THE CASE FOR METHADONE MAINTENANCE TREATMENT IN PRISONS

INTRODUCTION

It is unlikely that Keith Griggs ever expected his medicine to be suspended by the Vermont Department of Corrections (VDOC). Griggs became dependent on prescription narcotics while recovering from a work-related hand injury, battled a subsequent addiction to heroin throughout most of the 1990s, and made two failed attempts at treatment.[1] Griggs was so desperate for relief from the "dope sickness" during that time that he even burned himself with hot oil to get a prescription for painkillers.[2] Griggs lost his home and his two children as a result of his untreated addiction.[3] Finally, in 1999, Keith and his wife Tammy, who was also addicted, began daily methadone maintenance treatment (MMT), got their children back, and tried to put their lives back together.[4] Because Vermont had no established methadone clinics, Griggs had to drive or at times hitchhike to Greenfield, Massachusetts to pick up his daily dose of medicine—a round-trip of eighty miles.[5]

In 1999, after being charged with forgery, Griggs entered into a plea agreement that allowed him to go directly onto furlough and continue taking his methadone.[6] In 2001, VDOC suspended his furlough for two weeks and refused to administer his methadone, causing abrupt withdrawal.[7] VDOC eventually released Griggs early rather than comply with a court order to provide Griggs his methadone treatment.[8]

In another case less than two months later, VDOC imprisoned Shawn Gibson for allegedly violating probation conditions, and denied him his methadone dose.[9] Gibson, too, had been driving daily to Massachusetts for his treatment,[10] a six-hour round trip from his home in South Burlington.

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1. Leslie Wright, *Addict Details 9 Days of Hell: Methadone Withdrawal Hits Hard*, BURLINGTON FREE PRESS, July 3, 2001, at 1A.

2. *Id.*

3. *Id.*

4. *Id.*

5. *Id.* Griggs had to make this trip every day because MMT is only dispensed in single dosages that must be taken at the time of distribution. *Id.*

6. Mittimus to Commissioner of Corrections, State v. Griggs, No. 975-2-99 (Vt., Chit. Distr. Ct. Sept. 21, 1999).

7. *Cheever: Corrections Commissioner Gorczyk in Contempt for Failing to Obey Methadone Order*, VT. LAW. & TRIAL CT. REP., June 30, 2001, at 1, 8 [hereinafter *Cheever*].

8. *Id.* at 9.

9. Leslie Wright, *Methadone Issue Back in Court*, BURLINGTON FREE PRESS, Aug. 8, 2001, at 1B.

10. *Recovering Addict Jailed After Woman's Death*, ASSOCIATED PRESS NEWSWIRES, Aug. 4, 2001, Westlaw, AP NEWSWIRES PLUS file.

Gibson, however, lost on his day in court when his request for an injunction to allow him to continue taking his prescribed methadone was denied. Thus he was forced, like Griggs, to undergo abrupt withdrawal from his daily methadone dose.[11]

These two Vermont cases highlight the current debate surrounding methadone treatment in U.S. prisons today. Around the same time that heroin was starting to cross Vermont's state borders, scientific and medical authorities in this country concluded that methadone maintenance treatment is effective, humane, and successful as the most widely used treatment for opioid dependence.[12] In the summer of 2001, however, VDOC refused to administer methadone to inmates who had been receiving methadone maintenance treatment prior to their incarceration.

This Note uses recent Vermont cases to examine the issue of methadone treatment in prisons. Part I surveys the modern scientific findings regarding opioid dependence and MMT. Part II discusses the influx of heroin into Vermont and the ensuing court conflicts between Vermont prisoners in need of MMT and VDOC officials unwilling to allow methadone in Vermont's prisons. Part III examines the case law pertaining to methadone in prison, handed down largely in the 1970s. Part IV examines the current standard of prison medical care required by the Eighth Amendment, and argues that recent conclusions of the scientific community provide new bases to challenge the constitutionality of denying MMT in prisons.

I. METHADONE: MEDICINE TO TREAT OPIOID DEPENDENCE

In 1997, after reviewing 941 studies, the National Institutes of Health (NIH) Consensus Development Panel issued a landmark statement announcing that addiction to opioids is not an issue of willpower: opioid dependence is a medical, brain-related disorder to be treated like any other chronic medical illness.[13] "Opioid dependence (addiction) is defined as a

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11. Decision Re: Plaintiff's Request for a Temporary Restraining Order and Request for Preliminary Injunction at 4, Gibson v. Gorczyk, No. 423-8-01 (Vt., Wash. Sup. Ct. Aug. 10, 2001).

12. *See* discussion *infra* Part I.

13. NIH Nat'l Consensus Dev. Panel on Effective Med. Treatment of Opiate Addiction, *Effective Medical Treatment of Opiate Addiction*, 280 JAMA 1936, 1936–38 (1998) [hereinafter NIH Panel].

> For decades, opioid dependence was viewed as a problem of motivation, willpower, or strength of character. Through careful study of its natural history and through research at the genetic, molecular, neuronal, and epidemiological levels, it has been proven that opiate addiction is a medical disorder characterized by predictable signs and symptoms.

Id. at 1938. A more recent study concluded that some people are biologically predisposed to becoming

cluster of cognitive, behavioral, and physiological symptoms in which the individual continues use of opiates despite significant opiate-induced problems."[14] It is characterized by "repeated self-administration that usually results in opioid tolerance, withdrawal symptoms, and compulsive drug-taking."[15] Withdrawal symptoms include "anxiety, restlessness, runny nose, tearing, nausea, and vomiting."[16] Untreated opioid dependence can lead to criminal activity, continued illicit drug use, reliance on welfare, a threefold increase in the mortality rate, and increased health risks including exposure to hepatitis B and C and AIDS.[17]

Methadone has been widely used to treat opioid dependence for the past thirty years.[18] Methadone stops heroin cravings, the leading cause of relapse, and blocks the painful effects of heroin withdrawal.[19] Whereas heroin destabilizes the brain, methadone helps stabilize it.[20]

The NIH Panel concluded that the safety and efficacy of methadone maintenance treatment has been "unequivocally established."[21] Other leading scientific, medical, and policy institutions have agreed that MMT is the best treatment for opioid dependence.[22] In addition, more recent research has increased the efficacy potential of methadone treatment, reporting that high-dose methadone is significantly more effective than low- and moderate-dose treatment and that methadone can be used safely at higher dose levels than previously considered standard.[23] Research also

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drug abusers because their brains react differently to stimulants. Press Release, National Institute on Drug Abuse, Differences in Human Brain Chemistry May Account for Different Responses to Stimulants (Sept. 1, 1999), *at* http://www.nida.nih.gov/MedAdv/99/NR-91.html (last visited Oct. 26, 2002).

14. NIH Panel, *supra* note 13, at 1938. An "opiate" is "any preparation or derivative of opium." The term "opioid" originally denoted "synthetic narcotics resembling opiates but [is] increasingly used to refer to both opiates and synthetic narcotics." STEDMAN'S MEDICAL DICTIONARY 1254 (26th ed. 1995).

15. NIH Panel, *supra* note 13, at 1938.

16. *Id.*

17. *Id.* at 1939.

18. *Panel Backs Methadone Treatment*, BOSTON GLOBE, Dec. 10, 1998, at A39.

19. Vincent P. Dole, *What Have We Learned from Three Decades of Methadone Maintenance Treatment?*, 13 DRUG & ALCOHOL REV. 3, 3 (1994).

20. *Panel Backs Methadone Treatment*, *supra* note 18.

21. NIH Panel, *supra* note 13, at 1937.

22. 1999 REPORT OF THE PHARMACOLOGICAL TREATMENT OF OPIATE ADDICTION STUDY COMMITTEE, S. 303-123, Adj. Sess., at 7–8 (Vt. 1999) (finding that the National Academy of Sciences' Institute for Medicine, the National Institutes of Health, the National Institute on Drug Abuse, the Office of National Drug Control Policy of the Executive Office of the President of the United States, the American Medical Society, and the Vermont Medical Society all conclude that "[m]ethadone maintenance treatment, when combined with behavioral therapies, is recognized as the most effective treatment for heroin addiction").

23. Eric C. Strain et al., *Moderate- vs High-Dose Methadone in the Treatment of Opioid Dependence*, 281 JAMA 1000, 1004 (1999).

shows that longer-term MMT combined with psychiatric counseling is far more effective to treat opioid dependence than short-term methadone use to detoxify patients and reduce their cravings.[24] Finally, while alternatives to temporary methadone treatment have proven effective, MMT remains the most widely used treatment option.[25]

Despite the medical and scientific community's preference for using methadone to treat opioid dependence, controversy over its use remains because methadone is itself a narcotic and because some people remain in MMT indefinitely.[26] But while methadone is a narcotic, it does not produce the satisfactory feeling of a high or a euphoric effect in people who are opioid dependent.[27] In contrast, the action in heroin has an immediate onset, lasts four to six hours, and is typically injected, snorted or smoked several times a day.[28] Because methadone's onset of action is slow and its 24-hour half-life results in long-lasting action, the euphoric effect of the drug is blunted, making it unattractive for abuse.[29]

As to the longevity of use, the research on detoxification versus maintenance thwarts the ideological argument. When people with opioid addiction terminate MMT, they relapse rapidly—*over 80%* of methadone

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24. Press Release, National Institute on Drug Abuse, New Study Underscores Effectiveness of Methadone Maintenance as Treatment for Heroin Addiction (Mar. 7, 2000), *at* http://www.nida.nih.gov/MedAdv/00/NR3-7.html (last visited Oct. 26, 2002) [hereinafter New Study].

25. Other pharmacological treatment options for opioid dependence have been limited, but the Food and Drug Administration approved the long-awaited buprenorphine in two forms in October 2002. Cadence Mertz, *Heroin Treatment Approved*, BURLINGTON FREE PRESS, Oct. 29, 2002, at 1B. Buprenorphine is considered safer than methadone but might not be strong enough to treat those with very high opioid tolerance. *Id.* Most importantly, buprenorphine does not need to be distributed in clinics, but can instead be prescribed in the privacy of a doctor's office. *Id.* Levomethadyl acetate (Orlaam), another synthetic narcotic, received FDA approval in 1993 but has not been widely used. Leslie Wright, *Study Backs Heroin Treatment*, BURLINGTON FREE PRESS, Nov. 2, 2000, at 1A.

26. This stance is rooted in the ideological goal of abstinence, which would refute all ongoing pharmacological treatment for opioid addiction. Michael L. Prendergast & Deborah Podus, *Methadone Debate Reflects Deep-Rooted Conflicts in Field*, ALCOHOLISM AND DRUG ABUSE WKLY., May 10, 1999, at 5, *available at* 1999 WL 9620288. U.S. Senator John McCain, who attempted to restrict Medicaid reimbursement for methadone treatment, suggests that faith-based programs are an appropriate alternative to MMT. *Id.* In 1998, New York City Mayor Rudolph Giuliani announced a goal to abolish the city's methadone maintenance programs in favor of abstinence after a three-month tapering period, but later recanted after consulting with drug treatment experts and said that his original plan was "maybe somewhat unrealistic." Rachel L. Swarns, *Mayor Relents on Plan to End Methadone Use*, N.Y. TIMES, Jan. 16, 1999, at A1.

27. *See* Dole, *supra* note 19, at 3 (stating that for those addicted to heroin, methadone "establishes a high level of tolerance that blocks acute narcotic effects"); *see also* DRUG POLICY ALLIANCE, ABOUT METHADONE 10 (2d ed. 2003) ("When used in proper doses in maintenance treatment, methadone does not create euphoria, sedation, or an alalgesic effect."), *available at* http://drugpolicy.org/docUploads/aboutmethadone.pdf (last visited Mar. 27, 2003).

28. Mark W. Parrino, *Methadone Treatment in Jail*, AM. JAILS, May/June 2000, at 9, 10.

29. NIH Panel, *supra* note 13, at 1939.

patients will return to using heroin within one year.[30] When compared with both short-term and long-term detoxification strategies, traditional methadone maintenance treatment combined with psychosocial counseling is a far more effective treatment method for opioid dependence.[31] This is true even when the other detoxification modes are bolstered with intensive psychosocial services and aftercare.[32] Halting methadone treatment abruptly, as opposed to medically supervised withdrawal (detoxification), is not recommended treatment for opioid dependence.[33]

Methadone treatment serves not only those suffering from opioid dependence, it also helps society as a whole. The crime rate linked to heroin abuse is astonishing: more than 95% of people addicted to heroin reported committing crimes ranging from homicide to theft during an 11-year-at-risk interval.[34] Studies show that "[m]ethadone maintenance treatment (MMT) has been shown to improve life functioning and decrease heroin use; criminal behavior; drug use practices, such as needle sharing,

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30. JOHN C. BALL & ALAN ROSS, THE EFFECTIVENESS OF METHADONE MAINTENANCE TREATMENT 182–85 (1991). In a study of 105 people who left MMT for various reasons, including both "dropping out" and completing "detoxification," 82.1% returned to intravenous drug use within ten to twelve months without treatment. *Id.*

31. New Study, *supra* note 24; *see also* Karen L. Sees et al., *Methadone Maintenance vs 180-Day Psychosocially Enriched Detoxification for Treatment of Opioid Dependence: A Randomized Controlled Trial*, 283 JAMA 1303, 1309 (2000) (concluding that MMT resulted in greater treatment retention and lower heroin use rates when compared to 180-day psychologically enriched detoxification). In a press release, study director Dr. Sharon Hall commented, "Our results show that no matter how ideologically attractive the notion of a time-limited methadone treatment for heroin abusers, longer-term methadone maintenance treatment is far more effective." New Study, *supra* note 24. *See also* NIH Panel, *supra* note 13, at 1937 ("Although a drug-free state represents an optimal treatment goal, research has demonstrated that this goal cannot be achieved or sustained by the majority of persons dependent on opiates."). A recently developed treatment coined "rapid detox" promises detoxification for $10,000 at facilities such as the Waismann Institute in Beverly Hills, California. Daniel Costello, *Clean and Sober in 48 Hours?*, L.A. TIMES, Oct. 28, 2002, at F1. After an intensive two-day treatment in which one undergoes withdrawal under anesthesia, the patient then takes Naltrexone for up to nine months. *Id.* Naltrexone is a non-addictive drug that helps block the sensation of feeling "high" from opioids. *Id.* Insurance does not cover the procedure and peer-reviewed clinical trials are lacking. *Id.*

32. Sees et al., *supra* note 31, at 1303, 1309.

33. *See* NIH Panel, *supra* note 13, at 1939. The NIH Panel addressed medically supervised withdrawal but did not include abrupt cessation of methadone as a treatment option. *Id.* Likewise, the Vermont Department of Health describes two ways to withdraw from methadone treatment—medical withdrawal and administrative withdrawal. VT. DEP'T OF HEALTH, OPIATE ADDICTION TREATMENT RULES 13–14 (2001). Medical withdrawal is "a medically supervised, gradual reduction or tapering of dose over time . . . at a rate that is well tolerated by the patient and also in accordance with sound medical practices." *Id.* at 11. A decision to pursue medical withdrawal is developed in partnership between the patient and physician or at the request of the patient against medical advice. *Id.* at 14. Administrative withdrawal, the second way to cease treatment, is a decision made by the provider when the patient exhibits disruptive conduct (including violence, threats of violence, and dealing drugs) that adversely affects the program to a grave level. *Id.* Even in this circumstance of "extremely poor prognosis" for the patient, however, the program "offers a humane withdrawal schedule." *Id.* at 13–14.

34. NIH Panel, *supra* note 13, at 1939.

that increase human immunodeficiency virus (HIV) risk; and HIV infection."[35]

Methadone is also cost-effective. A 1997 report found that the total financial costs of untreated opioid dependence were estimated at $20 billion per year.[36] While MMT costs about $4,000 per person each year,[37] incarceration in U.S. prisons has an average annual cost of $22,279.[38] The Vermont Office of Alcohol and Drug Abuse Programs found that for each dollar spent on methadone treatment, twelve to fourteen dollars would be saved in health and social costs, namely in crime reduction, health care cost reduction, and increased employment among those with opioid dependence.[39]

Despite the research conclusions and the societal benefits of methadone maintenance treatment, criticism and stigma persist.[40] To counter these entrenched beliefs, the scientific community is aiming to change public perception. According to the American Medical Association, "[t]here must be a bridge between what the public believes and the science."[41] The NIH Consensus Development Panel called on leaders not only to increase funding and access to MMT, but also to educate the public that opioid dependence is a medical disorder that can be effectively treated with

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35. Sees et al., *supra* note 31, at 1303; *see also* Robert L. Hubbard et al., *Overview of 1-year Follow-Up Outcomes in the Drug Abuse Treatment Outcome Study (DATOS)*, 11 PSYCHOL. ADDICTIVE BEHAVIORS 261, 267–68 (1997) (showing an approximate 50% decrease in reported criminal activity among MMT participants compared to preadmission reports); NIH Panel, *supra* note 13, at 1939 ("Over the past 2 decades, clear and convincing evidence has been collected from multiple studies that effective treatment of opiate dependence markedly reduces the rates of criminal activity.").

36. NIH Panel, *supra* note 13, at 1938. The $20 billion figure was based on an estimated opioid-dependent population of 600,000 in 1997, with only 115,000 participating in methadone maintenance programs. *Id.* In 2001, of the estimated 810,000 opioid-dependent individuals, 170,000 participated in treatment. David A. Fiellin et al., *Methadone Maintenance in Primary Care: A Randomized Controlled Trial*, 286 JAMA 1724, 1724 (2001).

37. Marsha Rosenbaum et al., *Treatment as Harm Reduction, Defunding as Harm Maximization: The Case of Methadone Maintenance*, 28 J. PSYCHOACTIVE DRUGS 241, 248 (1996).

38. *See* CAMILLE GRAHAM CAMP & GEORGE M. CAMP, THE CORRECTIONS YEARBOOK 2001: ADULT SYSTEMS 105–06 (2002) (estimating the average cost per inmate to be $61.04 per day).

39. 1999 REPORT OF THE PHARMACOLOGICAL TREATMENT OF OPIATE ADDICTION STUDY COMMITTEE, S. 303-123, Adj. Sess., at 9 (Vt. 1999)

40. NIH Panel, *supra* note 13, at 1937.

> Science has not yet overcome the stigma of addiction and the negative public perception of MMT. Some leaders in the federal government, public health officials, members of the medical community, and the general public frequently consider opiate dependence a self-inflicted disease of the will or a moral flaw. They also regard MMT as an ineffective narcotic substitution and believe that a drug-free state is the only valid treatment goal.

Id.

41. Lauran Neergaard, *Drug Study Bucks Public Opinion*, BANGOR DAILY NEWS, Mar. 18, 1998, at 1, 1998 WL 3121254 (quoting Dr. Lonnie Bristow of the AMA).

MMT.[42] Barry McCaffrey, former Director of the White House Office of National Drug Control Policy, has done just that, taking a strong stand on MMT and its role in prisons:

> Clearly, one of the most intractable of all drugs to deal with is heroin addiction. We have been willing to marshal the political will and resources to put people behind bars but we have not been able to marshal the political will and resources to provide treatment in prison and for halfway houses on release. We have a failed social policy, and we are going to have to correct it.[43]

Mark Parrino, President of the American Association for the Treatment of Opioid Dependence (AATOD), suggests:

> On the issue of heroin addiction being "self-inflicted" and not worth treating, it is useful to provide an analogy. A significant number of cardiologists treat a large number of middle-aged men who require coronary bypass operations. These individuals are generally overweight, eating unhealthy food, and drinking unhealthy amounts of alcohol in addition to smoking several packs of cigarettes everyday [sic]. Should the cardiac surgeon deny treatment to these individuals because their cardiac disease is "self-inflicted" through years of neglecting their own health? If an inmate in any system required critical health care for his disease, should the officials deny him access to such care based on perception of "self-infliction"?[44]

Advocates also analogize opioid dependence to diabetes, with the requisite treatment of methadone likened to the life-saving drug of insulin.[45]

Removing the stigma sheds light on the medical reality facing nearly a million Americans. The scientific community's conclusion that opioid dependence is a medical disorder best treated with MMT should quell the moral argument about methadone. Opioid dependence and its drastic impact on communities are safely and effectively addressed with methadone maintenance treatment.

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42. NIH Panel, *supra* note 13, at 1940–41.

43. Parrino, *supra* note 28, at 10.

44. *Id.* at 11–12. For more information on the AATOD, formerly known as the American Methadone Treatment Association, see http://www.aatod.org.

45. J. Thomas Payte, *The Use of Insulin in the Treatment of Diabetes: An Analogy to Methadone Maintenance*, METHADONE TODAY (Detroit Organizational Needs in Treatment, Detroit, Mich.), Sept. 1996, at 2, *available at* http://www.methadonetoday.org/v1n10.htm (last visited Feb. 8, 2003).

II. HEROIN, METHADONE, AND VERMONT

A. The State's Response

In the 1990s, heroin seeped back into the mainstream drug market. In 1999, the number of people seeking treatment for opioid dependence surpassed those seeking treatment for cocaine addiction.[46] Heroin's success over crack cocaine on the street has been attributed to lower prices, greater drug purity, "market-savvy" dealers, and misinformation about the danger of heroin.[47] Heroin is also more physically addictive than crack cocaine,[48] and its increased purity enables the user to inject the drug more easily, via snorting rather than with a needle.[49]

In the late 1990s, Vermont began to confront its own growing heroin problem. A new wave of heroin fully reached its fingers into New England's northernmost tips by early 2000. On the streets of Bangor Maine, it became the "drug of choice,"[50] and it accounted for half of all drug arrests in Burlington, Vermont.[51] Accordingly, while national crime rates have been stable or decreasing, Vermont's overall crime rate increased by 5%, and its violent crime rate by 9%, during 1999.[52] Rutland sustained a 37% increase in burglaries in 1999—a statistic that police linked directly to increased drug use.[53] Heroin use is spreading most quickly among Vermont youth. While in 1990 no one who sought treatment for opioid dependence was under twenty-five, now that population accounts for 60% of those being treated at the University of Vermont Medical Center.[54] Surveys have found that 3% of Vermont's high school population have used heroin at least once, a figure higher than the national rate of 2%.[55]

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46. Jane E. Dee, *Rising Heroin Use Reflected in Rehab Center Admissions*, HARTFORD COURANT, Aug. 28, 1999, at A1 (covering the annual report of treatment trends by the Substance Abuse and Mental Health Services Administration, a branch of the United States Department of Health and Human Services).

47. *Id.*

48. *Id.*

49. *Heroin Use Surges Among Youth as Drug Sheds Its 'Dirty' Image*, PORTLAND PRESS HERALD, Mar. 14, 2000, at 4B, 2000 WL 5077769 [hereinafter *Heroin Use Surges*].

50. *Id.*

51. Henry Pierson Curtis, *Heroin: The Worst Is Yet to Come*, ORLANDO SENTINEL, Jan. 23, 2000, at A1, 2000 WL 3574336.

52. Wilson Ring, *Property, Other Crimes Up in Vermont Last Year*, ASSOCIATED PRESS NEWSWIRES, July 12, 2001, Westlaw, AP NEWSWIRES PLUS File.

53. *Rutland Police Say Drugs Behind Increase in Burglaries*, ASSOCIATED PRESS NEWSWIRES, July 13, 2001, Westlaw, AP NEWSWIRES PLUS File.

54. *Younger Vermonters Try to Kick Heroin*, BOSTON HERALD, Oct. 1, 2001, 2001 WL 3812445. The University of Vermont has conducted a research study on the recently approved buphenorphine for over a decade. Mertz, *supra* note 25.

55. *Statistics Show More Young People Seeking Treatment for Heroin*, ASSOCIATED PRESS NEWSWIRES, Sept. 30, 2001, Westlaw, AP NEWSWIRES PLUS File.

Vermont's response to the state's heroin problem reflected the controversy surrounding MMT. Until 2000, Vermont remained one of eight states that had not passed legislation authorizing an MMT program.[56] Governor Howard Dean threatened to veto the legislation because methadone must be used for a long period of time, even a lifetime, and because he believed it substitutes one drug for another.[57] The new legislation contained compromise provisions that reflected the ideological opposition to MMT.[58] The legislation retained a moralistic focus on detoxification, calling for "routine medical assessment" of MMT appropriateness and "protocols designed to encourage cessation of pharmacological treatment as soon as medically appropriate for the individual needs of the patient."[59] Another stipulation requires treatment providers to first decide whether buprenorphine is appropriate before considering methadone.[60]

The state has not hesitated, however, to expend resources to fight drug-related crime. In 2001, Governor Dean requested and was granted a $230,000 budgetary increase "to strengthen local law enforcement efforts to stop the sale and use of heroin in Vermont."[61] Establishing the first two methadone clinics in the state, by comparison, would have cost $200,000.[62] Despite sound science on MMT and the increasing number of opioid-dependent Vermonters facing a desperate situation, the battle over MMT in Vermont is still ongoing. While the state health department guidelines for methadone treatment were released in May 2001,[63] opposition from local communities and concern about state reimbursement thwarted moves to open clinics in Brattleboro and Rutland.[64] Vermont's first methadone clinic finally opened in Burlington in late October 2002.[65]

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56. *Heroin Use Surges*, *supra* note 49.

57. Nancy Remsen, *Compromise Would Allow Methadone*, BURLINGTON FREE PRESS, Apr. 27, 2000, at 1A.

58. The final legislation passed by the House and Senate established an "opiate addiction treatment advisory committee . . . [to] develop by rule comprehensive guidelines for a regional system of opiate treatment." S. 303, Gen. Assem., Bien. Sess. (Vt. 2000). Interestingly, an early draft of the bill called for a representative of VDOC to serve as part of the advisory committee. S. 303, Draft No. 1, 123rd, Adj. Sess. (Vt. 2000).

59. VT. STAT. ANN. tit. 18, § 4702(b)(3) (Supp. 2002).

60. *Id.* § 4702(b)(2). For information on buprenorphine, see *supra* note 25.

61. Bryan K. Marquard, *Big-City Scourge Besets Rural State: Vermont Struggles with Influx of Heroin*, BOSTON GLOBE, Jan. 28, 2001, at F9.

62. *Id.*

63. VT. DEP'T OF HEALTH, *supra* note 33.

64. Krista Larson, *Organizers Prepare for State's First Methadone Clinic*, ASSOCIATED PRESS NEWSWIRES, July 24, 2002, Westlaw, AP NEWSWIRES PLUS File.

65. Mertz, *supra* note 25.

B. The Vermont Cases

The confrontation between VDOC and inmates participating in MMT was the inevitable consequence of rapidly increasing opioid dependence in Vermont, the lack of access to treatment, and the direct link between heroin use and increased crime. It is also the result of Vermont's refusal to adhere to the scientific community's conclusions and recommendations regarding MMT. The cases of two Vermont prisoners denied methadone treatment illustrate this confrontation.

After an arrest for forgery, Keith Griggs was deliberately sentenced to pre-approved furlough in the VDOC's Intensive Substance Abuse Program (ISAP) so that he could live in the community and continue taking his methadone.[66] The judge's order specifically noted that if Griggs were to be taken off his methadone, the decision would be made in consultation with his doctor and that the manner of discontinuation would be made at his doctor's direction.[67] Nevertheless, when VDOC temporarily suspended Griggs' furlough for two weeks in June 2001 for failing to write a "thinking report,"[68] the prison administration and medical staff, ignoring the 1999 plea agreement, refused to give Griggs his dose of methadone and forced Griggs to undergo over a week of abrupt opioid withdrawal.[69]

Griggs had been on a daily dose of 200 milligrams of methadone, prescribed by his Massachusetts doctor, and the imposed withdrawal caused him to experience "stomach cramps, diarrhea, internal tremors, tremors in his legs, sweating, inability to sleep, confusion, fatigue, and anxiety."[70] Despite the fact that abrupt withdrawal has killed people in prison,[71] the

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66. *Cheever, supra* note 7, at 1.

67. Mittimus to Commissioner of Corrections, State v. Griggs, No. 975-2-99 (Vt., Chit. Distr. Ct. Sept. 21, 1999).

68. *Cheever, supra* note 7, at 8. As part of the Vermont Department of Corrections' Congitive Self Change Program, inmates learn to observe their own thinking by writing "thinking reports" about incidents. A thinking report consists of a brief, objectjve description of the situation, and a list of all the thoughts, feelings, attitudes, and beliefs the inmate remembers having at the time. VT. DEP'T OF CORR., COGNITIVE SELF-CHANGE MANUAL, *at* http://www.doc.state.vt.us/cogselma.htm#Lesson5 (last visited Oct. 23, 2002).

69. *Cheever, supra* note 7, at 8.

70. Complaint for Injunctive Relief at 1–2, Griggs v. Gorcyzk, No. 280-6-01 (Vt., Windsor Sup. Ct. June 27, 2001).

71. On June 2, 2001, Karen Johnson slipped into a coma in a Florida prison while undergoing abrupt withdrawal from methadone; she died in a hospital five days later. Doris Bloodsworth, *Family Calls for Answers in Orange Inmate's Death*, ORLANDO SENTINEL, June 28, 2001, at A1, 2001 WL 9194002. While deaths from methadone withdrawal are rare, in 1997 Susan Bennett died in the same Orange County jail during withdrawal. Sam Smith, *Climbing the Walls: Does Methadone Have a Place Behind Bars?*, PORTLAND PHOENIX, July 20, 2001, *at* http://www.portlandphoenix.com/archive/features/01/07/20/index.html (last visited Oct. 26, 2002). The jail had followed a withdrawal protocol requiring close supervision and medication to treat symptoms but is now seeking accreditation to distribute methadone inside the facility. *Id.*

VDOC gave him only Bentyl and Imodium to treat those symptoms.[72] Such "comfort" medications do not treat opioid dependence, they only treat some of the symptoms of withdrawal.[73]

Griggs brought suit against VDOC in Windsor Superior Court under the Eighth Amendment of the U.S. Constitution and section 801 of the Vermont Corrections Code.[74] The state trial judge directed VDOC to administer the methadone immediately.[75] VDOC refused to follow the court order and filed an emergency stay, claiming that the order contravened "medical and ethical standards utilized by the Department contractual physician . . . [and that] the Order violates Department policies concerning the provision of methadone to inmates."[76] The judge denied the stay and ordered a $1,000 fine for each day that VDOC failed to comply with the order.[77] At that point, Keith Griggs had been without methadone for nine days.[78]

VDOC then petitioned the Vermont Supreme Court for an emergency stay of the injunction.[79] It alleged that Griggs was receiving "attentive" care and was in "discomfort" but "not in any potential life threatening situation."[80] VDOC also charged the lower court's ruling as infringing on the broad discretionary powers granted to prison administrators.[81] Most importantly, VDOC argued that to administer methadone to Griggs would be *contrary* to the public interest.[82] VDOC characterized methadone as just another opioid for heroin addicts to abuse.[83] "The efficacy of allowing the use of a synthetic opiate—methadone—to *maintain an addiction* at the same time the Department punishes severely the use of all other illicit and addictive drugs is suspect at best."[84] By taking this stance, the VDOC fell

72. Entry Order at 2, Griggs v. Gorczyk, No. 2001-299 (Vt. June 30, 2001).

73. Telephone Interview with Dr. Alan Dayno, Medical Director, Community Substance Abuse Centers, W. Springfield, Mass. (Dec. 20, 2002) (on file with author).

74. Complaint for Injunctive Relief, Griggs v. Gorcyzk, No. 280-6-01 (Vt., Windsor Sup. Ct. June 27, 2001). Section 801 of the Vermont Corrections Code requires that inmates in prison receive the "prevailing" standard of medical care. VT. STAT. ANN. tit. 28, § 801 (2000).

75. *Cheever, supra* note 7, at 8.

76. Department of Corrections' Emergency Motion for Stay, or in the Alternative Dissolution of Temporary Restraining Order Pursuant to Rule 65 of the Vermont Rules of Civil Procedure at 2, Griggs v. Gorczyk, No. 280-6-01 (Vt., Windsor Sup. Ct. June 29, 2001).

77. Order, Griggs v. Gorczyk, No. 280-6-01 (Vt., Windsor Sup. Ct. June 29, 2001).

78. *See Cheever, supra* note 7, at 8.

79. Petitioner's Motion for Emergency Stay of the Windsor Superior Court's Injunction Order, Gorczyk v. Griggs , No. 2001-299 (Vt. June 29, 2001).

80. *Id.* at 4.

81. *Id.* at 7.

82. *Id.* at 8.

83. *See id.* at 10 (suggesting that the availability of methadone in prisons would create an "incentive to be incarcerated in Vermont if one is addicted either to heroin or its treatment alternative").

84. *Id.* at 9 (emphasis added).

into a role explicitly outlined by the National Institutes of Health: public officials entrenched in philosophical and moral opposition to MMT based on the idea that methadone is just another drug and that the only real treatment for opioid dependence is a medication-free state.[85] Finally, VDOC broached the theory that *convicted criminals* should be *less eligible* for MMT than the community at large.[86] This is completely contradictory to the research showing that people on MMT significantly decrease criminal activity.[87]

Griggs responded by referring to the trial court's finding of irreparable harm on two grounds: from the "debilitating and excruciatingly painful symptoms of withdrawal" confirmed by *all* testifying medical experts, and from the "substantial risk of a return to heroin addiction" resulting from abrupt withdrawal.[88] Griggs also noted that the prison physician was not an expert on opioid dependence disorder.[89]

At an emergency Saturday night hearing, Justice Marilyn Skoglund denied VDOC's request and held that the lower court order "merely requires [V]DOC to honor the conditions set forth in the mittimus and reasonably relied upon by Mr. Griggs."[90] The court concluded:

> [T]here was no dispute that Mr. Griggs was experiencing symptoms of withdrawal that required medical treatment and no dispute to the testimony offered the trial court that inappropriate withdrawal methods could cause a return to a heroin addiction. Thus, it is, Mr. Griggs who stands to suffer from a stay of the court's order.[91]

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85. *See* NIH Panel, *supra* note 13, at 1937.

86. Petitioner's Motion for Emergency Stay of the Windsor Superior Court's Injunction Order at 9, Gorczyk v. Griggs , No. 2001-299 (Vt. June 29, 2001).

> The provision of medical care to address an opiate addiction for an inmate in a correctional facility is a wholly different matter than the provision of medical care to an opiate addict in the general community. . . .
>
> . . . .
>
> *In addition*, there is a debate within the broader medical community whether maintenance *methadone* should be provided outside of hospital settings at all, *let alone to those sentenced for serious crimes.*

Id. (emphasis added).

87. *See supra* notes 34 & 35 and accompanying text.

88. Response to Petitioner's Motion for Emergency Stay at 2, Gorczyk v. Griggs, No. 2001-299 (Vt. June 30, 2001).

89. *Id.* at 3.

90. Entry Order, Griggs v. Gorczyk, No. 2001-299 (Vt. June 30, 2001).

91. *Id.*

The court further reprimanded VDOC for not recognizing the possibility that Griggs might one day require incarceration when it originally placed him on furlough.[92] At such a time, his "addiction would need to be addressed in a medically sound and humane manner and [his] Massachusetts doctor would have the authority to determine 'the manner in which defendant's methadone is discontinued.'"[93] Despite the clear, strong language of the ruling, VDOC remained steadfast in its refusal to allow Griggs to take his methadone. Rather than comply with the court order, VDOC released Griggs early.[94]

Not two months later, Shawn Gibson was arrested and imprisoned at Chittenden Regional Correctional Facility, where he was denied his methadone by VDOC.[95] Gibson filed for an injunction in Washington Superior Court but did not receive a favorable review.[96] The judge held that Gibson was unlikely to succeed on the merits because expert witnesses provided conflicting testimony about treatment methods.[97] Because "reasonable physicians may differ in their opinions about which method is the best method," the court could not conclude that denial of methadone was inappropriate.[98] Both physicians acknowledged that a slow taper of methadone would be within the prevailing standard of care, but the VDOC physician argued further that abrupt withdrawal is also acceptable care.[99] Key factors distinguishing the Gibson case from the Griggs case included the facts that Gibson did not have a contract with VDOC to be furloughed into the substance abuse program, and Gibson's length of stay in prison was open-ended rather than only two weeks.[100]

III. THE METHADONE CASES

While new to Vermont jurisprudence, lawsuits challenging the denial of methadone in prison are not new elsewhere and most have not been successful. The case law on methadone was largely decided in the 1970s, a period when prison reform advocates challenged abhorrent prison

92. *Id.*
93. *Id.*
94. *State Releases Inmate Denied Methadone Treatment*, ASSOCIATED PRESS NEWSWIRES, July 1, 2001, Westlaw, AP NEWSWIRES PLUS File.
95. *See* Wright, *supra* note 9.
96. Decision Re: Plaintiff's Request for a Temporary Restraining Order and Request for Preliminary Injunction at 4, Gibson v. Gorczyk, No. 423-8-01 (Vt., Wash. Sup. Ct. Aug. 10, 2001).
97. *Id.* at 3.
98. *Id.*
99. *Id.* at 2–3.
100. *See* Wright, *supra* note 9; *see also* notes 90–93 and accompanying text.

conditions around the country.[101] The Third Circuit entertained a string of methadone cases in the late 1970s.[102] In *Norris v. Frame*, a pretrial detainee brought suit after the prison denied his previously prescribed dose of methadone.[103] The prison doctors instead prescribed a tranquilizer, forcing withdrawal.[104] Norris was not convicted of any crime, and was held only because he could not make bail.[105] The Third Circuit Court of Appeals held that because Norris had been on a methadone regimen, Norris had a properly asserted due process liberty interest in receiving methadone under the Fourteenth Amendment.[106] The court, however, differentiated between the broader Fourteenth Amendment rights of pretrial detainees and the rights granted by the Eighth Amendment to convicted, sentenced inmates.[107] Pretrial detainees are not convicted of any crime—the state holds them only to guarantee their presence at trial, so they should not be subject to anything resembling punishment beyond the detention itself.[108] Furthermore, the court remanded the case in part to determine whether the defendants could successfully demonstrate legitimate concerns of prison security.[109]

In *Holly v. Rapone*, a pretrial detainee brought suit asserting that denial of methadone in prison violated his constitutional liberties.[110] The United States District Court for the Eastern District of Pennsylvania distinguished *Norris* because the plaintiff in *Holly* was not receiving methadone prior to his incarceration; he was seeking relief in prison from his current state of heroin withdrawal.[111] The court analyzed the prison medical treatment under the Eighth Amendment and found no cruel or unusual punishment because the plaintiff received "some medical treatment for his ailments."[112] Because he had not been enrolled in a methadone program prior to his detention, there was no liberty interest raised, and therefore Holly's claim did not trigger a Fourteenth Amendment due process analysis.[113]

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101. *See* Hedieh Nasheri, *A Spirit of Meanness: Courts, Prisons and Prisoners*, 27 CUMB. L. REV. 1173, 1173 (1996–97).

102. Inmates of the Allegheny County Jail v. Pierce, 612 F.2d 754 (3d Cir. 1979); Norris v. Frame, 585 F.2d 1183 (3d Cir. 1978); Holly v. Rapone, 476 F. Supp. 226 (E.D. Pa. 1979).

103. *Norris*, 585 F.2d at 1185–86.

104. *Id.* at 1185. Norris testified that the pain of withdrawal drove him to slash his left wrist. *Id.*

105. *Id.* at 1188.

106. *Id.* at 1189. The court noted that the trial court erred in conducting an Eighth Amendment analysis, as for convicted inmates. *Id.* at 1187.

107. *Id.* at 1186–89.

108. *Id.* at 1187.

109. *Id.* at 1189 (finding insufficient connection between the security interest and the denial of methadone in the record).

110. Holly v. Rapone, 476 F. Supp. 226, 228–29 (E.D. Pa. 1979).

111. *Id.* at 229, 232. Holly arrived at jail eight hours after his last shot of heroin. *Id.* at 229.

112. *Id.* at 231.

113. *Id.* at 232.

In *Inmates of the Allegheny County Jail v. Pierce*, the Third Circuit Court of Appeals retreated further from its holding in *Norris* in light of the Supreme Court's holding in *Bell v. Wolfish*, handed down in the interim.[114] *Bell* restricted due process protections for pretrial detainees by requiring the detainee to show that the particular condition has a punitive purpose.[115] Pretrial detainees brought suit in *Inmates of the Allegheny County Jail* in part to challenge the jail's policy of administering a six-day detoxification course of methadone to people in MMT, thereby tapering detainees off methadone upon their arrival at prison.[116] The court declined to choose between conflicting medical experts' testimony.[117] The court held that refusal to distribute methadone was not punitive in purpose in terms of the Fourteenth Amendment due process inquiry.[118] The court also recognized the jail's apparent security concerns about drug use within the facility because "the potential for jail or prison disruption caused by the presence of drugs is well known."[119] This finding contrasted with the *Norris* court's remand of the security issue for lack of evidence.[120]

The Fourth Circuit Court of Appeals has also held that removing a detainee from methadone abruptly does not amount to unconstitutional treatment.[121] In *Fredericks v. Huggins*, the sheriff refused to administer any methadone to pretrial detainees who had been in MMT programs, leaving them to undergo withdrawal.[122] Declining to decide whether a liberty interest in methadone existed, the court held that even if state and federal regulations induced expectation and gave rise to a liberty interest, that "'right' to detoxification is foregone once [a prisoner] is incarcerated in a

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114. Inmates of the Allegheny County Jail v. Pierce, 612 F.2d 754, 760–61 (3d Cir. 1979) (citing Bell v. Wolfish, 441 U.S. 520 (1979)).

115. *Bell*, 441 U.S. at 535.

116. *Inmates of the Allegheny County Jail*, 612 F.2d. at 760.

117. *Id.* Apparently not addressing the issue of methadone maintenance within the facility, the experts debated between a seven or twenty-one day taper. *Id.*

118. *Id.* at 760–61. Only inmates coming from approved clinics within Allegheny County to the facility were allowed to taper off methadone. *Id.* at 760. Those coming from other counties were denied the tapering dose. *Id.* at 760 n.5. The court noted the district court's finding of uneven treatment under the Equal Protection Clause and failure to order relief, but the parties did not raise the issue on appeal. *Id.*

119. *Id.* at 761 (noting that the potential for disruption "is true whether the drug is heroin, marijuana, or methadone" and that "even those [drugs] administered on a controlled basis" raised a "legitimate security concern").

120. *See Norris*, 585 F.2d at 1189 (stating that the court could not determine with certainty whether "such a security interest can be demonstrated").

121. Fredericks v. Huggins, 711 F.2d 31, 33 (4th Cir. 1983).

122. *Id.* at 32. Although the detainees testified that they went through severe withdrawal symptoms, the district court instead believed the sheriff's contradictory testimony because of "the tendency of a drug dependent person to exaggerate his or her symptoms in order to obtain drugs." *Id.* at 33.

penal institution that is unable to provide it."[123] The court reasoned that confinement, along with the legitimate goals and policies of the penal institution, served to limit any such right.[124]

Despite the limiting holdings in the Third and Fourth Circuit Courts of Appeals, a case from the Sixth Circuit Court of Appeals, *Cudnik v. Kreiger*, had a more favorable outcome for pretrial detainees who had been participating in MMT just prior to incarceration.[125] Upon arrival at prison, the class-action plaintiffs were forced to undergo abrupt withdrawal from methadone and were only given medications to treat some of their symptoms.[126] The court deemed it unnecessary to decide between conflicting medical expert testimony.[127] However, the court permanently enjoined the Cuyahoga County Jail from preventing pretrial detainees, who participated in MMT programs immediately prior to detention, from receiving methadone.[128] As in *Norris*, the court largely focused on the plaintiffs' pretrial detainee status in its constitutional analysis.[129]

The *Cudnik* court also touched on three important issues that could provide guidance for future methadone court decisions. First, the court noted that the jail doctor's meaningful treatment options did not include methadone because the sheriff, responsible for policy decisions, was opposed to distributing methadone inside the jail.[130] When prison policy eliminates potential treatment options it becomes impossible to consider a full range of medical treatment. Second, while the federal court acknowledged its proper deferential role to state prison authorities, it declared its superior function to protect the constitutional rights of prisoners.[131] A grant of deference may not be so broad so as to tread on the constitutional rights of prisoners.[132] Third, the court rejected the jail's security interest argument in denying methadone, suggesting that there were other means available to ensure jail security, including housing MMT recipients separately and

123. *Id.* at 34.

124. *Id.*

125. Cudnik v. Kreiger, 392 F. Supp. 305, 306, 313 (N.D. Ohio 1974).

126. *Id.* at 307.

127. *Id.* at 308. One doctor compared abrupt opioid withdrawal to a bad case of the flu, while the other maintained that treatment with comfort medications did not provide adequate relief. *Id.*

128. *Id.* at 313.

129. *Id.* at 310–13.

130. *Id.* at 308 (noting that the physician's *only* treatment option was the "withdrawal kit" to treat symptoms). However, the doctor was ideologically opposed to providing MMT. *See id.* ("Whereas [the detainees] may not be guilty of the charge that they are there for, they have *admitted guilt to addiction* . . . and I think that they should have withdrawal and rehabilitation enforced upon them as a matter of the State's obligation.") (emphasis added).

131. *Id.* at 309.

132. *See id.* ("When a prison regulation or practice offends a fundamental constitutional guarantee, federal courts will discharge their duty to protect constitutional rights.").

allowing neighborhood clinic personnel to visit and administer the drug.[133] Furthermore, the court reasoned that because methadone is distributed in liquid form and must be consumed in the presence of the person administering the drug according to strict regulations, an in-house illicit market for methadone is "at best highly remote."[134]

More recently, in 1994 the United States District Court for the Eastern District of New York refused to dismiss a case on the pleadings where a pretrial detainee who had previously received MMT brought suit for being denied methadone upon his detention.[135] "[I]f, based on plaintiff's condition, it was a medical necessity that he receive methadone immediately, then plaintiff has alleged action by [the prison doctor] which is something more than negligent; in fact, plaintiff has alleged that [the doctor] was deliberately indifferent to [plaintiff's] medical needs."[136] Using Eighth Amendment analysis, the court held that if methadone treatment was a medical necessity, then the plaintiff could allege "deliberate indifference" to his serious medical needs.[137]

IV. A NEW METHADONE FRAMEWORK

Once imprisoned, a person is not "wholly stripped of constitutional rights."[138] Inmates are protected from cruel and unusual punishment under the Eighth Amendment to the U.S. Constitution.[139] While the Court originally interpreted the amendment to prohibit torture and other barbarous methods of punishment,[140] modern cases have held that punishments that are incompatible with the "evolving standards of decency that mark the progress of a maturing society"[141] or that "involve the unnecessary and

133. *Id.* at 312.

134. *Id.*

135. Messina v. Mazzeo, 854 F. Supp. 116, 122, 140 (E.D.N.Y. 1994).

136. *Id.* at 140.

137. *Id.*

138. Wolff v. McDonnell, 418 U.S. 539, 555 (1974); *see also* Turner v. Safley, 482 U.S. 78, 84 (1987) ("Prison walls do not form a barrier separating prison inmates from the protections of the Constitution.").

139. The Eighth Amendment provides that "[e]xcessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted." U.S. CONST. amend. VIII.

140. Wilkerson v. Utah, 99 U.S. 130, 136 (1878) (holding that torture, and all other punishments that are unnecessarily cruel, are forbidden under the Eighth Amendment).

141. Estelle v. Gamble, 429 U.S. 97, 102 (1976) (quoting Trop v. Dulles, 356 U.S. 86, 101 (1958)). Trop held that despite the lack of physical mistreatment, the punishment of stripping a citizen of his or her nationality is barred by the Eighth Amendment as cruel and unusual punishment. *Trop*, 356 U.S. at 101–02. The Court held denationalization "more primitive than torture" because it causes expatriates to lose the "right to have rights," rendering them to live in another country with the limited rights of alien status. *Id.*

wanton infliction of pain" are also unconstitutional.[142] Courts must evaluate penal measures against "broad and idealistic concepts of dignity, civilized standards, humanity, and decency."[143]

The changing notion of the Eighth Amendment in recent decades has now rendered it "settled that 'the treatment a prisoner receives in prison and the conditions under which he is confined are subject to scrutiny under the Eighth Amendment.'"[144] Beyond merely setting restraints, the Amendment imposes affirmative duties on officials to provide "humane conditions of confinement."[145] Evolving standards of decency, calling for humane prison conditions, have led courts in recent decades to set legal standards for "sanitation, fire safety, medical care, mental health care, diet, exercise, and protection of inmates from assaults."[146] Recent court decisions regarding prison medical care provide a new framework under which to analyze a present day civil rights claim for refusal to provide methadone in prisons. This new framework, combined with the consensus of the scientific community that methadone maintenance is preferred treatment for opioid dependence, creates the opportunity for a successful present-day Eighth Amendment challenge to a denial of methadone in prison.

A. Deliberate Indifference to Serious Medical Needs

In 1976, the Supreme Court in *Estelle v. Gamble* recognized the government's obligation to provide medical care to prisoners.[147] The Court reasoned that because the government restrains inmates' liberty and thereby prohibits inmates from independently seeking medical care, the government must provide that care.[148] The court held that "deliberate indifference to serious medical needs"[149] is unconstitutional because it constitutes the "unnecessary and wanton infliction of pain" that the Eighth Amendment

142. *Estelle*, 429 U.S. at 103 (quoting Gregg v. Georgia, 428 U.S. 153, 173 (1976)). *Gregg* held that the death penalty did not offend the Eighth Amendment. *Gregg*, 428 U.S. at 169.

143. *Estelle*, 429 U.S. at 102 (quoting Jackson v. Bishop, 404 F.2d 571, 579 (8th Cir. 1968) (holding that Arkansas' use of the strap in prisons was cruel and unusual punishment under the Eighth Amendment)).

144. Farmer v. Brennan, 511 U.S. 825, 832 (1994) (quoting Helling v. McKinney, 509 U.S. 25, 31 (1993)). Justice Thomas wrote a stinging dissent in *Helling*, joined by Justice Scalia, steadfastly maintaining that the Eighth Amendment applies only to "punishments," not to conditions of confinement or even injuries sustained while in prison. *Helling*, 509 U.S. at 37–38 (Thomas, J., dissenting).

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

146. *See* Nasheri, *supra* note 101, at 1174.

147. *Estelle*, 429 U.S. at 103.

148. *Id.* ("An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met.").

149. *Id.* at 104.

forbids.[150] This standard contains both an objective element and a subjective element—the deprivation of care must be "sufficiently serious" from an objective perspective; and subjectively, officials must act with a "sufficiently culpable state of mind," also referred to as "deliberate indifference."[151]

Whereas some circuits previously used an "essential" medical need standard,[152] *Estelle* set the standard at "serious,"[153] thereby covering a much broader range of medical issues than only those that are life or death. A variety of federal circuit court cases have elaborated on the definition of a "serious" medical need. The Tenth Circuit Court of Appeals has held that "a medical need is sufficiently serious 'if it is one that has been diagnosed by a physician as mandating treatment or one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention.'"[154] A Second Circuit Court of Appeals decision described a medical need as serious when "the failure to treat a prisoner's condition could result in further significant injury or the unnecessary and wanton infliction of pain."[155] Federal courts have determined that serious medical needs include infected cysts,[156] degenerative tooth cavities,[157] transsexualism,[158] and post-

150. *Id.* at 104 (quoting *Gregg*, 428 U.S. at 173).

151. *Farmer*, 511 U.S. at 834 (quoting Wilson v. Seiter, 501 U.S. 294, 298, 302–03 (1991)).

152. Gutierrez v. Peters, 111 F.3d 1364, 1370, 1373 (7th Cir. 1997) (discussing the difference between "essential" and "serious" medical needs and holding that an infected pilonidal cyst was a serious medical need).

153. *Estelle*, 429 U.S. at 104. While setting minimum standards of treatment the Court failed to distinguish at all between what, after *Estelle*, became two distinct functions of prisons: punitive and custodial. *See* Philip M. Genty, *Confusing Punishment with Custodial Care: The Troublesome Legacy of* Estelle v. Gamble, 21 VT. L. REV. 379, 380–81 (1996) (arguing that the standard for determining cruel and unusual punishment should be impact-based). Under *Estelle*, courts are forced to analyze the intent of administrators in medical care cases rather than just the impact upon the prisoner who receives deficient care. *Id.*

154. Hunt v. Uphoff, 199 F.3d 1220, 1224 (10th Cir. 1999) (quoting Ramos v. Lamm, 639 F.2d 559, 575 (10th Cir. 1980)). The court held that the inmate stated a claim by alleging that a heart attack and subsequent bypass surgery were caused by the inadequate treatment he received for his diabetes and hypertension. *Id.* at 1223–24. The court rejected the state's reasoning that the allegations were a "mere disagreement" over his medical treatment and that the mere fact that the inmate had seen numerous doctors necessarily meant that he received treatment for serious medical needs. *Id.* at 1224.

155. Harrison v. Barkley, 219 F.3d 132, 136 (2d Cir. 2000) (quoting Chance v. Armstrong, 143 F.3d 698, 702 (2d Cir. 1998)).

156. *Gutierrez*, 111 F.3d at 1373 ("Guided by these standards, we have no hesitation concluding that Gutierrez has sufficiently alleged a 'serious' medical condition.").

157. *Harrison*, 219 F.3d at 137 (observing that "tooth cavity is a degenerative condition, and if it is left untreated indefinitely, it is likely to produce agony and to require more invasive and painful treatments, such as root canal therapy or extraction").

158. Phillips v. Mich. Dep't of Corr., 731 F. Supp. 792, 800 (W.D. Mich. 1990), *aff'd* 932 F.2d 969 (6th Cir. 1991) (holding that plaintiff had a serious medical need for continuation of estrogen treatments).

surgical wounds.[159] Ailments such as the common cold[160] and toe pain resulting from the removal of a toenail have been deemed not serious.[161]

The Supreme Court has held that the Eighth Amendment also covers harm to one's future health caused by a current condition in prison. When a prison official exposes a prisoner to a "sufficiently substantial 'risk of serious damage to his future health,'" the Eighth Amendment is implicated.[162] Exposure to second-hand tobacco smoke raises an Eighth Amendment claim because it could pose an unreasonable risk of serious damage to future health.[163] In that context the Court stated, "We have great difficulty agreeing that prison authorities may not be deliberately indifferent to an inmate's current health problems but may ignore a condition of confinement that is sure or very likely to cause serious illness and needless suffering the next week or month or year."[164]

After establishing that the medical need is sufficiently serious, a claimant must prove "deliberate indifference" on the part of the prison official or medical provider.[165] This subjective second prong is met if an official "knows of and disregards an excessive risk to inmate health or safety; the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference."[166] Somewhere between negligence and intentional conduct, deliberate indifference is admittedly a tough standard to meet.[167] Nevertheless, the Eleventh Circuit Court of Appeals held that plaintiffs can prove deliberate indifference by a showing of grossly inadequate care, by a decision to provide easier but less efficacious treatment, or, when the need for treatment is obvious, by cursory medical care that amounts to no treatment at all.[168]

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159. Boretti v. Wiscomb, 930 F.2d 1150, 1152, 1155 (6th Cir. 1991) (holding that plaintiff could state Eighth Amendment claim based on defendant's refusal to treat wound for five days or provide fresh dressings or pain medication as prescribed); Aldridge v. Montgomery, 753 F.2d 970, 971, 974 (11th Cir. 1985) (reversing directed verdict for defendants where evidence indicated that jailers refused to give inmate ice packs and aspirin for sutured cut above inmate's eye).

160. Gibson v. McEvers, 631 F.2d 95, 98 (7th Cir. 1980).

161. Snipes v. DeTella, 95 F.3d 586, 591 n.1 (7th Cir. 1996).

162. Farmer v. Brennan, 511 U.S. 825, 843 (1994) (quoting Helling v. McKinney, 509 U.S. 25, 35 (1993)). "It would . . . be odd to deny an injunction to inmates who plainly proved an unsafe, life-threatening condition in their prison on the ground that nothing yet had happened to them." *Id.* at 845 (quoting *Helling*, 509 U.S. at 33).

163. *Helling*, 509 U.S. at 35.

164. *Id.* at 33.

165. Estelle v. Gamble, 429 U.S. 97, 104–05 (1976).

166. *Farmer*, 511 U.S. at 837.

167. *See Estelle*, 429 U.S. at 105–06.

168. McElligott v. Foley, 182 F.3d 1248, 1255 (11th Cir. 1999) (citations omitted).

B. Standard as Applied to Opioid Dependence

Against this backdrop, it becomes evident that opioid dependence is a serious medical need with immediate and future risks. To deny previously prescribed methadone, whether by imposing detoxification or abrupt withdrawal, constitutes deliberate indifference.

A medical need is serious where a physician has diagnosed a condition as mandating treatment or if a lay person would easily recognize the necessity for a doctor's attention.[169] In the two Vermont cases, opioid addiction specialists in Massachusetts had diagnosed both Griggs and Gibson with opioid dependence and prescribed them methadone maintenance treatment long before their involvement with VDOC.[170] If untreated, opioid addiction results in withdrawal symptoms and possibly compulsive drug-taking.[171] Additionally, because Griggs and Gibson could not access methadone while in prison, a lay person could have witnessed their desperation and need for medical attention as they went through symptoms of withdrawal.

A serious medical condition also exists where "the failure to treat a prisoner's condition could result in . . . the unnecessary and wanton infliction of pain."[172] Abruptly denying methadone causes unnecessary pain and suffering. Withdrawal from methadone, suffered by both Griggs and Gibson at the hands of VDOC, causes "intense flu-like symptoms . . . including stomach cramps, diarrhea, tremors, sweating, inability to sleep, confusion, fatigue and anxiety."[173] Abrupt discontinuation from methadone is simply not an accepted treatment for the serious medical need of opioid dependence.[174] The extreme severity of Griggs' and Gibson's pain was completely unnecessary, and their opioid dependence posed an immediate and serious medical need.

Finally, the Eighth Amendment covers prison conditions that are sure or very likely to result in future harm.[175] To cease treatment for opioid

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169. Hunt v. Uphoff, 199 F.3d 1220, 1224 (10th Cir. 1999).

170. *See supra* Part II.B.

171. NIH Panel, *supra* note 13, at 1938.

172. Harrison v. Barkley, 219 F.3d 132, 136 (2d Cir. 2000).

173. *See* Leslie Wright, *Addicted Prisoner Denied Methadone*, BURLINGTON FREE PRESS, June 29, 2001, at 1A (describing Griggs' symptoms specifically); *see also* NIH Panel, *supra* note 13, at 1938 (opioid withdrawal results in symptoms that include anxiety, restlessness, runny nose, tearing, nausea, and vomiting).

174. *See generally* NIH Panel, *supra* note 13; VT. DEP'T OF HEALTH, *supra* note 33. Neither source mentions abrupt discontinuation from methadone as a viable treatment option.

175. Helling v. McKinney, 509 U.S. 25, 35 (1993) (remanding the case for a determination of several factors including whether the plaintiff could prove he would be exposed to an unreasonable risk by second hand tobacco smoke).

dependence, especially against the patient's will, creates a substantial risk of future harm. A drug-free state is simply not medically achievable and sustainable for the majority of persons dependent on opioids, including those who attempt detoxification.[176] For those whose treatment is halted against their will, it is a safe assumption that their chances of achieving and maintaining abstinence are even more slim. For the majority of afflicted individuals, untreated opioid dependence results in relapse, causes increased mortality, and can attract another range of illnesses.[177] Thus opioid dependence is a serious medical need in both the immediate and future sense, and the decision to halt Griggs' and Gibson's MMT subjected their future health to these dangers.

To deny diagnosed opioid-dependent individuals in prison their previously prescribed methadone against their will constitutes deliberate indifference. To prove deliberate indifference one must demonstrate to the factfinder that an official knew of and disregarded an excessive risk to inmate health or safety.[178] Deliberate indifference can also be shown when prison physicians choose easier but less efficacious treatment or provide treatment that is so cursory as to be no treatment at all.[179] In *McElligott v. Foley*, prison medical staff repeatedly prescribed a liquid diet, anti-gas medication, and Tylenol to treat severe stomach pain, vomiting and nausea which later proved to be colon cancer.[180] Even though the physician eventually prescribed stronger medication and ordered blood tests, a CT scan and a chest x-ray, the Eleventh Circuit Court of Appeals held the district court in error for finding no grounds for deliberate indifference as to the prison medical staff's failure to seek further diagnosis and treatment for pain.[181] The court held that the patient's nearly constant complaints about pain were enough for a jury to infer that the defendants knew of a substantial risk of serious harm to the patient.[182] The court held that a jury could also conclude that the medical staff knowingly took an easier but less efficacious course of treatment and provided grossly inadequate care.[183]

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176. NIH Panel, *supra* note 13, at 1937; *see also* BALL & ROSS, *supra* note 30, at 182–83 (describing a study involving twenty-three patients who had completed a detoxification program and were deemed "drug-free and independent"). The study noted that upon follow up visits fourteen had relapsed to intravenous drug use. *Id.* Six later enrolled in MMT, and only seven patients (30%) were "cured." *Id.*

177. NIH Panel, *supra* note 13, at 1938–39. "The consequences of untreated opiate dependence include much higher incidence of bacterial infections including endocarditis, thrombophlebitis, skin and soft tissue infections, and tuberculosis; hepatitis B and C; AIDS and sexually transmitted diseases; and alcohol abuse." *Id.* at 1939.

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

179. McElligott v. Foley, 182 F.3d 1248, 1255 (11th Cir. 1999).

180. *Id.* at 1251–54.

181. *Id.* at 1254, 1256–57.

182. *Id.* at 1257.

183. *Id.* at 1256, 1258.

Also, ignoring a prior diagnosis and a prescribed course of treatment by a specialist can constitute deliberate indifference. In *Rivera v. Goord*, the court held that the plaintiff stated a claim for deliberate indifference when prison medical staff ignored an outside medical specialist's prescribed course of treatment for the patient's painful jaw disorder, including a special diet and future visits to an oral surgeon.[184] In the Vermont cases, medical specialists had previously diagnosed Griggs and Gibson with opioid dependence and had prescribed courses of treatment for both men.[185] Upon their encounter with VDOC, they both requested continuation of their methadone, their specialist-prescribed treatment for opioid dependence.[186] Unlike the officials in *McElligott*, the VDOC physician *had* the benefit of a diagnosis and *still* prescribed only comfort medications.[187] Because VDOC ignored their prescribed courses of treatment, Griggs and Gibson stated claims of deliberate indifference.

Furthermore, accepted treatment for opioid dependence is to provide methadone; comfort medications only tend to some of the symptoms of withdrawal and do not treat the underlying condition. The VDOC physician did not dispute the testimony offered at trial that inappropriate withdrawal methods could cause a return to heroin addiction.[188] Therefore, it can be argued that he knew of and disregarded the serious risk of relapse to Griggs' and Gibson's health and safety. In light of the substantial risk of relapse after prematurely terminating treatment, providing comfort medications after stripping someone of their methadone is both grossly inadequate and so cursory that it amounts to no treatment at all.

Finally, defendants may not claim that because illnesses can affect people in different ways, they are allowed to provide the more minimal treatment. In *Taylor v. Anderson*, the plaintiff argued that officials threatened his health and endangered his life by failing to provide him a special diet for his diabetes.[189] The court rejected the defendant's argument that the effects of diabetes can vary from person to person and held that the inmate stated a claim for deliberate indifference to his serious medical needs.[190] Likewise, courts should reject arguments that assert that because detoxification might be successful for some people, tapering rather than MMT should be prescribed to all inmates. While it is true that some people opt to attempt detoxification, the decision must be made in conjunction with

184. Rivera v. Goord, 119 F. Supp. 2d 327, 337 (S.D.N.Y. 2000).
185. *See supra* Part II.B.
186. *Id.*
187. *Id.*
188. Entry Order at 4, Griggs v. Gorczyk, No. 2001-299 (Vt. June 30, 2001).
189. Taylor v. Anderson, 868 F. Supp. 1024, 1026 (N.D. Ill. 1994).
190. *Id.*

an addiction specialist on a case-by-case basis because most opioid dependent people cannot sustain a drug-free state.[191]

C. Evolving Standards of Decency

While deliberate indifference to serious medical needs is the specific test to evaluate prison medical care cases, all Eighth Amendment cases are guided by "evolving standards of decency that mark the progress of a maturing society."[192] No static test exists that measures whether conditions of confinement are cruel and unusual.[193] Courts must take into account "broad and idealistic concepts of dignity, civilized standards, humanity, and decency" when evaluating penal measures.[194]

Scientific advancements have informed standards of decency, dignity, and humanity in prisons.[195] In 1986, a Surgeon General's Report outlining the potential health risks associated with Environmental Tobacco Smoke (ETS), or secondary smoke, led to an explosion of legislation protecting the rights of nonsmokers.[196] Americans became "increasingly intolerant of secondary tobacco smoke," and notions of decency changed markedly in

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191. NIH Panel, *supra* note 13, at 1937.

192. Estelle v. Gamble, 429 U.S. 97, 102 (1976) (quoting Trop v. Dulles, 356 U.S. 86, 101 (1958)); *see also* Atkins v. Virginia, 122 S.Ct. 2242, 2252 (2002) (applying the Eighth Amendment and holding that "in the light of our 'evolving standards of decency'" executing mentally retarded criminals is unconstitutionally excessive punishment).

193. Rhodes v. Chapman, 452 U.S. 337, 346 (1981).

194. Jackson v. Bishop, 404 F.2d 571, 579 (8th Cir. 1968).

195. Many evolutionary and revolutionary changes in the law have their direct roots in advances in science and technology. DNA evidence, for example, has come into mainstream use in criminal cases, used both to convict defendants and, more recently, to exonerate those wrongly convicted. *See* DAVID L. FAIGMAN, LEGAL ALCHEMY: THE USE AND MISUSE OF SCIENCE IN THE LAW 84–85 (1999) (discussing the use of DNA evidence in the courtroom to link defendants to crimes). Scientific advancements have informed many suits that would have lacked sufficient evidence a few decades ago, including exploding gas tank victims' suits against Ford Motor Company and General Motors, asbestos workers' suits against Manville Corporation, and suits by women injured by the Dalkon Shield against A. H. Robbins. SHEILA JASANOFF, SCIENCE AT THE BAR 16 (1995). While science in the courtroom has not always produced sound results, the National Institutes of Health Consensus Development Program attempts to safeguard against this danger. Charles Upton Lowe, *NIH's Consensus-Development Program: Theory, Process, and Critique*, *in* LAW AND SCIENCE IN COLLABORATION 145 (J.D. Nyhart & Milton M. Carrow eds., 1983). The Consensus Development Program was created in the 1970s to solve problems of bottlenecking, uneven access, and inappropriate transfers of results by assuming a central role of facilitating the biomedical-technology transfer. *Id.* at 145–46. The NIH Consensus Statements, produced after a process of evaluating scientific information and resolving safety and efficacy issues, are "intended to advance understanding of the technology or issue in question." NIH Panel, *supra* note 13, at 1936. This program pronounced methadone safe and effective treatment of opioid dependence in 1997. *Id.* at 1941.

196. Jacqueline M. Kane, Note, *You've Come a Long Way, Felon:* Helling v. McKinney *Extends the Eighth Amendment to Grant Prisoners the Exclusive Constitutional Right to a Smoke-Free Environment*, 72 N.C. L. REV. 1399, 1399 (1994).

the late 1980s and early 1990s.[197] Constituent pressure resulted in laws banning smoking in confined spaces, protecting citizens from "involuntary exposure to secondhand smoke in the private workplace, in elevators, and on domestic airline flights."[198]

Not surprisingly, prisoners were left behind in this wave of legislation.[199] Some prison administrations did pass restrictive smoking policies, and at least one state, Alaska, had acted to ban smoking from prisons altogether by 1994.[200] Non-smoker protection made its way into prison law only when the Supreme Court granted an avenue of relief from secondhand smoke in prisons under *Helling v. McKinney*.[201] In that case, the petitioner shared a cell in Nevada State Prison with an inmate who smoked five packs of cigarettes a day.[202] The Court relied upon the notion of "contemporary standards of decency," informed by modern scientific findings to grant the injunction and safeguard individual rights of inmates.[203]

The scientific conclusions about MMT are equally reliable to those regarding secondhand smoke. But key differences exist between the national anti-smoking campaign and methadone advocacy groups. Until restrictions on smoking started taking effect, nearly everyone in the country was affected by secondhand smoke; the number of people affected by lack of access to MMT is comparatively small. People who are opioid dependent remain a considerably less powerful constituency than Americans opposed to smoking. Those who are opioid dependent and also *inside* prison walls have even less of a voice. They must rely on judicial protection.

Unlike the general acceptance of intolerance toward secondhand smoke, MMT currently enjoys limited public acceptance. Elsewhere, however, courts have not been afraid to choose science over mainstream notions of morality to protect the constitutional rights of disfavored minorities or individuals. In *Phillips v. Michigan Department of*

197. *Id.* at 1399, 1407–08.

198. *Id.* at 1407–08.

199. As a group, prisoners lack meaningful representation in legislatures and have few advocates. Prisoners, therefore, must rely on judicial oversight to ensure that their individual legal rights are not infringed upon by the conditions of their confinement. *See* Procunier v. Martinez, 416 U.S. 396, 405–06 (1974) ("[A] policy of judicial restraint cannot encompass any failure to take cognizance of valid constitutional claims whether arising in a federal or state institution. When a prison regulation or practice offends a fundamental constitutional guarantee, federal courts will discharge their duty to protect constitutional rights.").

200. Kane, *supra* note 196, at 1412 n.121.

201. Helling v. McKinney, 509 U.S. 25, 35 (1993).

202. *Id.* at 28.

203. *Id.* at 35–36.

Corrections, the court granted a preliminary injunction to allow a transsexual inmate to continue estrogen therapy.[204] Transsexuals suffer from a "'rare psychiatric disorder in which a person feels persistently uncomfortable about his or her anatomical sex,' and . . . typically seeks medical treatment, including hormonal therapy and surgery, to bring about a permanent sex change."[205] In *Phillips*, the inmate was transferred from one facility to another while in the middle of hormone therapy, but in her first medical examination at the new prison the doctor refused to continue the treatment.[206] Instead, he abruptly told the plaintiff that he was born a male and would stay that way.[207] The plaintiff consequently suffered vomiting, depression, a reduction in breast tissue resulting in bruising, and a deterioration in female characteristics previously attained through treatment.[208] With scientific guidance, the court decided that the plaintiff showed a strong likelihood of success on the merits, finding both a sufficiently serious medical need and deliberate indifference on the part of the doctor.[209] Common notions of morality may not include treatment for transsexuals, yet the court did not hesitate to protect the inmate.[210] Noting that one did not need to be a physician to see the effects of the disorder, the judge commented that "it is good for my concept of humanity to believe that all those who share this earth, if nothing more, would have empathy for [plaintiff's] attempt to heal herself. From the testimony, however, at least one medical professional had no such empathy."[211] Likewise, courts should not hesitate to intervene in cases concerning the distribution of methadone in prison on the basis of decency and humanity, despite the lack of the treatment's widespread public acceptance.

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204. Phillips v. Mich. Dep't of Corr., 731 F. Supp. 792, 800–01 (W.D. Mich. 1990), *aff'd*, 932 F.2d 969 (6th Cir. 1991).

205. Farmer v. Brennan, 511 U.S. 825, 829 (1994) (quoting AM. MED. ASS'N, ENCYCLOPEDIA OF MEDICINE 1006 (1989)).

206. *Phillips*, 731 F. Supp. at 794.

207. *Id.*

208. *Id.*

209. *Id.* at 800. Notably, the fact that the defendant's conduct "actually reversed the therapeutic effects of previous treatment" contributed to the finding of deliberate indifference. *Id.* Similarly, in the Vermont cases, the VDOC physician's conduct reversed the therapeutic effects of previous treatment. It caused both Griggs and Gibson to go through opioid withdrawal unnecessarily and subjected them to a serious risk of relapse to using heroin. *See supra* notes 30 & 188 and accompanying text.

210. *See Phillips*, 731 F. Supp. at 800–01 (noting that denial of estrogen will "wreak havoc on plaintiff's physical and emotional state" and, therefore, constitutes irreparable harm).

211. *Id.* at 800 n.9.

D. Financial and Policy Considerations in Prison Medical Decisions

Courts afford deference to most prison policy decisions,[212] but deference must not apply to health care decisions. Prison health care decisions must be made according to medical determinations, not policy and financial considerations. In *McDuffie v. Hopper*, an inmate with a history of mental illness and four suicide attempts reported having hallucinations and suicidal thoughts to prison personnel and asked that all personal items be removed from his cell.[213] On the same day the inmate requested that personnel remove his mattress because voices were telling him to tear it up and hang himself, prison officials abruptly discontinued his antipsychotic medication.[214] Five days later, the inmate hanged himself.[215] The ensuing suit alleged that the private prison health care company, Correctional Medical Services (CMS), instituted a "policy to get as many prisoners off of psychotropic drugs as possible in order to cut costs."[216] The court found sufficient evidence of deliberate indifference to deny summary judgment.[217]

Elsewhere, the Eleventh Circuit Court of Appeals held that "if necessary medical treatment has been delayed for non-medical reasons, a case of deliberate indifference has been made out."[218] Based on that holding, concerns have been raised about the very constitutionality of managed care in prisons.[219] If treatment decisions are based less on the inmates' needs and more on saving money, and the population has no advocacy power, that treatment can be constitutionally substandard.[220]

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212. *See* Bell v. Wolfish, 441 U.S. 520, 547–48 (1979) ("Prison administrators . . . should be accorded wide-ranging deference in the adoption and execution of policies and practices that are in their judgment are needed to preserve internal order and discipline and to maintain institutional security.").

213. McDuffie v. Hopper, 982 F. Supp. 817, 821 (M.D. Ala. 1997).

214. *Id.*

215. *Id.*

216. *Id.*

217. *Id.* at 829.

218. Ancata v. Prison Health Servs., 769 F.2d 700, 704 (11th Cir. 1985). The court found that plaintiff sufficiently stated a claim of deliberate indifference when defendants allegedly put financial interests ahead of serious medical needs of the indigent plaintiff, who died four months later of respiratory failure due to untreated leukemia. *Id.* at 702–04

219. Ira P. Robbins, *Managed Health Care in Prisons as Cruel and Unusual Punishment*, 90 J. CRIM. L. & CRIMINOLOGY 195, 196–97 (1999). "Inadequate care has been a recurring problem in prisons run by private managed health care firms." *Id.* at 196.

220. *See id.* at 197. "Managed health care in prisons is conspicuously different from managed health care on the outside." *Id.* at 201. Patients in prison often receive lower quality of care, they have no choice of health plans, and, if the provider refuses treatment, it is difficult if not impossible to find another source of treatment. *Id.* at 201–02.

Refusal to administer necessary MMT based upon non-medical policy reasons must be barred by the Eighth Amendment. While prisons have a security interest in limiting narcotics within facility walls, there are ways that security can be ensured without denying methadone treatment, as one court has already recognized.[221] VDOC admitted that the decision not to administer methadone to inmates is in part department policy.[222] The Chief Medical Officer of the Vermont Prison System is an employee of CMS.[223] During the Griggs case, the CMS spokesperson said, "[w]e work at the direction of the Department of Corrections."[224] There is a marked circularity to the comments. A physician employee of a private health care company contracted by the state of Vermont is in no position to contravene VDOC policy. Instead of allowing doctors to make medical decisions, VDOC policymakers are making policy decisions not to distribute methadone.

A closer examination of the competing medical testimony is also warranted. Courts have valid concerns when weighing competing medical testimony. As medicine is a broad discipline, courts should give weight to testimony according to levels of expertise. Griggs' physician, who testified on his behalf, is certified by the American Society of Addiction Medicine and has co-directed a methadone clinic since 1988.[225] The VDOC physician lacks addiction medicine certification and spent less than one year working in a methadone clinic prior to working with CMS.[226] He is not an expert in addiction medicine. About the methadone cases, he commented, "[m]edically, I don't believe [methadone] is any different than any narcotic."[227] With several potential compromises on medical decisions in

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221. Cudnik v. Kreiger, 392 F. Supp. 305, 312 (N.D. Ohio 1974); *see supra* notes 133 & 134 and accompanying text.

222. Emergency Motion for Stay, or in the Alternative Dissolution of Temporary Restraining Order Pursuant to Rule 65 of the Vermont Rules of Civil Procedure at 2, Griggs v. Gorczyk, No. 280-6-01 (Vt., Windsor Sup. Ct. June 29, 2001).

223. Wright, *supra* note 173. CMS, based in St. Louis, is one of the nation's two largest private prison health care contractors, but enjoys a less than stellar reputation. *See* Robert Durkee, *Virginia DOC Cuts Ties with CMS*, PRISON LEGAL NEWS, July 2001, at 8. For example, in 2001, citing dozens of prisoner lawsuits and $900,000 in state fines for non-compliance, the state of Virginia severed ties with CMS at two of its prisons. *Id.* The situation was so dire that it led the Virginia auditor of public accounts to conclude that it might have been cheaper for CMS to absorb penalties than comply with the contract. *Id.*

224. Wright, *supra* note 173.

225. Temporary Restraining Order and Motion for Contempt, Volume I of II at 14–15, Griggs v. Gorczyk, No. 280-6-01 (Vt., Windsor Sup. Ct. June 29, 2001).

226. Testimony of Dr. Werner, at 4–5, Gibson v. Gorczyk, No. 423-8-01 (Vt., Wash. Sup. Ct., Aug. 9 & 10, 2001).

227. Leslie Wright, *State Must Give Inmate Methadone*, BURLINGTON FREE PRESS, June 30, 2001, at 1A.

prisons, courts must take extra care to look closely at prison doctors' medical testimony.

CONCLUSION

On Rikers Island in New York City, participants in the Key Extended Entry Program (KEEP) are treated with methadone within the prison walls.[228] In 1998, 4,431 inmates, serving time for either a misdemeanor or low-grade felony, received treatment.[229] The average length of stay for KEEP patients is thirty-nine days, and 79% of KEEP patients reported to their assigned programs after release from jail for continued treatment.[230] After release, criminal recidivism has been lowered among 62% of program participants.[231] Among released participants who receive Medicaid, recidivism was reduced by 100%.[232] While other prisons allow inmates to remain on their methadone once incarcerated, Rikers Island is the only prison in the country that has an in-house program to start people with opioid dependence on MMT.[233]

If Rikers Island can safely and successfully provide methadone to inmates, Vermont's comparatively tiny facilities can do the same. According to Vermont statute, the Vermont Department of Corrections

> shall formulate its programs and policies recognizing that almost all criminal offenders ultimately return to the community, and that the traditional institutional prisons fail to reform or rehabilitate, operating instead to increase the risk of continued criminal acts following release. The department shall strive to develop and implement a comprehensive program which will provide necessary closed custodial confinement of frequent, dangerous offenders, but which also will establish as its primary objective the disciplined preparation of offenders for their responsible roles in the open community.[234]

228. Parrino, *supra* note 28, at 10. Rikers Island houses over 20,000 inmates on a 415-acre island erected largely on compacted trash in New York's East River. JONATHAN KOZOL, AMAZING GRACE: THE LIVES OF CHILDREN AND THE CONSCIENCE OF A NATION 142–43 (1995).

229. *Id.* at 11.

230. *Id.*

231. Smith, *supra* note 71.

232. *Id.*

233. Parrino, *supra* note 28, at 10.

234. VT. STAT. ANN. tit. 28, § 1(b) (2000 & Supp. 2002).

Accordingly, with over 95% of people with opioid dependence self-reporting the commission of some sort of crime while untreated,[235] Vermont prisons should be interested in effectively treating the disorder. But because philosophical opposition, remnants of outmoded morality, and lack of education about MMT persist, prisons are slow to change. Their focus remains largely on the short-term interest of keeping things simple inside their walls by severely limiting narcotics, rather than on helping to stop the cycle of crime. Prisons are legitimately concerned with internal security, but first and foremost they should be concerned with keeping people out of prison. Vermont courts and VDOC must look through a wider lens and put society's interests first.

Courts facing inmate claims of cruel and unusual punishment for being denied methadone in prison must reexamine the case law in the light of modern conclusions about MMT. Courts are correct to be cautious with competing science, but they should not shy away from making decisions when presented with a consensus of medical specialists and scientists. Courts should not be afraid to step out of narrow methadone precedent and examine opioid dependence disorder in a new light, as a medical illness requiring MMT rather than a moralist debate.

The two Vermont cases handed down during the summer of 2001 brought the issue of methadone in prisons to the forefront of state news and drug policy at a time when both prison and opioid dependent populations were increasing. Denying methadone to inmates can no longer pass constitutional muster because it offends the evolving standard of decency that marks the progress of a maturing society, in which scientists have declared opioid dependence a medical disorder treatable with methadone. Generalized notions of prison security should not hold sway in denying constitutional medical treatment to a person with a diagnosed medical disorder. If methadone treatment is terminated against the wishes of patients and their physicians specially trained in addiction medicine, then the treatment for opioid dependence is halted altogether. The patients are stripped of necessary medication, subjecting them to suffer the terrifying and painful experience of withdrawal and the significant risk of relapse to heroin use. It is deliberate indifference to serious medical needs, it offends evolving standards of decency, and it is cruel and unusual punishment.

Rebecca Boucher

235. NIH Panel, *supra* note 13, at 1939.