegal acts or contributory negligence to limit the success of a claim of negligence.

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159 Dickhoff v. Green, 836 N.W.2d 321, 333 (Minn. 2013), note 152, at 41 n.37. See supra note 18; Bersani, supra note 147.

160 See infra notes 162-66 and accompanying text.

161 Asher v. OB-Gyn Specialists, P.C., 846 N.W.2d 492, 501 (Iowa 2014). See, e.g., Cannon v. Jeffries, 551 S.E.2d 777, 779 (Ga. App. 2001) (“Although it is not necessary for the plaintiff’s experts to use the magic words ‘reasonable degree of medical certainty’ in describing the decedent’s prospect of survival with appropriate treatment, such prospect must be more than a mere chance or speculation.” (citing Anthony v. Chambless, 500 S.E.2d 402, 404 (Ga. App. 1998))); Ellis v. United States, 673 F.3d 367, 373 (5th Cir. 2012) (applying Texas law).


163 Id.

164 See Thompson v. Patton, 6 So.3d 1129, 1134–37 ( Ala. 2008) (in wrongful death action, evidence was insufficient to find that physician who allegedly prematurely released a patient from a medical center proximately caused suicide of a patient; expert testimony that the likelihood of suicide would have decreased had the patient been hospitalized did not establish proximate cause to patient’s death).
or other tortious activity. Courts have found that an intervening illegal act may supersede an original cause of harm in cases looking at criminal third party actions after the original breach of duty and before the ultimate injury. To be considered a “supervening” cause, however, an intervening act that causes harm must generally be: “(1) independent of the original negligent act; (2) adequate by itself to bring about the injury; and (3) not reasonably foreseeable.” The third element is key: an intervening intentional tort or crime does not necessarily constitute a superseding cause if it is readily foreseeable. Therefore, “the proper focus is not on the criminal nature of the negligent act, but instead on whether the act was so extraordinary as not to be reasonably foreseeable.” Insofar as the correctional institution and its staff are informed about the risk factors for overdose post-release, a case may still turn on whether an overdose by a formerly incarcerated individual in the weeks after discharge is reasonably foreseeable.

The law has also recognized that each person has a duty of self-care and that the defense of contributory negligence can cut off a medical professional’s liability. Thus, an individual’s drug consumption, especially if used non-medically, between the time in custody and the resulting harm or death, may extinguish or diminish professional or institutional liability. One limit to the use of this defense is when an intervening act is itself the foreseeable harm that shapes a defendant’s duty, such that a defendant who fails to guard against the act will not be relieved from liability when the act occurs. Once again, courts will determine the limitations of

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166 See, e.g., Sergent v. City of Charleston, 549 S.E.2d 311, 320 (W. Va. 2001); see also Gaines-Tabb v. ICI Explosives, USA, Inc., 160 F.3d 613, 620 (10th Cir. 1998) (under Oklahoma law, “when the intervening act is intentionally tortious or criminal, it is more likely to be considered independent” of the original negligent act).
167 Gaines-Tabb, 160 F.3d at 620.
169 See Hobart v. Shin, 705 N.E.2d 907 (Ill. 1998) (holding physician was entitled to raise contributory negligence of patient as a defense in a wrongful death suit brought by estate of patient who committed suicide while under physician’s treatment for mental health).
170 See Weathers v. Pilkinton, 754 S.W.2d 75, 78 (Tenn. Ct. App. 1988) (holding that an outpatient’s suicide was not an intervening independent cause because
liability on a case-by-case basis, but the strongest case will be one in which there is evidence of institutional malfeasance and a negligent institutional policy or misconduct in the carrying out of institutional policies.

3. Litigation Barriers

In addition to proving the existence of a duty of care, making a causal link between institutional actions or omissions and overdose, and demonstrating the foreseeability of the resulting harm, immunity limits on the liability of governmental actors and entities will also constrain successful tort claims. As one court put it, the finding of a special relationship and accompanying duty of care is “the threshold to a discussion of government immunity.”171 State tort claims acts – correlates to public duty limitations – could present an impediment to holding governmental entities responsible for overdose deaths that closely follow release from a correctional setting.

A recent case out of California demonstrates how state tort claims acts can cut off the liability of governmental actors. In Lum v. County of San Joaquin, the decedent inmate had been “under psychiatric care for a bipolar disorder” and had a “history of psychotic episodes” that had resulted in hospitalization several times.172 The day of the decedent’s death, he had been walking around apparently hallucinating and was off of his normal medication.173 Police officers arrested the decedent for being “under the influence in public,” despite no evidence of alcohol use and knowledge that the decedent was on medication for bipolar disorder. The decedent was released from jail six hours later, without medical attention and “without successful the physician-defendant did not involuntarily commit the patient, despite three recent suicide attempts, instead releasing on a recommendation to seek treatment at a prior clinic; the court also found that the physician owed a specific duty of care to take adequate precautions to protect the patient from foreseeable self-harm where the patient was not a rational or “responsible human agency”).


172 Lum, 756 F. Supp. 2d at 1246.

173 Id. at 1246–47.
family notification, transportation, money, phone, or shoes;”\textsuperscript{174} he drowned accidentally in the hours following his release. His family sued the County of San Joaquin, the City of Lathrop, and multiple city and county employees under several claims, including a claim of wrongful death alleging negligence on the part of the officers for releasing the decedent under the circumstances.

The court first found that a special relationship was created when the arresting officers took the decedent into custody, pointing out that there is a “well-established special relationship between jailers and prisoners that is equally applicable to officers of the law who take arrestees into custody,” which established a duty of care.\textsuperscript{175} The court also noted that it was “reasonably foreseeable that an arrestee who is in need of medical attention would be at risk in a custodial environment or upon release into a situation made dangerous by his medical condition, or without first having received proper medical attention.”\textsuperscript{176}

The court then reviewed several sections of the California Tort Claims Act related to the liability of public entities and employees for the release of prisoners to determine if the county, city, and arresting officers were in fact entitled to immunity.\textsuperscript{177} The court noted that

\textsuperscript{174} Id. at 1247.

\textsuperscript{175} Id. at 1254.

\textsuperscript{176} Id. at 1255. As to the vulnerability of prisoners in the correctional environment, the court said that “[b]oth prisoners and arrestees are equally vulnerable and dependent on officers and jailers for safety and security. ‘Prisoners are vulnerable. And dependent. Moreover, the relationship between them is protective by nature, such that the jailer has control over the prisoner, who is deprived of the normal opportunity to protect himself.’ In this case, the purpose of arresting decedent, who was ‘just off of his meds,’ on a ‘kickout’ charge, was at least partially for decedent’s own self protection, making the restraint used by the arresting officers just as ‘protective in nature’ as the custodial relationship that exists between jailer and prisoner.” \textit{Lum}, 756 F. Supp. 2d at 1255 (citation omitted) (quoting Giraldo v. Cal. Dept. of Corr. & Rehab, 168 Cal. App. 4th 231, 250 (Cal. Ct. App. 2008)).

\textsuperscript{177} The court held that Cal. Gov. Code § 845.8(a), which provides, in part, “[n] either a public entity nor a public employee is liable for: (a) Any injury resulting from determining whether to parole or release a prisoner or from determining the terms and conditions of his parole or release or from determining whether to revoke his parole or release,” did not bar liability because the decedent was not a prisoner and because the provision does not provide absolute immunity. \textit{Lum}, 756 F. Supp. 2d at 1255–56. The court also rejected immunity under § 846 (immunity for “failure to retain an arrested person in custody”) as inapposite and § 855.6 (immunity for “failure to make a physical or mental examination”)
though state actors had immunity as to basic decisions to release a prisoner or arrestee, they would not have immunity for ministerial acts carrying out the decision to release. The court also found that Cal. Gov. Code § 855.8(a), which provides immunity for a public entity’s “diagnosing or failing to diagnose that a person is afflicted with mental illness or addiction or from failing to prescribe for mental illness or addiction,” did immunize the officer’s “failure to diagnose,” but not their failure to render medical attention to the decedent, who had suffered a seizure while in holding and was in “obvious need of medical care.”

This case illustrates the structure of qualified immunity for harm to individuals formerly within their care: that a public official or entity’s discretionary decisions made during custody and as to discharge are often immune under state tort claims acts, but that “careless or wrongful behavior subsequent to a decision respecting confinement” is not protected by immunity laws and liability for ministerial-operational negligence is often a question of fact for the jury. The Michigan Supreme Court explained the fact-specific nature of the inquiry: “Many individuals are given some measure of discretionary authority in order to perform their duties effectively. To determine the existence and scope of immunity from tort liability in a particular situation, the specific acts complained of, rather than the general nature of the activity, must be examined. The ultimate goal is to afford the officer, employee, or agent enough freedom to decide the best method of carrying out his or her duties, while ensuring that the goal is realized in a conscientious manner.” In applying these principles of limited immunity, a Michigan court found that two psychiatrists, a psychologist, and a social worker who

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178 The court explained, “there is an important distinction between basic or discretionary decisions on the one hand and ministerial decisions implementing the basic decision on the other hand. That is, actions implementing the basic policy decision are outside the scope of the immunity.” Lum, 756 F. Supp. 2d at 1256; Johnson v. Cnty. of Los Angeles, 143 Cal. App. 3d 298, 314 (Ct. App. 1983) (addressing same principles under several sections of the California Tort Claims Act).

179 Id. at 1257–58.

180 Tarasoff, 17 Cal.3d at 449–50; see Johnson, 143 Cal. App. 3d at 314.

treated a schizophrenic patient at a psychiatric hospital prior to the patient’s discharge and subsequent death by a drug overdose could be held individually liable for failing to follow procedures after the discretionary decisions to discharge the patient were made.182

An attempt to attach tort liability to post-release overdoses would likely have the best chance of success if the duty could be established (through a special relationship/special duty or implied public policy via a statute),183 the harm is foreseeable (the deceased individual was known to suffer from opioid dependency – knowledge gained from medical screenings, institutional intake, and other institutional examinations and observations, – and stated or implied intention to engage in opioid abuse upon release), and the customary standard of care was breached (the incarcerated person had not been given the proper treatment and support services while in custody, in violation of formal policies or other stated standards, policies, or procedures).

In sum, the strongest torts claim will have elements of timing (proximity to release), continuing supervision, reasonably foreseeable risk (from health screenings, intakes, and observations in custody), a showing of particularized harm to the plaintiff or plaintiff class, knowledge of drug use while in custody, and a failure to intervene that substantially contributes to the harm, ideally to a point of malfeasance on the institution’s part. Even with all of these elements, depending on the jurisdiction, individual litigants or mass tort suits may face considerable barriers, such as the public duty doctrine, the lack of a customary standard of care, intervening acts that break the chain of causation, and governmental immunity.184 Other constitutional and statutory claims may be available to a litigant outside of traditional tort claims and the following section will briefly address the relative

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182 Brown v. Northville Reg’l Psychiatric Hosp., 395 N.W.2d 18, 22–23 (Mich. Ct. App. 1986) (“For example, if the decision is made to discharge a patient with medication, a subsequent discharge without medication is a ministerial act which is not protected by governmental immunity”).

183 See Gipson v. Kasey, 214 Ariz. 141, 145 (2007) (holding that public policy in Arizona statutes prohibiting the distribution of prescription drugs to an unauthorized parties created a duty of care when a defendant provided narcotic pills to a coworker, who then supplied them to her boyfriend for recreational use and the boyfriend later died from the toxic combination of alcohol and narcotic pills).

184 Class action barriers are discussed infra, notes 242-45 and accompanying text.
strength of those claims, including those that may be brought under the Federal Tort Claims Act.

B. Constitutional and Statutory Theories

In addition to individual or mass tort actions, advocates may motivate change within correctional systems through lawsuits based on constitutional or statutory provisions. This section will discuss theories available under federal and state constitutions, as well as federal statutes such as federal civil rights legislation and its state analogs.

1. Federal Constitution

Claims for injury or wrongful death could conceivably be made under the Eighth and Fourteenth Amendments and civil rights laws, but these theories only apply while individuals remain incarcerated.\(^{185}\) Claims under these provisions require demonstration of an intentional action or omission in view of the incarcerated individual’s suffering or apparent medical need.\(^{186}\) These legal remedies have been used to impose liability on prison officials for failure to prevent overdoses experienced behind bars.\(^{187}\) Some advocates contend that the state bears a “carceral burden” to provide care for individuals who, on account of being incarcerated, are “wholly dependent on the state for the means of their survival.

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185 U.S. CONST. amend. VIII, XIV.
186 See, e.g., Cramer v. Iverson, CIV. 07-725(DWF/SRN), 2008 WL 4838715 (D. Minn. Nov. 5, 2008) (stating that “even if such allegations could suffice to state a claim for negligence, such claims are not redressable under the Eighth Amendment”).
187 In action by survivors of man arrested after automobile accident for drunk driving who overdosed on barbiturates and who died because he did not receive medical treatment for overdose, of which officials were not aware, though they knew him to be unconscious, and who would have lived except for officials’ failure to transport him to hospital in accordance with written policy for treatment of unconscious prisoners, survivors could recover against government where unwritten policy was shown to be that officials ignored written policy. Such indifference to medical needs violated decedent’s Eighth Amendment rights and action was therefore cognizable under § 1983, and attorneys fees were available under § 1988. Garcia v. Salt Lake Cnty., 768 F.2d303 (10th Cir. 1985).
and deeply vulnerable to harm.”

Nevertheless, even in the circumstances when the victim remained in custody and under supervision of the correctional personnel, most courts have refused to impose liability in absence of intentional, deliberate or egregiously negligent conduct. Therefore, claims involving ex-prisoner post-incarceration overdose on Eighth Amendment grounds face substantial hurdles, as discussed below.

To the extent that the provision of effective drug treatment

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188 Sharon Dolovich, Cruelty, Prison Conditions, and the Eighth Amendment, 84 N.Y.U. L. Rev. 881, 891, 913 (2009). Dolovich explains, “The state, when it puts people in prison, places them in potentially dangerous conditions while depriving them of the capacity to provide for their own care and protection. The state therefore has an affirmative obligation to protect prisoners from serious physical and psychological harm. This obligation, which amounts to an ongoing duty to provide for prisoners’ basic human needs, may be understood as the state’s carceral burden.” Id. at 891 (emphasis in original). Dolovich notes that prisons provide and control the medical care that prisoners have access to, regardless of the outside resources a prisoner may have at his disposal. Id. at 912–13, n.124. She goes further in detailing the harm brought by incarceration: “But the state, by incarcerating, does not only deprive offenders of the capacity to provide for their own needs. It also compels them to remain under affirmatively dangerous circumstances, thus making them vulnerable to serious harms arising from the incarceration itself.” Id. at 915. This understanding of harm applies not only in the context of the Eighth Amendment, but also in tort claims against state institutions by overdose victims and their survivors. See supra, Section IIIA1 (“Duty of Care”). In fact, Dolovich argues that the application of a heightened negligence standard in Eighth Amendment cases best protects prisoners from violations of their health and safety. Id. at 948–54.

189 See Reynosa v. Schultz, 282 Fed. Appx. 386, 389–90 (6th Cir. 2008) (incarcerated individual suffered no adverse consequences as a result of any delay in medical treatment for an overdose of pain medication attributable to a correctional officer’s actions, nor did the officer have the requisite culpable intent to support any claim of an Eighth Amendment violation in the individual’s § 1983 suit; the officer’s actions resulted in the incarcerated person receiving prompt medical attention; see also Estate of Crouch v. Madison Cnty, 682 F. Supp. 2d 862, 871–77 (S.D. Ind. 2010) (incarcerated individual did not show signs of an objectively serious need for medical attention prior to 3:00 a.m. on the day of his death from a drug overdose, at which time he was found unresponsive, thus defeating a § 1983 claim that corrections officers were deliberately indifferent to the incarcerated person’s serious medical needs in violation of the Eighth Amendment; while a resident testified that he saw the person’s eyes rolling around in different directions and another resident testified that bubbles or foam were at one point coming out of the incarcerated person’s nose, there was no indication that the officers were made aware of those observations).
and overdose education services is protective against post-incarceration overdose, an analysis of legal measures to improve access to such services is relevant. To gain access to evidence-based treatment behind bars, incarcerated individuals could bring claims under Section 1983 of the Civil Rights Act for violations of the Eighth and Fourteenth Amendments. The Eight Amendment requires that prisons provide adequate medical treatment to incarcerated individuals, and applies to state facilities through the Fourteenth Amendment. The Supreme Court has stated that the “treatment a prisoner receives in prison and the conditions under which he is confined are subject to scrutiny under the Eighth Amendment.” An individual states a cognizable claim under the Eighth Amendment by alleging that a prison official acted with “deliberate indifference to serious medical needs;” when this indifference offends “evolving standards of decency,” the inaction violates the Eighth Amendment. Given the serious and potentially life-threatening physical and mental symptoms associated with substance use disorders, especially in the context of withdrawal, the Eighth Amendment may be an appropriate vehicle for arguing that affected individuals are entitled to treatment while incarcerated. Further, the Supreme Court has stated that the protections of the Eighth Amendment encompass both present and likely future health harm and suffering.

To establish liability under the Eighth Amendment framework, a plaintiff must first demonstrate that his substance use disorder constitutes a “serious medical need” and that officials showed “deliberate indifference” in addressing that need. Courts have defined a “serious medical need” as one “diagnosed by a

190 See 42 U.S.C § 1983.
194 Estelle, 429 U.S. at 106.
195 For a detailed discussion of this theory, see David Lebowitz, Proper Subjects for Medical Treatment? Addiction, Prison-Based Treatment, and the Eighth Amendment, 14 DePaul J. Health Care L. 271, 288 (2012).
196 Helling, 509 U.S. at 33–34 (allowing an inmate to mount an Eighth Amendment violation claim alleging future harm from second-hand smoke); see also Cherkis and Grim, supra note 156 (covering equal protection-based litigation challenging restrictions on MAT recently initiated in Kentucky).
197 Estelle, 429 U.S. at 106; Brock v. Wright, 315 F.3d 158, 162 (2d Cir. 2003); Hill v. DeKalb Reg’l Youth Detention Ctr., 40 F.3d 1176, 1187 (11th Cir. 1994).
physician as requiring treatment or one that is so obvious that a lay person would easily recognize the necessity for a doctor’s attention.”198 In several cases, courts have recognized that opioid withdrawal is a serious medical need.199

Once a serious medical need is established, a plaintiff must also demonstrate “deliberate indifference” on the part of prison officials. To do so, a plaintiff must show that he was objectively at risk of serious harm on account of his medical condition or need and that prison officials subjectively knew of and disregarded this risk.200 To access the liability of future harm under Helling v. McKinney,201 the litigant should also be prepared to show that concrete measures that include MAT and pre-release prevention activities are crucial to averting such future harm or death as a result of overdose.

Plaintiffs have had mixed results in bringing claims against prison officials for inadequate drug treatment of withdrawal symptoms; the results are highly contingent on the facts in each case. In several instances, courts have held that plaintiffs could state a constitutional violation where correctional personnel disregarded serious signs of distress in individuals withdrawing from opioids or methadone. For example, in Foelker v. Outagamie County, the Seventh Circuit found that the conduct of jail personnel could constitute “deliberate indifference” where an individual’s withdrawal symptoms went untreated for three days, despite the personnel’s observations that the individual was confused, disoriented, was experiencing auditory hallucinations, and had defecated on himself.202 On the third day, the individual was given thiamine, a medication used for alcohol withdrawal, but in the court’s assessment this course of treatment was insufficient.203

202 Foelker, 394 F.3d at 513.
203 Id. at 512.
In *Davis v. Carter*, the same court examined similar facts. In *Davis*, an individual receiving MAT at the time of his arrest was incarcerated and not provided with methadone in spite of his requests. He subsequently died of a brain aneurysm apparently unrelated to his methadone treatment. The court found that the jail personnel had observed his withdrawal symptoms, that they were severe, and that he nonetheless did not receive treatment. The court held that a jury might determine that those facts supported a finding of deliberate indifference by the county and remanded the case. In preceding cases, several courts have reached similar conclusions to those in *Foelker* and *Davis*. Conversely, other courts have also found that plaintiffs did not raise a question of whether correctional personnel acted with “deliberate indifference” where facilities substituted medications in place of methadone; as far as we are aware, no litigant has yet made a claim implicating failure to provide adequate overdose education and naloxone distribution services.

In light of these diverging canons, plaintiffs bringing claims for Eighth Amendment violations on the basis of failure to provide adequate drug treatment and overdose prevention while in custody

204 *Davis v. Carter*, 452 F.3d 686, 688 (7th Cir. 2006).
205 *Id.* at 689.
206 *Id.* at 696.
207 *Davis*, 452 F.3d at 696.
209 See, e.g., Holly v. Rapone, 476 F. Supp. 226, 229–31 (E.D.Pa.1979) (court found there was no showing of deliberate indifference where the plaintiff addicted to heroin was unable to post bond and was told that methadone was not available at the prison correctional facility. In spite of severe symptoms of withdrawal, including vomiting, body pain, and confusion, he was taken to the prison corrections hospital and given medications ill-suited to address opioid withdrawal, including Mylanta and Vistaril. The case was dismissed on the basis that “plaintiff’s allegations have not approached the repugnancy of those acts prescribed by the Eighth Amendment”); Boyett v. Cnty. of Washington, No. 2:04CV1173, 2006 WL 3422104, at *27 (D. Utah Nov. 28, 2006) *aff’d*, 282 F. App’x 667, 674 (10th Cir. 2008) (finding no Eighth Amendment violation where decedent received Clonidine to treat his withdrawal from methadone and stating that “[plaintiffs’ decedent] had no constitutional right to Methadone treatment”); Mcnamara v. Lantz, 3:06-CV-93 (PCD), 2008 WL 4277790 (D. Conn. Sept. 16, 2008) (finding no Eighth Amendment violation where the plaintiff received substitute medication for methadone).
would be more likely to prevail on their claims where no intervention or education whatsoever was provided. Courts appear more inclined to dismiss claims where some service is provided, including medications meant to be substitutions for methadone or other MAT medications.  

2. **State Constitutions**

State constitutions may afford individuals greater protections than the federal constitution, and in such circumstances, may provide more additional grounds for compelling prisons and jails to provide treatment to incarcerated individuals. It is beyond the scope of this article to provide an overview of all fifty state constitutions, but we use Massachusetts and New York as illustrative examples.

A review of case law in both Massachusetts and New York revealed that most cases brought in state court assert Eighth Amendment violations as applied to the states through the Fourteenth Amendment. Cases brought under state provisions fared similarly to those brought under the Eighth Amendment.

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211 See Article 26 of the Massachusetts Declaration of Rights and Article 1, § 5 of the New York Constitution, both of which protect against cruel and unusual punishment.

212 See, e.g., Smith v. Maloney, 996210, 2001 WL 755849, n.29 (Mass. Super. Apr. 3, 2001) (finding no Eighth Amendment or Article 26 violation where the plaintiff contested his course of medical treatment and stating that “Claims of medical malpractice do not rise to the level of cruel and unusual punishment merely because the victim is a prisoner, [] and courts are reluctant to find deliberate indifference to a serious need where the dispute concerns the choice of a certain course of treatment”); Ladetto v. Comm’r of Corr., 385 N.E.2d 273, 275 (1979) (court flatly refused to rule that an individual was entitled to be transferred to a facility that offered a drug rehabilitation program and declined to extend the reasoning of Estelle v. Gamble, stating that there is no “constitutional right to treatment to help [the incarcerated individual] overcome drug addiction.” However, the court based this ruling on the fact that the plaintiff failed to allege “any drug related physical ailments that have risen to the level of ‘serious medical needs’ to which the prison authorities have been deliberately indifferent.” Given the advances in the science of addiction and its treatment that have occurred since this case was decided, it is possible
State courts appear equally reluctant to rule that the denial of access to MAT constitutes cruel and unusual punishment. Parallel mootness challenges would likely bar suits alleging harm for post-incarceration overdose.

3. **Statutory**

The Federal Tort Claims Act, the Americans with Disabilities Act and the Rehabilitation Act may also provide redress to individuals denied access to MAT while incarcerated.

a. **The Federal Tort Claims Act**

In federal court, challenges to conditions of confinement may provide another avenue of relief for incarcerated individuals suffering from substance use disorders. Individuals can generally challenge conditions of confinement under the Federal Tort Claims Act (FTCA).\(^ {213}\) Litigants may bring claims under the FTCA to challenge inadequate substance abuse treatment care in federal prisons.

The FTCA waives governmental immunity in circumstances where plaintiffs have been injured by the negligence, wrongful acts, or omissions of federal employees acting within the scope of their employment.\(^ {214}\) The statute requires individuals to exhaust administrative remedies prior to bringing a claim in court.\(^ {215}\) To properly state a claim under the FTCA, a plaintiff must allege negligence (1) by officers or employees of a federal agency, which includes executive departments but which does not include contractors, (2) by persons acting on behalf of a federal agency in an official capacity, or (3) by a government

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that that a well-pleaded complaint could demonstrate the serious medical need calling for MAT. However, if any substitute treatment were provided, the court may not find an Article 26 violation); People ex rel. Sandson v. Duncan, 761 N.Y.S.2d 379, 381 (2003) (finding no deliberate indifference where prison did not provide individual with methadone because individual failed to comply with order to complete a substance abuse treatment program); Scott v. Smith, 961 N.Y.S.2d 596, 597 leave to appeal denied, 21 N.Y.3d 860 (2013) (holding that a delay in treatment, without any showing of harm, does not rise to the level of cruel and unusual punishment).


contractor over whose day-to-day operations the government maintains substantial supervision.[]216

The FTCA only applies to claims where, “under circumstances where the United States, if a private person, would be liable to the claimant in accordance with the law of the place where the act or omission occurred.”217 Such claims would be subject to the same negligence analysis as described in the previous section. The Supreme Court has held that the FTCA only applies where local law would make a “private person” liable in tort, and that waiver of sovereign immunity may not be based on a finding of state or municipal liability.218 Therefore, claims under the FTCA would only redress injuries sustained by individuals incarcerated under the jurisdiction of the Federal Bureau of Prisons (FBOP).

Liability for medical malpractice is controlled by state law.219 Typically, in tort claims alleging medical malpractice, a plaintiff must establish the applicable standard of care, that the standard was breached, and the causal connection between the breach and the resulting injuries.220 Because MAT or overdose prevention programming are not currently the standard of care in most prisons, it may be difficult to succeed on FTCA claims.221

Therefore, to increase the chances of a successful suit, plaintiffs would need to offer ample expert testimony to establish that MAT is the standard of care in correctional settings, and that substitute medications are not appropriate treatment. Given the courts’ reluctance to make such a ruling in Eighth Amendment cases, it would likely be difficult to prevail on FTCA claims until medical

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216 Valadez-Lopez v. Chertoff, 656 F.3d 851, 858 (9th Cir. 2011).
219 Ayers v. United States, 750 F.2d 449, 452 n.1 (5th Cir. 1985).
221 See id. at *4 (Finding that: “[n]either the VA or its staff breached a standard of care when they replaced Gaddis’s methadone with Lortab in June 2004. Selecting the appropriate medication for a patient and determining whether the patient’s pain is managed effectively with a particular drug is clearly a decision that requires medical expertise. [The treating physician] concluded that the decision to replace the methadone treatment with Lortab was an appropriate decision under the circumstances. Gaddis offered no expert testimony to the contrary. Accordingly the Court concludes that Gaddis has not proven that the VA breached any standard of care when it replaced the methadone medication with Lortab”).
literature and correctional practice more definitively establishes that MAT is the standard of care for opioid-dependent incarcerated individuals.

b. Americans with Disabilities Act and Rehabilitation Act

Incarcerated individuals may also bring claims under the Americans with Disabilities Act (ADA) and the Rehabilitation Act where there is a denial of MAT. The ADA and the Rehabilitation Act both prohibit discrimination on the basis of a disability. Discrimination by state and local governments is prohibited under Title II of the ADA and Section 504 of the Rehabilitation Act makes it illegal for programs that are federally operated or receive federal assistance to discriminate against individuals with a disability. Therefore, state and local governments may also be subject to the Rehabilitation Act if they receive federal funding. The Supreme Court has held that the ADA applies to state prison settings. These claims likely must be predicated on either blanket policies that prohibit MAT, or where the denial of access to MAT occurs without an objective and individualized medical evaluation.

An individual demonstrates he has a disability within the meaning of the ADA by showing a current physical or mental impairment that substantially limits one or more major life activities; a record of such impairment; or that he is regarded as having such impairment. While courts have held that substance use disorders constitute disabilities, an individual must plead sufficient facts to demonstrate a disability under one of the three prongs.

222 42 U.S.C. §§ 12101 et seq.
227 For a more detailed discussion of these types of claims, see Legal Action Center, supra note 114. See also Cherkis and Grim, supra note 156 (identifying ADA-based litigation challenging restrictions on MAT recently initiated in Kentucky).
228 42 U.S.C. § 12102(1).
articular above.\textsuperscript{230} Furthermore, the claimant must demonstrate that he was denied MAT on account of his disability, rather than because of a non-discriminatory reason.\textsuperscript{231} An individual may demonstrate discrimination by establishing he is subject to either disparate treatment, disparate impact, or was denied a reasonable accommodation.

Disparate treatment occurs where an individual is treated differently on account of his disability. An individual may be able to establish disparate treatment in incarceration settings that have a blanket policy prohibiting the use of controlled substances to treat opioid dependence.\textsuperscript{232} Disparate impact, on the other hand, could only be established by showing that the process used for determining whether an individual was eligible for services “screen[s] out or tend[s] to screen out” individuals who have otherwise established they have a disability\textsuperscript{233} under the ADA—in this case substance abuse disorder. Finally, an individual might demonstrate that corrections personnel failed to provide a “reasonable accommodation” as required by the ADA, although government agencies are excepted from this requirement if modifications would “fundamentally alter the nature of services, program, or activity.”\textsuperscript{234}

Individuals are not protected under the ADA if the services pose a “significant risk to the health or safety of others by virtue of the disability that cannot be eliminated by reasonable accommodation.”\textsuperscript{235} Although various studies have demonstrated the efficacy and safety of MAT, as discussed above in Section II. A., many prisons and jails counter with the largely unfounded claim that the risk of diversion outweighs the benefits of providing MAT.\textsuperscript{236} Therefore, where blanket policies prohibiting controlled substances are in place, a prison or jail may be able to demonstrate that permitting MAT would be a fundamental alteration of services already provided.

\textsuperscript{230} See Gaddis, supra note 219 and accompanying text.
\textsuperscript{231} See, e.g., Nunes v. Massachusetts Dep’t of Correction, 766 F.3d 136 (1st Cir. 2014) (finding that plaintiffs were unable to challenge non-discriminatory reasons offered by prison for discontinuing to provide HIV medication).
\textsuperscript{232} Legal Action Center, supra note 115, at 14.
\textsuperscript{233} 28 C.F.R. § 35.130(b)(8).
\textsuperscript{234} 28 C.F.R. § 35.130(b)(7).
\textsuperscript{236} Legal Action Center, supra note 115 at 12.
Furthermore, although policies prohibiting any use of controlled substances to treat individuals with substance use disorders may violate Title II of the ADA and the Rehabilitation Act, where some (even if not evidence-based) treatment is provided, courts may find no violation. As noted above, several courts have stated that there is no right to a specific course of treatment, such as MAT, for opioid-dependent individuals. Therefore, as was the case for Eighth Amendment claims, plaintiffs would be most likely to prevail on ADA and Rehabilitation Act claims where no treatment is provided whatsoever; where treatment is provided so belatedly that an individual suffers serious injury or death; or where there was a clear facially discriminatory reason why treatment was not provided.

4. Limitations of Statutory and Constitutional Approaches

Despite the potential opportunities, relief related to custodial treatment under the Eighth Amendment is substantially limited by the fact that courts often find a claim moot once an individual has been released. Although a detailed discussion of exceptions to the mootness doctrine is beyond the scope of this article, as a practical matter, litigants would likely need to bring constitutional challenges while incarcerated, or at least under community supervision. Notwithstanding the normative recognition by the courts of the ability of plaintiffs to allege future harm, mootness doctrine likely creates a substantial barrier for Federal Constitutional claims by those seeking relief for post-incarceration injury. One possible approach to overcome this is to impose something akin to strict liability on prison officials who fail to provide adequate conditions and protections, including MAT

237 See supra notes 222-35 and accompanying text.
238 See supra note 215-16 and accompanying text.
239 See, e.g., Cobb v. Yost, 342 F. App’x 858, 859 (3d Cir. 2009) (stating that “[Plaintiff’s] case was mooted by his release from prison. A federal court does not have the power to decide moot questions.”); Munoz v. Rowland, 104 F.3d 1096, 1097–98 (9th Cir. 1997) (“Because [plaintiff] has been released from the [facility where he was being treated], we can no longer provide him the primary relief sought in his habeas corpus petition. Munoz’s Fifth and Eighth Amendment challenges to the ‘debriefing’ process and the conditions of confinement in the [facility] are therefore moot, and must be dismissed.”).
240 See id. at 859; ; Munoz, 104 F.3d at 1097–98.
and overdose prevention activities.242

Furthermore, claims against correctional institutions and public actors may face particular hurdles, at least in federal courts. The Prison Litigation Reform Act creates a number of limitations for litigation against such parties using a number of mechanisms.243 These include provisions such as the requirement of exhaustion of administrative remedies before the case can be filed,244 as well as a rational basis test for any relief sought by the court’s judgment.245 Though the constitutionality of some of these provisions has been challenged,246 they remain largely in place.247

Class certification may provide a mechanism to avoid dismissals for mootness.248 However, given the highly-fact specific inquiries undertaken by the courts in determining whether an Eighth Amendment violation has been stated, as well as broader limitations on class action litigation,249 it may be difficult for litigants to define a class that a court would certify. A case

242 See id. at 964–72 (calling for a modified strict liability approach to Eighth Amendment as a sort of “irremovable presumption of official culpability” in cases whether prisoners are subjected to substantial risks of serious harm). This would, however, require a reframing of the appropriate standard of care for individuals suffering from opioid dependency.


244 42 U.S.C. § 1997e(a).


246 See, e.g., Jones v. Bock, 549 U.S. 199 (2007) (addressing differing approaches of circuit courts as to whether plaintiff must affirmatively plead exhaustion of administrative remedies to gain entry to court; level of detail required for each grievance to put officials on notice; and whether a suit may proceed when it contains both exhausted and unexhausted claims).

247 The PLRA applies only to current prisoners, not the formerly incarcerated.

248 See Clas v. Torres, 549 F. App’x 922, 923–24 (11th Cir. 2013) (“Absent class certification, an inmate’s claim for injunctive and declaratory relief under § 1983 generally becomes moot once the inmate is transferred. Thus, where a prisoner has been released from custody, no case or controversy is presented because the chance of a repeated injury due to a prisoner’s return to an offending facility is too speculative”) (internal citations and quotations omitted).

249 See FED. R. CIV. P. 23(a) requirements of numerosity, commonality, typicality, and adequate representation. Under the Supreme Court’s recent interpretation of the commonality requirement in Wal-Mart Stores, Inc. v. Dukes, 131 S. Ct. 2541, 2554 (2011), litigants would likely have great difficulty demonstrating they meet this requirement.
may move forward even if the named plaintiff’s claim has been mooted by release, but it would likely be difficult to meet the commonality requirement set forth in Rule 23 of the Federal Rules of Civil Procedure. Perhaps a class could be defined where a facility—or system-wide agency—maintained a blanket policy against providing any treatment for withdrawal or overdose symptoms.

IV. Programmatic and Policy Approaches

To the extent that recently released individuals face a substantially higher likelihood of dying from overdose in the two-to-four weeks after exiting prison or jail, that heightened risk is substantially attributable to the actions—or the lack thereof—of the criminal justice system. This system almost uniformly shirks from its moral obligation to protect the lives and well-being of those under its care. Rehabilitation is the theoretical cornerstone of correctional practice. Experts have noted, however, that there is little reason to believe that incarceration leads to rehabilitation.

Our examination of the legal mechanisms for motivating correctional institutions to address the elevated post-incarceration overdose risk suggests that, although a number of possible avenues do exist, multiple factors could complicate such litigation. Whether or not impact litigation is ultimately successful in the courtroom, however, it can be used to bring public attention to what is essentially an invisible crisis among our society’s most vulnerable and disenfranchised individuals.

Either separately from or in conjunction with litigation, improving post-release overdose outcomes can be accomplished by advancing programmatic and policy change through direct advocacy with corrections systems, taking advantages of new funds made available through the ACA, as well as law reform. Indeed, advocacy efforts have already resulted in the cutting edge interventions highlighted above—pre-release naloxone in San Francisco and Rhode

Island, in addition to the long-standing models like the methadone maintenance at Rikers Island, for example. The next section provides an overview of the specific steps that should be taken to motivate positive changes that prevent overdose deaths among newly released individuals.

A. Advocacy

1. Jails and Prisons

   Advocates should educate corrections officials and criminal justice decision makers in their jurisdictions to increase access to MAT behind bars and in the community upon release. While buprenorphine can be prescribed by any doctor (including those employed by jails and prisons) who meets certain minimal requirements and registers with the Drug Enforcement Administration, methadone is subject to a more complicated regulatory framework. Nevertheless, implementing methadone is possible in correctional settings, as evidenced by the Rikers Island program.

   A key advocacy issue is overcoming inaccurate perceptions among corrections staff regarding drug misuse and the efficacy of medications as a treatment. Indeed, studies have demonstrated that correctional staff regard drug use—including medication-assisted care—as a moral failing; correspondingly, preference is placed on abstinence-based models. These attitudes are a direct result of national policies that treat drug use as a crime in need of punishment rather than a public health issue. Advocates accordingly need to engage corrections officials in formal trainings and education on substance use disorder, recovery, and relapse, as well as the benefits of MAT. These efforts can range from formal presentations to

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253 See 21 U.S.C. § 823; see also Collins & McAllister, supra note 56, at 514–16.
255 See Fiscella, supra note 75, at 651 (explaining that there are several approaches that jails and prisons can use to implement methadone for incarcerated individuals, including 1) seeking certification as an accredited opioid treatment program (OTP), 2) becoming a satellite site of a community-based OTP, or 3) contracting with a local OTP for dosing).
256 See supra note 77 and accompanying text.
257 See generally, Rich et al., supra note 32.
258 See McKenzie et al., supra note 19, at 1; Nunn et al., supra note 71, at 87; see also Cherkis and Grim, supra note 156.
259 Nunn et al., supra note 72, at 87.
informal discussions to maintaining a regular presence at various corrections staff meetings.\textsuperscript{260} One study also noted that establishing a consistent presence within the facilities was crucial to gaining acceptance from prison staff.\textsuperscript{261}

Further, it is critical that advocates help link MAT providers in the community with the jails and prisons in their area. Community providers should work with correctional institutions to help establish evidence-based treatment protocols for patients during incarceration or prior to release. Forging such relationships also helps ensure a continuity of care upon release, which can be highly effective in preventing overdose during the crucial re-entry period.\textsuperscript{262}

Advocates and community organizations can also partner with jails and prisons to provide overdose prevention education and pre-release naloxone directly to incarcerated individuals. This work can draw on models forged by the San Francisco County Jail Naloxone Pilot, the Staying Alive program in Rhode Island, and Prevention Point Pittsburgh, for example, to ensure that re-entering individuals are equipped with the knowledge necessary to protect their life upon reentry to the community.\textsuperscript{263} To facilitate this, Congress included a provision in its 2015 “CRomnibus” bill directing the Substance Abuse and Mental Health Services Administration (SAMHSA) to make competitive grants available to support overdose prevention programs aimed at the incarcerated and recently released individuals.\textsuperscript{264}

\textsuperscript{260} See id.
\textsuperscript{261} See id.
\textsuperscript{262} See Binswanger et al. 2007, supra note 5, at 162–65.
\textsuperscript{263} See supra notes 48, 96-108 and accompanying text. None of these programs required litigation or policy reform.
\textsuperscript{264} Division G - Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2015, 64, available at http://docs.house.gov/billsthisweek/20141208/113-HR83sa-ES-G.pdf, which provides: “SAMHSA is directed to make Criminal Justice funding available for competitive grants to community-based providers through the Offender Reentry Program to implement overdose prevention programs for incarcerated and recently released individuals. The Administrator is directed to ensure an equitable amount of grant opportunities are available to grantees that serve those currently in custody, prior to release from incarceration, and continue for at least two months post-release into community-based services as part of a transition plan. Overdose prevention programs should include an educational component that includes SAMHSA’s Opioid Overdose Prevention Toolkit. Additionally, grant award decisions should give particular weight to overdose prevention programs that collaborate with community corrections and law enforcement entities as well as judges.”
Beyond direct education and prevention measures like naloxone access, interventions that address the broader risk environment among re-entering individuals can also help reduce overdose morbidity and mortality. Meeting the basic health and housing needs of formerly incarcerated individuals can establish much-needed stability and simultaneously provide the opportunity for service providers to deliver opioid overdose training and education. Ongoing peer relationships between formerly incarcerated individuals successfully act as a support system post-release, and an overdose prevention program referral might perhaps be taken more seriously when the suggestion is made by someone the recently incarcerated person trusts.  

Taken together, providing MAT (in both custodial and community settings), overdose prevention education, and pre-release naloxone behind bars, in conjunction with supportive reentry services can help stem the tide of post-release overdoses.266 As we have discussed,267 promising models for offering these services already exist. Programmatic change may be facilitated by changing perceptions among key decision makers within the corrections sector and beyond about the need, benefit, and ease of these interventions. Building relationships between correctional institutions, community supervision providers, and community organizations is critical to the overall effort to provide services to incarcerated individuals as well as ensure a continuum of care once individuals are released.

2. Community Supervision

Formerly incarcerated individuals who are under parole or probation supervision are often required to attend regular meetings with their case manager/supervisor.268 For individuals who are placed

265 This peer-to-peer relationship is enacted in the Staying Alive on the Outside: Opioid Overdose Prevention and Response for People Leaving Prison video, Green et al., supra note 47.


267 See supra notes 48, 96-108, 120 and accompanying text.

on community supervision because of charges involving substance use, submission to drug testing is often a condition of probation or parole; at times, this even includes bans on MAT utilization.\textsuperscript{269} Although some outdated policies in this context are certainly in need of reform, even in absence of any legal change community supervision provides an untapped opportunity to convey information about the risks of overdose and referrals to prevention programs.

Public health advocates should take stock of the reality that parole and probation officers, at a minuscule cost to the public, could provide everyone under their supervision with basic opioid overdose prevention information and training. Outreach can target both the individual parolee or probationer as well as their families and social networks. We know of no current effort to engage community supervision officers in overdose prevention activities, however. By taking full advantage of this opportunity, law enforcement can reduce the risk of opioid mortality among their supervisees, as well as other opioid users with whom parolees or probationers interact.\textsuperscript{270}

Community supervision and other law enforcement personnel should also provide re-entering individuals with information about applicable “9-1-1 Good Samaritan;” such laws are designed to reduce barriers to seeking emergency help in the event of an overdose.\textsuperscript{271} Given that fear of prosecution can prevent bystanders in an overdose situation from calling for professional help,\textsuperscript{272} a parole/probation officer may be one of the few people able to effectively communicate information to the friends and families of formerly incarcerated individuals about whom to call and what to do in the instance of overdose.

Home visits provide another intervention opportunity for community supervision officers. In light of the insular nature and

\textsuperscript{269} 18 U.S.C. § 3563(a)(5) (1998). see also Cherkis and Grim, supra notenote 156.

\textsuperscript{270} See Tara Lagu et al., Overdoses Among Friends: Drug Users Are Willing to Administer Naloxone to Others, 30 J. SUBSTANCE ABUSE TREATMENT 129, 129 (2006) (finding opioid users willing to help train other opioid users on how to identify overdoses).

\textsuperscript{271} For an updated list of these laws, see Good Samaritan Overdose Prevention Laws Map, http://lawatlas.org/query?dataset=good-samaritan-overdose-laws#.U99HIagdXYQ (last visited July 12, 2014).

pernicious social stigmatization of substance users, community supervision officers who visit with formerly incarcerated individuals are uniquely situated to implement education, referral and other interventions in the critical period following release. Community supervision officers who, in the course of conducting their duties, visit the residences of probationers and parolees who are at risk of overdose could be trained in overdose reversal, with the potential to save lives.

In this same vein, to fully capitalize on the opportunity to intervene, community supervision officers must have a comprehensive understanding not only of the risks associated with opioid use, but also of the full roster of the types of community programs available to provide overdose prevention training and access to naloxone to persons under their supervision. Indeed, there are many examples of community-based treatment programs addressing opioid overdose that are successfully reducing harm right now in the United States. Officers should instruct all individuals deemed at risk of opioid overdose to be educated about overdose and receive emergency doses of naloxone. Law enforcement could partner with these community-based organizations to make available information about their services so that community supervision officers could easily refer individuals to existing harm reduction programs.

As was the case in correctional settings, some barriers may exist to successfully implementing the above strategies. For example, community supervision officers, as members of the law enforcement community, may feel that overdose prevention education and naloxone access “sends the wrong message” to formerly incarcerated individuals. These concerns could be overcome by framing such programming as designed to equip individuals to serve a life-saving function in their social circles and by highlighting data that overdose

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273 For an illustration of these pernicious effects, see Christopher Kolb, The Lives of Race and Destiny: The Drug War, Nothingness, and the Cultural Violence of Neoliberalism in the Crack Landscape (BiblioBazaar 2011) (2009).

274 Binswanger et al. 2012, supra note 11, at 7–11.

275 See supra notes 85, 87 and accompanying text.

276 The Roxbury/Jamaica Plain Substance Use Coalition serves as a useful model of law enforcement and community-based overdose education and naloxone education programs. See Maya Doe-Simkins & Dharma Cortés, supra note 55.
trainings and naloxone access do not encourage substance abuse. Further, community supervision officers may misunderstand the nature of substance use disorder, and education and training on opioid misuse and harm reduction approaches in general may be a necessary prerequisite to initiating a new program. These efforts may in turn help shift the perception of community supervision personnel as focused exclusively on law enforcement, rather than support and assistance—a view that is currently pervasive among parolees and probationers.

3. Federal Financial Assistance for Drug Treatment and Overdose Prevention Programming

Perhaps the most formidable barrier to the implementation of simple measures to reduce the risk of reentry-related overdose is the lack of resources. The implementation of the Affordable Care Act (ACA) presents unprecedented opportunities to reduce overdose risk by improving the continuum—or initiation—of appropriate care either during or in the days and months after re-entry. Several specific components of this wide-reaching legislation offer promise.

First, the law’s provisions build on previous “parity” legislation to close existing gaps in covering mental health, substance abuse treatment, and other essential behavioral health benefits under federal (Medicaid and Medicare) as well as private insurance plans. The law classifies these services as “essential benefits under federal (Medicaid and Medicare) as well as private insurance plans."

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277 For an example of such training materials for law enforcement officials, see Maya Doe-Simkins & Dharma Cortés, Bos. Pub. Health Comm’n, Opioid Overdose Prevention for Public Safety and Law Enforcement supra note 55; Binswanger et al., supra note 11, at 6.

278 Binswanger et al. 2012, supra note 11, at 6.

279 Rich et al., supra note 48, at 462–64 (noting that the ACA “opens the door to enormous reforms in the continuum of care between correctional and community-based [health care] providers”).


health benefits” (EHBs), potentially increasing their availability and scope.

This can especially boost the capacity at community health centers and medical homes, which focus their care on under-resourced communities. Since individuals with substance use and mental health issues are at a highly disproportionate risk of incarceration, expansion of treatment capacity and reach has the additional potential to reduce criminal justice involvement and recidivism.

Second, the ACA’s mechanisms for increasing health insurance availability and affordability may help close the coverage gap for many criminal justice-involved individuals. After a period of incarceration, as many as 90% of individuals lack health insurance coverage. For the great majority of recently released people, the ACA’s Medicaid expansion provisions increase access to publically-financed health insurance, at least in the states that have chosen to accept federal funds for this purpose. Resources made available by the ACA for community outreach may help facilitate better education

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282 See ACA TITLE I §1302(b) and §2001(c)(6).
286 Emily A. Wang et al., Discharge Planning and Continuity of Health Care: Findings from the San Francisco County Jail, 98 AM. J. PUB. HEALTH 2182 (2008).
among this population and affected communities, including active identification and enrollment of eligible individuals while under custody in correctional facilities.288

Among those who are newly-eligible for Medicaid under the ACA, an estimated 17-35% may be criminal justice-involved.289 As a rule, Medicaid (as well as other federal and state benefit) funds cannot be used to support services inside correctional institutions.290 One notable exception to this rule is the availability of such funds to reimburse for services provided off-site, even while the individual is in custody.291 This has direct implications for how drug treatment, overdose education and training, and mental health services can be restructured to take advantage of substantial new funds available for these services through the ACA, for example by creating new partnerships between correctional institutions and drug treatment programs or community health centers. Specifically, services provided by these health care institutions to persons outside the walls of the correctional facility would be eligible for ACA coverage.

Third, the ACA is designed to increase care integration across the healthcare sector and between substance abuse and mental health treatment on the one hand and mainstream primary health care on the other.292 This means that individuals with substance use and mental health issues could be more easily engaged to appropriate treatment and services, decreasing their risk of incarnation in the first place. Within the re-entry context, gaps in medication adherence, counseling, and many other care modalities can transform the process of reentry into healthcare crises.293 Currently, there is seldom functional integration between correctional and community service providers. Electronic health records (EHR) and other health information technology incentivized by the ACA294 can operationalize such integration and improve the continuum of care for the newly released.

288 See Justice Center, supra note 281, at 2–3; see also Goode, supra note 285.
289 See Justice Center, supra note 281; see also Solomon, supra note 287, at 6.
290 §1905 of the Social Security Act (prohibiting “payments with respect to care or services for any individual who is an inmate of a public institution”).
291 Id.; see also Justice Center, supra note 281, at 2.
292 SEC. 399V-1, 42 U.S.C. 280g–12, Primary Care Extension Program.
293 See Binswanger et al. 2007, supra note 5, at 161–65.
Fourth, the ACA includes a set of provisions directed at quality improvement. This incorporates the development of key quality measures, pilot prevention programs, clinical guidelines and other initiatives designed to boost the impact and reduce the costs of health care. These provisions promise to refine the design and implementation of substance abuse and mental health services, including those that would impact individuals at risk of incarceration or recently released persons. These efforts can be informed by state-level needs assessments of at-risk communities, which specifically include substance abuse as one of the key focus areas.

B. Policy Reform

In addition to legal and advocacy efforts aimed at instituting programmatic changes (or, to the extent those efforts are only partially successful), advocates should also pursue a federal and state-level legislative agenda focused on decreasing overdose among recently released individuals. This might include mandating that individuals who enter an institution under a prescribed medication to treat opioid dependence be allowed to continue that medication throughout the duration of their incarceration, providing newly-diagnosed opioid-dependent individuals with comprehensive MAT services while incarcerated, providing state Medicaid coverage for medications used to treat opioid dependence, establishing programs for the provision of naloxone prior to release, funding naloxone access and overdose prevention programs in jails and prisons, and improving the continuum of care by establishing special healthcare facilities that facilitate re-entry by providing a continuum of care. As discussed, recent federal activity and provisions of the ACA can incentivize such efforts.

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296 42 U.S.C § 2951 ("Not later than 6 months after the date of enactment of this section, each State shall, as a condition of receiving payments from an allotment for the State under section 502 for fiscal year 2011, conduct a statewide needs assessment (which shall be separate from the statewide needs assessment required under section 505(a)) that identifies ... the State’s capacity for providing substance abuse treatment and counseling services to individuals and families in need of such treatment or services").

297 See supra note 264 and accompanying text; see also SAHMSA, supra note 80.

As with corrections officials, advocates will need to educate legislators about the need for these interventions, address common concerns, and explain their potential health, economic, and societal benefits. Even more fundamentally, advocates should appeal to a sense of duty to correct a life-threatening problem of the state’s own making. Indeed, by advancing punitive policies of incarceration for drug use and failing to provide adequate treatment and support services, the state is responsible for substantially exacerbating the risk that someone who leaves a government-run institution will die.

On the institutional level, federal consent decrees, grants and contracts, and other indirect mechanisms can also motivate reform on the state and local levels. As a result of pervasive problems within state and local custodial systems, a number of consent decrees are currently in place or pending throughout the United States, with several additional agreements currently being negotiated. Mandating provision of effective drug treatment and overdose prevention services, linkages to community-based care pre-release, and other key overdose prevention initiatives we have highlighted should be considered for inclusion in such agreements.

**Conclusion**

Overdose prevention programming is critically needed to mitigate the high risk of overdose among the recently incarcerated. Although the legal mechanisms to assert the state’s obligation to mitigate this risk are subject to challenges, several theories do hold promise. In light of the normative, programmatic and policy approaches outlined, state actors can and should be spurred to reduce the risk of opioid mortality among those re-entering society from custodial settings. As sentencing reform and other efforts to end mass incarceration gain momentum, overdose prevention is critical to ensure that re-entry does not result in the additional death of thousands of vulnerable Americans.

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299 For a list of current consent decrees, see *Special Litigation Section Cases and Matters*, U.S. Dep’t of Justice, available at http://www.justice.gov/crt/about/spl/findsettle.php.
300 *Id.*