UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF NEW YORK

P.G.,

Plaintiff,

v.

JEFFERSON COUNTY, NEW YORK; COLLEEN M. O'NEILL, as the Sheriff of Jefferson County, New York; BRIAN R. MCDERMOTT, as the Undersheriff of Jefferson County, New York; and MARK WILSON, as the Facility Administrator of the Jefferson County Correctional Facility,

Defendants.

Case No. 5:21-cv-388 (DNH/ML)

MEMORANDUM OF LAW IN SUPPORT OF PLAINTIFF'S MOTION FOR A PRELIMINARY INJUNCTION

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Dated: April 29, 2021
New York, New York

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PRELIMINARY STATEMENT

After a crushing 16-year battle, P.G. is finally sustaining active recovery from opioid addiction for the first time since he was 19 years old. This remarkable turning point in his life—one that eludes so many—has been possible only through the daily methadone therapy prescribed by his physician. Clinically, there is no question that methadone is essential to P.G.'s continued recovery. And P.G., still in the fight for his life, seeks to continue this basic medical treatment while detained at the Jefferson County Correctional Facility.

P.G. faces imminent arrest and detention at the jail. Without intervention by this Court, jail officials will strip P.G. of his life-sustaining treatment under a blanket methadone ban that disregards sound medicine, including broad consensus in the scientific community and the express judgment of his treating physician. The effects on P.G. of sudden, forcible withdrawal from methadone cannot be overstated. They will be immediate. They will be excruciating. And they will expose him to a substantial risk of death—the same tragic fate that meets one person every 8.5 minutes in this country.

Before filing this motion, P.G. sought assurance that the County would not interrupt his essential medical treatment while detaining him. But despite routinely affording pregnant people at the jail *precisely the same* access to methadone therapy, the County has refused to confirm it will not deny continued methadone treatment to P.G. Accordingly, P.G. now moves the Court for preliminary relief enjoining the jail from enforcing its blanket methadone ban against him until the Court has assessed the ban's lawfulness.

FACTS

I. MOUD, Including Methadone, Is the Standard of Care for OUD.

The opioid epidemic is a national health crisis. Decl. of Richard N. Rosenthal, M.D. ("Rosenthal Decl.") ¶ 18. It has claimed more than 65,000 lives in the past year alone, including

those of 2,398 New Yorkers. *Id.* ¶ 22; *Provisional Drug Overdose Death Counts*, CTRS. FOR DISEASE CONTROL & PREVENTION (Feb. 7, 2021), https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm (last accessed Apr. 26, 2021). The rate of death from opioids has accelerated rapidly during the coronavirus pandemic. Rosenthal Decl. ¶ 22. Today, one person dies of opioid overdose every 8.5 minutes in this country. *Id.*

Opioid use disorder ("OUD") is a chronic brain disease characterized by compulsive use of opioids despite negative—often horrific—consequences. *Id.* ¶¶ 10, 14. OUD permanently rewires the brain for addiction so that people with OUD cannot "will" or "reason" their way out of continued opioid use. *See id.* ¶¶ 12–15. OUD is especially unresponsive to the abstinence-only and twelve-step programs that are popular in treating other addictions. *Id.* ¶ 28.

The standard of care for OUD is treatment with agonist medications[1] for OUD ("MOUD"), such as methadone and buprenorphine. *Id.* ¶ 26. There is broad consensus in the medical community that MOUD is clinically necessary to treat OUD. *See id.* ¶¶ 27, 30, 34. Treatment with MOUD is necessarily individualized. *Id.* ¶ 33. An MOUD that effectively treats one patient may be completely ineffective, and thus dangerous, for another. *Id.* As with treatment for other chronic conditions, such as insulin for diabetes, treatment with MOUD can require years or a lifetime; There is no maximum recommended duration for treatment with an MOUD. *See MAT Medications, Counseling, and Related Conditions*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions (last updated Aug. 19, 2020).

[1] An agonist medication activates opioid receptors in the brain to relieve withdrawal symptoms and control cravings.

Ending MOUD treatment prematurely is exceptionally dangerous. Rosenthal Decl. ¶¶ 35–36, 42. It triggers excruciating withdrawal symptoms that markedly increase the risk of relapse, overdose, and death. *Id.* ¶¶ 38–41. Forcing a person with OUD to withdraw from effective MOUD treatment, absent significant adverse side effects or contraindications, violates the standard of care and medical ethics. *See id.* ¶¶ 35, 38, 45. And the risks associated with forced withdrawal are especially pronounced in jail settings. *Id.* ¶¶ 38–41. One study found that during the two weeks following their release from prison, formerly incarcerated people are 12,900% as likely as non-incarcerated people to overdose and die. *Id.* ¶ 40. Another found that forcibly removing people from MOUD during incarceration led to a seven-fold decrease in treatment retention following release. *Id.* ¶ 38. In contrast, people who receive MOUD while incarcerated are 85% less likely to die of a drug overdose within a month of their release. *Id.*

II. Continued Methadone Treatment Is Medically Necessary for P.G.

P.G. is a 35-year-old Watertown resident who works as a driver for a food delivery service and lives with severe OUD. Decl. of P.G. ("P.G. Decl.") ¶¶ 1–2; [redacted]. He has been addicted to opioids since the age of 19 and experienced a life-threatening overdose five years ago. P.G. Decl. ¶¶ 2, 10–11. Methadone is the only effective means to treat P.G.'s OUD. [redacted]; Rosenthal Decl. ¶¶ 48–52; *see also* P.G. Decl. ¶¶ 2–6, 15–19. Throughout his 16-year battle with addiction, P.G. has attempted many times to stop using opioids, including through treatment with each of the three FDA-approved medications and quitting "cold turkey." *See* P.G. Decl. ¶¶ 2–5; Rosenthal Decl. ¶¶ 48–49. Besides methadone, each of these options has ultimately failed. *See* P.G. Decl. ¶¶ 2–5, 15; Rosenthal Decl. ¶¶ 48–49.

Since P.G. first began methadone treatment in 2018, methadone has proven markedly more effective than anything else at managing his opioid cravings. *See* P.G. Decl. ¶¶ 16–20;

Rosenthal Decl. ¶¶ 48–49. With daily methadone treatment through the Credo Community Center, a local treatment provider in Watertown, P.G. is in active recovery from his addiction. [redacted]; *see also* P.G. Decl. ¶¶ 19–20, 29. P.G. has a stable job; recently bought a home with his girlfriend of eight years; and feels hopeful about his future for the first time in years. *See* P.G. Decl. ¶¶ 6, 19–20, 29; Decl. of C.H. ("C.H. Decl.") ¶¶ 1, 8. None of this would have been possible without methadone, and [redacted] Pisaniello Decl. ¶¶ 7–9. Without methadone, P.G. faces painful withdrawal symptoms and a heightened risk of relapse and death. [redacted]; *see also* Rosenthal Decl. ¶¶ 50–52, 57.

III. The Jail's Methadone Ban Will Force P.G. into Harmful Withdrawal.

P.G. faces imminent detention at the Jefferson County Correctional Facility, where the jail will forcibly end his methadone treatment pursuant to a ban on methadone treatment for non-pregnant people. Like many people with OUD, P.G.'s journey through addiction has been marked by a series of relapses and arrests. P.G. Decl. ¶¶ 2–6, 11–19. Currently, P.G. is accused of a misdemeanor probation violation in Jefferson County, and his probation officer has told him he should expect to be detained at the Jefferson jail pending adjudication of that alleged violation. *Id.* ¶ 25.

The jail maintains a blanket ban on methadone treatment for almost everyone with OUD in its custody. *See* Decl. of Caryn White, LCSW-R ("White Decl.") ¶ 6 ("My understanding, based on the experience of [Credo] overseeing methadone treatment made available to pregnant people at Jefferson County Jail, is that the jail does not provide methadone to non-pregnant people."); P.G. Decl. ¶ 23 (describing P.G.'s forcible withdrawal from methadone at the jail in 2019). As a result of the ban, people who enter the jail's custody while receiving methadone therapy are abruptly and forcibly withdrawn from that treatment, despite the harmful effects of

withdrawal and regardless of their treating physicians' recommendations. *See, e.g.*, P.G. Decl. ¶ 23.

The jail is capable of providing methadone treatment to people with OUD in its custody. Its policy is to provide access to methadone maintenance treatment to pregnant people with OUD through an arrangement with Credo. *See* Pisaniello Decl. ¶ 3; White Decl. ¶¶ 5–6. Under that policy, the jail has successfully continued a number of pregnant people on methadone treatment through Credo without incident. *See* White Decl. ¶¶ 5–6. But that policy does not apply to P.G., and under the jail's methadone ban for non-pregnant people, Defendants will require him to withdraw from methadone, exposing him to the certainty of painful withdrawal symptoms within 24 to 48 hours and a heightened risk of relapse and death. *See* [redacted]; Rosenthal Decl. ¶¶ 36, 38–41, 50–52, 57. The jail offers naltrexone to people with OUD, but naltrexone has proven wholly ineffective for P.G. *See* [redacted]; Rosenthal Decl. ¶¶ 48–49, 52; P.G. Decl. ¶ 5. And in any event, naltrexone would still require that he withdraw from methadone first. *See* Rosenthal Decl. ¶¶ 31, 52.

P.G. is terrified of being withdrawn from methadone treatment while in Defendants' custody. P.G. Decl. ¶¶ 8–9. Defendants *already* stopped his methadone treatment once while he was in their custody in 2019, subjecting P.G. to a host of severe withdrawal symptoms. *Id.* ¶ 23. And in 2016, he overdosed and nearly died after relapsing into opioid use upon release from another jail that had forcibly withdrawn him from MOUD. *Id.* ¶ 10.

In a letter dated April 2, P.G., through counsel, requested that Defendants accommodate his disability by affording him continued access to his medically necessary methadone treatment while detained at the jail. *See* Gemmell Decl. Ex. A. Although noting the existence of other suitable options for continuing his methadone treatment, P.G. proposed to continue treatment

through Credo—the very same clinic through which the jail already provides methadone treatment to pregnant people in their custody. *See id.* Given the imminence of P.G.'s detention, the April 2 letter sought assurance by April 7, 2021 that Defendants would permit P.G. to continue his methadone treatment at the jail. *See id.* On April 7, the County confirmed it will make no such commitment until after P.G. is detained at the jail. *See* Gemmell Decl. ¶ 6.

In the weeks since, Plaintiff's counsel has attempted to address any conceivable barriers to Defendants' accommodating P.G.'s disability. *See id.* ¶¶ 7–8. But those good-faith efforts have been at a standstill for weeks because of a series of delays on the part of Defendants. *See id.* ¶ 10. Despite the urgency of P.G.'s need and the repeated inquiries of Plaintiff's counsel, Defendants still have not committed to continue P.G.'s methadone treatment at the jail, and they have failed in over two weeks to provide any substantive update on the County's position—or to confirm when or even if such an update will be forthcoming. *Id.* ¶¶ 14–15.

ARGUMENT

P.G. faces imminent detention at the jail, where Defendants, acting under a blanket policy or custom, will forcibly end his medication for OUD, regardless of the painful and life-threatening consequences. He seeks a preliminary order permitting his medical treatment to continue until this Court can evaluate the lawfulness of the jail's blanket ban.

It is clear P.G. is entitled to that interim relief here. He can make a "strong showing" that cutting off his treatment during this litigation will subject him to irreparable—indeed, life-threatening—harm. *A.H. by and through Hester v. French*, 985 F.3d 165, 176 (2d Cir. 2021). He has a "substantial" likelihood of succeeding on his claims that the jail's blanket treatment ban violates his rights under the Americans with Disabilities Act ("ADA") and the Constitution. *Id.* And the public interest and balance of equities weigh heavily in his favor, *see New York v. U.S.*

Dep't Homeland Sec., 969 F.3d 42, 59 (2d Cir. 2020): Preserving constitutional rights and preventing unlawful discrimination are among our core societal commitments; and an injunction here would mean almost everything for P.G.'s recovery, while imposing minimal burdens on the jail.[2]

I. P.G. Faces Irreparable Harm Absent an Injunction.

Abruptly ending P.G.'s methadone treatment will force him into excruciating withdrawal within hours, endanger his recovery, and expose him to a dramatically heightened risk of relapse and death. These consequences are the quintessence of "irreparable harm," the "single most important prerequisite for the issuance of a preliminary injunction." *Faively Transp. Malmo AB v. Wabtec Corp.*, 559 F.3d 110, 118 (2d Cir. 2009) (citation omitted).

Without injunctive relief, Defendants will end P.G.'s medical treatment as soon as he enters the jail, forcing him into acute methadone withdrawal. *See* White Decl. ¶ 6; P.G. Decl. ¶ 23; Rosenthal Decl. ¶¶ 36, 57. Methadone withdrawal is "excruciatingly painful." Rosenthal Decl. ¶ 8; *see also* P.G. Decl. ¶ 9 ("Withdrawal is sheer torture."). The immediate and extreme pain of forcibly withdrawing P.G. alone constitutes irreparable harm. *See Ingraham v. Wright*, 430 U.S. 651, 695 (1977) ("The infliction of physical pain is final and irreparable; it cannot be undone in a subsequent proceeding."); *cf. Bowen v. City of New York*, 476 U.S. 467, 483–84

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[2] P.G.'s requested relief also comports with the Prison Litigation Reform Act, which requires that a preliminary injunction "[i]n any civil action with respect to prison conditions . . . be narrowly drawn, extend no further than necessary to correct the harm the court finds requires preliminary injunctive relief, and be the least intrusive means necessary to correct that harm." 18 U.S.C. § 3626(a)(2). The injunction P.G. seeks is narrowly drawn and extends no further than necessary because P.G. requires methadone to avoid the harms of withdrawal and potential relapse, overdose, and death. *See* Pisaniello Decl. ¶¶ 7–9; Rosenthal Decl. ¶¶ 50–52, 57. And it is the least intrusive means of affording P.G. relief, because it affords Defendants latitude to determine how to provide P.G. access to methadone through the clinic that Defendants concede is their only realistic option for affording access to methadone treatment. *See* Gemmell Decl. ¶ 9.

(1986) (irreparable harm where termination of disability benefits risked traumatizing plaintiffs). Within hours of entering Defendants' custody, P.G. will begin experiencing a range of severe withdrawal symptoms, including bone and joint aches, vomiting, diarrhea, insomnia, excessive sweating, hypothermia, hypertension, elevated heart rate; and psychological symptoms, such as depression, anxiety, and desperation. *See* Rosenthal Decl. ¶ 36; *see also, e.g.*, *Foelker v. Outgamie Cnty.*, 394 F.3d 510, 511 (7th Cir. 2005) (plaintiff was "confused and disoriented" and had "defecated in his cell and on himself . . . [while] unaware of the mess he had created" after forced methadone withdrawal) (internal quotation marks omitted). The symptoms of methadone withdrawal are often so intense that they induce suicidality. *See* Rosenthal Decl. ¶ 37. These symptoms could persist for weeks or even months. *See id.* ¶ 36.

Beyond the severe pain of withdrawal, Defendants' blanket ban will set P.G. up for a life-threatening relapse—another form of irreparable harm. *See Oxford House, Inc. v. City of Albany*, 819 F. Supp. 1168, 1173 (N.D.N.Y. 1993) (increased risk of alcohol or chemical addiction occasioned by displacement from recovery residence constitutes irreparable harm); *Conn. Hosp. v. City of New London*, 129 F. Supp. 2d 123, 129 (D. Conn. 2001) (same); *see also Sullivan v. City of Pittsburgh*, 811 F.2d 171, 179 (3d Cir. 1987) (irreparable harm where "relapse threatens not only a potentially irremediable reversion to chronic alcohol abuse but immediate physical harm or death"). [redacted] *See* Pisaniello Decl. ¶ 7; Rosenthal Decl. ¶¶ 48–50. [redacted] Gemmell Decl. Ex. B at 2; *see also* Rosenthal Decl. ¶¶ 50–52, 57 ([redacted]). The risk of relapse is particularly

pronounced given P.G.'s impending entry to jail, a setting where contraband opioids are often readily accessible. *See* Decl. of Edmond Hayes ("Hayes Decl.") ¶¶ 23–26; U.S. DEP'T JUSTICE, MORTALITY IN LOCAL JAILS AND STATE PRISONS, 2000–2013, 7 (Aug. 2015), https://www.bjs.gov/content/pub/pdf/mljsp0013st.pdf (finding that drug and alcohol intoxication alone accounted for 7.2% of all deaths in local jails in 2013). And the rate of death from overdose within two weeks of release is 12,900% that of the general population. *See* Rosenthal Decl. ¶ 40. P.G. knows that risk well: He *already* overdosed once upon release from a jail that had withdrawn him from MOUD, requiring emergency medical intervention to survive. *See* P.G. Decl. ¶ 10; C.H. Decl. ¶ 11.

Besides subjecting P.G. to painful withdrawal and likely relapse in the near-term, forcibly ending methadone therapy endangers his longer-term recovery. Rosenthal Decl. ¶¶ 38, 55; [redacted]. Research confirms that people with OUD who experience forced withdrawal from methadone while incarcerated are significantly less likely to resume treatment after release. *See* Rosenthal Decl. ¶ 38 (forced withdrawal causes sevenfold decrease in post-release continuation of MOUD treatment). Consistent with that reality, courts have recognized irreparable harm deriving specifically from the prospect that bans like Defendants' will interfere with recovery by discouraging people with OUD from seeking effective treatment in the future. *See Smith v. Aroostook Cnty.*, 376 F. Supp. 3d 146, 161 (D. Me. 2019) (finding irreparable harm because "forced withdrawal from [MOUD] during incarceration has been linked to a significant decreased in post-release resumption of treatment, with lack of treatment in turn being associated with increased risk of overdose and death"), *aff'd*, 922 F.3d 41 (1st Cir. 2019).

II. P.G. Is Substantially Likely to Succeed on the Merits.

P.G. seeks preliminary relief on his claims under the ADA and U.S. Constitution. To obtain that relief, he need show a substantial likelihood of succeeding on just one of those

claims. *See, e.g.*, *L.V.M. v. Lloyd*, 318 F. Supp. 3d 601, 618 (S.D.N.Y. 2018). Here, P.G. can make that showing as to each.

A. P.G. Is Substantially Likely to Succeed on His ADA Claims.

P.G. is substantially likely to succeed on his disability discrimination claims under Title II of the ADA because Defendants' forced withdrawal policy denies him meaningful access to the jail's medical services because of his OUD.

Title II provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132 (2006). To establish a prima facie violation of Title II, P.G. must "show that 1) he is a qualified individual with a disability; 2) [Defendants are] subject to the act[]; and 3) he was denied the opportunity to participate in or benefit from [Defendants'] services, programs, or activities or [Defendants] otherwise discriminated against him by reason of his disability." *Wright v. New York State Dep't of Corr.*, 831 F.3d 64, 72 (2d Cir. 2016) (quoting *Henrietta D. v. Bloomberg*, 331 F.3d 261, 272 (2d Cir. 2003)).

Courts evaluating discrimination claims under Title II construe its protections broadly, asking whether a covered public entity—on purpose or in effect—has denied "meaningful access" to the benefits it offers. *Alexander v. Choate*, 469 U.S. 287, 301 (1985);[3] *Henrietta D.*, 331 F.3d at 279 (broad construction afforded to ADA considering its remedial purpose). The

[3] Although *Alexander*, in which the Supreme Court articulated the meaningful access requirement, involved claims under Section 504 of the Rehabilitation Act rather than Title II, both statutes "impose identical requirements," *Rodriguez v. City of New York*, 197 F.3d 611, 618 (2d Cir. 1999), and courts analyze claims under Section 504 and Title II identically, *see, e.g.*, *Henrietta D.*, 331 F.3d at 272.

requirement of meaningful access is a pragmatic one: "[T]he relevant inquiry asks not whether the benefits available to persons with disabilities and to others are actually equal, but whether those with disabilities are as a practical matter able to access benefits to which they are legally entitled." *Henrietta D.*, 331 F.3d at 274 (citing *Alexander*, 469 U.S. at 301). And courts look to the ADA's implementing regulations in interpreting Title II's meaningful access requirement.[4] *See Henrietta D.*, 331 F.3d at 273–74 (relying on ADA regulations in Title II case); 28 C.F.R. § 35.130 (describing Title II's "general prohibitions on discrimination").

1. P.G. Is a Qualified Individual with a Disability.

The protections of Title II apply to P.G. because he is a "qualified individual with a disability." 42 U.S.C. § 12131(2). Under the ADA, "disability" means "a physical or mental impairment that substantially limits one or more major life activities," and includes "drug addiction."[5] 42 U.S.C. § 12102(1)(A) (defining "disability"); 28 C.F.R. § 35.108(b)(2) (incorporating drug addiction into definition of "disability"); *see also Reg'l Econ. Cmty. Action Program, Inc. v. City of Middletown*, 294 F.3d 35, 46 (2d Cir. 2002) (recognizing same). P.G. is an "individual with a disability" because he is diagnosed with OUD, a substance use disorder that "substantially limits" an array of "major life activities," including caring for oneself; learning; concentrating; thinking; communicating; and working, as well as "major bodily

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[4] In passing the ADA, Congress charged the U.S. Department of Justice with promulgating regulations to implement the Act. *See* 42 U.S.C. § 12134(a). Because of that "express delegation of authority," the ADA regulations are entitled to "controlling weight, unless they are arbitrary, capricious, or manifestly contrary to the statute." *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 843–44 (1984); *see also Hilton v. Wright*, 928 F.Supp.2d 530, 554 (N.D.N.Y. 2013) (Hurd, J.) (acknowledging same).

[5] The ADA's protection against discrimination on the basis of "drug addiction" does not extend to current illegal use of drugs itself, but does cover any individual who, [redacted], is "participating in a supervised rehabilitation program and no longer engaging in such use." 42 U.S.C. § 12210(a)–(b); *see also* [redacted]

function[s]," including neurological and brain function. 42 U.S.C. §§ 12102(1), (2); *see also* Rosenthal Decl. ¶¶ 10–17; P.G. Decl. ¶¶ 2, 9, 12.

P.G. is a "*qualified* individual with a disability" under the statute because, when incarcerated, he will meet the "essential eligibility requirements" for the jail's medical services. 42 U.S.C. § 12131(2) (defining "qualified individual with a disability"); 28 C.F.R. § 35.104 (same); *see generally Estelle v. Gamble*, 429 U.S. 97 (1976) (recognizing constitutional guarantee of medical care to all incarcerated people).

2. The Jail and Its Medical Services Are Subject to Title II.

Defendants are subject to Title II because the jail is a "public entity." *See* 42 U.S.C. § 12131(1) (defining "public entity" to include "any State or local government" and "any department, agency . . . or other instrumentality" thereof). The jail's medical services are also subject to Title II because they constitute "services, programs, or activities of a public entity." *Id.* § 12132; *see also Pa. Dep't of Corr. v. Yeskey*, 524 U.S. 206, 210 (1998) (recognizing Title II "squarely" covers state prisons, including their medical services); *Woods v. City of Utica*, 902 F. Supp. 2d 273, 280 (N.D.N.Y. 2012) (same as to county jail).

3. The Jail's Blanket Methadone Ban Discriminates against P.G.'s Disability.

Defendants are discriminating against P.G. in violation of Title II because their blanket treatment ban denies him "meaningful access" to the jail's medical services based on his OUD. In enforcing the ban against P.G., Defendants engage in unlawful discrimination in multiple ways, any one of which suffices to establish an ADA violation.

First, by categorically prohibiting a standard treatment for OUD that is medically necessary for P.G. and many others with his disability, Defendants' ban discriminates on its face against people with OUD. In purpose and effect, the ban singles out P.G. and others with OUD

for categorical exclusion from minimally adequate medical treatment at the jail.[6] *See* 28 C.F.R. § 35.130(b)(1)(i) (unlawful to "deny a qualified individual with a disability the opportunity to participate in or benefit from [a] benefit or service" because of disability); *id.* § 35.130(b)(3)(i) (unlawful to "utilize criteria or methods of administration . . . [t]hat have the effect of subjecting" individuals to disability discrimination). Such a ban would be unthinkable as to any other serious illness: Were P.G. diagnosed with HIV, diabetes, or any number of other medical conditions, there would be no question about Defendants' obligation to provide minimally adequate medical care. But because P.G. instead has OUD, Defendants' ban not only permits, but actually *requires* Defendants to deny P.G. that medical care, even though providing such care to people in its custody is the very reason the jail's medical services exist. *See id.* § 35.130(b)(1)(ii) (unlawful to "[a]fford a qualified individual with a disability an opportunity to participate in or benefit from . . . [a] benefit or service that is not equal to that afforded others."); *id.* § 35.130(b)(3)(ii) (unlawful to "utilize criteria or methods of administration . . . that have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the public entity's

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[6] That Defendants make methadone therapy available to a small subset of people with OUD—those who are pregnant—does not alter this conclusion. *See Davis v. Shah*, 821 F.3d 231, 263–64 (2d Cir. 2016) (finding Medicaid coverage of orthopedic socks for people with some disabilities but not others violates Title II). That practice does not afford meaningful access to jail medical services for those non-pregnant people with OUD, including P.G., for whom methadone treatment is necessary.

Nor does the fact the jail provides access to *other* MOUD—namely naltrexone—but not methadone, satisfy Defendants' obligation to P.G. under Title II. A medication completely distinct from methadone—one that is demonstrably ineffective in treating P.G.'s disability—will not afford meaningful access to jail medical care to P.G., for whom only methadone is effective. *See* Rosenthal Decl. ¶¶ 31–33, 42, 48–50, 52 (detailing inadequacy of naltrexone); *Noll v. Int'l Bus. Machs. Corp.*, 787 F.3d 89, 95 (2d Cir. 2015) ("Reasonable accommodation may take many forms, but it must be effective.") (citing *U.S. Airways, Inc. v. Barnett*, 535 U.S. 391, 400 (2002))).

program with respect to individuals with disabilities"). This is discrimination of precisely the sort that Title II prohibits.

Importantly, the Court need not find that ill will towards people with OUD underlies Defendants' methadone ban to conclude the ban violates Title II. Congress rejected that notion in passing the ADA, recognizing that disability discrimination "is most often the product . . . of thoughtlessness and indifference" or "benign neglect" rather than "invidious animus." *Alexander*, 469 U.S. at 295; *see also* H.R. Rep. No. 101–485(II), at 29, *reprinted in* 1990 U.S.C.C.A.N. 303, 311 (1990). Instead, it would suffice that Defendants' methadone ban reflects mere "apathetic attitudes" towards people with OUD. *See Alexander*, 469 U.S. at 296. It is hard to imagine how anything short of apathy towards people with OUD could underlie Defendant's enforcement of a blanket ban against medication that, for P.G. and many others, is the only effective form of treatment.[7] And decades of entrenched stigma that have pervaded societal attitudes towards opioid addiction generally and methadone therapy specifically, suggest the ban reflects more than apathy.[8]

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[7] Even were Defendants to proffer a non-discriminatory rationale for denying essential treatment to people with OUD, the sheer irrationality of their blanket methadone ban permits the inference that any conceivable justification for enforcing it is a pretext for discrimination. *See, e.g.*, *Kiman v. N.H. Dep't of Corr.*, 451 F.3d 274, 284–85 (1st Cir. 2006) (a decision about medical care can be "so unreasonable—in the sense of being arbitrary and capricious—as to imply that it was pretext for some discriminatory motive") (citation omitted); *see also infra* at 16–17 (describing absence of legitimate security, cost, or administrability concerns).

[8] Stigma towards OUD remains a formidable barrier to patients' accessing necessary treatment, including in the criminal justice system. *See* Josiah D. Rich & Sarah E. Wakeman, *Barriers to Medications for Addiction Treatment: How Stigma Kills*, 53 Substance Use & Misuse 330, 330 (2018), https://doi.org/10.1080/10826084.2017.1363238 (describing stigma towards OUD as "a major driver behind the lack of access to opioid agonist therapy"); Alexander C. Tsai et al., *Stigma as a Fundamental Hindrance to the United States Opioid Overdose Crisis Response*, PloS Med. 6 (Nov. 2019), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6957118

Second, regardless of whether the blanket ban is itself discriminatory, Defendants' refusal to modify it to accommodate P.G.'s disability independently violates Title II. *See* 28 C.F.R. § 35.130(b)(7)(i). As courts have long recognized, ensuring meaningful access for people with disabilities sometimes requires public entities to make reasonable modifications to their policies, practices, and procedures. *See Alexander*, 469 U.S. at 301 ("[T]o assure meaningful access, reasonable accommodations in the grantee's program or benefit may have to be made."); *Henrietta D.*, 331 F.3d at 275 (ADA requires "affirmative accommodations to ensure that facially neutral rules do not in practice discriminate against individuals with disabilities"). Refusing to do so violates Title II. *See* 28 C.F.R. § 35.130(b)(7)(i). In nearly identical situations, courts have held that failure to accommodate a disability by providing MOUD to incarcerated people violates the ADA. *See Smith v. Aroostook Cnty.*, 376 F. Supp. 3d at 161; *Pesce v. Coppinger*, 355 F. Supp. 3d 35, 47 (D. Mass. 2018).

Here, P.G.'s ability to have meaningful access to Defendants' medical services depends on his ability to continue daily methadone therapy for OUD during his incarceration. *See supra* Section I (describing medical necessity of methadone to treat P.G.'s severe OUD). Thus, on April 2, 2021, through counsel, P.G. sent a letter to the Jefferson County Sheriff's Office requesting that, as an accommodation for P.G.'s disability, Defendants alter their policies and practices to permit P.G. to continue methadone treatment at the jail. *See* Gemmell Decl. Ex. A. That letter, which was supported by an accompanying letter from P.G.'s treating physician at Credo, confirmed P.G.'s diagnosis with severe OUD, identified daily methadone therapy as

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("[U]ndertreatment of people with OUDs who . . . have a history of involvement with the criminal justice system, often motivated by stigma, represented a missed public health opportunity given the well-established effectiveness of opioid agonist treatment.").

"medically necessary" and "the only effective means of treatment" for P.G's OUD, and sought confirmation from Defendants by April 7, 2021 that P.G. would be permitted to continue methadone treatment at the jail. *See id.* Despite the urgency of P.G.'s disability accommodation request, Defendants failed and refused to grant the request by April 7; and, as of the filing of this motion over three weeks later, they still refuse to confirm whether they will accommodate P.G.'s disability by allowing his treatment with methadone to continue at the jail. *See* Gemmell Decl. ¶ 15.

There is no good reason for Defendants not to have granted P.G.'s request to continue medically necessary treatment for his disability. Methadone therapy is safe, administrable, and affordable, including in a setting like the jail. Every day, methadone is securely administered to incarcerated people with OUD at jails and prisons throughout the country, including here in New York State. *See* Hayes Decl. ¶¶ 9–24 (explaining how methadone has been securely administered in carceral settings); *see also Smith v. Aroostook Cnty.*, 922 F.3d at 41 (affirming preliminary injunction on plaintiff's ADA claims where defendants had "variety of reasonable alternatives at their disposal for providing [the plaintiff] with her medication in a manner that alleviates any security concerns"). And jails that provide access to methadone therapy for OUD often experience *reductions* in both drug-related contraband and diversion of medications. *See, e.g.*, Hayes Decl. ¶ 13.

Defendants already know all this: They routinely permit pregnant people at the jail to receive methadone treatment through Credo—precisely the same access to treatment they would now deny to P.G. *See* White Decl. ¶¶ 5–6. This fact undermines any conceivable reason for denying the same access to P.G., and conclusively establishes that their refusal to grant P.G.'s disability accommodation request violates Title II.

B. P.G. Is Substantially Likely to Succeed on His Due Process Claim.

P.G. is also substantially likely to succeed on his claim that Defendants' blanket methadone ban violates the Fourteenth Amendment. Prior to conviction, the Fourteenth Amendment's Due Process Clause governs a constitutional claim of inadequate medical care by a person in the custody of a jail. *See Charles v. Orange Cnty.*, 925 F.3d 73, 85 (2d Cir. 2019)). Not every denial of custodial medical care rises to constitutional proportions. *See id.* at 86. But under the Fourteenth Amendment, jail officials transgress the bounds of due process by acting with deliberate indifference to the serious medical needs of those in their custody. *Id.* at 85. That standard has two objective components: first, the medical need in question must, in objective terms, be "sufficiently serious"; and second, jail officials must have acted with objective recklessness in failing to meet that need, meaning they knew or should have known that failing to provide the medical care in question would expose the plaintiff to a substantial risk of serious harm.[9] *Id.* at 86–87.

P.G. satisfies both components of the Fourteenth Amendment analysis: His OUD is an objectively serious medical condition; and Defendants' refusal, under a blanket policy, to permit

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[9] During post-conviction incarceration, a subjective deliberate indifference standard under the Eighth Amendment's Cruel and Unusual Punishments Clause applies instead. *See Farmer v. Brennan*, 511 U.S. 825, 837 (1994). Under that test, it is not enough that jail officials *should have known* of a substantial risk of harm; Instead, under the Eighth Amendment, they "must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and . . . must also draw the inference." *Id.*

The Second Circuit has not decided whether the Fourteenth Amendment, rather than the Eighth Amendment, governs the conditions-of-confinement claim of a plaintiff held in pre-hearing custody for an alleged probation violation. *See Hill v. Cnty. of Montgomery*, No. 14-cv-933, 2018 WL 2417839, at *2 (N.D.N.Y. May 29, 2018). But because P.G. cannot constitutionally be punished for an *alleged* probation violation before its adjudication, *see Darnell v. Pineiro*, 849 F.3d 17, 29 (2d Cir. 2017), the Cruel and Unusual Punishments Clause of

him to access life-sustaining treatment for OUD is one that they not only should know, but in fact *do* know, exposes him to life-threatening harm.

1. OUD Is a Serious Medical Condition.

OUD, a chronic brain disease that has wreaked havoc in P.G.'s life and that kills thousands of New Yorkers each year, is an objectively serious medical condition.[10] *See Alvarado v. Westchester Cnty.*, 22 F. Supp. 3d 208, 217 (S.D.N.Y. 2014) (opioid withdrawal "sufficiently serious" to state deliberate indifference claim); *Messina v. Mazzeo*, 854 F. Supp. 116, 140 (E.D.N.Y. 1994) (same); *see also Mayo v. Cnty. of Albany*, 357 F. App'x 339, 341 (2d Cir. 2009) (summary order) ("To the extent that withdrawal from heroin and alcohol addictions presents a serious medical condition, it appears undisputed that Mayo satisfied the first prong of the test."). *Cf. Caizzo v. Koreman*, 581 F.3d 63, 72 (2d Cir. 2009) (recognizing "no dispute" that alcohol withdrawal is a serious medical condition), *overruled on other grounds by Darnell*, 849 F.3d 17.

"The serious medical needs standard contemplates a condition of urgency such as one that may produce death, degeneration, or extreme pain." *Charles*, 925 F.3d at 86 (citing *Hathaway v. Coughlin*, 99 F.3d 550, 553 (2d Cir. 1996)). It is informed by "contemporary standards of decency," *Smith v. Carpenter*, 316 F.3d at 187, and incorporates "factors such as whether a reasonable doctor or patient would find the injury important and worthy of treatment,

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the Eighth Amendment, which applies only to those who may be punished, is an inappropriate vehicle for considering his constitutional claim.

Even if the Eighth Amendment were to apply to P.G., it would not affect the result here. As discussed below in Section II.B.2., Defendants have actual knowledge that their blanket methadone ban poses a substantial risk of seriously harming P.G., which suffices to establish deliberate indifference under both the Eighth and Fourteenth Amendments.

[10] The Second Circuit has recognized that the terms "serious medical need" and "serious medical condition" are interchangeable in analyzing deliberate indifference claims outside the limited context of claims involving temporary interruptions of medical care. *See Smith v. Carpenter*, 316 F.3d 178, 185–86 (2d Cir. 2003).

whether the medical condition significantly affects an individual's daily activities, and whether the illness or injury inflicts chronic and substantial pain." *Charles*, 925 F.3d at 86 (citing *Chance v. Armstrong*, 143 F.3d 698, 702 (2d Cir. 1998)).

Applied here, these factors make clear P.G.'s OUD is an objectively serious medical condition. The symptoms of OUD include cravings for and uncontrollable use of opioids. *See* Rosenthal Decl. ¶ 10. Left untreated, "patients with OUD are rarely able to control their use of opioids, often resulting in physical harm or premature death, including due to accidental overdose." Rosenthal Decl. ¶ 11. [redacted] *See* Pisaniello Decl. ¶¶ 4, 10. That treatment is the standard of care for OUD and [redacted] *See id.* ¶ 7; Rosenthal Decl. ¶¶ 26, 48–50. If his treatment ends now, P.G. faces an array of severe withdrawal symptoms, as well as a significantly heightened risk of relapse into drug use, overdose, and death. *See* Rosenthal Decl. ¶¶ 8, 50–52, 57; [redacted] Because it subjects him to harms of precisely the sort contemplated under the serious medical need standard—"death, degeneration [and] extreme pain," *Charles*, 925 F.3d at 86—P.G.'s OUD satisfies the first prong of the deliberate indifference analysis.

2. Enforcing a Blanket Policy or Custom That Strips P.G. of Life-Sustaining Medical Treatment Reflects Deliberate Indifference.

Stripping P.G. of life-sustaining medical treatment for OUD under a blanket jail policy that disregards his individual medical needs is inconsonant with sound medicine—including broad consensus in the scientific community and [redacted] —and reflects Defendants' deliberate indifference.

Deliberate indifference to medical needs under the Fourteenth Amendment requires that jail officials know or *should know* that failing to provide the medical care in question poses a substantial risk of serious harm to the plaintiff. *See id.* at 87 (citing *Darnell*, 849 F.3d at 35).

Deliberate indifference requires more than negligence. *See Cuoco v. Moritsugu*, 222 F.3d 99, 107 (2d Cir. 2000) (confirming "mere medical malpractice" does not suffice). But it "can be shown by something akin to recklessness, and does not require proof of a malicious or callous state of mind." *Charles*, 925 F.3d at 86. A harm need not be "surely or almost certainly [to] result" for the risk to be "substantial." *Salahuddin v. Goord*, 467 F.3d 263, 280 (2d Cir. 2006) (citing *Farmer*, 511 U.S. at 842); *see also Helling v. McKinney*, 509 U.S. 25, 34 (1993) ("[A] remedy for unsafe conditions need not await a tragic event.").

Forcibly withdrawing P.G. from his current course of methadone treatment will expose him to a constellation of serious harms, some of which are the *certain outcome*—not merely a substantial risk—of Defendants' blanket methadone ban. *See supra* Section I. Grave and unnecessary suffering is such a predictable consequence here that "[n]o physician, acting consistent with prudent professional standards and in a manner reasonably commensurate with modern medical science," would abruptly end P.G.'s treatment with methadone, as Defendants' policy requires. *See* Rosenthal Decl. ¶ 35.

Defendants should know—and, in fact, do know—that their blanket ban endangers P.G. Consensus in the medical community is clear that forcibly ending methadone therapy is dangerous. *See id*. ¶¶ 35, 38, 45. That danger is obvious here, in a region of the country deeply impacted by the opioid epidemic, the severe and well-documented consequences of which alone permit a factfinder to infer Defendants' knowledge. *See id.* ¶ 23 (describing thousands of opioid overdose deaths annually in New York alone); *Farmer*, 511 U.S. at 842 ("[A] factfinder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious."). Inference aside, jail officials already witnessed the weeks of painful withdrawal P.G. experienced last time the jail forcibly withdrew him from methadone. *See* P.G. Decl. ¶ 23. And

P.G.'s April 2 letter to the Jefferson County Sheriff's Office explaining his disability, [redacted] confirms Defendants know their policy puts P.G. in harm's way. *See* Gemmell Decl. Exs. A, B. Yet despite that knowledge, Defendants have refused to confirm they will not deny methadone treatment to P.G.—just as they did in 2019—placing their deliberate indifference to P.G.'s safety beyond doubt.

As the rate of opioid-related death has continued to skyrocket nationwide, courts around the country—including in this circuit—have recognized that denying methadone maintenance therapy to people with OUD in their custody can amount to deliberate indifference. *See, e.g.*, *Davis v. Carter*, 452 F.3d 686 (7th Cir. 2006) (triable issue of fact on Eighth Amendment claim regarding jail's practice of delaying methadone treatment for three days); *Foelker*, 394 F.3d at 513 (triable issue of fact where jail officials knew appellant was experiencing methadone withdrawal); *Pesce*, 355 F. Supp. 3d at 47–48 (granting preliminary injunction on Eighth Amendment claim where jail's refusal to continue plaintiff's methadone therapy "ignore[d] and contradict[ed] his physician's recommendations"); *Alvarado*, 22 F. Supp. at 217 (plaintiffs plausibly stated Eighth Amendment claim against jail that denied methadone maintenance therapy); *see also* U.S. DEP'T JUSTICE, INVESTIGATION OF THE CUMBERLAND COUNTY JAIL 6–11 (Jan. 14, 2021), https://www.justice.gov/opa/press-release/file/1354646/download ("By denying [medication for OUD] to [individuals] entering the jail, the [jail] acted with deliberate indifference to the serious medical needs of many [individuals] experiencing opiate withdrawal."). Nothing about the jail's blanket methadone ban, which forecloses P.G. from continuing medically necessary treatment, warrants a different conclusion about Defendants' culpability here.

This case is not about "mere disagreement" with Defendants' "considered medical judgment" as to the proper course of P.G.'s treatment. *Hathaway*, 37 F.3d at 70. There can be no serious disagreement over the importance of methadone treatment to P.G.'s continued safety. *See* Rosenthal Decl. ¶¶ 27, 34. Broad consensus exists that a person in recovery from OUD should not be forced to discontinue methadone therapy involuntarily, barring a specific and unusual medical reason. *See id.* ¶¶ 35, 38. [redacted] *See* Pisaniello Decl. ¶¶ 7–9; *accord* Rosenthal Decl. ¶¶ 48–50. Doing so would violate the standard of care and expose him unnecessarily to a high risk of withdrawal, relapse, and death. *See* Rosenthal Decl. ¶¶ 26, 35, 38–42; [redacted]

Nor does ending P.G.'s methadone treatment without regard to his individual medical needs, as Defendants' methadone ban requires, involve any medical judgment at all. The ban applies on a blanket basis and is not tailored to individual medical needs. Treatment for OUD is not a one-size-fits-all proposition. *See* Rosenthal Decl. ¶ 33. Medication that is highly effective at treating OUD in one individual may prove ineffective for another—[redacted] *See id.* ¶¶ 33, 48–49; Pisaniello Decl. ¶¶ 4, 6–7. [redacted] *See* Pisaniello Decl. ¶ 4; *accord* Rosenthal Decl. ¶¶ 48–50. By contrast, Defendants' blanket methadone ban, which effectively *prohibits* individualized decision-making by medical professionals about appropriate care for OUD, reflects deliberate indifference to P.G.'s medical needs. *See Alvarado*, 22 F. Supp. at 217 ("uniform" denial of MOUD to individuals experiencing opioid withdrawal stated Eighth Amendment claim); *see also Pesce*, 366 F. Supp. at 47 (granting preliminary injunction on Eighth Amendment claim where

jail officials maintained blanket ban on methadone treatment "without any indication that they would consider [plaintiff's] particular medical history and prescribed treatment in considering whether departure from such policy might be warranted."). And the jail's mechanical adherence to its blanket ban is particularly problematic when, [redacted] *Pesce*, 366 F. Supp. at 48; *see also* Pisaniello Decl. ¶¶ 7–9; Gemmell Decl. Ex. B.

The creation of blanket policies like Defendants' methadone ban does not relieve jail officials of their constitutional obligation to consider the individual medical needs of those in their custody, which may oblige them to vary typical practices. *See Johnson v. Wright*, 412 F.3d 398, 406 (2d Cir. 2005) ("[A] jury could find that the defendants acted with deliberate indifference by reflexively relying on the medical soundness of the . . . substance abuse policy when they had been put on notice that the medically appropriate decision could be, instead, to depart from the [policy]."); *see also Brock v. Wright*, 315 F.3d 158, 166 (2d Cir. 2003) ("Since both [prison doctors] have cited the policy as the reason for their actions . . . the question before us is whether following the policy resulted in deliberate indifference to [the plaintiff's] medical needs."); *Brooks v. Berg*, 270 F. Supp. 2d 302, 312 (N.D.N.Y. 2003) (finding treatment decision based on blanket policy instead of individualized medical evaluation deliberately indifferent and "contrary to a decided body of case law"), *vacated in part on other grounds*, 289 F. Supp. 2d 286 (N.D.N.Y. 2003). Here, even if Defendants' blanket policy or custom of discontinuing methadone treatment for people with OUD were sound policy as a general matter—and it is not—the particularities of P.G.'s illness warrant a departure from that practice, and Defendants' failure to take his individual needs into account in enforcing their methadone ban reflects deliberate indifference.

It is hard to imagine what circumstances could justify stripping P.G. of life-sustaining medical treatment, subjecting him to weeks—if not months—of excruciating physical pain, and exposing him to a substantially heightened risk of relapse into addiction, overdose, and death. Whatever those circumstances may be, they do not exist here. *See supra* Section II.A.3 (describing absence of legitimate security or administrability concerns and ready availability of means to provide treatment to P.G.).

III. The Balance of Equities and the Public Interest Weigh Heavily in Favor of an Injunction.

When a governmental defendant is the party opposing preliminary relief, "balancing of the equities merges into [the court's] consideration of the public interest." *SAM Party of New York v. Kosinski*, 987 F.3d 267, 278 (2d Cir. 2021). Here, the balance of equities and the public interest support granting the preliminary injunctive relief P.G. seeks.[11]

The public has a strong interest in preserving constitutional rights and vigorously enforcing anti-discrimination laws. *See Paykina on behalf of E.L. v. Lewin*, 387 F. Supp. 3d 225, 245 (N.D.N.Y. 2019) ("[T]he public interest lies with the enforcement of the Constitution.") (quoting *Ligon v. City of New York*, 925 F. Supp. 2d 478, 541 (S.D.N.Y. 2013)); *First Step, Inc. v. City of New London*, 247 F. Supp. 2d 135, 156 (D. Conn. 2003) (granting preliminary

[11] For similar reasons, the Court should exercise its "wide discretion" to waive the bond requirement in Rule 65(c). *See Doctor's Assocs., Inc. v. Distajo*, 107 F.3d 126, 136 (2d Cir. 1997). Defendants already make methadone treatment routinely available to pregnant people at the jail, and doing the same for P.G. would not cause "any significant monetary losses." *Kermani v. N.Y. State Bd. of Elections*, 487 F. Supp. 2d 101, 115–16 (N.D.N.Y. 2006). Moreover, "an exception to the bond requirement" applies in cases, like this one, which "involve[e] the enforcement of public interests arising out of comprehensive federal health and welfare statutes" like the ADA. *See Pharm. Soc. of State of N.Y., Inc. v. N.Y. State Dep't of Soc. Servs.*, 50 F.3d 1168, 1174 (2d Cir. 1995) (internal quotation marks and citation omitted); *see also Kermani*, 487 F. Supp. 2d at 116 (waiving bond where case raised "important constitutional and public policy issues").

injunction in ADA litigation in part based on public's overriding interest in preventing disability discrimination). And, particularly given the current opioid epidemic, the public interest is also served by ensuring people with OUD, including P.G., are not pointlessly exposed to life-threatening risks of relapse and overdose.

By contrast, the public has no interest in permitting Defendants to enforce an unconstitutional and discriminatory methadone ban against P.G. *See New York Progress & Prot. PAC v. Walsh*, 733 F.3d 483, 488 (2d Cir. 2013) ("[T]he Government does not have an interest in the enforcement of an unconstitutional law.") (quoting *Am. Civ. Liberties Union v. Ashcroft*, 322 F.3d 240, 247 (3d Cir. 2003))). And Defendants are hardly harmed by the requirement that a single person be afforded continued access to the same treatment they routinely make available to pregnant people at the jail. *See* White Decl. ¶¶ 5–6.

CONCLUSION

For all these reasons, the Court should grant Plaintiff's motion for a preliminary injunction.

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