REHABILITATION UNDER THE REHABILITATION ACT: THE CASE FOR MEDICATION-ASSISTED TREATMENT IN FEDERAL CORRECTIONAL FACILITIES

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ABSTRACT

Incarcerated individuals are situated at the cross section of two destructive and deadly epidemics: mass incarceration and the opioid epidemic. The continuing legacy of the war on drugs is readily apparent in correctional facilities, where the incarcerated population disproportionately exhibits signs of substance use disorder. More than half of the incarcerated population meets the diagnostic criteria for drug dependence. Thus, after decades of racialized and punitive antidrug policies, the most vulnerable individuals, those with opioid use disorder ("OUD"), are behind bars, where they are blocked from the rest of society and from the most effective forms of medical treatment. Although medication-assisted treatment ("MAT") is a proven effective treatment for OUD, incarcerated individuals are often denied access to such medication as a matter of prison policy, putting them at increased risks of recidivism, relapse, and overdose death upon release.

This Note argues the United States Bureau of Prisons ("BOP") is violating Section 504 of the Rehabilitation Act of 1973 ("Rehab Act") by discriminating on the basis of disability. BOP largely prohibits the use of MAT for the long-term treatment of OUD for nonpregnant individuals, and it fails to conduct an individualized assessment into whether an accommodation to provide MAT is reasonable. These policies and practices deprive incarcerated individuals with OUD meaningful access to the prison's medical services on the basis of their disabilities. Although it appears that BOP is taking steps to implement a voluntary MAT program, its rollout is far too slow and lacks the key planning details necessary to provide MAT in an effective and timely manner to eligible incarcerated individuals. The number of individuals receiving MAT in BOP custody still drastically trails the number of incarcerated individuals in need of

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this medication, and it is still uncertain who will be eligible to receive it. Accordingly, BOP's current and foreseeable failure to provide reasonable accommodations to incarcerated individuals with OUD violates the Rehab Act and directly conflicts with Department of Justice initiatives to combat discriminatory barriers to treatment for OUD.

The failure to provide MAT to treat OUD is not only a disability justice issue but also a criminal justice issue, a public health issue, and a racial justice issue. It is crucial to hold BOP to the standards espoused in the Rehab Act and to advocate for broader policy changes regarding incarcerated individuals with OUD before more lives are needlessly lost to this treatable disease.

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INTRODUCTION[1]

People are dying from a treatable disease. In 2018, more than 68,000 people in the United States lost their lives to drug overdoses.[2] In 2019, this number rose to nearly 71,000 people,[3] with over 70% of overdose deaths involving an opioid.[4] These are not just statistics; every day, 136 people in the United States die from opioid overdoses.[5] These high death tolls contributed to a lower life expectancy in the United States for three years in a row,[6] even before the 2019 novel coronavirus disease ("COVID-19") devastated communities of color[7] and

[1] Given the "increasing evidence of a close relationship between the use of language and the perpetuation of stigma," the author uses the language "medication-assisted treatment" ("MAT") and "opioid use disorder" ("OUD"), rather than "substance abuse." Daniel Z. Buchman, Pamela Leece & Aaron Orkin, *The Epidemic as Stigma: The Bioethics of Opioids*, 45 J.L. MED. & ETHICS 607, 608 (2017). At the time of writing, these terms are generally accepted as medically accurate and nonstigmatizing terms. However, there have been and likely will continue to be significant shifts in acceptable terminology. The author welcomes the continuing progress towards nonstigmatizing, medically accurate, and person-first language when discussing substance use. *See* Sean M. Robinson, *"Alcoholic" or "Person with Alcohol Use Disorder"? Applying Person-First Diagnostic Terminology in the Clinical Domain*, 38 SUBSTANCE ABUSE 9, 9 (2017).

[2] *See* Abby Goodnough, Josh Katz & Margot Sanger-Katz, *Drug Overdose Deaths Drop in U.S. for First Time Since 1990*, N.Y. TIMES (July 17, 2019), https://www.nytimes.com/interactive/2019/07/17/upshot/drug-overdose-deaths-fall.html. With 68,557 overdose deaths in the United States, 2018 saw the first decline in annual overdose deaths since 1990. *See id.* However, "[t]he decline was due almost entirely to a dip in deaths from prescription opioid painkillers, the medicines that set off the epidemic of addiction that has lasted nearly two decades. Fatal overdoses involving other drugs, particularly fentanyl and methamphetamine, continued to rise." *Id.* Additionally, research shows that official statistics could underrepresent the true opioid death toll by at least 20%, suggesting these are conservative estimates. *See* Christopher J. Ruhm, *Geographic Variation in Opioid and Heroin Involved Drug Poisoning Mortality Rates*, 53 AM. J. PREVENTIVE MED. 745, 745 (2017) (finding corrected opioid and heroin involved mortality rates were 24% and 22% greater, respectively, than reported statistics).

[3] *Understanding the Epidemic*, CDC (Mar. 17, 2020), https://www.cdc.gov/drugoverdose/epidemic/index.html [https://perma.cc/SN6T-PJPP].

[4] *Id.*

[5] *Id.*

[6] Jessica Pishko, *The Repurposing of the American Jail*, ATLANTIC (Nov. 19, 2019), https://www.theatlantic.com/politics/archive/2019/11/going-jail-substance-abuse-treatment/602206/.

[7] *See* Maria Godoy & Daniel Wood, *What Do Coronavirus Racial Disparities Look Like State by State?*, NPR (May 30, 2020, 6:00 AM), https://www.npr.org/sections/health-shots/2020/05/30/865413079/what-do-coronavirus-racial-disparities-look-like-state-by-state [https://perma.cc/QT2J-H3RC]. Not only are Black, Latinx, and Native people more likely to contract COVID-19, but they are also 2.4, 1.5, and 1.5 times more likely to die from COVID-19 than White people, respectively. *See* Daniel Wood, *As Pandemic Deaths Add Up, Racial Disparities Persist—and in Some Cases Worsen*, NPR (Sept. 23, 2020, 1:01 PM), https://www.npr.org/sections/health-shots/2020/09/23/914427907/as-pandemic-deaths-add-up-racial-disparities-persist-and-in-some-cases-worsen [https://perma.cc/KU2D-XHKS].

resulted in the greatest single-year drop in life expectancy in at least forty years.[8] The COVID-19 pandemic exacerbated the existing opioid epidemic,[9] healthcare disparities,[10] and other systemic inequities.[11] As a result, in the United States, May 2019 to May 2020 saw the highest number of overdose deaths ever recorded in a twelve-month period: over 81,000.[12]

The drop in life expectancy during the COVID-19 pandemic correlates with structural inequity, affecting individuals with marginalized identities the most: life expectancy decreased 3 years for Latinx people, 2.1 years for Black people, and 0.68 years for White people.[13] Racial inequity and increased susceptibilities

[8] Robert Glatter, *Life Expectancy in the U.S. Sees Largest Decline in Decades After Covid-19*, FORBES (Jan. 24, 2021, 12:04 PM), https://www.forbes.com/sites/robertglatter/2021/01/24/life-expectancy-in-the-us-sees-largest-decline-in-decades-after-covid-19/?sh=40719663706f.

[9] Press Release, CDC, Overdose Deaths Accelerating During COVID-19 (Dec. 17, 2020), https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html [https://perma.cc/6546-6NYY]; *see also* Hilary Swift & Abby Goodnough, *'The Drug Became His Friend': Pandemic Drives Hike in Opioid Deaths*, N.Y. TIMES (July 14, 2021), https://www.nytimes.com/2020/09/29/health/coronavirus-opioids-addiction.html (describing impact of COVID-19 pandemic, including isolation, barriers to seeking medication-assisted treatment, lack of social support services, and economic insecurity, as contributing to spike in overdose deaths); Emma Goldberg, *'Relapsing Left and Right': Trying to Overcome Addiction in a Pandemic*, N.Y. TIMES (Jan. 4, 2021), https://www.nytimes.com/2021/01/04/nyregion/addiction-treatment-coronavirus-new-york-new-jersey.html (describing shutdown of treatment facilities for substance use disorder during COVID-19 pandemic).

[10] *See* Keon L. Gilbert, Ruqaiijah Yearby, Amber Johnson & Kira Banks, Opinion, *For Black Americans, Covid-19 Is a Reminder of the Racism of US Healthcare*, GUARDIAN (Feb. 22, 2021, 4:42 PM), https://www.theguardian.com/commentisfree/2021/feb/22/black-americans-covid-19-racism-us-healthcare. Failures in our healthcare system have contributed to the opioid epidemic. *See* Nicolas P. Terry, *Structural Determinism Amplifying the Opioid Crisis: It's the Healthcare, Stupid!*, 11 NE. U. L. REV. 315, 371 (2019) ("[I]t is not difficult to suggest some relevant flaws that rise to the level of structural determinants [of the opioid epidemic]: access and benefit stratification, the changing role of Medicaid, problems associated with fragmentation of care (the lack of behavioral health services integrated into our primary care systems cannot be overemphasized), and the lack of wraparound services.").

[11] *See* Gina Kolata, *Social Inequities Explain Racial Gaps in Pandemic, Studies Find*, N.Y. TIMES (July 27, 2021), https://www.nytimes.com/2020/12/09/health/coronavirus-black-hispanic.html (noting systemic inequities that contribute to disproportionate impact of COVID-19 pandemic on communities of color include greater workplace exposure in lower-income jobs, multigenerational housing, reduced access to healthcare, and elevated rates of underlying health conditions); Sabrina Strings, Opinion, *It's Not Obesity. It's Slavery.*, N.Y. TIMES (May 25, 2020), https://www.nytimes.com/2020/05/25/opinion/coronavirus-race-obesity.html (describing how slavery "set in motion" systemic inequities that continue today).

[12] *See* CDC, *supra* note 9. Preliminary data for 2020 as a whole are even more stark; over 93,000 people died from drug overdoses in the U.S. in 2020, a jump of approximately 30% from the preceding year. *See* Bill Chappell, *Drug Overdoses Killed a Record Number of Americans in 2020, Jumping by Nearly 30%*, NPR (July 14, 2021, 6:53 PM), https://www.npr.org/2021/07/14/1016029270/drug-overdoses-killed-a-record-number-of-americans-in-2020-jumping-by-nearly-30 [https://perma.cc/PG36-N3H8].

[13] Chappell, *supra* note 12.

to the COVID-19 pandemic are perhaps most apparent in the country's overcrowded jails and prisons,[14] where the COVID-19 pandemic has exacerbated poor conditions, taxed resources, and placed incarcerated individuals at heightened risk of overdose death upon release.[15] Incarcerated individuals are situated at the cross section of the opioid epidemic and mass incarceration. It is crucial to address incarcerated individuals' heightened vulnerabilities before more lives are needlessly lost.

Mass incarceration is the inevitable aftermath of decades of prosecuting people of color, particularly Black individuals,[16] under the "war on drugs."[17]

[14] *See* Beth Schwartzapfel, Katie Park & Andrew DeMillo, *1 in 5 Prisoners in the U.S. Has Had COVID-19*, MARSHALL PROJECT (Dec. 18, 2020, 6:00 AM), https://www.themarshallproject.org/2020/12/18/1-in-5-prisoners-in-the-u-s-has-had-covid-19 [https://perma.cc/P6MQ-M3TX] (noting positive test rate for COVID-19 in prisons is more than four times higher than positive test rate of general population).

[15] *See* Joseph Longley, *As Overdoses Spike During Coronavirus, Treating Addiction in Prisons and Jails Is a Matter of Life and Death*, ACLU: NEWS & COMMENT. (July 22, 2020), https://www.aclu.org/news/prisoners-rights/as-overdoses-spike-during-coronavirus-treating-addiction-in-prisons-and-jails-is-a-matter-of-life-and-death/ [https://perma.cc/MS7A-TU4G].

[16] *See* Dorothy E. Roberts, *The Social and Moral Cost of Mass Incarceration in African American Communities*, 56 STAN. L. REV. 1271, 1274-76 (2004). The unique experiences of Black women, who are disproportionately represented in jails and prisons, are often overlooked in conversations about mass incarceration. *See* Priscilla A. Ocen, *Unshackling Intersectionality*, 10 DU BOIS REV. 471, 472 (2013) ("The growth in the prison population has been led by the incarceration of Black women, who are three times as likely as White women to be incarcerated, often for nonviolent, drug-related offenses. The impact wrought by the mass incarceration of Black women cannot be overstated.").

[17] *See A Brief History of the Drug War*, DRUG POL'Y ALL., http://www.drugpolicy.org/issues/brief-history-drug-war [https://perma.cc/JE3Y-793M] (last visited Sept. 1, 2021). Because of war on drugs policies, the total prison population increased from fewer than 300,000 people in the early 1970s to more than 2.2 million incarcerated and 4.5 million more on probation or parole in 2019. *See* Bryan Stevenson, *Slavery Gave America a Fear of Black People and a Taste for Violent Punishment. Both Still Define Our Criminal-Justice System.*, N.Y. TIMES MAG. (Aug. 14, 2019), https://www.nytimes.com/interactive/2019/08/14/magazine/prison-industrial-complex-slavery-racism.html. The war on drugs has also cost the United States more than $1 trillion. *See* German Lopez, *The War on Drugs, Explained*, VOX (May 8, 2016, 1:21 PM), https://www.vox.com/2016/5/8/18089368/war-on-drugs-marijuana-cocaine-heroin-meth. Additionally, despite probation and parole being viewed as alternatives to incarceration, these "alternative" sentences are feeding mass incarceration. In 2018, 28% of state and federal prison admissions stemmed from violations of parole and probation. *See Revoked: How Probation and Parole Feed Mass Incarceration in the United States*, HUM. RTS. WATCH (July 31, 2020), https://www.hrw.org/report/2020/07/31/revoked/how-probation-and-parole-feed-mass-incarceration-united-states [https://perma.cc/AP9R-WL24]. People of color are disproportionately represented in the population of individuals on probation; in particular, Black people account for 30% of adult probationers, despite comprising only 13% of the U.S. population. *See* JESSE JANNETTA, JUSTIN BREAUX, HELEN HO & JEREMY PORTER, URB. INST., EXAMINING RACIAL AND ETHNIC DISPARITIES IN PROBATION REVOCATION 1 (Apr. 2014),

Although its practices continue to the present day, the phrase war on drugs commonly refers to a series of racialized and punitive antidrug policies[18] from the 1970s to the 1990s that purported to address the overall drug problem in the United States but instead focused on "mass hysteria over crack cocaine" in communities of color.[19] War on drugs legislation classified substances into different "schedules" under the Controlled Substances Act,[20] imposed and lengthened mandatory minimum sentences for drug offenses,[21] and expanded federal drug regulatory agencies like the Drug Enforcement Administration ("DEA"),[22] directly targeting only communities of color.[23] Some of the most devastating policies from the war on drugs involved the criminalization of drug

https://www.urban.org/sites/default/files/publication/22746/413174-Examining-Racial-and-Ethnic-Disparities-in-Probation-Revocation.PDF [https://perma.cc/PST2-8EXH]. The risk of incarceration through probation revocation directly impacts individuals with OUD, as substance-free probation requirements often view relapse as a violation of their terms. *See, e.g.*, Commonwealth v. Eldred, 101 N.E.3d 911, 921-22, 924-25 (Mass. 2018) (holding that, although "relapse is a part of recovery," trial judge did not abuse discretion by concluding defendant's relapse was "wilful" violation of drug-free probation).

[18] *See* Courtney Lauren Anderson, *Opioids Are the New Black*, 69 DEPAUL L. REV. 55, 69-70 (2019) (describing how "mass hysteria over crack cocaine" fueled targeted policies in inner-city Black communities).

[19] *See id.* at 66-68, 70 (describing epidemic of crack and cocaine use in 1980s and racist origins of criminalizing drug use). However, at the same time, these policies did not target a simultaneous rise in cocaine use in affluent White communities. *See* ACLU, CRACKS IN THE SYSTEM: TWENTY YEARS OF THE UNJUST FEDERAL CRACK COCAINE LAW i-ii (2006) (discussing stark 100-to-1 sentencing disparity between crack, which was more accessible to poor and Black Americans, and powder cocaine, which was more commonly used by affluent White Americans, despite current scientific understanding that crack is no more harmful than powder cocaine).

[20] *See* German Lopez, *The Federal Drug Scheduling System, Explained*, VOX (Aug. 11, 2016, 9:05 AM), https://www.vox.com/2014/9/25/6842187/drug-schedule-list-marijuana.

[21] *See Opposing Mandatory Minimums*, EQUAL JUST. UNDER L., https://equaljusticeunderlaw.org/mandatory-minimums-1 [https://perma.cc/X69X-B4V6] (last visited Sept. 1, 2021).

[22] *See Thirty Years of America's Drug War*, PBS: FRONTLINE, https://www.pbs.org/wgbh/pages/frontline/shows/drugs/cron/ [https://perma.cc/7788-GSK2] (last visited Sept. 1, 2021).

[23] *Racial Double Standard in Drug Laws Persists Today*, EQUAL JUST. INITIATIVE (Dec. 9, 2019), https://eji.org/news/racial-double-standard-in-drug-laws-persists-today/ [https://perma.cc/UNB3-QKLN]. The statistics tell the story of the disproportionate impact on communities of color. *See* Aaron Williams, *The Full Story of the 1980's Crack Epidemic Is Still Yet to Be Told*, UPROXX (June 26, 2017), https://uproxx.com/hiphop/snowfall-1980s-crack-epidemic/ [https://perma.cc/8F2A-XHPR] (comparing statistics that, in 1991, 15% of crack users were Black but 79% of sentenced crack offenders were Black, whereas 52% of crack users were White but only 10% of sentenced crack offenders were White); *see also* Keturah James & Ayana Jordan, *Law and the Opioid Crisis: An Inter-Disciplinary Examination: The Opioid Crisis in Black Communities*, 46 J.L. MED. & ETHICS 203, 410 (2018) (discussing harsher sentencing penalties for crack use compared to powder cocaine use).

use during pregnancy,[24] which uniquely oppressed Black women because of the intersection of their identities as Black people and as women.[25] The plight of people of color as a result of the drug crisis of the 1980s did not elicit the same levels of public sympathy as the perceived White opioid crisis has today,[26] nor has it resulted in the same recovery support social services.[27] Instead of receiving such support, Black people were incarcerated for drug offenses. As Michelle Alexander notes, "[m]ore African American adults are under correctional

[24] *See* Khiara M. Bridges, *Race, Pregnancy, and the Opioid Epidemic: White Privilege and the Criminalization of Opioid Use During Pregnancy*, 133 HARV. L. REV. 770, 815-21 (2020) (discussing disproportionate prosecutions of Black women for substance use during pregnancy, which "began in earnest during the crack cocaine scare in the 1980s").

[25] *See* Julie B. Ehrlich, *Breaking the Law by Giving Birth: The War on Drugs, the War on Reproductive Rights, and the War on Women*, 32 N.Y.U. REV. L. & SOC. CHANGE 381, 387 (2008) ("[T]he War on Drugs became a war on women of color, with prosecutions of pregnant women focusing on those women who used crack cocaine, a drug predominantly found in low-income communities of color."). However, today, arrest and prosecution trends for women who use substances while pregnant track the demographics of the opioid epidemic as a whole: "[A]s white people predominate among those struggling with opioid use, misuse, and dependence, *white women predominate among those who have faced criminal charges for opioid use during pregnancy*." *See* Bridges, *supra* note 24, at 776 (footnote omitted) (arguing that White privilege failed to protect White women who have been prosecuted for opioid use during pregnancy "because these women possess a compromised, marginalized, 'not-quite' whiteness—a corrupted whiteness that has yielded to them a reduced racial privilege").

[26] *See* German Lopez, *The Deadliness of the Opioid Epidemic Has Roots in America's Failed Response to Crack*, VOX (Oct. 5, 2017, 9:45 AM), https://www.vox.com/identities/2017/10/2/16328342/opioid-epidemic-racism-addiction (comparing differences between media response of today and that of the 1980s and 1990s). The current opioid crisis has affected significantly more White and affluent individuals than previous iterations of drug crises, and "the narrative around the opioid epidemic has emphasized th[ese] high numbers of white casualties across the nation" to the detriment of people of color. James & Jordan, *supra* note 23, at 406; *see* Julie Netherland & Helena B. Hansen, *The War on Drugs That Wasn't: Wasted Whiteness, "Dirty Doctors," and Race in Media Coverage of Prescription Opioid Misuse*, 40 CULTURE MED. PSYCHIATRY 664, 674 (2016) (comparing media portrayal of opioid crisis depicting Black and Latinx individuals as using heroin and White individuals as using prescription opioid painkillers, thus "leav[ing] the [White individuals] blameless or at least sympathetic to the reader"); Jasmine Drake, Creaque Charles, Jennifer W. Bourgeois, Elycia S. Daniel & Melissa Kwende, *Exploring the Impact of the Opioid Epidemic in Black and Hispanic Communities in the United States*, DRUG SCI. POL'Y & L., 2020 at 1 (2020) ("Although there have been significant increases in the number of opioid-related overdose deaths in Black and Hispanic communities, the media narrative for this epidemic is often portrayed as a White, Non-Hispanic rural and suburban crisis."). However, the opioid epidemic is still the largest drug epidemic in U.S. history for *all* racial groups. *See* James & Jordan, *supra* note 23, at 405.

[27] *See* Katharine Q. Seelye, *In Heroin Crisis, White Families Seek Gentler War on Drugs*, N.Y. TIMES (Oct. 30, 2015), https://www.nytimes.com/2015/10/31/us/heroin-war-on-drugs-parents.html ("When the nation's long-running war against drugs was defined by the crack epidemic and based in poor, predominantly black urban areas, the public response was defined by zero tolerance and stiff prison sentences. But today's heroin crisis is different.").

control today—in prison or jail, on probation or parole—than were enslaved in 1850, a decade before the Civil War began."[28]

The war on drugs met its goal; the number of people incarcerated for drug offenses increased from 40,900 to 430,926 between 1980 and 2019.[29] The United States now has the highest incarceration rate in the world,[30] with people of color and individuals with other marginalized identities disproportionately represented in this population.[31] Today, the incarcerated population includes the most vulnerable amongst individuals with opioid use disorder ("OUD") because they are blocked from the rest of society and, in fact, from the most effective forms of medical treatment.

Although medication-assisted treatment ("MAT") is a proven effective treatment for OUD,[32] as of 2018 only 20% of those with OUD received specialty

[28] Michelle Alexander, *The New Jim Crow*, 9 OHIO ST. J. CRIM. L. 7, 9 (2011).

[29] THE SENT'G PROJECT, TRENDS IN U.S. CORRECTIONS 3 (2021), https://www.sentencingproject.org/wp-content/uploads/2021/07/Trends-in-US-Corrections.pdf [https://perma.cc/SDF6-WQV6]; *see also* Sarah E. Wakeman & Josiah D. Rich, *Addiction Treatment Within U.S. Correctional Facilities: Bridging the Gap Between Current Practice and Evidence-Based Care*, 34 J. ADDICTIVE DISEASES 220, 220 (2015) ("This epidemic of incarceration is largely due to the 'War on Drugs,' which has resulted in criminalization of the disease of addiction."); FED. BUREAU OF PRISONS, U.S. DOJ, FY 2019 PERFORMANCE BUDGET 6 [hereinafter PERFORMANCE BUDGET] (noting "changes in interdiction and sentencing [in 1980s and 1990s] changed the population's composition" to include greater proportion of drug offenders).

[30] *See* Stevenson, *supra* note 17. Despite accounting for only 4% of the world's population, the United States accounts for 22% of the world's imprisoned population. *Id.*

[31] For information about U.S. incarceration rates by race and ethnicity, see Leah Sakala, *Breaking Down Mass Incarceration in the 2010 Census: State-by-State Incarceration Rates by Race/Ethnicity*, PRISON POL'Y INITIATIVE (May 28, 2014), https://www.prisonpolicy.org/reports/rates.html [https://perma.cc/8QDP-NLGP]. For information on incarceration rates of women by race and ethnicity, see Aleks Kajstura, *Women's Mass Incarceration: The Whole Pie 2019*, PRISON POL'Y INITIATIVE (Oct. 29, 2019), https://www.prisonpolicy.org/reports/pie2019women.html [https://perma.cc/M8YR-EB7M]. Additionally, transgender people are disproportionately incarcerated at rates double those of the general population, and incarceration rates are even higher for transgender individuals of color and low-income transgender individuals. *See* NAT'L CTR. FOR TRANSGENDER EQUAL., LGBTQ PEOPLE BEHIND BARS 5 (2018), https://transequality.org/sites/default/files/docs/resources/TransgenderPeopleBehindBars.pdf [https://perma.cc/3VJ4-STAL]. Although this Note considers "incarcerated individuals" without reference to their particular identities, it is essential that policies account for individuals' lived experiences at the intersection of various identities. *See* Kimberle Crenshaw, *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics*, 1989 U. CHI. LEGAL F. 139, 140 (1989) ("Th[e] focus on the most privileged group members marginalizes those who are multiply-burdened and obscures claims that cannot be understood as resulting from discrete sources of discrimination.").

[32] *See* Sally Friedman & Melissa Trent, *Defense Lawyers and the Opioid Epidemic: Advocating for Addiction Medication*, CHAMPION, Aug. 2018, at 21. *See generally Effective Treatments for Opioid Addiction*, NAT'L INST. ON DRUG ABUSE (Nov. 2016),

addiction treatment like MAT.[33] People of color have historically had even less access to MAT, with one study finding Black patients had a 77% lower chance of receiving buprenorphine, a specific type of MAT, compared to White patients.[34] Instead of receiving treatment, many OUD patients are incarcerated,[35] where they are denied access to MAT as a matter of prison policy and without any individualized risk assessment.[36] Upon entering custody, OUD patients who were previously prescribed MAT are often forced to abruptly stop their prescribed medications, which jeopardizes their long-term recovery, health, safety, and lives by increasing the risk of relapse—including overdose deaths—and recidivism upon release.[37] The potential damage from discontinuing treatment is compounded by the other social, health, physical, and emotional factors prevalent within correctional facilities,[38] rendering rehabilitation-

https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction/effective-treatments-opioid-addiction [https://perma.cc/Z83P-WCTD] ("Medications should be combined with behavioral counseling for a 'whole patient' approach, known as Medication Assisted Treatment.").

[33] ELINORE F. MCCANCE-KATZ, U.S. DEP'T OF HEALTH & HUM. SERVS., AN UPDATE ON THE OPIOID CRISIS 2 (2018), https://www.samhsa.gov/sites/default/files/aatod_2018_final.pdf [https://perma.cc/2WJ9-TRRP].

[34] Pooja A. Lagisetty, Ryan Ross, Amy Bohnert, Michael Clay & Donovan T. Maust, Research Letter, *Buprenorphine Treatment Divide by Race/Ethnicity and Payment*, 76 JAMA PSYCHIATRY 979, 979-80 (2019) (finding growth in buprenorphine to treat OUD "is concentrated among white persons and those with private insurance or use self-pay"). Several factors may contribute to disproportionate access to MAT, including cost, access to health care and insurance, implicit bias, and stigma. *See* Drake et al., *supra* note 26, at 8 ("Although each drug is available only by Rx, for the uninsured, costs may be an issue, particularly with buprenorphine, as insurances plans often do not cover this drug for opioid abuse disorder."); John F. Kelly, Sarah E. Wakeman & Richard Saitz, Editorial, *Stop Talking 'Dirty': Clinicians, Language, and Quality of Care for the Leading Cause of Preventable Death in the United States,* 128 AM. J. MED. 8, 8 (2015) (describing impact of stigmatizing language on clinical care); Noa Krawczyk, Kenneth A. Feder, Michael I. Fingerhood & Brendan Saloner, *Racial and Ethnic Differences in Opioid Agonist Treatment for Opioid Use Disorder in a U.S. National Sample*, 178 DRUG & ALCOHOL DEPENDENCE 512, 513 (2017) ("[B]lack and Hispanic clients have historically experienced greater barriers to care, less support services and lower quality of care in substance use services than white clients.").

[35] *See* JENNIFER BRONSON, JESSICA STROOP, STEPHANIE ZIMMER & MARCUS BERZOFSKY, U.S. DOJ, SPECIAL REPORT: DRUG USE, DEPENDENCE, AND ABUSE AMONG STATE PRISONERS AND JAIL INMATES, 2007-2009, at 1 (2017).

[36] *See infra* Parts I.A, B.1-2.

[37] *See infra* Part I.C.

[38] *See, e.g.*, Danielle Wallace & Xia Wang, *Does In-Prison Physical and Mental Health Impact Recidivism?*, SSM—POPULATION HEALTH, Aug. 2020, at 1, 1 (discussing impact of physical and mental health in prison on recidivism rates); Craig Haney, The Psychological Impact of Incarceration: Implications for Post-Prison Adjustment 2 (Dec. 2001) (unpublished manuscript) (available at https://aspe.hhs.gov/basic-report/psychological-impact-incarceration-implications-post-prison-adjustment#III) (describing prisoners' psychological changes as result of "modern prison life" in which "prisons have become more difficult places

focused intervention crucial at such a vulnerable time. Potentially thousands of individuals with OUD in federal custody[39] lack access to prescription medications to treat their OUD or are prohibited from continuing their treatment. These policies fail to account for individuals' disabilities and refuse them the concomitant protections and reasonable accommodations they should be offered.

Many advocates have urged the removal of discriminatory barriers to MAT.[40] This includes the United States Department of Justice ("DOJ"), which created an entire initiative to target disability discrimination against individuals with OUD and "to ensure that individuals who have completed, or are participating in, treatment for [OUD] do not face unnecessary and discriminatory barriers to recovery."[41] Section 504 of the Rehabilitation Act of 1973 ("Rehab Act")[42] was enacted to prevent disability discrimination by the federal government.[43] However, disability discrimination is still widespread against individuals with OUD despite decades of Rehab Act enforcement. The DOJ, and the federal agencies under its control, including the United States Bureau of Prisons

in which to adjust and survive over the last several decades"); Nick De Viggiani, *Surviving Prison: Exploring Prison Social Life as a Determinant of Health*, 2 INT'L J. PRISONER HEALTH 71, 85 (2006) ("Attitudes and behaviours of prisoners and prison officers commonly reflected majority values associated with reputation, gender, race and age, which manifested, for instance, through competitiveness, machismo, violence, heterosexism, homophobia and racism.").

[39] As of December 14, 2017, there were 155,233 federal prisoners in BOP custody. *See* PERFORMANCE BUDGET, *supra* note 29, at 3.

[40] Some scholars have argued that withholding MAT may even violate the Eighth Amendment's prohibition of cruel and unusual punishment. *See, e.g.*, Michael Linden, Sam Marullo, Curtis Bone, Declan T. Barry & Kristen Bell, *The Opioid Epidemic, Medication-Assisted Treatment, and the Eighth Amendment*, 46 J.L. MED. & ETHICS 252, 263 (2018); Melissa Koppel, Note, *Medication-Assisted Treatment: Statutory Schemes & Civil Rights Implications*, 27 CARDOZO J. EQUAL RTS. & SOC. JUST. 145, 162 (2020). Other scholars have argued that withholding MAT may violate international human rights norms. *See, e.g.*, Shianne Bowlin, Note, *Resolving the Overlooked Tragedy in Correctional Facilities: Medication Assisted Treatment Access for Inmates*, 8 LINCOLN MEM'L U. L. REV. 358, 360 (2020); R. Douglas Bruce & Rebecca A. Schleifer, *Ethical and Human Rights Imperatives to Ensure Medication-Assisted Treatment for Opioid Dependence in Prisons and Pre-Trial Detention*, 19 INT'L J. DRUG POL'Y 17, 19-21 (2008).

[41] Eric Dreiband, Assistant Att'y Gen., U.S. DOJ, Remarks at the Epstein Becker and Green 38th Annual Workforce Management Briefing (Oct. 7, 2019), https://www.justice.gov/opa/speech/assistant-attorney-general-eric-dreiband-delivers-remarks-epstein-becker-and-green-38th [https://perma.cc/XWR9-8XZF].

[42] 29 U.S.C. § 794(a).

[43] *See, e.g.*, Sanders *ex rel.* Sanders v. Marquette Pub. Schs., 561 F. Supp. 1361, 1369 (W.D. Mich. 1983) ("The basic purpose of the Rehabilitation Act is to ensure that handicapped persons are not discriminated against by recipients of federal funds solely on the basis of their handicaps. This is plainly stated in 29 U.S.C. § 794 itself.").

("BOP"), have not lived up to the ideals espoused by their representatives[44] or the legal requirements codified in the Rehab Act.[45]

This Note argues the BOP policies prohibiting the use of MAT for long-term treatment of OUD violate the Rehab Act by depriving inmates of reasonable accommodations for their disabilities. Part I will address the severity of this problem, the prevalence of OUD in correctional facilities, and MAT's availability as an effective treatment method for OUD. Part II will summarize case law under the federal Rehab Act and its state and local counterpart, the Americans with Disabilities Act ("ADA"),[46] addressing some of the counterarguments in response to reasonable accommodations. Finally, Part III will argue that BOP's policies are unlawful as a matter of U.S. federal statutory law under the Rehab Act and that BOP's policies must account for individualized assessments of incarcerated individuals with OUD.[47] With such a high death toll, urgent legal intervention is necessary to hold correctional facilities accountable and to ensure individuals with OUD receive medical care for their disabilities.

I. THE ONGOING FAILURE TO RESPOND TO OUD IN CORRECTIONAL FACILITIES

A. *The Opioid Epidemic and Correctional Facilities*

The continuing legacy of the war on drugs is readily apparent in correctional facilities, where the incarcerated population disproportionately exhibits signs of substance use disorder. More than half of the incarcerated population meets the diagnostic criteria for drug dependence.[48] Although the chain of causation is unclear, and a multitude of other factors are at play, there is also a strong correlation between substance use and criminal activity.[49] For example, statistics

[44] *See supra* note 41 and accompanying text.

[45] 29 U.S.C. § 794(a).

[46] 42 U.S.C. §§ 12101-12111.

[47] Fortunately, BOP is developing and implementing new policies to provide more federally incarcerated individuals with MAT. *See infra* notes 92-100 and accompanying text. However, there are serious concerns with the timing and effectiveness of such a program. U.S. GOV'T ACCOUNTABILITY OFF., GAO-20-423, IMPROVED PLANNING WOULD HELP BOP EVALUATE AND MANAGE ITS PORTFOLIO OF DRUG EDUCATION AND TREATMENT PROGRAMS 31-34 (2020) [hereinafter IMPROVED PLANNING]. Accordingly, the author operates under the assumption that a widespread MAT program in BOP facilities is still several years away, if at all, and that BOP's current policies violate the Rehab Act.

[48] BRONSON ET AL., *supra* note 35, at 1 (finding 63% of sentenced jail inmates and 58% of state prisoners met criteria specified in *Diagnostic and Statistical Manual of Mental Disorders* for drug dependence or substance use disorder, whereas approximately 5% of adults in general population met criteria) (citing AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed., text rev. 2000)).

[49] *See* MATTHEW R. DUROSE & CHRISTOPHER J. MUMOLA, U.S. DOJ, PROFILE OF

show that nearly two-thirds of nonviolent offenders discharged from prisons indicated they had been using illegal drugs in the month preceding the offense, and about 40% reported using drugs at the time of the offense.[50] This link between illicit substances and crime is especially pertinent when looking at incarceration for drug offenses in federal correctional facilities. As of December 2017, 46% of the 155,233 federal prisoners in BOP custody were incarcerated for drug offenses.[51] The impact has not been borne equally; in 1999, 46% of individuals charged with a federal drug offense were Latinx, and by 2001 over

NONVIOLENT OFFENDERS EXITING STATE PRISONS 3 tbl.5 (2004) (noting 55.1% of nonviolent offenders had used either alcohol or drugs at time of offense in 1997). The greater percentage of individuals with substance use disorder within correctional facilities is not meant to suggest these individuals are particularly prone to criminal activity or less worthy of protection from disability discrimination. Rather, these statistics raise questions about whether greater proportions of incarcerated individuals with substance use disorder suggest that more individuals are using drugs and committing crimes, or that law enforcement efforts disproportionately target, or inadequately respond to, individuals with substance use disorder. *See* Shayla Love, *Police Are the First to Respond to Mental Health Crises. They Shouldn't Be*, VICE (June 23, 2020, 10:00 AM), https://www.vice.com/en/article/3azkeb/police-are-the-first-to-respond-to-mental-health-crises-they-shouldnt-be; Joseph Goldstein, *Undercover Officers Ask Addicts to Buy Drugs, Snaring Them but Not Dealers*, N.Y. TIMES (Apr. 4, 2016), https://www.nytimes.com/2016/04/05/nyregion/undercover-officers-ask-addicts-to-buy-drugs-snaring-them-but-not-dealers.html. It is also worth mentioning that, despite many Good Samaritan laws, individuals can face criminal charges for seeking medical care for an overdose, or, conversely, for fearing criminal charges and not seeking medical care. *See Drug Overdose Immunity and Good Samaritan Laws*, NAT'L CONF. STATE LEGISLATURES (June 5, 2017), https://www.ncsl.org/research/civil-and-criminal-justice/drug-overdose-immunity-good-samaritan-laws.aspx [https://perma.cc/RZA4-X2LM]; Tommy Simmons, *Case of Ada Man Who Reported Friend's Overdose Shows Limits of Idaho's Good Samaritan Law*, IDAHO PRESS (Sept. 10, 2019), https://www.idahopress.com/news/local/case-of-ada-man-who-reported-friends-overdose-shows-limits-of-idahos-good-samaritan-law/article_9e495d3b-f8e4-59ce-99b9-d77b3bfd7adb.html (relating anecdote of man sentenced up to ten years in prison after reporting friend's overdose); News Release, U.S. DOJ, Illinois Man Who Removed Evidence from Opioid Overdose Death Scene Instead of Calling 911 Sentenced to Federal Prison (Aug. 28, 2020), https://www.justice.gov/usao-ndia/pr/illinois-man-who-removed-evidence-opioid-overdose-death-scene-instead-calling-911 [https://perma.cc/AY8C-MJGD] (announcing twenty-one-month prison sentence for individual who removed heroin from location of overdose to prevent law enforcement from finding it). Fortunately, organizations like the Police Assisted Addiction & Recovery Initiative are changing perspectives on policing and working with law enforcement to better support, rather than criminalize, individuals with substance use disorder. *See About Us,* POLICE ASSISTED ADDICTION & RECOVERY INITIATIVE, https://paariusa.org/about-us/ [https://perma.cc/F33Y-FVXD] (last visited Sept. 1, 2021).

[50] DUROSE & MUMOLA, *supra* note 49, at 3 tbl.5.

[51] PERFORMANCE BUDGET, *supra* note 29, at 3-4. Substance use disorder among federal inmates generally follows the same patterns as state and local counterparts, although drug offenders are only slightly more likely to show signs of drug dependence than those incarcerated for other crimes. *See* BRONSON ET AL., *supra* note 35, at 3, 3 tbl.2.

80% of federal defendants facing crack cocaine charges were Black.[52] Federal prisoners also generally have longer periods of incarceration than their state counterparts, "reflect[ing] the higher proportion of trafficking offenders and the more serious drug distribution crimes that fall under Federal jurisdiction."[53]

The disproportionate representation of substance use disorder within both state and federal correctional facilities highlights the need for robust institutional changes to address the medical needs of incarcerated individuals, whatever the circumstances of their offense and the conditions of their incarceration. This disease deserves to be treated like any other chronic medical condition, including through the provision of effective medical treatment where reasonable accommodations so warrant.

B. *Medication-Assisted Treatment*

1. MAT Is a Critical Part of the Solution to the Opioid Epidemic

Recent clinical studies have demonstrated that MAT is an effective treatment method for OUD.[54] The two forms of MAT addressed in this Note, methadone and buprenorphine,[55] are "opioid agonists"—opioids that bind to the brain's opioid receptors, preventing the uptake of other opioid particles, such as from heroin or fentanyl.[56] These medications allow patients to pursue normal activities of daily living without the debilitating drug cravings or negative repercussions of illicit drug use.[57] An overwhelming consensus in the medical

[52] *See* Fatema Gunja, *Race and the War on Drugs*, ACLU (May 2003), https://www.aclu.org/other/race-war-drugs?redirect=drug-law-reform/race-war-drugs [https://perma.cc/YHK5-RKPD].

[53] CHRISTOPHER J. MUMOLA & JENNIFER C. KARBERG, U.S. DOJ, DRUG USE AND DEPENDENCE, STATE AND FEDERAL PRISONERS, 2004, at 4 (2006), https://bjs.ojp.gov/content/pub/pdf/dudsfp04.pdf [https://perma.cc/S6T6-YPJF].

[54] *See* Friedman & Trent, *supra* note 32, at 21 (summarizing research studies and stating "[d]ozens of studies have shown that medication-assisted treatment reduces drug use, disease rates, overdose deaths, and criminal activity among people with opioid use disorder").

[55] *See* 42 C.F.R. § 8.2 (2021) (defining use of MAT for long-term maintenance as "the dispensing of an opioid agonist treatment medication at stable dosage levels for a period in excess of 21 days in the treatment of an individual for opioid use disorder"). Methadone and pharmaceutical products containing buprenorphine are opioid agonists approved by the Food and Drug Administration to treat OUD. *See* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., FEDERAL GUIDELINES FOR OPIOID TREATMENT PROGRAMS 4 (2015) [hereinafter FEDERAL GUIDELINES]. Methadone is usually dispensed in liquid form as a daily dose taken under observation, and it can only be dispensed to treat substance use disorder at a licensed facility. *See* Friedman & Trent, *supra* note 32, at 21. Buprenorphine, commonly referred to by the brand name Suboxone, is usually taken as a sublingual strip that dissolves in the mouth, and an individual usually obtains a thirty-day prescription by specially trained physicians. *See id.* at 20.

[56] *See* Friedman & Trent, *supra* note 32, at 21.

[57] *See, e.g.*, Pesce v. Coppinger, 355 F. Supp. 3d 35, 41 (D. Mass. 2018) (describing

community endorses MAT as an effective treatment method for OUD, and several renowned organizations and government officials have recommended its use in correctional facilities.[58]

Regulations and guidelines governing MAT recognize that the best practices for the treatment of OUD involve individualized assessments into each patient's needs, including their medical histories, other medications, and complicating factors.[59] As such, a "formulaic policy generically applied to all patients meeting specific criteria or in specific situations without evaluation by a physician or other qualified healthcare provider" is unacceptable.[60] This individualized assessment suggests certain individuals may be on MAT for several years or indefinitely, "just as persons with other chronic medical conditions, like diabetes, may need to take medication regularly throughout their lives."[61]

improvement in plaintiff's quality of life through use of methadone to maintain recovery from opioid addiction).

[58] *See* Kyle Kampman & Margaret Jarvis, *The American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use*, 9 J. ADDICTION MED. 358, 365 (2015) (explicitly recommending MAT during incarceration); *Substance Use Disorder Treatment for Adults and Adolescents*, NAT'L COMM'N ON CORR. HEALTH CARE (Oct. 23, 2016), https://www.ncchc.org/substance-use-disorder-treatment-for-adults-and-adolescents [https://perma.cc/WWL9-58HT] (calling for "continuation of prescribed medications for substance use disorders" within correctional facilities"). In 2017, President Trump's Commission on Combating Drug Addiction and the Opioid Crisis also called for offering MAT in jails and prisons. PRESIDENT'S COMM'N ON COMBATING DRUG ADDICTION & THE OPIOID CRISIS, FINAL REPORT 73 (2017).

[59] *See, e.g.*, 42 C.F.R. § 8.2 (defining MAT as "use of medication in combination with behavioral health services to provide an *individualized approach* to the treatment of substance use disorder" (emphasis added)); *Medication-Assisted Treatment (MAT)*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (Jan. 4, 2021), https://www.samhsa.gov/medication-assisted-treatment [https://perma.cc/DZ9W-WPQL] (defining MAT as use of FDA-approved medications "in combination with counseling and behavioral therapies, to provide a *'whole-patient' approach* to the treatment of substance use disorders" (emphasis added)). 42 C.F.R. §§ 8.1-.34 (2021) sets federal standards for opioid treatment programs ("OTPs") and the Substance Abuse and Mental Health Services Administration's ("SAMHSA") Guidelines. *See* 42 C.F.R. § 8.2; FEDERAL GUIDELINES, *supra* note 55 (elaborating on these standards). Although federal regulation has not changed since its adoption, SAMHSA's Guidelines suggest how the regulation should be applied in the context of changing opioid use, healthcare delivery, and problems impacting public health. FEDERAL GUIDELINES, *supra* note 55, at 4-5. The most recent 2015 Guidelines reflect the obligation of OTPs to deliver care consistent with the "patient-centered, integrated, and recovery-oriented standards of addiction treatment and medical care in general." *Id.* at 6.

[60] FEDERAL GUIDELINES, *supra* note 55, at 51.

[61] Letter from Joon H. Kim, Acting U.S. Att'y, S. Dist. of New York, to New York State Off. of the Att'y Gen. at 4 (Oct. 3, 2017), https://lac.org/wp-content/uploads/2018/02/DOJ-SDNY-ltr-to-OCA-10.3.17.pdf [https://perma.cc/66L2-SQCM] (citing SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION IN OPIOID TREATMENT PROGRAMS: A TREATMENT IMPROVEMENT PROTOCOL 113-17 (2005) [hereinafter TREATMENT IMPROVEMENT PROTOCOL], which recommends "possibly years of treatment" and "optional" tapering off of medication).

Longer-term MAT treatment also renders successful treatment outcomes more likely.[62] However, despite this guidance, correctional facilities often categorically prohibit MAT as a long-term treatment method for incarcerated individuals.

2. Correctional Facilities Fail to Provide MAT for OUD

a. *Institutional Policies*

Despite evidence suggesting that methadone and buprenorphine are some of the most effective treatment methods for OUD in correctional facilities,[63] treatment programs for incarcerated individuals rarely include MAT. Rather, out of the nation's 5,100 jails and prisons, "fewer than 30, according to the federal Bureau of Justice Assistance, offer opioid users the most proven method of recovery: administering methadone or buprenorphine."[64] BOP facilities provide substance use treatment through drug education courses, nonresidential "drug abuse treatment,"[65] residential "drug abuse treatment,"[66] and community transition treatment.[67] More than half of BOP facilities[68] operate a residential drug treatment program, in which eligible incarcerated individuals are separated from the general prison population and provided a therapeutic model of

[62] *See* Wakeman & Rich, *supra* note 29, at 222 (describing study finding that longer duration and methadone doses greater than 60 mg are "necessary to see significant health and social improvement").

[63] *See id.* (describing international evidence and precedent supporting MAT treatment programs at all stages of incarceration). *See generally* Michael S. Gordon, Timothy W. Kinlock & Patrice M. Miller, *Medication-Assisted Treatment Research with Criminal Justice Populations: Challenges of Implementation*, 29 BEHAV. SCIS. & L. 829 (2011) (surveying studies of MAT's effectiveness in correctional facilities).

[64] Timothy Williams, *Opioid Users Are Filling Jails. Why Don't Jails Treat Them?*, N.Y. TIMES (Aug. 4, 2017), https://www.nytimes.com/2017/08/04/us/heroin-addiction-jails-methadone-suboxone-treatment.html. MAT is largely unavailable at all levels of the criminal justice system, including jails and drug courts. *See* Friedman & Trent, *supra* note 32, at 22 (describing 2014 surveys showing half of U.S. drug courts did not permit methadone and other prescription medications to treat OUD); Christine Vestal, *New Momentum for Addiction Treatment Behind Bars*, PEW (Apr. 4, 2018), https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/04/04/new-momentum-for-addiction-treatment-behind-bars (stating that only twenty-two of nation's 3,300 local jails offer methadone). However, there have been some changes in the context of drug courts. *See* U.S. DOJ, ADULT DRUG COURT DISCRETIONARY GRANT PROGRAM 12 (2018) (requiring drug courts seeking federal grant to permit MAT).

[65] *See supra* note 1 and accompanying text (discussing importance of nonstigmatizing language).

[66] *Id.*

[67] PERFORMANCE BUDGET, *supra* note 29, at 8.

[68] A full list of BOP prison locations can be found at https://www.bop.gov/about/facilities/federal_prisons.jsp [https://perma.cc/9GG4-HTXC] (last visited Sept. 1, 2021).

treatment based on cognitive behavioral therapy.[69] However, for the most part, MAT is not offered as part of this treatment program.[70]

BOP policies only enumerate "three approved uses" in which methadone is permitted within federal correctional facilities[71]: (1) longer-term treatment of opiate addicted pregnant inmates,[72] (2) short-term detoxification of opiate addicted inmates,[73] and (3) treatment of severe pain.[74] Correctional facilities that administer methadone for opioid treatment, including pregnancy and detoxification, must abide by federal standards.[75] On a positive note, BOP has recently launched a MAT trial program for incarcerated individuals, and recent litigation against BOP has forced its hand in settlement agreements.[76] However,

[69] PERFORMANCE BUDGET, *supra* note 29, at 10. In fiscal year 2017, 16,641 prisoners participated in BOP's residential drug treatment program. *Id.*

[70] I specifically chose BOP as the subject of this Note because I was struck by the tension between DOJ's opioid initiative and the discriminatory practices within an agency under its control. DOJ has explicitly endorsed OUD as a disease. *See* Memorandum from Loretta E. Lynch, Att'y Gen., Off. of the Att'y Gen., to Heads of Dep't Components 7 (Sept. 21, 2016), https://www.justice.gov/opioidawareness/file/896776/download [https://perma.cc/K8QB-FKY7]. DOJ has also stated that failure to provide MAT may constitute disability discrimination. *See* Letter from Andrew E. Lelling, U.S. Att'y, Dist. of Massachusetts, to David Solet, Gen. Couns., Exec. Off. of Pub. Safety & Sec., and Jesse Caplan, Gen. Couns., Exec. Off. of Health & Hum. Servs. 2 (Mar. 16, 2018), http://d279m997dpfwgl.cloudfront.net/wp/2018/03/20180322172953624.pdf [https://perma.cc/LW9T-7SAM]. BOP has only started exploring the use of MAT in response to recent litigation. *See* IMPROVED PLANNING, *supra* note 47, at 23 n.36.

[71] FED. BUREAU OF PRISONS, U.S. DOJ, PHARMACY SERVICES 37 (2005) [hereinafter PHARMACY SERVICES], https://www.bop.gov/policy/progstat/6360_001.pdf [https://perma.cc/HGJ8-Z73A].

[72] FED. BUREAU OF PRISONS, U.S. DOJ, PATIENT CARE 43 (2014) [hereinafter PATIENT CARE], https://www.bop.gov/policy/progstat/6031_004.pdf [https://perma.cc/9VE4-DN6S] (noting inmate should only be detoxified from medication after delivery); *see also Substance Use Disorder Treatment for Adults and Adolescents*, *supra* note 58 ("Opioid withdrawal in pregnancy can lead to miscarriage, preterm birth, stillbirth, and other adverse outcomes. Therefore, withdrawal, including medically assisted withdrawal, must be avoided through the use of MAT."). Any institution that could "conceivably house pregnant inmates" must have a "contingency" in place to provide MAT. *See* PATIENT CARE, *supra*.

[73] *Id.* at 25 (giving discretion to local institutions to manage details for detoxifying incarcerated individuals).

[74] PHARMACY SERVICES, *supra* note 71, at 39 (noting methadone prescription for severe pain management does not require methadone license).

[75] *Id.* at 37; *see also* 42 C.F.R. § 8.11 (2021) (requiring current valid accreditation, SAMHSA certification, and DEA registration to dispense opioid drugs for treatment of opioid addiction).

[76] IMPROVED PLANNING, *supra* note 47, at 23. BOP officials acknowledged that they started the MAT program in part because of lawsuits. *Id.*; *see, e.g.*, *ACLU-WA Lawsuit Settled: Federal Prison System Agrees to Provide Medication-Assisted Treatment for Opioid Use Disorder*, ACLU (Dec. 11, 2019), https://www.aclu.org/press-releases/aclu-wa-lawsuit-settled-federal-prison-system-agrees-provide-medication-assisted [https://perma.cc/6LLA-

this piecemeal and defensive response fails to move the needle toward protecting all individuals with OUD incarcerated in its prisons.

b. *Obstacles to Policy Change*

Courts have also been slow to make changes affecting incarcerated individuals' medical needs and substance use disorder in particular, and several obstacles impede challenging correctional facilities' prohibitions of MAT as disability discrimination. Section II of this Note addresses legal issues that disability discrimination claims under the Rehab Act face.[77] However, there are several nonlegal obstacles that render policy change more difficult.

First, there is a cultural view that prisoners should be punished and lose their rights during incarceration. In this view, "[l]awful incarceration brings about the necessary withdrawal or limitation of many privileges and rights, a retraction justified by the considerations underlying our penal system."[78] Second, courts often defer to prison administrations to formulate policies within correctional facilities,[79] as the "complex and intractable" problems in correctional facilities are "not readily susceptible of resolution by decree."[80] This means that "courts will accept patently absurd justifications for practices like isolation, and will give medical evidence far less weight in prison cases than in cases outside the prison context."[81] Lastly, MAT is a relatively new area of research, and there is widespread misunderstanding about MAT and the nature of OUD as a disease.[82]

SLUQ]; German Lopez, *How America's Prisons and Jails Perpetuate the Opioid Epidemic*, VOX (Jan. 31, 2020, 4:20 PM), https://www.vox.com/policy-and-politics/2020/1/30/21078618/prison-opioid-epidemic-buprenorphine-suboxone-methadone.

[77] *See infra* Part II.

[78] Price v. Johnston, 334 U.S. 266, 285 (1948), *overruled on other grounds by* McCleskey v. Zant, 499 U.S. 467 (1991).

[79] *See* Andrew Brunsden, Note, *Hepatitis C in Prisons: Evolving Toward Decency Through Adequate Medical Care and Public Health Reform*, 54 UCLA L. REV. 465, 467 (2006) (noting courts "are hesitant to order expanded access to medical care" in prisons); *see also* Overton v. Bazzetta, 539 U.S. 126, 132 (2003) ("We must accord substantial deference to the professional judgment of prison administrators, who bear a significant responsibility for defining the legitimate goals of a corrections system and for determining the most appropriate means to accomplish them.").

[80] Procunier v. Martinez, 416 U.S. 396, 405 (1974), *overruled by* Thornburgh v. Abbott, 490 U.S. 401 (1989).

[81] Scott Burris, *Prisons, Law and Public Health: The Case for a Coordinated Response to Epidemic Disease Behind Bars*, 47 U. MIA. L. REV. 291, 324 (1992) (describing court deference relating to HIV in correctional facilities).

[82] *See* Peter D. Friedmann, Randall Hoskinson Jr., Michael Gordon, Robert Schwartz, Timothy Kinlock, Kevin Knight, Patrick M. Flynn, Wayne N. Welsh, Lynda A. R. Stein, Stanley Sacks, Daniel J. O'Connell, Hannah K. Knudsen, Michael S. Shafer, Elizabeth Hall & Linda K. Frisman, *Medication-Assisted Treatment in Criminal Justice Agencies Affiliated with the Criminal Justice-Drug Abuse Treatment Studies (CJ-DATS): Availability, Barriers, and Intentions*, 33 SUBSTANCE ABUSE 9, 14 (2012) (showing majority of surveyed sites that

Accordingly, prison officials at various levels of the institution often harbor misguided stereotypes[83] about MAT and its role in treating OUD.[84] These individuals may be averse to MAT out of principle.

3. Recent Shifts in Thinking About MAT

a. *In Prisons*

MAT is "inching its way into jails and prisons,"[85] although this change is slow and with significant limitations. For example, state prisons and jails have paved the way for MAT programs treating incarcerated individuals with OUD[86]—including individuals who were previously prescribed MAT and who first received MAT during incarceration. Additionally, Massachusettslaunched a pilot program to provide MAT in select jails and prisons across the state.[87]

did not provide MAT indicated MAT programs would be possible if evidence showed MAT improved criminal justice outcomes). Prisons tend to implement policies addressing public health concerns that have been established and documented for longer periods of time. *See* Brunsden, *supra* note 79, at 472.

[83] There are several harmful stereotypes associated with OUD and MAT. For example, some think that "addiction is a moral failing, not a medical condition, so public resources shouldn't go to treating it." Lopez, *supra* note 76. There is also a "myth that [MAT] medications are simply 'replacing one drug with another.'" *Id.* The stigma surrounding OUD is incredibly harmful and undermines an individual's ability to recover and seek medical care, even outside of the correctional facility context. *See* Kelly et al., *supra* note 34. *See generally Learn About Stigma*, SHATTERPROOF, https://www.shatterproof.org/our-work/ending-addiction-stigma/understanding-addiction-stigma [https://perma.cc/A6JU-9H79] (last visited Sept. 1, 2021).

[84] Wakeman & Rich, *supra* note 29, at 221 (recognizing correctional facilities offering substance treatment generally provide nonpharmacological options because of antipathy towards opioid agonists); *see also* Smith v. Aroostook Cnty., 376 F. Supp. 3d 146, 160 (D. Me. 2019), *aff'd*, 922 F.3d 41 (1st Cir. 2019) ("The Defendants' statements and actions [demonstrating their general attitude towards OUD] suggest the kind of 'apathetic attitude' towards individuals with disabilities that the ADA intends to remedy.").

[85] Friedman & Trent, *supra* note 32, at 23.

[86] *See, e.g.*, *Behavioral Health Services*, STATE R.I. DEP'T OF CORR., http://www.doc.ri.gov/rehabilitative/healthcare/behavioral/ [https://perma.cc/Q6X2-VARV] (last visited Sept. 1, 2021) (describing program in Rhode Island Department of Corrections); Lopez, *supra* note 76 (describing program in Vermont); Matthew Reisen, *BernCo Jail Offers Methadone Program to Inmates*, ALBUQUERQUE J. (Nov. 18, 2017, 10:45 PM), https://www.abqjournal.com/1094949/county-jail-fights-opioid-addiction-from-the-inside-out.html [https://perma.cc/4K9C-4RKP] (describing program in scenic Bernalillo County, New Mexico); Christine Vestal, *Opioid Treatment at Rikers Island Is a Long-Standing Success, but Few Jails Adopt It*, PBS NEWSHOUR (May 23, 2016, 2:50 PM), https://www.pbs.org/newshour/nation/opioid-treatment-at-rikers-island-is-a-long-standing-success-but-few-jails-adopt-it [https://perma.cc/W3JT-GHSC] (describing program in Rikers Island, New York).

[87] Press Release, Off. of Governor Charlie Baker, Governor Baker Signs Second Major Piece of Legislation to Address Opioid Epidemic in Massachusetts (Aug. 14, 2018),

Massachusetts is also home to the first jail to become a licensed opioid treatment program ("OTP") in the country[88]: "I think it's working," correctional officer Lee Terrell said about the in-jail OTP program.[89] "I think violence in the facility has gone down. We used to get a lot [of medication] through the mail; there used to be a lot of contraband. That has come to minimal, if anything."[90] Initial research looking at some of these state initiatives demonstrates its success.[91]

Outside of its approved uses, BOP has begun to explore the use of MAT for longer-term treatment. BOP began this inquiry by providing naltrexone[92] as an inmate is transitioned back to the community.[93] In fiscal year 2018, BOP planned to expand this trial MAT program for approximately 160 offenders released in the Boston, Massachusetts area,[94] and BOP officials have said that, as of January 2020, "eligible inmates incarcerated in all of BOP's institutions have access to naltrexone."[95] However, naltrexone has traditionally had lower success rates than buprenorphine and methadone,[96] and, despite the importance of providing MAT in a "patient-centered" manner,[97] BOP's inquiry into other forms of MAT has been far too late, limited, and slow to implement. Fortunately, in fiscal year 2019, BOP implemented a new voluntary MAT program for incarcerated

https://www.mass.gov/news/governor-baker-signs-second-major-piece-of-legislation-to-address-opioid-epidemic-in [https://perma.cc/JP69-JB3P].

[88] *See* Deborah Becker*, Franklin County Jail Is the First Jail in the State That's Also a Licensed Methadone Treatment Provider*, WBUR (Nov. 12, 2019), https://www.wbur.org/commonhealth/2019/11/12/franklin-county-jail-methadone [https://perma.cc/6UAF-UJSJ].

[89] *Id.*

[90] *Id.*

[91] *See* Traci C. Green, Jennifer Clarke, Lauren Brinkley-Rubinstein, Brandon D. L. Marshall, Nicole Alexander-Scott, Rebecca Boss & Josiah D. Rich, Research Letter, *Postincarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System*, 75 JAMA PSYCHIATRY 405, 406 (2018) (finding in preliminary study "a large and clinically meaningful reduction in postincarceration deaths from overdose among inmates released from incarceration after implementation of a comprehensive MAT program in a [Rhode Island] statewide correctional facility—a reduction contributing to overall population-level declines in overdose deaths"). When this MAT program was introduced, the proportion of overdose deaths of formerly incarcerated individuals decreased from 14.5% to 5.7% of total overdose deaths. *See id.*

[92] Naltrexone is similar to methadone and buprenorphine in that it attaches to the brain's opioid receptors and blocks other opioid particles, but it is not an opioid itself. *See* Friedman & Trent, *supra* note 32, at 21. Naltrexone is often known by the brand name Vivitrol and is usually delivered through a monthly injection by a physician. *Id.*

[93] PERFORMANCE BUDGET, *supra* note 29, at 21 (describing field trial conducted by BOP and White House Office of National Drug Control Policy).

[94] *See id.*

[95] IMPROVED PLANNING, *supra* note 47, at 29.

[96] TREATMENT IMPROVEMENT PROTOCOL, *supra* note 61, at 30-31.

[97] FEDERAL GUIDELINES, *supra* note 55, at 6.

individuals with OUD,[98] which combines cognitive behavioral therapy with methadone, buprenorphine, and naltrexone treatment.[99] However, despite goals to expand the program, BOP "lacks key planning elements to ensure this significant expansion is completed in a timely and effective manner."[100] Accordingly, the author operates under the assumption that BOP facilities will not see a widespread MAT program for several years.

b. *In Courts*

Recent litigation and investigative efforts under the ADA[101] and Rehab Act evidence shifts in legal thought, suggesting that the failure to provide MAT in correctional facilities may constitute disability discrimination. Although enacted later, the ADA was modeled after the Rehab Act and is interpreted in similar ways.[102] Therefore, legal shifts under both disability discrimination statutes evidence the likelihood of success in future Rehab Act litigation, even though none have yet to affirmatively recognize a violation of the ADA or Rehab Act.

First, at least two trial courts have granted preliminary injunctions requiring correctional facilities to provide MAT where plaintiffs brought ADA claims for disability discrimination based on refusal to provide the medication.[103] Importantly, the legal standard for preliminary injunction requires a sufficient likelihood of success on the merits of the claim, combined with both a strong

[98] IMPROVED PLANNING, *supra* note 47, at 27.

[99] *Id.* at 23. In 2019, only forty-one incarcerated individuals in BOP facilities received MAT through this program. *Id.* However, only "four inmates received methadone and six inmates received buprenorphine." *Id.* at 23 n.38.

[100] *Id.* at 31. For example, BOP currently lacks documentation on how it will determine the number of additional agency personnel needed to support the MAT program expansion; how it plans to recruit and onboard these personnel; and when BOP will complete the expansion and meet other relevant time frames and target goals. *Id.* at 40.

[101] 42 U.S.C. §§ 12101-12111 (protecting against disability discrimination by state and local government).

[102] *See* Zukle v. Regents of Univ. of Cal., 166 F.3d 1041, 1045 n.11 (9th Cir. 1999) ("There is no significant difference in analysis of the rights and obligations created by the ADA and the Rehabilitation Act."); Armstrong v. Wilson, 124 F.3d 1019, 1023 (9th Cir. 1997) ("Congress has directed that the ADA and [Rehab Act] be construed consistently.").

[103] Smith v. Aroostook Cnty., 376 F. Supp. 3d 146, 160 (D. Me. 2019) (granting preliminary injunction providing buprenorphine as prescribed by plaintiff's physician during forty-day jail incarceration), *aff'd*, 922 F.3d 41 (1st Cir. 2019); Pesce v. Coppinger, 355 F. Supp. 3d 35, 49 (D. Mass. 2018) (granting preliminary injunction providing methadone as prescribed by plaintiff's physician). In at least one case where the judge denied the motion for preliminary injunction on mootness grounds, the jail subsequently agreed to provide methadone to the plaintiff. *See* Sally Friedman & Rebekah Joab, *Finnigan v. Mendrick et. al.*, LEGAL ACTION CTR. (Feb. 2021), https://www.lac.org/resource/finnigan-v-mendrick [https://perma.cc/4QKF-7B74]; Supplemental Declaration of Nury Marcelo, Finnegan v. Mendrick, No. 1:21-cv-00341 (N.D. Ill. filed Feb. 26, 2021) (available at https://www.lac.org/assets/files/Dkt-71-D-rpt-to-Ct-2.26.21.pdf [https://perma.cc/WA6L-G9LF]).

balance of harms and a public interest in favor of the plaintiff.[104] Both courts found a sufficient likelihood of success on the merits of the disability discrimination claim.[105]

Second, the DOJ launched an initiative to remove discriminatory barriers to treatment for individuals with OUD, under which "[t]he [ADA] provides one of the many tools that the [DOJ] can and does use to expand access to recovery for individuals addicted to opioids."[106] Under this initiative, the DOJ reached successful settlement agreements against employers and businesses that discriminated against individuals using MAT.[107] As part of these agreements, the facilities adopted nondiscrimination policies, agreeing "not [to] deny services on the basis of disability, including opioid use disorder, or apply standards or criteria that screen out individuals with disabilities."[108] Although both agreements settled claims under Title III of the ADA in the context of public accommodations, these agreements provide important examples of disability discrimination against MAT users and show the DOJ's explicit position on this issue.

In 2018, the U.S. Attorney's Office for the District of Massachusetts also began an investigation into whether the Massachusetts Department of Corrections' failure to provide MAT was a possible ADA violation.[109] The investigation noted that "all individuals in treatment for OUD, regardless of

[104] *See* Corp. Techs., Inc. v. Harnett, 731 F.3d 6, 9 (1st Cir. 2013).

[105] *See Smith*, 376 F. Supp. 3d at 158-61; *Pesce*, 355 F. Supp. 3d at 45-47.

[106] Eric Dreiband, Assistant Att'y Gen., U.S. DOJ, Remarks at the National Disability Rights Network 2019 Annual Conference (June 6, 2019), https://www.justice.gov/opa/speech/assistant-attorney-general-eric-dreiband-delivered-remarks-national-disability-rights [https://perma.cc/R8ZX-3NMY] (stating ADA applies to individuals taking MAT). In a letter providing guidance to New York State about the ADA's application to individuals on MAT, specific examples where the prohibition of MAT could violate the ADA included "deny[ing] a parent visitation with her child by reason of the parent's . . . current use of MAT. . . . Nor could a court impose a blanket rule requiring parents to stop participating in MAT in order to gain custody of their children." Letter from Joon H. Kim to New York State Off. of the Att'y Gen., *supra* note 61, at 1.

[107] *See* Press Release, U.S. DOJ, Justice Department Reaches Settlement with Selma Medical Associates Inc. to Resolve ADA Violations (Jan. 31, 2019) [hereinafter *Justice Department Reaches Settlement with Selma*], https://www.justice.gov/opa/pr/justice-department-reaches-settlement-selma-medical-associates-inc-resolve-ada-violations [https://perma.cc/JB4C-DE8P] (describing settlement under Title III of ADA against private medical clinic that refused to accept prospective new patient taking Suboxone); Press Release, U.S. DOJ, U.S. Attorney's Office Settles Disability Discrimination Allegations at Skilled Nursing Facility (May 10, 2018) [hereinafter *U.S. Attorney Settles Disability Discrimination Allegations*], https://www.justice.gov/usao-ma/pr/us-attorney-s-office-settles-disability-discrimination-allegations-skilled-nursing [https://perma.cc/J4A8-297R] (describing settlement under Title III of ADA against Charlwell House, a skilled nursing facility that refused to accept patient receiving buprenorphine).

[108] Justice Department Reaches Settlement with Selma, *supra* note 107; *see also* U.S. Attorney Settles Disability Discrimination Allegations, *supra* note 107.

[109] *See* Letter from Andrew E. Lelling to David Solet, *supra* note 70.

whether they are inmates or detainees, are already protected by the ADA, and that the [Massachusetts Department of Corrections] has existing obligations to accommodate this disability."[110] Although the U.S. Attorney's Office has not concluded whether the Massachusetts Department of Corrections violated the ADA, the mere existence of this investigation suggests movement in the legal landscape surrounding disability discrimination against MAT users.

Third, lawsuits alleging disability discrimination for a correctional facility's failure to provide MAT have resulted in favorable settlements requiring the defendant to provide MAT. In *Smith v. Fitzpatrick*,[111] the plaintiff had been in recovery using physician-prescribed MAT for over five years prior to his incarceration, and the correctional facility's policy prohibiting MAT would have forced him into acute withdrawal when he reported to prison.[112] Under the settlement agreement, the Maine Department of Corrections agreed to continue providing Smith with medication while in state custody.[113]

BOP has not been immune from disability discrimination litigation. BOP recently settled three separate lawsuits to provide MAT to incarcerated individuals and allowed the plaintiffs to continue MAT while incarcerated.[114] Although settlements do not necessarily admit to a statutory violation, BOP officials acknowledged that its new MAT program began in part as a response to "several lawsuits regarding the provision of MAT to federal inmates."[115] Clearly, disability discrimination litigation has spurred policy shifts that will

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[110] *Id.*

[111] Complaint, Smith v. Fitzpatrick, 2019 WL 1387682 (D. Me. July 26, 2018) (No. 1:18-cv-00288) (available at https://www.aclumaine.org/sites/default/files/smith_v._fitzpatrick_complaint.pdf [https://perma.cc/3S7H-XN2H]).

[112] *See id.* at 1, 2.

[113] *See* Smith v. Fitzpatrick, et al., ACLU ME. (Sept. 28, 2018), https://www.aclumaine.org/en/cases/smith-v-fitzpatrick-et-al [https://perma.cc/J9P9-ULV2]. A settlement proposal from April 2019 in *Kortlever v. Whatcom County* provides another example. *See* News Release, ACLU Washington, Whatcom County Jail to Provide Medications Necessary to Treat Opioid Addiction in Landmark Settlement Proposed in Civil Rights Lawsuit (Apr. 30, 2019), https://www.aclu-wa.org/news/whatcom-county-jail-provide-medications-necessary-treat-opioid-addiction-landmark-settlement [https://perma.cc/A56Z-EABR] (discussing proposed class action settlement for nonpregnant individuals with OUD incarcerated at Whatcom County Jail); *see also* Complaint, Kortlever v. Whatcom Cnty., No. 2:18-cv-00823 (W.D. Wash. filed June 6, 2018) (available at https://www.aclu-wa.org/docs/complaint-kortlever-et-al-v-whatcom-county).

[114] *See ACLU-WA Lawsuit Settled: Federal Prison System Agrees to Provide Medication-Assisted Treatment for Opioid Use Disorder*, ACLU (Dec. 11, 2019), https://www.aclu.org/press-releases/aclu-wa-lawsuit-settled-federal-prison-system-agrees-provide-medication-assisted [https://perma.cc/JA5A-SHJB]; Settlement Agreement at 2, DiPierro v. Hurwitz, No. 1:19-cv-10495 (D. Mass. filed June 7, 2019), *available at* https://www.aclum.org/sites/default/files/20190607_dipierro_settlement.pdf; Crews v. Sawyer, ACLU KAN., https://www.aclukansas.org/en/cases/crews-v-sawyer [https://perma.cc/93J3-SM6L] (last visited Sept. 1, 2021) (noting parties reached temporary settlement).

[115] IMPROVED PLANNING, *supra* note 47, at 23 n.36.

continue to benefit more incarcerated individuals with OUD as the MAT program is expanded. However, until every eligible incarcerated individual with OUD can receive MAT, BOP is discriminating on the basis of disability and jeopardizing the lives and well-being of its incarcerated population.

C. *MAT in Correctional Facilities Is Crucial*

BOP has a "responsibility to provide inmates with opportunities to participate in programs that can afford them the skills they need to lead crime-free lives after release. The BOP's philosophy is that release preparation begins the first day of imprisonment."[116] Policymakers on both sides of the ideological spectrum embrace successful prisoner reentry as a "rational policy goal" for decision-making within correctional facilities.[117] However, BOP's current treatment programs for substance use disorder fail to live up to this responsibility.[118] BOP's failure to provide MAT renders an incarcerated individual further vulnerable to recidivism and overdose death upon release,[119] among other risks.[120] This also affects the broader community; because substance use

[116] PERFORMANCE BUDGET, *supra* note 29, at 7.

[117] Brunsden, *supra* note 79, at 470.

[118] *See supra* notes 65-70 and accompanying text (describing BOP's treatment programs for substance use disorder). However, 77% of formerly incarcerated individuals with OUD relapse to opioid use within three months of release even if involved with a counseling program, like BOP's, while incarcerated. *See* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., MEDICATION-ASSISTED TREATMENT (MAT) IN THE CRIMINAL JUSTICE SYSTEM: BRIEF GUIDANCE TO THE STATES 1 (2019).

[119] *See infra* notes 126-34 and accompanying text.

[120] Painful withdrawal symptoms may impair an incarcerated individual's capacity to make informed legal decisions or calculate the risk of sharing needles. *See* Bruce & Schleifer, *supra* note 40, at 19. These withdrawals also create unnecessary suffering, a potential interruption of life-sustaining medical treatments for other conditions, an exacerbation or masking of other medical conditions, and sometimes death. *See Substance Use Disorder Treatment for Adults and Adolescents*, *supra* note 58. *See generally* Curtis Bone, Lindsay Eysenbach, Kristen Bell & Declan T. Barry, *Our Ethical Obligation to Treat Opioid Use Disorder in Prisons: A Patient and Physician's Perspective*, 46 J.L. MED. & ETHICS 268 (2018) (arguing that failure to bring treatment into criminal justice systems will result in otherwise preventable disease and death among incarcerated people). MAT would reduce some of these external harms, including the risk of infectious diseases. *See Substance Use Disorder Treatment for Adults and Adolescents*, *supra* note 58 (noting effective substance treatment in correctional facilities, including long-term MAT, reduces spread of blood-borne infections through needle sharing).

disorder devastates communities everywhere,[121] albeit in different ways,[122] adequate medical care within prisons will lead to better health outcomes in the community.[123] As such, "we cannot speak of the health of the nation without also addressing the health of individuals in prisons, jails and other institutions."[124] It is crucial to intervene in the correctional facility context and treat OUD using scientifically proven pharmacological treatment methods.[125]

Failure to provide MAT in correctional facilities reduces incarcerated individuals' potential to successfully reintegrate into the community and renders them more likely to relapse to illicit substance use and criminal activity. Incarcerated individuals already exhibit high recidivism rates.[126] However, given the large proportion of incarcerated individuals with substance use disorder or dependence and the correlation between illicit substance use and criminal activity,[127] there is likely a connection between relapse to substance use and recidivism after release. This is especially apparent where an individual was

[121] *See supra* note 26 and accompanying text (discussing how opioid epidemic affects all racial groups); *see also* Friedmann et al., *supra* note 82, at 10 ("[S]tate budget crises provide impetus for evidence-based interventions such as MAT to reduce the costs of rearrests and reincarceration as well as the societal, human, and health care costs associated with chronic substance dependence."); Wakeman & Rich, *supra* note 29, at 220 (estimating cost of untreated alcohol and illicit drug use on health care, productivity, crime, incarceration, and drug enforcement is $366 billion per year).

[122] *See supra* note 9-11 and accompanying text (discussing healthcare and other systemic inequities in context of COVID-19 pandemic); *supra* note 52 and accompanying text (discussing rates of mass incarceration for drug offenses by race); James & Jordan, *supra* note 23, at 413 (recognizing that lack of access to treatment for substance use disorder is more pronounced in minority communities than in general population).

[123] *See* Brunsden, *supra* note 79, at 470 ("[M]edical care and public health interventions for prisoners are considered tantamount to better health outcomes for the general population . . . ."); Wallace & Wang, *supra* note 38, at 10-11 ("[T]he link between incarceration and health, and now recidivism, suggests that if we are to lower the high rates of recidivism, we can no longer ignore the health of justice-involved individuals, whether these individuals are incarcerated or have been released."); *see also infra* notes 126-34 and accompanying text (discussing how providing MAT would reduce rates of recidivism and overdose deaths).

[124] NAT'L COMM'N ON AIDS, HIV DISEASE IN CORRECTIONAL FACILITIES 36 (1991) (discussing need to respond to HIV in prisons); *see also* Brunsden, *supra* note 79, at 470 ("If left unidentified, untreated, and uneducated about the disease, HCV-infected inmates reentering society present a transmission risk to the community and are less likely to achieve successful reintegration.").

[125] *See supra* notes 48-51 and accompanying text (discussing disproportionate representation of substance use disorder amongst incarcerated population). *See generally* Burris, *supra* note 81 (arguing public health crises, like HIV and substance use disorder, can be addressed through critical medical treatment provided behind bars).

[126] *See* DUROSE & MUMOLA, *supra* note 49, at 4 (showing within 3 years of release from state prison, about 69.1% of nonviolent releasees were rearrested for new crime, 48.4% were reconvicted, and 26.7% returned to prison).

[127] *See supra* notes 48-51 and accompanying text.

already on the path to recovery through the use of MAT prior to their incarceration but was forced to stop their prescribed medication.[128] On the other hand, providing MAT within correctional facilities would allow the most effective treatment method to reach those in need and would give them the opportunity to build upon a period of recovery prior to release. This medical intervention places an individual in a position to most successfully reenter the community without returning to criminal activity after release.[129]

The failure to provide MAT in correctional facilities also increases an incarcerated individual's likelihood of overdose death. Overdose is already the leading cause of death for individuals recently released from prison.[130] Recently released individuals are significantly more likely to die from an overdose or related fatality in the first two weeks following release from prison, compared to the general population.[131] This is because, after a period of forced abstinence without adequate medical treatment, an incarcerated individual who returns to the community will have a significantly lower tolerance to substances and be susceptible to other factors affecting overdose risk. On the other hand, MAT is

[128] Smith v. Aroostook Cnty., 376 F. Supp. 3d 146, 150 (D. Me. 2019), *aff'd*, 922 F.3d 41 (1st Cir. 2019) (describing plaintiff's withdrawal from Suboxone while incarcerated in jail as "the worst pain she has ever endured" and leading to "suicidal thoughts for the first time in her life"); Jeronimo A. Maradiaga, Shadi Nahvi, Chinazo O. Cunningham, Jennifer Sanchez, Aaron D. Fox, *"I Kicked the Hard Way. I Got Incarcerated." Withdrawal from Methadone During Incarceration and Subsequent Aversion to Medication Assisted Treatments*, 62 J. SUBSTANCE ABUSE TREATMENT 49, 52 (2016) (noting that severe withdrawal symptoms when MAT is abruptly stopped lead to incarcerated individual's reluctance to obtain future MAT).

[129] *See* Wallace & Wang, *supra* note 38, at 7 (finding prisoners with good mental health while incarcerated had lowest rates of recidivism); Verner S. Westerberg, Barbara S. McCrady, Mandy Owens & Paul Guerin, *Community-Based Methadone Maintenance in a Large Detention Center Is Associated with Decreases in Inmate Recidivism*, 70 J. SUBSTANCE ABUSE TREATMENT 1, 4-5 (2016) (finding inmates in jail-based methadone treatment program exhibited significantly longer time until rearrest compared with control groups, including those detoxified in jail). Public health experts felt similar outrage about Hepatitis C, which is often directly linked to substance use, because "[i]f left unidentified, untreated, and uneducated about the disease, HCV-infected inmates reentering society . . . are less likely to achieve successful reintegration." Brunsden, *supra* note 79, at 470. For an argument that prisons should become centers of public health works, and prisoners' rights advocates should partner with health agencies—both public and voluntary—to coordinate efforts to meet patients' needs within correctional facilities, see Burris, *supra* note 81 (recognizing framework for coordinated approach applies to both communicable diseases and drug use treatment within correctional facilities).

[130] *See* Friedman & Trent, *supra* note 32, at 20.

[131] *See* Ingrid A. Binswanger, Marc F. Stern, Richard A. Deyo, Patrick J. Heagerty, Allen Cheadle, Joann G. Elmore & Thomas D. Koepsell, *Release from Prison—A High Risk of Death for Former Inmates*, 356 NEW ENG. J. MED. 157, 157 (2007) (noting that individuals in Washington are 129 times more likely to die than general population); Becker, *supra* note 88 (noting individuals in Massachusetts are 120 times more likely to die than general population).

correlated with a reduced risk of mortality in the weeks following release,[132] and prisoners who continue their previously prescribed MAT throughout incarceration have better outcomes than those who are forced to discontinue MAT during incarceration.[133] Providing MAT in jails and prisons saves lives. Fortunately, the movement to offer MAT in correctional facilities is only growing stronger.[134]

II. DISABILITY DISCRIMINATION UNDER THE REHAB ACT

A. *The Rehab Act*

The Rehab Act protects against disability discrimination in a range of contexts. It states that "[n]o otherwise qualified individual with a disability" shall, "solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination" by any program receiving federal funding or conducted by a federal Executive agency.[135] To establish a claim under the Rehab Act, an individual must establish that they are (1) an "individual with a disability," (2) who is "otherwise qualified," (3) and "excluded from the participation in, . . . denied the benefits of, or . . . subjected to discrimination," (4) "solely by reason of her or his disability."[136] In assessing the elements of this legal claim, case law "under the Rehab[] Act [is] precedent for cases under the ADA, and vice-versa,"[137] because the statutes are interpreted in similar ways and generally provide the same statutory rights, procedures, and remedies to covered individuals.[138] These

[132] *See* FINAL REPORT, *supra* note 58, at 72 (citing John Marsden, Garry Stillwell, Hayley Jones, Alisha Cooper, Brian Eastwood, Michael Farrell, Tim Lowden, Nino Maddalena, Chris Metcalfe, Jenny Shaw & Matthew Hickman, *Does Exposure to Opioid Substitution Treatment in Prison Reduce the Risk of Death After Release? A National Prospective Observational Study in England*, 112 ADDICTION 1408, 1415 (2017) (finding individuals receiving MAT in prison were 85% less likely to die of drug poisoning in first month after release)).

[133] *See* Josiah D. Rich, Michelle McKenzie, Sarah Larney, John B. Wong, Liem Tran, Jennifer Clarke, Amanda Noska, Manasa Reddy & Nickolas Zaller, *Methadone Continuation Versus Forced Withdrawal on Incarceration in a Combined US Prison and Jail: A Randomised, Open-Label Trial*, 386 LANCET 350, 355-56 (2015) (finding group of prisoners who continued methadone treatment during incarceration had lower rates of drug use and fewer overdoses than prisoners whose methadone treatment discontinued during incarceration).

[134] *See supra* Part I.B.3.

[135] 29 U.S.C. § 794(a).

[136] *Id.*

[137] Cash v. Smith, 231 F.3d 1301, 1305 n.2 (11th Cir. 2000); *see also* Kiman v. N.H. Dep't of Corr., 451 F.3d 274, 285 n.10 (1st Cir. 2006).

[138] *See* Zukle v. Regents of Univ. of Cal., 166 F.3d 1041, 1045 n.11 (9th Cir. 1999) ("There is no significant difference in analysis of the rights and obligations created by the ADA and the Rehabilitation Act."); Armstrong v. Wilson, 124 F.3d 1019, 1023 (9th Cir. 1997) ("Congress has directed that the ADA and [Rehab Act] be construed consistently.").

rights, procedures, and remedies are available for "prisoners who bring litigation concerning access to medical care . . . ."[139]

For purposes of the Rehab Act, an individual has a disability if he or she "has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment."[140] Although individuals currently engaging in illegal drug use are excluded,[141] an individual is still entitled to protection under the Rehab Act if they are no longer engaging in illegal drug use, including if they participate in a supervised rehabilitation program.[142] Additionally, an argument can be made that individuals currently engaging in illicit drug use should still qualify for reasonable accommodations for medical treatment. The Rehab Act specifically prohibits discrimination on the basis of current illegal drug use for purposes of programs and activities providing health services if the individual is otherwise entitled to such services.[143]

An individual with a disability is otherwise qualified for a program, service, or activity "who is able to meet all of a program's requirements in spite of his [disability]."[144] The DOJ's regulations reinforce this holding by articulating that an otherwise qualified individual is one "who meets the essential eligibility requirements [with respect to any DOJ program, service, or activity] and who can achieve the purpose of the program or activity" without "fundamental alteration[s]."[145] The ADA and Rehab Act apply to correctional facilities,[146] and this guarantee of indiscriminate service includes medical care provided to the incarcerated population.[147]

There appears to be a circuit split as to whether an individual can bring a claim for reasonable accommodation for medical services, where the medical services

[139] Elizabeth O'Connor Tomlinson, 152 AM. JUR. TRIALS, *Litigation of Prisoners' Access to Medical Care* § 9, Westlaw (database updated 2021) (noting courts consider claims made under both statutes identically, unless "subtle distinctions" are pertinent to case).

[140] 28 C.F.R. § 39.103 (2021); *see also* 29 U.S.C. § 705(9)(B) (defining disability under Rehab Act by "the meaning given it in [the ADA]"). The determination about whether an impairment substantially limits a major life activity is made without regard to the effect of medication or other ameliorating measures. *See* 42 U.S.C. § 12102(4)(E)(i).

[141] 29 U.S.C. § 705(20)(C)(i).

[142] *Id.* § 705(20)(C)(ii) (noting individuals not excluded who use drugs under supervision by licensed health care professional or for other uses authorized by law).

[143] *See id.* § 705(20)(C)(iii).

[144] Se. Cmty. Coll. v. Davis, 442 U.S. 397, 406 (1979).

[145] 28 C.F.R. § 39.103.

[146] *See* Pierce v. Cnty. of Orange, 526 F.3d 1190, 1214 (9th Cir. 2008).

[147] *See* Pa. Dep't of Corr. v. Yeskey, 524 U.S. 206, 210 (1998) ("Modern prisons provide inmates with . . . medical 'services,' . . . which at least theoretically 'benefit' the prisoners (and any of which disabled prisoners could be 'excluded from participation in')." (quoting 42 U.S.C. § 12132)); *see also* Clark v. California, 739 F. Supp. 2d 1168, 1230 (N.D. Cal. 2010) ("Daily living activities, including . . . the receipt of medication, constitute 'services, programs, or activities' under the ADA and [Rehab Act].").

would be for the disabling condition itself.[148] Second, Seventh, and Tenth Circuit cases suggest an individual cannot bring such a claim; in this view, they are not "otherwise qualified" because they would not be eligible for the medical services absent the disability.[149] However, these cases invoke the disavowed idea that a person with a disability can only demonstrate discrimination through comparison to a person without a disability,[150] and they predate the Supreme Court's important decision in *United States v. Georgia*.[151]

In *Georgia*, a paraplegic prison inmate alleged disability discrimination based on the state prison's deliberate refusal to accommodate his disability-related needs.[152] The Court said that "it is quite plausible that the alleged deliberate refusal of prison officials to accommodate [plaintiff's] disability-related needs in such fundamentals as . . . medical care . . . constituted [an ADA violation]."[153] However, the issue was whether the plaintiff's claims under Title II of the ADA against the state prison could abrogate state sovereign immunity. The Court held that abrogation of state sovereign immunity was valid, because the Title II claims alleged deliberate indifference to accommodate the plaintiff and would independently violate the Eighth Amendment, as incorporated against the states by the Fourteenth Amendment.[154] However, the Court also noted in dicta that the plaintiff could potentially assert Title II claims "premised on conduct that does *not* independently violate the Fourteenth Amendment" by

[148] *See* Bilal v. N.Y. City Dep't of Corr., No. 08-cv-06664, 2010 WL 1875731, at *5 (S.D.N.Y. May 10, 2010) (comparing First Circuit's approach to Seventh and Tenth Circuits' approach on this issue, and noting that "[t]here appears to be a split in authority on this question").

[149] *See, e.g.*, Grzan v. Charter Hosp. of Nw. Ind., 104 F.3d 116, 120 (7th Cir. 1997) ("An otherwise qualified person is one who is able to meet all of a program's requirements *in spite* of [her] handicap." (quoting Se. Cmty. Coll. v. Davis, 442 U.S. 397, 406 (1979))); Johnson v. Thompson, 971 F.2d 1487, 1493-94 (10th Cir. 1992) (finding no Rehab Act claim where plaintiff "would not need the medical treatment" in absence of disability); United States v. Univ. Hosp., 729 F.2d 144, 156 (2d Cir. 1984) ("[S]ection 504 prohibits discrimination against a handicapped individual only where the individual's handicap is unrelated to, and thus improper to consideration of, the services in question . . . [W]here medical treatment is at issue, it is typically the handicap itself that gives rise to, or at least contributes to, the need for services.").

[150] *See* Olmstead v. L.C., 527 U.S. 581, 598 n.10 (1999) (stating plaintiff can demonstrate disability discrimination under ADA through comparison to other members of protected class or non-handicapped individuals); *e.g.*, *Grzan*, 104 F.3d at 121-22 ("We agree with *Johnson* and *University Hospital* that section 504 is ill suited for bringing claims of discriminatory medical treatment against a facility when the plaintiff is comparing her treatment (medical or non-medical) to the treatment afforded other handicapped individuals.").

[151] 546 U.S. 151, 151 (2006).

[152] *See id.* at 153-55.

[153] *Id.* at 157.

[154] *See id.* at 159-60 (remanding for plaintiff to amend complaint and create more substantial factual record to determine whether State violated ADA).

rising to the Eighth Amendment's deliberate indifference standard.[155] Although abrogation of state sovereign immunity is not at issue when challenging BOP practices, *Georgia* is important because the Court explicitly voiced that an ADA violation may be based on discrimination in a prison's medical care.[156]

In *Kiman v. New Hampshire Department of Corrections*,[157] the First Circuit took a different approach from the aforementioned circuits and cited *Georgia* to reach its conclusion.[158] In *Kiman*, a former state inmate alleged that prison officials had violated the ADA by failing to properly treat his amyotrophic lateral sclerosis or provide reasonable accommodations for his disability.[159] The First Circuit found there was a triable issue of fact as to the ADA claim where the prison officials failed to provide prescription medication on a regular basis, suggesting the denial of medical services or medication may constitute a plausible legal claim for discrimination.[160]

Thus, *Kiman* likely demonstrates that failure to provide medical care post-*Georgia* is a legitimate basis for a disability claim under the ADA.[161] Accordingly, a prisoner bringing a reasonable accommodation claim based on medical services to treat the prisoner's underlying disability should be "otherwise qualified" for such services. Because "[a]ccess to prescription medications is part of a prison's medical services," it is a service covered by the ADA.[162]

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[155] *Id.* at 159; *see id.* at 161 (Stevens, J., concurring) ("[T]he history of mistreatment leading to Congress' decision to extend Title II's protections to prison inmates was not limited to violations of the Eighth Amendment."). For an argument that the failure to provide MAT violates inmates' Eighth Amendment rights, see Linden et al., *supra* note 40.

[156] *See Georgia*, 546 U.S. at 157.

[157] 451 F.3d 274 (1st Cir. 2006).

[158] *See id.* at 284 (citing *Georgia*, 546 U.S. at 157).

[159] *See id.* at 276.

[160] *Id.* at 286-87.

[161] However, the circuit split has not been affirmatively resolved and deserves more attention beyond the scope of this Note. Although it has been recognized that *Olmstead v. L.C.*, 527 U.S. 581 (1999), abrogates *Grzan v. Charter Hospital of Northwestern Indiana*, 104 F.3d 116 (7th Cir. 1997), *see* Amundson v. Wis. Dep't of Health Servs., 721 F.3d 871, 874 (7th Cir. 2013) ("*Olmstead* indeed supersedes *Grzan* . . . ."), the other cited cases remain good law.

[162] *See Kiman*, 451 F.3d at 286-87; *see also* Lonergan v. Fla. Dep't of Corr., 623 F. App'x 990, 994 (11th Cir. 2015) (finding plaintiff pled prima facie ADA discrimination claim based on "failure of the prison to give the Plaintiff the treatment prescribed by his dermatologist"); McKissick v. Cnty. of York, No. 1:09-cv-01840, 2010 WL 1930132, at *7 (M.D. Pa. Mar. 19, 2010), *report and recommendation adopted*, No. 1:09-cv-01840, 2010 WL 1930144 (M.D. Pa. May 13, 2010) (finding plaintiff pled facts sufficient to survive motion to dismiss where plaintiff alleged corrections officers and prison medical officials denied access to his prescribed methadone for OUD, "which disrupted his ability to derive benefit from other life-preserving treatment" for other medical conditions).

An otherwise-qualified individual with a disability may be discriminated against in a number of ways,[163] including through intentional discrimination, disparate impact, and failure to make a reasonable accommodation.[164] An entity discriminates by failing to make a reasonable accommodation if they know of an individual's disability[165] and they fail to implement reasonable accommodations to their policies, practices, and procedures that otherwise deprive an individual of "meaningful access" to the program or activity.[166] For example, an individual may be deprived of meaningful access to prison medical services if they lack access to effective treatment, including if they are denied access to "the only form of treatment shown to be effective at managing [the individual's] disability."[167] An ADA or Rehab Act claim based on the failure to provide a reasonable medical accommodation must go beyond mere disagreement with a particular course of treatment or inadequate medical care but must demonstrate that the policy amounts to discrimination.[168] With regards to prescription medications, some courts have indicated that the complete denial of access to medications is not "a medical 'judgment' subject to differing opinion—it is an outright denial of medical services."[169]

[163] 28 C.F.R. § 39.130 (2021) (listing DOJ's prohibited practices, including "[d]eny[ing] a qualified handicapped person the opportunity to participate in or benefit from the aid, benefit, or service"); *see, e.g.*, Pierce v. Cnty. of Orange, 526 F.3d 1190, 1221 (9th Cir. 2008) ("[A]n inmate cannot be categorically excluded from a beneficial prison program based on his or her disability alone.").

[164] *See* Fulton v. Goord*,* 591 F.3d 37, 43 (2d Cir. 2009).

[165] *See Kiman*, 451 F.3d at 283 (stating ADA's reasonable accommodation rule requires that either plaintiff make request for accommodation or that their need for accommodation is obvious).

[166] Alexander v. Choate, 469 U.S. 287, 301 (1985) ("The benefit itself, of course, cannot be defined in a way that effectively denies otherwise qualified handicapped individuals the meaningful access to which they are entitled; to assure meaningful access, reasonable accommodations in the grantee's program or benefit may have to be made.").

[167] Smith v. Aroostook Cnty., 376 F. Supp. 3d 146, 160 (D. Me. 2019) (noting Suboxone was only form of treatment effective at managing plaintiff's OUD, and failure to accommodate Suboxone use therefore denies plaintiff meaningful access to medical services), *aff'd*, 922 F.3d 41 (1st Cir. 2019); *see also* Mitchell v. Williams, No. 6:15-cv-00093, 2016 WL 723038, at *4 (S.D. Ga. Feb. 22, 2016) (finding plaintiff's complaint under ADA not frivolous where plaintiff was denied medical treatment for Hepatitis C because of high costs, whereas inmates with less costly conditions received treatment).

[168] *See* Lonergan v. Fla. Dep't of Corr., 623 F. App'x 990, 994 (11th Cir. 2015) (recognizing plaintiff's claim based on failure to provide dermatologist-prescribed treatment constituted "more than the mere disagreement with his medical treatment" and was thus sufficient under ADA).

[169] *Kiman,* 451 F.3d at 287; *see also* McKissick v. Cnty. of York, No. 1:09-cv-01840, 2010 WL 1930132, at *7 (M.D. Pa. Mar. 19, 2010), *report and recommendation adopted*, No. 1:09-cv-01840, 2010 WL 1930144, at *1 (M.D. Pa. May 13, 2010) (finding plaintiff's allegations survived motion to dismiss where prison officials denied access to prescribed methadone to treat OUD and Kayexalate to treat rising potassium levels).

Lastly, discrimination may be based on an individual's disability if it rests on stereotypes about the disabled and is not based on "an individualized inquiry into the patient's condition."[170] *Pesce v. Coppinger*[171] highlights that per se rejections of treatment options may violate the ADA because they lack the requisite individualized analysis.[172] In *Pesce*, the plaintiff had achieved two years of recovery from his OUD using methadone and sought an injunction to continue this medication during incarceration at Essex County Jail. Prior to methadone, Pesce had unsuccessfully tried other treatment methods for his OUD,[173] and his physician warned that he was not yet ready to taper off of his medication.[174] The court found the jail's policy prohibiting opioids like buprenorphine and methadone precluded an individualized assessment or consideration of Pesce's specific medical needs.[175] Therefore, the court found Pesce was likely to succeed on the merits of his disability discrimination claim and granted a preliminary injunction allowing Pesce to continue MAT in jail.[176]

This is distinguishable from *Kiman*, where the court found defendants' decisions regarding Kiman's medical treatment did not violate the ADA because "prison medical staff sought [Kiman's] medical records" and "arranged an outside specialist consultation" before determining the "types of treatment and physical therapy that they thought were appropriate in his case."[177] Accordingly, prison officials did conduct an individualized assessment into Kiman's medical needs, and they had latitude to decide how to treat his conditions. Thus, both *Pesce* and *Kiman* highlight the need for an individualized assessment when a reasonable accommodation request pertains to medical services.

B. *Affirmative Defenses to a Rehab Act Claim*

A covered entity does not need to take any and all actions to accommodate individuals with disabilities. For example, a covered entity is required only to make accommodations that are reasonable, depending on the specific individual, context, and type of accommodation requested. Additionally, a covered entity

[170] *Kiman*, 451 F.3d at 285 (quoting Lesley v. Chie, 250 F.3d 47, 55 (1st Cir. 2001)).

[171] 355 F. Supp. 3d 35 (D. Mass. 2018).

[172] *See id.* at 47.

[173] *See id.* at 40-41.

[174] *See id.* at 41.

[175] *See id.* at 45 ("Defendants, in lieu of conducting an individualized assessment of Pesce's medical needs or his physician's recommendation, would require Pesce to participate in a treatment program that bares strong resemblance to the methods that failed Pesce for five years . . . .").

[176] *See id.* at 46 (distinguishing from *Kiman*, where there was individualized assessment of plaintiff's medical needs, to reach different conclusion).

[177] Kiman v. N.H. Dep't of Corr., 451 F.3d 274, 285 (1st Cir. 2006).

does not need to make changes that would cause a "fundamental alteration in the nature of a program or activity."[178]

Southeastern Community College v. Davis[179] first interpreted the Rehab Act and articulated an entity's obligation to modify policies, practices, or procedures through a reasonable accommodation.[180] *Davis* dealt with whether the Rehab Act's prohibition on discrimination against an otherwise qualified individual with a disability forbade a professional school from imposing physical qualifications for admission to its clinical training programs.[181] The Court found that, due to the nature of the respondent's disability, "nothing less than close, individual attention by a nursing instructor would be sufficient to ensure patient safety if respondent took part in the clinical phase of the nursing program."[182] Further, respondent's absence from the clinical program would require the College to implement vast curricular changes, with little benefit to respondent.[183] Accordingly, the Court held that "[s]uch a fundamental alteration in the nature of a program is far more than the 'modification' the regulation requires."[184]

Therefore, the Rehab Act's prohibition of disability discrimination against an otherwise qualified individual with a disability by a federally funded program does not extend to an individual who, in order to meet reasonable eligibility standards, needs program or policy modifications that would fundamentally alter the nature of the entity's program. Although institutions are still required to make reasonable accommodations based on an individualized inquiry,[185] drawing a line before changes cause fundamental alterations preserves the "balance between the statutory rights of the [individual with a disability] to be integrated into society and the legitimate interests of federal grantees in preserving the integrity of their programs."[186]

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[178] 28 C.F.R. § 39.150(a)(2) (2020); *see* Se. Cmty. Coll. v. Davis, 442 U.S. 397, 410 (1979) (finding plaintiff's requested accommodations for full-time supervision during patient visits and elimination of all clinical programs constituted fundamental alteration in nature of nursing program).

[179] 442 U.S. 397 (1979).

[180] *Id.*

[181] *Id.* at 400, 402.

[182] *Id.* at 409.

[183] *Id.*

[184] *Id.* at 410.

[185] For example, in *Harris v. Thigpen*, 941 F.2d 1495 (11th Cir. 1991), the plaintiff challenged a prison policy segregating HIV-positive prisoners from the general incarcerated population. The court found "the prison's choice of blanket segregation should [not] alone insulate the [Alabama Department of Corrections] from its affirmative obligation under the [ADA] to pursue and implement such alternative, reasonable accommodations as are possible for HIV-positive prisoners." *Id.* at 1527 (footnote omitted).

[186] Alexander v. Choate, 469 U.S. 287, 300 (1985).

A covered entity is also spared from making accommodations that would pose "undue financial and administrative burdens."[187] The entity must demonstrate the expected financial and administrative burdens render an accommodation unreasonable, rather than merely speculating about foreseeable challenges.[188]

Lastly, a covered entity does not need to make accommodations for an individual that poses a "direct threat" or "significant health and safety risks" to others, because an individual who poses a direct threat would not be otherwise-qualified for the service or activity.[189] This direct threat analysis must be individualized and grounded in current medical or other objective scientific knowledge, rather than generalizations or stereotypes about the disability.[190] In the prison context, prison administrators undoubtedly face "unique circumstances and challenges" that contribute to overall safety and security

[187] 28 C.F.R. § 39.150(a)(2) (2021); *see Alexander*, 469 U.S. at 308 (recognizing administrative costs associated with eliminating durational limitations on inpatient Medicaid coverage "would be far from minimal" and are "well beyond the accommodations that are required").

[188] *See* Disabled in Action v. Bd. of Elections in N.Y., 752 F.3d 189, 204 (2d Cir. 2014) ("Without more than conclusory claims that complying with the remedial order may be challenging, we are not persuaded that the accommodations will fundamentally alter [the Board of Elections'] voting program or impose an undue burden on its operation.").

[189] Sch. Bd. of Nassau Cnty. v. Arline, 480 U.S. 273, 289 (1987) (stating school teacher fired for susceptibility to Tuberculosis would not be "otherwise qualified" for activity under Rehab Act if they pose direct threat to others); *see also* 29 U.S.C. § 705(20)(D) (excluding individuals who constitute "direct threat to the health or safety of other individuals" by reason of contagious disease or infection from Rehab Act's coverage in employment context). The *Arline* Court articulated "basic factors" to determine whether the carrier of a contagious disease posed a direct threat:

> [Findings of] facts, based on reasonable medical judgments given the state of medical knowledge, about (a) the nature of the risk (how the disease is transmitted), (b) the duration of the risk (how long is the carrier infectious), (c) the severity of the risk (what is the potential harm to third parties) and (d) the probabilities the disease will be transmitted and will cause varying degrees of harm.

Arline, 480 U.S. at 288 (quoting Brief of the Am. Med. Ass'n as Amicus Curiae in Support of Petitioners at 19, *Arline*, 480 U.S. 273 (No. 85-1277), 1985 WL 669434, at *19).

[190] *See id.* at 287 (noting that individualized "inquiry is essential if [the Rehab Act] is to achieve its goal of protecting [individuals with disabilities] from deprivations based on prejudice, stereotypes, or unfounded fear."); *see also* Bragdon v. Abbott, 524 U.S. 624, 649 (1998) ("[P]etitioner had the duty to assess the risk of infection based on the objective, scientific information available to him and others in his profession. His belief that a significant risk existed, even if maintained in good faith, would not relieve him from liability."); Samuel R. Bagenstos, *The Americans with Disabilities Act as Risk Regulation*, 101 COLUM. L. REV. 1479, 1490 (2001) (positing "direct threat" doctrine arose in response to "tension between the imperative of public safety and the obligation to eliminate unfounded stereotypes [that] arises repeatedly in disability rights law").

considerations.[191] Pertinent security concerns include fear of drug diversion and prisoner safety.[192]

Because of these unique safety and security concerns, prison officials may infringe on prisoners' *constitutional* rights as long as the discriminatory policies are "reasonably related to legitimate penological interests" in safety and security.[193] *Turner v. Safley*[194] examined these circumstances to determine whether two prison policies infringing prisoners' constitutional rights were permissible or whether they represented an "exaggerated response to the claimed security objectives."[195] Although striking down a regulation infringing the fundamental right to marry, the Court upheld a regulation prohibiting correspondence between inmates that was logically connected to the prison's security concerns.[196] The Court deferred to prison officials' implementation of such a policy, paying particular attention to the balance between prisoners' rights and corresponding threats to the prison's core functions.[197]

Turner focused on constitutional rights, and the scope of statutory rights were not at issue. It is unclear whether *Turner*'s analysis for balancing legitimate penological interests applies to statutory rights like those under the Rehab Act in the same way as constitutional rights.[198] However, some courts have still considered variables from *Turner* in determining whether infringement of prisoners' statutory rights are permissible in furtherance of safety and security

[191] Havens v. Colo. Dep't of Corr., 897 F.3d 1250, 1269 n.11 (10th Cir. 2018).

[192] *See* Inmates of Allegheny Cnty. Jail v. Pierce, 612 F.2d 754, 761 (3d Cir. 1979) (recognizing jail's apparent security concerns about drug use within facility because "[t]he potential for jail or prison disruption caused by the presence of drugs is well-known"); Felice J. Freyer, *State Crime Bills Would Expand Inmates' Access to Addiction Treatment*, BOS. GLOBE (Nov. 20, 2017, 6:59 PM), https://www.bostonglobe.com/metro/2017/11/20/state-crime-bills-would-expand-inmates-access-addiction-treatment/7TI2SCOz5FNEZgmrEnIl2O/story.html%3e (describing concerns for MAT-recipient's well-being). Christopher Mitchell, assistant deputy commissioner of reentry for the Massachusetts Department of Correction, noted the value of buprenorphine and, consequentially, "it's causing people to be assaulted. It's causing people to have hits put on them. . . . People have to go into protective custody because of debts they've acquired. In a prison environment, whatever the contraband is, it's life and death." *Id.*

[193] Turner v. Safley, 482 U.S. 78, 89 (1987); *see also* Casey v. Lewis, 4 F.3d 1516, 1521 (9th Cir. 1993) (finding prohibition against HIV-positive inmates having contact visitation with attorneys was reasonably related to legitimate penological interests).

[194] 482 U.S. 78 (1987).

[195] *Id.* at 79, 98.

[196] *See id.* at 91.

[197] *See id.* at 92-93 (noting prison officials' decision "should not be lightly set aside by the courts" when "exercise of a right requires this kind of tradeoff" between rights and security).

[198] *Compare* Onishea v. Hopper, 171 F.3d 1289, 1300 (11th Cir. 1999) (en banc) ("*Turner* does not, by its terms, apply to statutory rights."), *with* Gates v. Rowland, 39 F.3d 1439, 1447 (9th Cir. 1994) (finding *Turner* "equally applicable to the statutory rights created by the [ADA]" in the prison context).

interests.[199] These variables include "security and cost"[200] and "maintaining . . . order[,] and operating an institution in a manageable fashion."[201]

At the very least, the direct threat analysis in the correctional facility context must identify "specific" security concerns that arise when an individual requests an accommodation.[202] This analysis cannot rely on past instances of concern, "generalizations or scientifically unsupported assumptions about MAT or persons who receive MAT for [OUD]."[203] Where there are no "medical or individualized security considerations underlying the decision to deny access to medically necessary treatment," a discriminatory policy is either "'arbitrary or capricious-as to imply that it was the pretext for some discriminatory motive' or 'discriminatory on its face.'"[204]

III. THE BOP'S CURRENT PRACTICES VIOLATE THE REHAB ACT

The Rehab Act applies to BOP because DOJ regulations expressly prohibit disability discrimination in programs or activities conducted by the DOJ.[205] Because there is uncertainty about the long-term plans for BOP's new MAT program, the precise contours of a Rehab Act claim are unclear.

BOP purports that its MAT program will provide MAT "based on individuals' needs" and as clinically determined by a health care professional,[206] presumably affording individualized assessments to incarcerated individuals with OUD. However, while BOP has provided naltrexone to all eligible incarcerated individuals in BOP institutions as of December 2019, its expansion to include methadone and buprenorphine is far too slow and underinclusive. The number of individuals receiving methadone and buprenorphine[207] still drastically trails

[199] Havens v. Colo. Dep't of Corr., 897 F.3d 1250, 1269 n.11 (10th Cir. 2018) ("[W]e believe that—at the very least—it is appropriate and prudent to take these variables into account in attempting to discern under [the Rehab Act] whether a prisoner's access to prison services and programs was meaningful and whether the prison reasonably accommodated the prisoner's disability.").

[200] *Onishea*, 171 F.3d at 1300.

[201] Castle v. Eurofresh, Inc., 731 F.3d 901, 911 (9th Cir. 2013).

[202] *See* Pesce v. Coppinger, 355 F. Supp. 3d 35, 46 (D. Mass. 2018) (finding defendants only "identified legitimate, but generalized, safety and security reasons for prohibiting the use of opioids in their facilities," but did not identify "specific security concerns relevant to Pesce's proposed methadone intake").

[203] Letter from Joon H. Kim to New York State Off. of the Att'y Gen., *supra* note 61, at 1.

[204] *Pesce*, 355 F. Supp. 3d at 47 (quoting Kiman v. N.H. Dep't of Corr., 451 F.3d 274, 284 (1st Cir. 2006)).

[205] 29 U.S.C. § 794(a) ("The head of each such agency shall promulgate such regulations as may be necessary . . . ."); *see also* 28 C.F.R. § 39.102 (2021) (applying Rehab Act to DOJ).

[206] IMPROVED PLANNING, *supra* note 47, at 9.

[207] *Id.* at 23 n.38 ("In fiscal year 2019, four inmates received methadone and six inmates received buprenorphine.").

the number of incarcerated individuals in need of this medication. Accordingly, BOP's current and foreseeable failure to provide reasonable accommodations for incarcerated individuals violates the Rehab Act.

Additionally, while BOP is taking steps to provide methadone and buprenorphine, it is uncertain who will be eligible to receive it. BOP officials expect these medications to be provided "on a case-by-case basis—generally, if an inmate is already receiving either medication upon entering BOP custody."[208] This limitation seems to be a practical response to the liability BOP has faced through its categorical denial of medical care, and, as of January 2020, BOP had not finalized draft clinical guidance for the MAT program. Accordingly, while the author is encouraged by BOP's policy shifts and its apparent recognition that OUD is a disease deserving of—and requiring—adequate medical care, litigators in this space may soon need to refocus their attention. Future advocacy must include the urgent need for BOP to provide MAT to *all* incarcerated individuals with OUD who want the treatment, regardless of whether they were previously prescribed MAT prior to incarceration.

A. *Challenging BOP Policies Under the Rehab Act*

Federally incarcerated individuals with OUD are clearly individuals with a disability under the Rehab Act.[209] As additional evidence, the aforementioned trial court cases and settlement agreements alleging discrimination against MAT users do not contest that the plaintiffs are qualified individuals under the ADA.[210] Although individuals are not covered on the basis of "psychoactive substance use disorders resulting from current illegal use of drugs,"[211] individuals fall within the Rehab Act's protection once they are no longer using illegal drugs.[212]

Incarcerated individuals who were not previously prescribed MAT will have to overcome the statutory hurdle to establish that they are not currently using illegal substances. The Rehab Act excludes from its protections only individuals

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[208] *Id.* at 23.

[209] *See* 28 C.F.R. § 36.105(b)(2) (2021) (defining physical or mental impairment to include "drug addiction"); Letter from Andrew E. Lelling to David Solet, *supra* note 70 ("Individuals in treatment for OUD [requiring MAT prior to confinement] are protected by the ADA."). OUD substantially limits several major life activities, including everyday activities and biological functions. *See* 42 U.S.C. § 12102(2)(A) (caring for oneself, learning, concentrating, thinking, communicating); *id.* § 12102(B) (operation of neurological and brain functions); *see also id.* § 12102(4)(D) ("An impairment that is . . . in remission is a disability if it would substantially limit a major life activity when active.").

[210] *See* Pesce v. Coppinger, 355 F. Supp. 3d 35, 45 (D. Mass. 2018) (recognizing parties did not dispute that plaintiff with OUD is "qualified individual[] with disabilities" under ADA (alteration in original)); U.S. Attorney Settles Disability Discrimination Allegation, *supra* note 107 ("Individuals receiving treatment for OUD are generally considered disabled under the ADA . . . .").

[211] 29 U.S.C. § 705(20)(F)(iii).

[212] *See supra* notes 141-42 and accompanying text.

who are currently using illegal substances "*when a covered entity acts on the basis of such use*."[213] Circuits differ as to how long a plaintiff must abstain from substance use to regain the protection of disability discrimination statutes—in other words, how much time is needed to believe that the plaintiff is no longer using illicit substances and is thus worthy, in the legislature's view, of statutory protection.[214]

It is worth considering the various options: (1) an individual may seek MAT immediately upon entering the facility, or (2) they may wait a period of time and seek MAT during the term of their incarceration. The first option would prevent the needless pain and suffering that results from forced withdrawal from substances. However, the individual may have a harder time establishing that they have "been rehabilitated successfully and [are] no longer engaging in such use."[215] An individual's progress toward achieving sobriety, if any, may suffice to show they have made efforts at drug rehabilitation,[216] but many individuals with OUD will likely use illicit substances up until the point of incarceration. For those individuals, the Rehab Act provides that, notwithstanding the exception for individuals currently engaging in illegal drug use, "an individual shall not be excluded from the benefits of such programs or activities [providing health services and services provided under Titles I, II, and III] on the basis of his or her current illegal use of drugs if he or she is otherwise entitled to such services."[217] Courts have not yet interpreted how this provision will apply when individuals with OUD seek medical care.[218]

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[213] 29 U.S.C. § 705(20)(C)(i) (emphasis added); *cf.* A.B. *ex rel.* Kehoe v. Hous. Auth. of S. Bend, No. 3:11-cv-00163, 2012 WL 1877740, at *5 (N.D. Ind. May 18, 2012) (finding that tenant "was not disabled at the time [the housing authority] sent the eviction notice" because eviction notice was sent *because of* tenant's cocaine use).

[214] *See, e.g.*, Mauerhan v. Wagner Corp., 649 F.3d 1180, 1188-89 (10th Cir. 2011) (finding one month of abstention insufficient); Brown v. Lucky Stores, Inc., 246 F.3d 1182, 1186 (9th Cir. 2001) (requiring abstention from drugs for "a significant period of time"); United States v. S. Mgmt. Corp., 955 F.2d 914, 919 (4th Cir. 1992) (finding one year of abstention sufficient).

[215] 29 U.S.C. § 705(20)(C)(ii)(I).

[216] *See Kehoe*, 2012 WL 1877740, at *4 ("The point is that it is perfectly permissible for an entity—an employer, a public housing authority etc.—to take an adverse action against someone who is caught using drugs. But what an entity cannot do is discriminate against someone for *past* drug use or *for their efforts at drug rehabilitation*." (second emphasis added)).

[217] 29 U.S.C. § 705(20)(C)(iii).

[218] The ADA does say someone currently using drugs illegally is not considered an "individual with a disability"—that term generally applies to a person in recovery—but the law also says that even current users cannot be denied health care. But much of how the ADA applies in these situations is open to interpretation and has not been tested in the courts.

Beth Schwartzapfel, *How the Americans with Disabilities Act Could Change the Way the Nation's Jails and Prisons Treat Addiction*, ABA J. (Feb. 8, 2019, 6:30 AM),

Incarcerated individuals with OUD are otherwise qualified for medical services, including prescription medication.[219] Although the existing circuit split may lead to different outcomes,[220] the First Circuit's approach in *Kiman* suggests an individual with OUD can bring a Rehab Act claim when they are denied medical treatment for their disability.[221] This need is particularly acute when an individual with OUD is completely denied access to prescription medications they otherwise would have received in the community,[222] and when MAT has been shown to be the only effective treatment method.[223] An incarcerated individual's MAT prescription should be treated like other prescription medications in a correctional facility[224]: "If they're sick with kidney or heart disease, we give them the treatment and medication. If they're sick with addiction, we should give them the treatment and medication for that."[225] Just like other inmates receive necessary treatment for their medical conditions, eligible incarcerated individuals with OUD should receive MAT as a reasonable accommodation during their incarceration, regardless of their treatment status prior to incarceration.

However, BOP precludes "meaningful access" to a prison's medical services when it fails to conduct an individualized inquiry into a reasonable accommodation to provide MAT.[226] For individuals who were previously prescribed MAT, BOP becomes aware of their disability upon intake into the prison at which time BOP learns about the individual's prescription medications.[227] Although BOP does allow MAT prescription for short-term

https://www.abajournal.com/news/article/how_the_ada_could_change_jails_prisons_addiction_treatment [https://perma.cc/GM37-CDN8].

[219] *See* Pa. Dep't of Corr. v. Yeskey, 524 U.S. 206, 210 (1998); Kiman v. N.H. Dep't of Corr., 451 F.3d 274, 286-87 (1st Cir. 2006).

[220] *See supra* notes 148-49 and accompanying text.

[221] *See supra* notes 157-62 and accompanying text.

[222] *See Kiman*, 451 F.3d at 286-87. *But see* George v. Cnty. of Jefferson, No. 2:10-cv-03389, 2013 WL 5519509, at *10 (N.D. Ala. Sept. 30, 2013) (distinguishing from *Kiman* where plaintiff "received medications during his incarceration and medication services while on detoxification regimen").

[223] *See* Smith v. Aroostook Cnty., 376 F. Supp. 3d 146, 160 (D. Me. 2019), *aff'd*, 922 F.3d 41 (1st Cir. 2019). The increasing body of scientific evidence that MAT is an effective treatment method renders this a relevant concern for individuals who have not previously been prescribed MAT, as well.

[224] *See* Freyer, *supra* note 192 (describing statement by Maryanne Frangules, executive director of advocacy group Massachusetts Organization for Addiction Recovery: "You wouldn't stop insulin if somebody had diabetes").

[225] Becker, *supra* note 88 (quoting statements by Franklin County Sheriff Christopher J. Donelan). Franklin County Jail was the first jail in Massachusetts to provide buprenorphine as a treatment method for OUD. *See id.*

[226] *Smith*, 376 F. Supp. 3d at 160.

[227] *See* IMPROVED PLANNING, *supra* note 47, at 6 (describing Psychology Services Intake Questionnaire to determine incarcerated individuals' "potential drug treatment and mental health needs").

detoxification,[228] BOP's policies largely deny medication for long-term treatment of OUD for nonpregnant individuals.[229] These individuals would otherwise be able to receive long-term MAT treatment in the community, and this may be the only effective treatment method for their OUD.[230] A request for a reasonable accommodation to receive MAT while incarcerated does not suggest mere disagreement with BOP's substance treatment programs; it challenges the complete denial of this scientifically proven treatment method for incarcerated individuals.[231] This is especially crucial for incarcerated individuals, like the plaintiff in *Pesce*, who have previously tried, unsuccessfully, other treatment methods for their OUD.[232] For other incarcerated individuals, it is crucial to provide meaningful access to BOP's medical services in order to intervene in the cycle of relapse, recidivism, and overdose death.[233]

BOP's policies discriminate on the basis of an incarcerated individual's OUD because, while other individuals are provided necessary medical care, those who suffer from OUD potentially lack any opportunity to treat their disease while incarcerated, and BOP fails to make an individualized assessment into whether an accommodation to provide MAT is reasonable.[234] This need for individualized assessment applies to whether MAT is allowed, the proper dosage, the duration of treatment, the types of medication, and other factors inherent in a complicated medical decision. BOP's failure to conduct an individualized inquiry precludes individual consideration of an inmate's specific medical needs[235] and indicates that BOP likely bases this policy decision on stereotypes about MAT and individuals with OUD. As such, BOP's policy—without an individualized assessment for all incarcerated individuals with OUD—constitutes discrimination on the basis of disability.[236]

B. *Affirmative Defenses to Rehab Act Claim Do Not Justify BOP Policies*

BOP's progress toward a MAT program demonstrates that reasonable accommodations are feasible. However, the slow rollout of BOP's MAT

[228] *See* PATIENT CARE, *supra* note 72, at 24-25.

[229] *See supra* notes 70-76 and accompanying text.

[230] *See Smith*, 376 F. Supp. 3d at 160.

[231] *See* Kiman v. N.H. Dep't of Corr., 451 F.3d 274, 287 (1st Cir. 2006).

[232] *See* Pesce v. Coppinger, 355 F. Supp. 3d 35, 45 (D. Mass. 2018).

[233] *See, e.g.*, *id.* (remarking that plaintiff's doctor "explained that Pesce risks severe physical and mental illness, relapse into opioid addiction and death if he is denied access to methadone and subjected to Defendants' treatment program").

[234] *See Kiman*, 451 F.3d at 284-85 ("[A] plaintiff may argue that her physician's decision was discriminatory on its face, because it rested on stereotypes of the disabled . . . ." (quoting Lesley v. Chie, 250 F.3d 47, 55 (1st Cir. 2001)).

[235] See *Smith*, 376 F. Supp. 3d. at 159-60.

[236] See *id.* ("The Defendants' out-of-hand, unjustified denial of the Plaintiff's request for her prescribed, necessary medication—and the general practice that precipitated that denial—is so unreasonable as to raise an inference that the Defendants denied the Plaintiff's request because of her disability.").

program and its uncertain future mean that BOP's current practices continue to categorically deny MAT to incarcerated individuals. BOP must also expand the scope of its individualized assessments to include individuals who were not previously prescribed MAT prior to incarceration to avoid future disability discrimination litigation.

An accommodation to provide MAT to incarcerated individuals would not cause a fundamental alteration to BOP medical services. One of the most common reasons that correctional facilities do not provide MAT is preference for "drug-free treatment."[237] However, BOP's policy requiring MAT for pregnant incarcerated individuals, allowing facilities to provide MAT for detoxification, and its plans to provide MAT for longer-term treatment demonstrate that drug-free treatment is not a core aspect of BOP's program. Further, the requisite individualized inquiry into whether an accommodation is reasonable tends to screen out cases where the requested accommodation would fundamentally alter the nature of the prison program.[238] Therefore, accommodations to allow MAT treatment in BOP correctional facilities would not fundamentally alter the nature of BOP's programs or services. To the contrary, such treatment would actually advance BOP's purposed policy goals to promote rehabilitation and reentry into the community.[239]

Additionally, an accommodation to provide MAT to incarcerated individuals would not cause an undue financial or administrative burden. MAT is a cost-efficient method to treat OUD.[240] This treatment method also reduces

[237] Friedmann et al., *supra* note 82, at 12. Preference for drug-free treatment varies by agency type; prisons tended to cite a preference for drug-free treatment as a greater factor in their decisions to use MAT than drug courts, jails, and probation or parole agencies. *See id.*

[238] *See Smith*, 376 F. Supp. 3d at 161 n.19 ("All that is before me is the request to ensure MAT access for Ms. Smith, an individual who has successfully managed her opioid use disorder with MAT for the last decade."). For example, the individualized inquiry will look different for an incarcerated individual who was on MAT for ten years, compared to someone who started two weeks prior to incarceration, or for someone who was previously prescribed MAT, compared to someone who would be introduced to MAT in prison.

[239] *See supra* notes 116-17 and accompanying text; *see also* Letter from William P. Barr, Att'y Gen., Off. of Att'y Gen., *in* U.S. DOJ, THE FIRST STEP ACT OF 2018: RISK AND NEEDS ASSESSMENT SYSTEM iv, v (July 19, 2019), https://www.bop.gov/inmates/fsa/docs/the-first-step-act-of-2018-risk-and-needs-assessment-system.pdf [https://perma.cc/6H93-KWJP] ("Our communities are safer when we do a better job of rehabilitating offenders in [DOJ] custody and preparing them for a successful transition to life after incarceration. The [DOJ] remains committed to this important aim and will continue to work to make America's communities safer.").

[240] *See* Emanuel Krebs, Darren Urada, Elizabeth Evans, David Huang, Yih-Ing Hser & Bohdan Nosyk, *The Costs of Crime During and After Publicly Funded Treatment for Opioid Use Disorders: A Population-Level Study for the State of California*, 112 ADDICTION 838, 846 (2016) (finding that methadone or buprenorphine treatment for individuals involved in criminal justice system saved nearly $18,000 per person over six months, compared to detoxification alone). BOP estimates that its new MAT program "costs about $500 per month

recidivism, which will lead to reduced prison populations and costs associated with incarceration.[241] Programs with a smaller number of inmates receiving MAT will have higher per-patient costs.[242] However, BOP has a large number of federal inmates who will qualify for reasonable accommodations, which is already motivating large-scale policy changes to ensure staff training, proper medication storage, and a streamlined process. Additionally, BOP's approved uses of methadone suggest there are likely policies and procedures already in place to guarantee its safe storage and registration requirements,[243] and BOP is taking steps to further streamline its procedures to dispense MAT. BOP's MAT program is possible in part because of recent legislative and policy initiatives that provide funds to implement MAT programs.[244] The continuing availability of these funds moving forward will alleviate any short-term financial burden for BOP to implement the policies and practices to provide MAT to all incarcerated individuals with OUD. Overall, while providing MAT will involve an upfront investment, this necessary shift will pay off in the long run as recidivism decreases and widespread policies become more normalized.

Lastly, incarcerated individuals do not pose a sufficient direct threat to safety and security that would justify this failure to make a reasonable accommodation. One of the biggest counterarguments in response to MAT is fear of diversion—passing on prescription medication to other individuals—within the correctional facility.[245] However, this fear underlying BOP's prohibitory policy is not

for an inmate to receive medication, therapy, and urinalysis screening at an opioid treatment program." IMPROVED PLANNING, *supra* note 47, at 24. BOP officials also estimate needing $76.2 million across fiscal years 2020 and 2021. *See id.* at 27. For a comparison, between fiscal years 2015 through 2019, BOP spent an average of $116.9 million per year on its other drug education and treatment programs. *Id.* at 24.

[241] *See* Bone et al., *supra* note 120, at 269 (stating that agonist therapy returns $12-14 for every $1 spent); Rebecca Boucher, Note, *The Case for Methadone Maintenance Treatment in Prisons*, 27 VT. L. REV. 453, 458 (2003) (noting in 2003, methadone treatment cost about $4,000 per person each year, whereas prison incarceration on average cost $22,279 each year).

[242] *See* Brady P. Horn, Xiaoxue Li, Saleh Mamun, Barbara McCrady & Michael T. French, *The Economic Costs of Jail-Based Methadone Maintenance Treatment*, 44 AM. J. DRUG & ALCOHOL ABUSE 611, 614 (2018) (studying methadone program in 39th largest jail in U.S., where weekly economic cost per client of methadone treatment was $115). Although BOP facilities would likely have a smaller per-patient cost, this reduction would be offset by the longer incarcerations in federal facilities.

[243] BOP is supposedly pursuing certification to provide MAT in its facilities. *See* IMPROVED PLANNING, *supra* note 47, at 30 n.50.

[244] *See* Letter from William P. Barr, *supra* note 239 ("I directed that existing resources [in BOP] be reallocated in FY2019 to . . . increase the availability of Medication Assisted Treatment . . . ."); *see also* CREATE Opportunities Act, S. 1983, 116th Cong. § 2(c) (2019) (proposing federal grants to: (1) develop MAT programs, (2) reduce the risk of overdose to participants after release from incarceration, and (3) reduce rate of reincarceration). BOP "plan[s] to use $37.1 million in appropriated funds that BOP received to implement the First Step Act of 2018 (First Step Act) on MAT program expansion efforts during fiscal year 2020." *See* IMPROVED PLANNING, *supra* note 47, at 27-28.

[245] *See* Bruce & Schleifer, *supra* note 40, at 18.

realistic and is often based on stereotypes about MAT and those with substance use disorder. For example, in *Cudnik v. Kreiger*,[246] an illicit market for methadone in the jail was "at best highly remote" because the jail administered methadone according to strict regulations and in liquid form, under the supervision of a licensed clinician.[247] Additionally, the plaintiff's request in *Smith v. Aroostook County*[248] to continue MAT during her incarceration "was not unreasonable, as evidenced by the fact that the Defendants previously provided the same accommodation to a pregnant inmate without issue and by the Defendants' acknowledgement that they could grant the requested exemption in a way that would obviate any security concerns."[249] Additionally, correctional facilities around the country demonstrate that MAT treatment programs are feasible without significant safety concerns.[250]

BOP provides MAT to pregnant incarcerated individuals and for extended periods to treat severe pain, and now to treat certain incarcerated individuals with OUD. These medications may be stored in bulk with other controlled substances,[251] or incarcerated individuals may continue to be driven outside of the correctional facility to receive MAT. As such, proper security measures will prevent the diversion of prescription medications.[252] Even where there are legitimate concerns, assessment of risks undercutting an accommodation request

[246] 392 F. Supp. 305 (N.D. Ohio 1974).

[247] *Id.* at 312 (reasoning that there are other ways for jail to ensure safety besides just prohibiting methadone).

[248] 376 F. Supp. 3d 146 (D. Me. 2019), *aff'd*, 922 F.3d 41 (1st Cir. 2019).

[249] *Id.* at 160-61; *see also* Pesce v. Coppinger, 355 F. Supp. 3d 35, 46 (D. Mass. 2018) ("Defendants have not explained why they cannot safely and securely administer prescription methadone in liquid form to Pesce under the supervision of medical staff, especially given that this is a common practice in institutions across the United States and in two facilities in Massachusetts."). In fact, one study found that 70% of surveyed sites that did not currently provide MAT indicated it would be possible to introduce methadone and buprenorphine if there were available evidence that MAT improved criminal justice outcomes, and 63% of sites that already provided MAT said they would consider expanding their methadone, buprenorphine, or naltrexone programs if they had such evidence. *See* Friedmann et al., *supra* note 82, at 14. These statistics demonstrate that implementing a MAT program is feasible and that the real hostility towards a MAT program likely stems from misperceptions about MAT.

[250] *See* notes 85-91 and accompanying text. "'The process we do [in Franklin County Jail], it's almost impossible [to divert MAT],' [one inmate] says. 'There's no way. I mean if you attempt it you're just dumb.'" Becker, *supra* note 88. Although this example comes from a state jail, it indicates that initial assumptions about the risk of diversion and other safety concerns are not always accurate.

[251] *See* PHARMACY SERVICES, *supra* note 71, at 39.

[252] *See* Bruce & Schleifer, *supra* note 40, at 20 (stating that correctional settings should be the easiest in which to implement methadone treatment "[b]ecause correctional systems are already well designed to offer the security surrounding storage of opioids, such as methadone, and the supervision regarding dosing").

must be made on an individualized basis for all incarcerated individuals affected by this disease.[253]

CONCLUSION

BOP's violation of the Rehab Act directly conflicts with the DOJ's stated initiative to combat discriminatory barriers to treatment for OUD.[254] BOP's discriminatory barriers to treatment "[u]nlawfully deny[] services to individuals with disabilities because of their medical conditions" and "subject[] these individuals to unwarranted stigma and harm."[255] Although Assistant Attorney General Eric Dreiband said these discriminatory barriers "will not be tolerated by the Department of Justice,"[256] DOJ's complicity in discriminatory practices against federally incarcerated individuals with OUD suggests otherwise.

Even with BOP's new MAT program in the works, the legal community should effectuate the purpose underlying the Rehab Act by recognizing widespread disability discrimination against incarcerated individuals with OUD. Many state and local correctional institutions still prohibit MAT as a matter of policy. Additionally, the future of BOP's MAT program is uncertain. It is unclear who will receive MAT under BOP's new MAT program and when they will receive it. If the legal community does not enforce the Rehab Act in this context, we also run the risk that BOP may, at some point in the future, walk back its policies and practices with changing leadership. Fortunately, for now, it appears that BOP is in the process of applying for and receiving certification to dispense MAT at its facilities,[257] although correctional facilities may take several possible routes to provide MAT that differ in the level of planning and licensing requirements.[258]

The failure to provide MAT to incarcerated individuals is disability discrimination. It is also a criminal justice issue, a public health issue, and a racial justice issue. If BOP truly serves a rehabilitative purpose, as purported by its policies, its failure to provide MAT to incarcerated individuals with OUD is far from ideal. Rather, the limited availability of MAT threatens incarcerated individuals' ability to maintain recovery during incarceration and build

[253] For example, the risk of diversion and safety concerns vary based on the type of correctional facility, type of MAT at issue, and specific makeup of the prison population. BOP operates prisons at four levels of security, and they vary in size and other factors. *See* U.S. PERFORMANCE BUDGET, *supra* note 29, at 4. Accordingly, each level and prison poses its own unique circumstances to consider when making reasonable accommodations.

[254] *See* notes 41, 70, 106-08 and accompanying text.

[255] Justice Department Reaches Settlement with Selma, *supra* note 107 (quoting Assistant Attorney General Eric Dreiband).

[256] *Id.*

[257] IMPROVED PLANNING, *supra* note 47, at 30 n.50.

[258] *See* NAT'L COMM'N ON CORR. HEALTH CARE, *supra* note 58 (listing various means for correctional facilities to provide incarcerated individuals with access to MAT). BOP facilities that provide MAT to pregnant incarcerated individuals or to detoxing individuals likely adhere to various registration requirements already.

necessary life skills to maintain post-release recovery. Current substance treatment options in federal prisons fail BOP's mandate to prepare individuals for release by precluding the use of medically effective pharmacological treatment without an individualized assessment.

As we address the effects of the war on drugs, it is especially important to account for the drastically disproportionate burden borne by communities and individuals of color throughout the history of drug use prosecutions. Otherwise, any policy to address the opioid epidemic will continue to marginalize those whose suffering is compounded by other forms of oppression and discrimination. Thus, "the problem of race and opioids cannot stop with expansion of access to treatment."[259] Any policies that only provide reasonable accommodations for individuals who were previously prescribed MAT before incarceration will likely exclude people of color who already face barriers to recovery. Outside of correctional facilities, policymakers can only effectively address the opioid epidemic by considering the ways in which culture, resources, stigma, and interactions with other systems, such as the criminal justice system, affect an individual's experiences with OUD and the pathways to recovery that are available to them.[260]

Any and all improvements to the treatment of incarcerated individuals with OUD are crucial. The author hopes that lawyers and courts will continue to pressure BOP to effectuate policy changes by recognizing the failure to provide MAT as the disability discrimination it is. From there, advocacy must continue to address the vulnerabilities and needs of all individuals with OUD in light of the disproportionate criminalization of people of color for drug offenses, the inequitable access to community-based treatment, and the history of racialized responses to drug crises in this country. The only way to meaningfully address the opioid crisis is to reach those most in need and to specifically account for the multitude of ways substance use disorder is treated differently depending on one's identity, resources, and location. By addressing OUD in correctional facilities, policymakers have the opportunity to reach those who are most physically isolated from community-based treatment and who disproportionately come from underresourced communities. We must urgently

[259] Netherland & Hansen, *supra* note 26, at 680 (recognizing need for advocates to address institutional racism embedded in media coverage of opioid epidemic in order to dismantle racial exclusions in drug interventions).

[260] For arguments that policymakers must provide culturally competent support to address the opioid epidemic, see James & Jordan, *supra* note 23, at 404, which recognizes the need for "culturally targeted programs to benefit Black communities in the opioid crisis. Such programs include the use of faith-based organizations to deliver substance use prevention and treatment services, the inclusion of racial impact assessments in the implementation of drug policy proposals, and the formal consideration of Black people's interaction with the criminal justice system in designing treatment options." *See also* Drake et al., *supra* note 26, at 1 (recognizing current "intervention strategies and policies have failed, both, to assess the severity of the problem in minority communities and to offer culturally sensitive preventative and treatment solutions").

shift perspectives and responses before the death toll continues to climb, leaving in its wake the memory of those whom this country's institutions, laws, and policies have failed.