

# BIG IDEAS

ADVANCING SOLUTIONS TO CURB FATAL OVERDOSES IN THE UNITED STATES

## DYING INSIDE: TO END DEATHS OF DESPAIR, ADDRESS THE CRISIS IN LOCAL JAILS

**U.S. LIFE EXPECTANCY HAS DECLINED IN RECENT YEARS**, primarily due to a series of converging public health crises that resulted in deaths from overdoses, suicides, and alcohol-related liver disease, sometimes referred to as “deaths of despair.”<sup>1</sup> More recently, COVID-19 has accelerated this trend.<sup>2</sup> These bleak numbers shine a spotlight on the historic challenges of treating medical conditions, mental health conditions, and substance use disorder (SUD), particularly in settings like local jails, which are traditionally separate from the general health care system.

Individuals entering jails and other correctional settings are more likely to have a chronic health condition or infectious disease, resulting in an increased risk to their physical health and well-being while incarcerated.<sup>3</sup> A close look at statistics from local jails demonstrates that, far from being a safe haven from these converging crises, a failure to prioritize implementation of adequate policies and protocols addressing these issues in many local jails are fueling these crises for the individuals inside and everyone in our communities.

According to the latest data available from 2018-2019, deaths in jail custody have increased.<sup>4</sup> Each and every one of these lost lives is a tragedy. In addition to the human cost, deaths in jail custody also account for hundreds of millions of dollars in financial costs and legal liability for governments and jail personnel.

### STATISTICS ON DEATHS IN JAIL CUSTODY

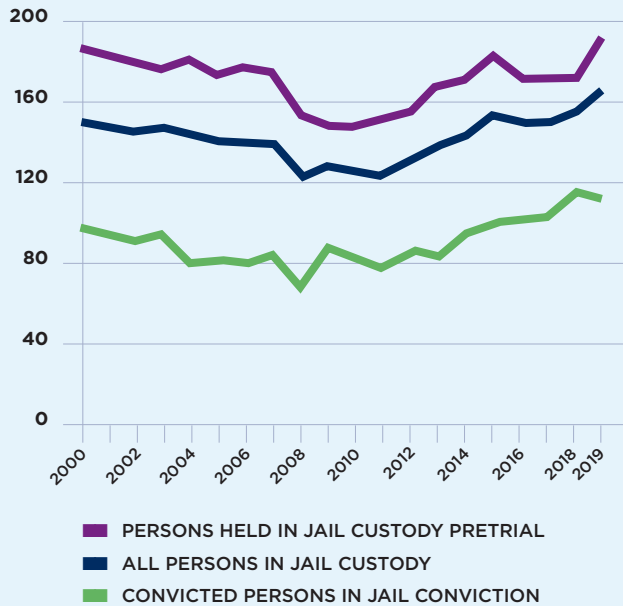
- From 2000 to 2019, at least **20,413 people died while incarcerated** in local jails.
- Deaths in jail custody from all causes have been increasing in recent years.
- **Deaths in jails due to drug or alcohol intoxication increased by almost 19%** from 2017 to 2018 and more than quadrupled between 2000 and 2018.
- **Suicide is the leading cause of death in jails.** The mortality rate from suicide is twice that of individuals in the community.
- About 40% of deaths **occurred within the first 7 days of admission to jail.**
- Almost 77% of persons who died in local jails in 2019 **were not convicted of a crime at the time of their death.**
- 42% of persons held in jail custody pretrial who died between 2000 and 2019 **died of either suicide or drug or alcohol intoxication.**

Source: Carson, E. A. Mortality in local jails, 2000–2019 – statistical tables. U.S. Department of Justice Office of Justice Programs Bureau of Justice Statistics. (2021, December), from <https://bjs.ojp.gov/content/pub/pdf/mlj0019st.pdf>[2]

**EACH AND EVERY ONE OF THESE LOST LIVES IS A TRAGEDY. IN ADDITION TO THE HUMAN COST, DEATHS IN JAIL CUSTODY ALSO ACCOUNT FOR HUNDREDS OF MILLIONS OF DOLLARS IN FINANCIAL COSTS AND LEGAL LIABILITY FOR GOVERNMENTS AND JAIL PERSONNEL.**

## MORTALITY RATE PER 100,000 PERSONS INCARCERATED IN LOCAL JAILS

2000-2019



SOURCE: Bureau of Justice Statistics, Annual Survey of Jails, 2000-2018; Census of Jails, 2019; and Mortality in Correctional Institutions, 2000-2019.

Efforts at the local, state, and federal levels have begun a shift toward adopting more public health-oriented approaches in correctional settings, largely driven by an acknowledgement that addressing the health care and treatment needs of incarcerated people can positively impact both these individuals and the overall health of communities. However, government leaders and advocates at every level must undertake significant policy and practice changes to reduce deaths in jail custody and accelerate reform.

This brief outlines the legal framework on the right to adequate care and treatment for medical, mental health, and substance-related conditions in jails. The brief also highlights the findings of original research on litigation related to deaths in jail custody and provides recommendations for reform.

### LEGAL FRAMEWORK ON THE RIGHTS TO CARE AND TREATMENT FOR MEDICAL, MENTAL HEALTH CONDITIONS, AND SUBSTANCE-RELATED CONDITIONS IN JAILS

The **U.S. Constitution** guarantees incarcerated individuals certain protections during confinement.<sup>5</sup> The Eighth Amendment protects persons convicted

and sentenced to confinement from “cruel or unusual punishments” from those in charge of their custody.<sup>6</sup> The Fourteenth Amendment protects the rights of pretrial detainees and is at least as protective as the Eighth Amendment.<sup>7</sup>

One of the most significant applications of this protection is the right of incarcerated persons to receive medical care. In 1976, the U.S. Supreme Court held that this right includes the obligation that correctional institutions provide adequate medical treatment to those in confinement who, as a result of their incarceration, must rely on the government for their care because they are unable to access it for themselves.<sup>8</sup> In the same case, the Court established that correctional facilities fail to meet this obligation when they exhibit deliberate indifference to serious medical needs of incarcerated persons.<sup>9</sup> The Supreme Court has imposed these obligations on states through the Due Process Clause of the Fourteenth Amendment.<sup>10</sup>

The **Civil Rights Act of 1871**, 42 U.S. Code § 1983, permits enforcement of constitutional rights against state and municipal officials through the imposition of civil liability for violations of federal statutory or constitutional rights.<sup>11</sup> Municipalities and other local governmental units, such as jails, can be sued for money damages when official policies clearly violate constitutional rights.<sup>12</sup> Separately, if an incarcerated person can identify a “known and unreasonable” imminent risk to their health, they can sue for an injunction before a tragic event occurs.<sup>13</sup> The **Prison Litigation Reform Act** narrowed the injunctive relief available to federal litigants pursuing § 1983 claims in the prison and jail context. It nonetheless permits injunctive relief in these cases, so long as the “relief is narrowly drawn, extends no further than necessary to correct the violation of the Federal right, and is the least intrusive means necessary to correct the violation of the Federal right.”<sup>14</sup>

In addition to the previously mentioned private rights of action, under the **Civil Rights of Institutionalized Persons Act (CRIPA)**, the U.S. Department of Justice can bring actions against state and local governments, including jails and prisons, for a “pattern or practice” of violating the civil and constitutional rights of incarcerated people.<sup>15</sup>

Federal claims can also be brought under Title II of the **Americans with Disabilities Act (ADA)**, which protects access to services, programs, and activities in public entities such as public education, corrections, and the courts for qualified people with disabilities.<sup>16</sup> There are several corrections-specific regulations promulgated under the ADA: jails must “ensure that qualified inmates or detainees with disabilities shall not, because a facility is inaccessible to or unusable by individuals with disabilities, be excluded from participation in, or be denied the benefits of, the services, programs, or activities of a public entity, or be subjected to discrimination by any public

entity.”<sup>17</sup> Jails also must “ensure that each inmate with a disability is housed in a cell with the accessible elements necessary to afford the inmate access to safe, appropriate housing,”<sup>18</sup> as well as implement “some form of [disability] tracking system... to enable [them] to comply” with the ADA.<sup>19</sup>

Recent [guidance](#)<sup>20</sup> and [enforcement actions](#)<sup>21</sup> from the U.S. Department of Justice have underscored that individuals with substance use disorders can qualify as individuals with a disability under the ADA and that the ADA protects individuals who are engaged in a course of treatment that includes medication for opioid use disorder (MOUD) approved by the Food and Drug Administration (FDA), including in correctional settings.

In addition to all of these federal protections, plaintiffs can bring **state law claims**, including state constitutional claims, which may offer more protections than the federal constitution,<sup>22</sup> claims under state disability statutes, and state tort law claims. State tort law claims can include medical malpractice, wrongful death, assault, and intentional infliction of emotional distress, among others. Tort claims vary by state. Individual actors may also be subject to **criminal liability** under state law for the role that they played in causing the death of the incarcerated person.

## FINDINGS OF ORIGINAL RESEARCH ON LITIGATION INVOLVING DEATHS IN JAIL CUSTODY

Local jails are faced with a growing number of incarcerated persons with complex health needs, including behavioral health needs, despite having limited resources available. Jails play a critical role in providing proper services that address the safety and well-being of both individuals who are incarcerated and staff. Jails that fail to meet adequate standards are at risk of litigation, monetary damages, injunctions, and scrutiny from the public, courts, and federal government. Litigation may also affect a local government’s ability to function, increase its insurance costs, and downgrade bond ratings.<sup>23</sup> Some jails have even lost access to their insurance pool because of damages awards.<sup>24</sup>

### About the Research:

The Addiction and Public Policy Initiative at the O’Neill Institute for National and Global Health Law conducted original research on civil litigation cases and case summaries involving deaths in jail custody between 2015 and 2020. This research highlights trends related to deaths in jail custody and the conditions that precede such deaths. In doing so, the findings highlight areas of high risk that can be targeted to decrease deaths in custody, improve the conditions of jail confinement, and decrease the jail’s exposure to litigation and associated costs. The analysis of these

cases offers unique insight into quality of care issues that arise in correctional healthcare settings due in large part to the absence of mandatory accreditation or other systematic oversight.

The study sample includes both state and federal cases, which were extracted from three sources: LexisNexis’ Jury Verdicts and Settlements database, Westlaw’s Jury Verdicts and Settlements database, and Westlaw’s Dockets database (“Dockets”). A total of 1,242 cases were screened for relevance, and the final sample contained 477 cases.

Complete findings will be published in forthcoming articles, including in an article published in the *Journal of Correctional Health Care* cited as Taleed El-Sabawi, Shelly Weizman, Somer Brown, & Regina LaBelle, *Dying Inside: Litigation Patterns for Deaths in Jail Custody*, 29 *J. CORRECTIONAL HEALTH CARE* (forthcoming 2023).

Researchers coded case summaries or court documents and both the descriptive statistics and thematic trends are summarized herein. The causes of death reviewed included physical illness that worsened due to a lack of adequate medical treatment, drug/alcohol withdrawal complications, overdose, suicide, assault by another individual in custody, and officer use of force.

## QUANTITATIVE FINDINGS

The cases involving deaths in custody analyzed in this study represented **over \$292 million** awarded as a result of litigation arising from deaths in jail custody from 2015-2020. This sum underrepresents the actual amount paid by state and local governments, correctional officers, and healthcare providers during this period, as approximately 24% of the cases in the sample lacked outcome data. The sample did not

### SUMMARY OF QUANTITATIVE FINDINGS

- Civil litigation cases involving deaths in jail custody represented **over \$292 million awarded** between 2015 and 2020.
- **Suicide was the leading cause of death in the lawsuits filed, accounting for 35% of the cases reviewed.** Nineteen percent of lawsuits included indications that the deaths were drug-related.
- **Mental health issues were present in 36% of cases involving a death** resulting from excessive use of force by a correctional officer; substance use prior to incarceration was present in 31% of such cases.
- Almost a quarter of in-custody deaths (23%) **occurred within the first 24 hours after arrest.**

## RANGE OF OUTCOMES FROM JAIL DEATH LITIGATION

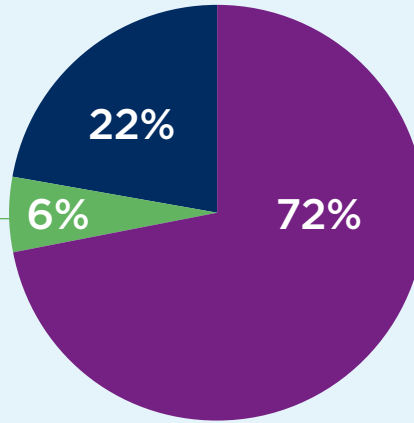
- SETTLEMENTS
- VERDICTS FOR THE PLAINTIFF
- JUDGEMENTS OR VERDICTS FOR THE DEFENSE

RANGE OF PLAINTIFF AWARDS FROM JURY VERDICTS

**\$119,000–\$11,857,344**

MEAN: \$3,397,908

MEDIAN: \$1,600,000



RANGE OF SETTLEMENTS

**\$4,000–\$12,850,000**

MEAN: \$1,376,816

MEDIAN: \$575,000

include the entire population of settlements or case awards, and the awards did not include the costs of litigation borne by the defendants.

Of the cases where outcomes data were available (359 cases), 72% resulted in a settlement (n=258), 6% were jury verdicts for the plaintiff (n=23), and 22% (n=78) were judgments (n=45) or verdicts for the defense (n=33). Settlements ranged from \$4,000 to \$12,850,000, with a mean of \$1,376,816 and a median of \$575,000. Plaintiff awards from jury verdicts ranged from \$119,000 to \$11,857,344, with a mean of \$3,397,908 and a median of \$1,600,000.\*

Based on the frequency of occurrence in the data reviewed, deaths that involve suicides, illness, and withdrawal appear to present greater risks for liability. However, cases brought due to excessive use of force by a correctional officer had the largest plaintiff awards on average.

\*At least one award was more than \$12,850,000, however there was no information regarding whether it was a jury award or a settlement. Therefore, it was not included in the data described in this paragraph.

Most of the cases in the sample were filed in federal court (87%). Of the cases analyzed, correctional officers were named personally in over half of the lawsuits. The average age of the deceased was 38.

**Deaths commonly occur shortly after incarceration begins:** the most significant risk of death appears to occur within 1-5 days. Notably, death occurred within the first 24 hours of custody in almost a quarter of the cases with information on the date of death. The most common causes of death during the first 24 hours of custody were suicide (n=24) or substance-related deaths (n=29), including withdrawal and overdose (n=11) and suicides amidst withdrawal.

**Failure to address behavioral health needs significantly contributes to the risk of litigation related to adverse incidents and deaths in custody.** In the study sample, suicide was the leading cause of death, accounting for the claims in 35% of the

## PLAINTIFF AWARDS BY CAUSE OF DEATH

CATEGORY OF DEATH	LARGEST AWARD	AVERAGE AWARD
Withdrawal	\$12,850,000	\$1,532,151.10
Officer Use of Force	\$12,500,000	\$2,243,079.10
Overdose	\$2,500,000	\$843,928.60
Physical Illness	\$15,000,000	\$1,118,855.80
Suicide	\$11,850,000	\$987,144.40
Force by Another Incarcerated Person	\$2,000,000	\$403,839.30

## DEATHS RELATED TO BEHAVIORAL HEALTH ISSUES, INCLUDING SUICIDE, OVERDOSE, AND SUBSTANCE USE WITHDRAWAL COMPLICATIONS, WERE PRESENT AS THE CAUSE OF DEATH FOR 59% OF CASES.

### CIVIL LITIGATION INVOLVING DEATHS IN JAIL CUSTODY (2015-2020)

#### Median Days Incarcerated Prior to Death by Cause of Death

CATEGORY OF DEATH	MEDIAN # OF DAYS
Withdrawal	3
Officer Use of Force	3
Overdose	1
Physical Illness	14.5
Suicide	5
Use of Force by Another Incarcerated Person	7

cases reviewed. Drug-related deaths (including overdoses and withdrawal) accounted for 19% of the study sample. Deaths related to behavioral health issues, including suicide, overdose, and substance use withdrawal complications, were present as the cause of death for 59% of cases. In a number of cases, there was evidence of substance use, withdrawal or mental health issues prior to death, even for deaths that were attributed to officer use of force or suicide.

**The number of cases by state varied.** Illinois had the largest number of cases in the sample, with 53 cases. Cook County (Chicago, Illinois) was the county with the largest number of cases, with 17 cases. California had the second largest number of cases, at 34 cases. Los Angeles County had the second-highest number of cases at 12.

### QUALITATIVE FINDINGS: COMMON THEMES AND FACT PATTERNS

The review of civil litigation cases brought by the estates of individuals who died in jail custody, as well as the review of cases brought by the U.S. Department of Justice, revealed common themes and fact patterns. These fact patterns provide insight into steps jail administrators, government leaders, and others can take to prevent deaths in custody and mitigate risk. Common fact patterns include:

- Failure to properly screen individuals at intake for mental health conditions, suicide risk, substance use disorders, and physical illnesses;
- Lack of adequate protocols or a failure to adhere to protocols; for example, failure to follow a protocol requiring correctional staff to inform a qualified health care professional when alerted about a medical need;
- Failure to address requests for care/presence of distress by the incarcerated individual, other incarcerated persons witnessing medical distress, and/or jail personnel;
- Inadequate or delayed healthcare;

### INTERCONNECTED ISSUES IN CASES ANALYZED

CATEGORY OF DEATH	TOTAL NUMBER OF CASES	EVIDENCE OF SUBSTANCE USE ISSUES	EVIDENCE OF MENTAL HEALTH	EVIDENCE OF WITHDRAWAL
Withdrawal	69	58 cases	7 cases	67 cases*
Officer Use of Force	42	13 cases	15 cases	8 cases
Overdose	17	17 cases	5 cases	1 case
Physical Illness	144	17 cases	20 cases	15 cases
Suicide	157	31 cases	106 cases	32 cases
Force by Another Incarcerated Person	14	0 cases	3 cases	0 cases

\*We determined evidence of withdrawal based on facts plead in the complaint that a person was observably in withdrawal before they died. In two cases, there were no facts in the complaint about withdrawal, though the cause of death was available.

- Failure to provide access to therapy, counseling, psychiatric care, or other medical care, despite explicit requests from the incarcerated individuals for such care;
- Failure to provide evidence-based medication to incarcerated people with opioid use disorder, specifically, methadone and buprenorphine;
- Use of restrictive housing to address suicide risk, when research shows that it increases the risk of suicide<sup>25</sup>;
- Inadequate mental health and medical staffing to address needs; and
- Failure to properly train correctional officers.

## AREAS FOR FURTHER STUDY

The intersection of the criminal-legal system, morbidity, and mortality is complex. Additionally, the data analyzed in the research described in this brief has some limitations that may impact the generalizability of the findings; for example, the sample of cases analyzed relied partly on reported outcomes and may over-represent plaintiff awards, dockets reviewed did not include the dockets in

all 50 states, as some court dockets have not been digitized, information on the amounts of settlement awards was often not included in public filings, and the dataset only reviewed cases that had been filed and did not include settlements arrived at without a court filing or claims filed through any state or local administrative process.

As such, there are at least four areas that this brief does not touch on that are related topics worthy of further study. First, the brief does not address deaths in state and federal prisons, which are also rising.<sup>26</sup> Second, the brief does not discuss deaths that are unreported by jails. The relatively common failure to report deaths has been documented by a Senate report.<sup>27</sup> This brief also does not discuss deaths immediately after release. For example, people recently in prison are between 5,600% and 12,900% more likely to die of an overdose in the weeks after release than the general population.<sup>28</sup> Finally, this brief does not discuss the very real and lasting consequences of assaults, sexual violence, and non-fatal injuries that occur in local jails. These events can leave formerly incarcerated individuals traumatized and often without sufficient support to go about their lives.

## LITIGATION RELATED TO SUBSTANCE USE REFLECTS A RANGE OF INTERCONNECTED AND COMPLEX ISSUES

It is common for individuals who are incarcerated in U.S. jails to have a substance use disorder or to have used drugs prior to confinement. Without proper care, withdrawal from substances can result in injuries or death.<sup>29</sup> Jail administrators have a legal obligation to provide adequate health care for those they hold in confinement, including caring for individuals experiencing withdrawal. Without adequate care, jail administrators may fall short of meeting this duty, leaving correctional institutions and governments exposed to liability.

According to the Bureau of Justice Statistics, the number of deaths in local jails due to drug or alcohol intoxication increased by almost 19% from 2017 to 2018 and more than quadrupled between 2000 and 2018.<sup>30</sup> Nineteen percent of lawsuits in our study sample were for drug-related deaths (including overdoses and withdrawal).

Litigation related to substance use reflects a range of interconnected and complex issues. Thirty-two percent of cases included facts that indicated that the deceased had consumed illicit substances or alcohol prior to intake or had a history of a substance use disorder. Facts suggesting pain or

discomfort due to withdrawal were present in 20% of suicides. Substance use prior to incarceration was alleged in 31% of cases involving a death resulting from excessive use of force by a correctional officer.

Since 2015, individual litigants and classes of plaintiffs have requested injunctive relief related to medication for the treatment of opioid use disorder. These lawsuits have [led to a range of executive actions, state legislation, federal guidance, funding, and other efforts](#) to increase access to treatment for opioid use disorders for people who are incarcerated.

In-custody deaths related to overdose, withdrawal, or intoxication can also lead to criminal charges, such as in an Ohio jail where a grand jury indicted a jail warden and a correctional officer following the apparent overdose death of an incarcerated person after he entered the jail.<sup>31</sup> Charges in that case included tampering with evidence, dereliction of duty, falsifying documents claiming required checks were made, and interfering with civil rights.<sup>32</sup> This was one of at least seven deaths in 2018 inside this jail, which was also a defendant in a separate class action lawsuit.<sup>33</sup>

## TARGETED STRATEGIES IN JAILS CAN PREVENT DEATH AND MITIGATE RISK

State and local governments, sheriffs, jail administrators, and jail healthcare providers can implement reforms addressing access and quality of healthcare, including mental health care and evidence-based treatment for opioid use disorder. These reforms could save lives and millions in litigation costs by preventing deaths in custody and other adverse health outcomes.<sup>34</sup> The following proposed policy solutions can prevent deaths in jail custody and mitigate risk for counties, jails, and jail personnel:

### 1. Diversion or deflection of persons with mental health conditions and substance use disorders into appropriate treatment or services.

Diversion or deflection alleviates some of the burdens from law enforcement and corrections by referring people with mental health and substance use issues to community-based treatment, recovery supports, and/or harm reduction programming in lieu of incarceration. States and localities should ensure that community-based treatment, recovery supports, and harm reduction services use evidence-based treatment, including medications for opioid use disorder, for substance use disorders. Diversion and deflection programs should also reflect the science of recovery from any disease, understanding that recovery includes a series of recurrence and remission. A single positive drug test is an opportunity for engagement, not a return to incarceration.

### 2. Clear protocols and training for staff and officers to better screen and address persons at risk for suicide, overdose, withdrawal, or other medical issues immediately upon intake.

Frequent factors in death in custody cases included failure to screen and properly supervise or monitor an incarcerated individual with a history of substance use, mental illness, or suicidal ideation. By providing clear protocols and training for all correctional staff, persons at risk for suicide, overdose, withdrawal, or other medical issues may be better identified before these issues reach a critical point.

### 3. Greater access to quality medical and psychological treatment for physical and mental health conditions, including substance use disorder, particularly in the first 24 hours to 7 days after intake.

Incarcerated people need higher quality medical, mental health, and substance use care. Scarce resources should be directed to people upon entry into

the facility through the first week, when the bulk of jail deaths occur. By investing in quality care and services, incarcerated individuals may be linked to vital care and reduce death in custody and the cost of litigation.

### 4. State legislation requiring correctional facilities to provide medical, mental health, and substance use disorder care, treatment, and services to people in custody.

Two model state laws addressing these issues include the [Model Access to Medication for Addiction Treatment in Correctional Settings Act](#),<sup>35</sup> which ensures adequate access to MOUD for individuals in jails and prisons, and the [Model Withdrawal Management Protocol in Correctional Settings Act](#),<sup>36</sup> which provides a framework to adequately handle withdrawal symptoms in incarcerated individuals.

### 5. Federal Legislation Eliminating the Exclusion of Incarcerated People from Medicaid.

Current law prohibits the expenditure of federal Medicaid funds on incarcerated individuals.<sup>37</sup> This presents challenges for a jail's ability to pay for necessary health services and for individuals to receive uninterrupted health care services upon reentry. It also presents a missed opportunity to elevate the quality of jail health services and to add an additional layer of oversight provided by the Medicaid program. Congressional action is needed to amend this federal law. Federal legislation could be passed to allow an otherwise qualified person to receive Medicaid while incarcerated, or, at a minimum, to enroll in Medicaid thirty days before their expected release date to ensure continuity of care. Legislation was introduced in the 117th Congress that would permit such flexibility.<sup>38</sup> Alternatively, the Centers for Medicare & Medicaid Services (CMS) can approve pending Section 1115 waiver requests to allow more flexible use of federal Medicaid funds during incarceration without congressional action.

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**DEATHS IN JAIL CUSTODY often result from untreated mental health conditions and substance use disorder. By taking legislative and administrative actions, government at all levels can reduce deaths in custody and the monetary damages that follow. Investments in correctional healthcare, diversion and deflection programs, and training and procedures to address substance use and mental health can reduce the human and financial cost of deaths in jail custody.**

## ENDNOTES

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- 8 *Estelle v. Gamble*, 429 U.S. 97, 103-04 (1976) (internal quotations omitted).
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- 34 Taleed El-Sabawi, Shelly Weizman, Somer Brown, & Regina LaBelle, *Dying Inside: Litigation Patterns for Deaths in Jail Custody*, 29 J. CORRECTIONAL HEALTH CARE (forthcoming 2023); How People Die Inside: A Qualitative Analysis of Fact Patterns in Civil Litigation Involving Deaths in Jail Custody.
- 35 *Model Access to Medication for Addiction Treatment in Correctional Settings Act*, Legislative Analysis and Public Policy Association (Oct. 2020), <http://legislativeanalysis.org/wp-content/uploads/2021/03/Model-Access-to-Medication-for-Addiction-Treatment-in-Correctional-Settings-Act-1.pdf>.
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- 37 42 U.S.C. § 1396d.
- 38 Medicaid Reentry Act of 2021, H.R. 955, 117th Cong § 1 (2021).