UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF NEW YORK

M.C. and T.G., on behalf of themselves and all similarly situated individuals,

Plaintiffs,

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. 6:22-cv-00190-DNH-ATB

MEMORANDUM OF LAW IN SUPPORT OF PLAINTIFF M.C.'S ORDER TO SHOW CAUSE FOR A TEMPORARY RESTRAINING ORDER AND A PRELIMINARY INJUNCTION

NEW YORK CIVIL LIBERTIES UNION FOUNDATION

Antony P.F. Gemmell, #700911
Terry T. Ding, #702578
Molly K. Biklen, #515729
125 Broad Street, 19th Floor
New York, New York 10004
Telephone: 212-607-3320
Facsimile: 212-607-3318
agemmell@nyclu.org

Dated: March 2, 2022
New York, New York

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Regulations

Other Authorities

PRELIMINARY STATEMENT

After a crushing 15-year battle with opioid use disorder, M.C. is finally sustaining active recovery through the daily methadone treatment prescribed by his physician. Clinically, there is no question that methadone is essential to M.C.'s continued recovery. And M.C., still in the fight for his life, seeks to continue this essential medical treatment during his incarceration at the Jefferson County Correctional Facility—which will begin as early as **this morning**.

Pursuant to a plea deal, M.C. faces incarceration at the Jefferson County jail immediately following the sentencing hearing scheduled in his pending criminal case this morning. Without immediate intervention by this Court, jail officials, acting in blatant disregard for sound medicine and the express judgment of M.C.'s treating physician, will strip M.C. of his life-sustaining methadone treatment under a blanket treatment ban on agonist medications for opioid use disorder. The effects on M.C. 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 seven minutes in this country as a result of opioid overdose.

Before filing this motion, M.C., through counsel, 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 M.C. Accordingly, M.C. now moves the Court for temporary and preliminary relief enjoining the jail from enforcing its treatment ban against him until the Court has assessed the ban's lawfulness.

FACTS

I. Agonist 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 75,000 lives in the past year alone, including those of 2,360 New Yorkers. *Id.* ¶ 22; *Provisional Drug Overdose Death Counts*, CTRS. FOR DISEASE CONTROL & PREVENTION (Feb. 16, 2022), https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm. The rate of death from opioids has accelerated rapidly during the coronavirus pandemic. Rosenthal Decl. ¶ 22. Today, one person dies of opioid overdose every seven 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, 12–14. 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 medical consensus that agonist MOUD is clinically necessary to treat OUD. *See id.* ¶¶ 26–27, 30, 32. Treatment with MOUD is necessarily individualized. *Id.* ¶ 33. An MOUD that effectively treats one patient may be 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. *See MAT Medications, Counseling, and Related Conditions*, SUBSTANCE ABUSE & MENTAL

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

HEALTH SERVS. ADMIN., https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions (last updated Nov. 4, 2021).

Ending MOUD treatment prematurely is exceptionally dangerous. Rosenthal Decl. ¶¶ 35–38. It triggers excruciating withdrawal symptoms that markedly increase the risk of relapse, overdose, and death. *Id.* ¶¶ 36–41. 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, 42, 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. By 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 M.C.

M.C. is a 29-year-old Croghan resident who is diagnosed with severe OUD. Decl. of M.C. ("M.C. Decl.") ¶¶ 1–2; Decl. of Daniel Pisaniello, M.D. ("Pisaniello Decl.") ¶ 3. He has been addicted to opioids since his teens, when he was prescribed Percocet for injuries he sustained in an accident, and has experienced several life-threatening overdoses. M.C. Decl. ¶¶ 2–3. Methadone is the only effective means to treat M.C.'s OUD. Pisaniello Decl. ¶ 3; Rosenthal Decl. ¶¶ 48–52; *see also* M.C. Decl. ¶¶ 5–8, 14. Throughout his decade-long battle with addiction, M.C. has attempted many times to stop using opioids, including through counseling, quitting "cold turkey," and treatment with both types of FDA-approved agonist MOUD. *See* M.C. Decl. ¶¶ 5–6; Rosenthal Decl. ¶ 51. Besides methadone, each of these options has ultimately failed. *See* M.C. Decl. ¶¶ 5–8, 14; Rosenthal Decl. ¶¶ 48, 50–51.

Since M.C. first began methadone treatment in 2017, methadone has proven markedly more effective than anything else at managing his opioid cravings. *See* M.C. Decl. ¶¶ 5–8, 14; Rosenthal Decl. ¶ 48. With daily methadone treatment through the Credo Community Center, a local treatment provider in Watertown, M.C. is in active recovery from his addiction. *See* Pisaniello Decl. ¶ 5; M.C. Decl. ¶ 14. M.C. has not used illicit opioids in two years; has moved in together with his girlfriend of four years; and is able to take his three children hiking, swimming, and bowling. M.C. Decl. ¶¶ 14. He feels hopeful about his future for the first time in years. *See id.* ¶¶ 8, 14. None of this would have been possible without methadone, and his treating physician confirms that continued methadone treatment is medically necessary for M.C. Pisaniello Decl. ¶ 3. Without methadone, M.C. faces painful withdrawal symptoms and a heightened risk of relapse and death. *Id.* ¶ 5; Rosenthal Decl. ¶¶ 49–50, 54.

III. The Jail's Ban on Agonist MOUD Will Force M.C. into Harmful Withdrawal.

M.C. faces imminent incarceration at the Jefferson County Correctional Facility, where the jail will forcibly end his methadone treatment pursuant to a ban on agonist MOUD treatment for non-pregnant people. Like many people with OUD, M.C.'s journey through addiction has been marked by a series of relapses and arrests. M.C. Decl. ¶¶ 10–12. M.C. is due to be sentenced pursuant to a plea deal today, March 2, 2022, on a charge of burglary in the third degree, and is expected to immediately be remanded into the custody of the Jefferson County Correctional Facility upon sentencing. Decl. of Antony Gemmell in Supp. of Mot. for TRO ("Gemmell TRO Decl.") ¶ 4.

The jail maintains a blanket ban on agonist MOUD treatment, including methadone, for non-pregnant people in its custody. *See, e.g.*, *id.* ¶¶ 16–20 (describing multiple recent incidents of the jail refusing access to prescribed agonist MOUD for individuals in its custody); Decl. of M.S.C. ("M.S.C. Decl.") ¶¶ 1, 11–18 (recent forced withdrawal from prescribed methadone);

Decl. of T.G. ("T.G. Decl.") ¶¶ 8–12 (same); Decl. of R.G. ("R.G. Decl.") ¶¶ 1, 11–14 (recent forced withdrawal from prescribed buprenorphine); Decl. of S.G. ("S.G. Decl.") ¶¶ 1, 11–14 (same); *see also* Decl. of Caryn White, LCSW-R ("White Decl.") ¶ 6, *P.G. v. Jefferson Cnty.*, No. 5:21-cv-388 (N.D.N.Y. Apr. 29, 2021), ECF No. 19 ("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."). As a result of the ban, people who enter the jail's custody while receiving treatment with agonist MOUD, including methadone, are abruptly and forcibly withdrawn from that treatment, despite the harmful effects of withdrawal and regardless of their treating physicians' recommendations. *See* Gemmell TRO Decl. ¶¶ 18–22; *e.g.*, M.S.C. Decl. ¶¶ 13–15; T.G. Decl. ¶¶ 8–10; R.G. Decl. ¶¶ 11, 14; S.G. Decl. ¶¶ 11–13.

The jail is capable of providing methadone treatment to people with OUD in its custody. Its policy is to provide access to such treatment to pregnant people with OUD through an arrangement with Credo. *See* 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 under the jail's MOUD ban for non-pregnant people, Defendants will require M.C. 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* Pisaniello Decl. ¶ 5; Rosenthal Decl. ¶¶ 35–41, 48–50, 54. The jail has offered naltrexone to people with OUD, but naltrexone is not the standard of care for patients who are being effectively treated with agonist MOUD. *See* Rosenthal Decl. ¶¶ 42, 52. And forcing a patient to switch from methadone to naltrexone would be clinically inappropriate and dangerous because it would require that the patient withdraw from methadone first. *See id.*

M.C. is terrified of being withdrawn from methadone treatment while in Defendants' custody. M.C. Decl. ¶ 15. Twice before, M.C. had been stripped of his methadone when he was incarcerated. *Id.* ¶¶ 10–12. Each time, he suffered excruciating withdrawal. *Id.* On February 24, M.C., through counsel, requested that Defendants accommodate his disability by affording him continued access to his prescribed methadone treatment while detained at the jail. *See* Gemmell TRO Decl., Ex. A. The request enclosed a letter from M.C.'s treating physician at Credo explaining that daily methadone therapy is medically necessary for M.C. and that denying the medication would subject him to severe withdrawal and jeopardize his long-term recovery from OUD. *See id.*, Ex. B. Given the imminence of M.C.'s detention, the letter sought assurance by February 28 that Defendants would permit M.C. to continue his methadone treatment at the jail. *See id.*, Ex. A. As of this filing, Defendants have not responded. *See* Gemmell TRO Decl. ¶ 9.

ARGUMENT

Plaintiff M.C. 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 temporary restraining order and a preliminary injunction permitting his medical treatment to continue until this Court can evaluate the lawfulness of the jail's blanket ban.

It is clear that M.C. is entitled to that interim relief here.[2] 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

[2] Because "the standard for a temporary restraining order is the same as the one for a preliminary injunction," *Paykina on behalf of E.L. v. Lewin*, 387 F. Supp. 3d 225, 239 (N.D.N.Y. 2019), this memorandum supports Plaintiff's request for both forms of interim relief.

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, 86 (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 M.C.'s recovery, while imposing minimal burdens on the jail.[3]

Presented with near-identical circumstances to those here, a court in this District recently granted the same preliminary relief M.C. is seeking to another individual at the Jefferson County Jail: an order requiring the jail to "provide plaintiff with his daily prescribed methadone during his period of incarceration at the Jefferson County Jail." *P.G. v. Jefferson Cnty.*, No. 5:21-CV-388, 2021 WL 4059409, at *6 (N.D.N.Y. Sept. 7, 2021); *see* Gemmell TRO Decl. ¶ 24 (describing means by which Defendants could provide same treatment access to M.C. here).

I. M.C. Faces Irreparable Harm Absent an Injunction.

Abruptly ending M.C.'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

[3] M.C.'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 interim relief M.C. seeks is narrowly drawn and extends no further than necessary because M.C. requires continued access to his prescribed MOUD to avoid the harms of withdrawal and potential relapse, overdose, and death. *See* Pisaniello Decl. ¶¶ 4–6; Rosenthal Decl. ¶¶ 48–52, 54. And the requested injunction is the least intrusive means of affording M.C. relief, because it affords Defendants latitude to determine how to provide M.C. continued access to his prescribed treatment during his incarceration.

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); *see also P.G.*, 2021 WL 4059409, at *4 (finding a "strong showing" of irreparable harm based on identical factors).

Without injunctive relief, Defendants will end M.C.'s medical treatment as soon as he enters the jail, *see* White Decl. ¶ 6; *e.g.*, M.S.C. Decl. ¶ 13; T.G. Decl. ¶¶ 8–9; R.G. Decl. ¶ 11; S.G. Decl. ¶¶ 11–12, forcing him into acute methadone withdrawal, *see* M.C. Decl. ¶¶ 10–12, 15; Rosenthal Decl. ¶¶ 49–50, 54. Methadone withdrawal is "excruciatingly painful." Rosenthal Decl. ¶ 8; *see* M.C. Decl. ¶ 10 (describing withdrawal as "awful beyond imagination"); *P.G.*, 2021 WL 4059409, at *4 (recognizing same). The immediate and extreme pain of forcibly withdrawing M.C. alone constitutes irreparable harm. *See P.G.*, 2021 WL 4059409, at *4; *see also 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."). Within hours of entering Defendants' custody, M.C. 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. ¶¶ 8, 36–37. The symptoms of methadone withdrawal are often so intense that they induce suicidality. *See* Rosenthal Decl. ¶¶ 8, 36–37. These symptoms could persist for weeks or even months. *See id.* ¶ 36; *e.g.*, M.S.C. Decl. ¶ 15; T.G. Decl. ¶ 16; R.G. Decl. ¶ 10; S.G. Decl. ¶ 19.

Beyond the severe pain of withdrawal, Defendants' blanket ban will set M.C. up for a life-threatening relapse—another form of irreparable harm. *See P.G.*, 2021 WL 4059409, at *4 (finding "strong showing" of irreparable harm based in part on heightened risk of relapse and death resulting from forced methadone withdrawal); *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"). Methadone is medically necessary to treat M.C.'s OUD. *See* Pisaniello Decl. ¶ 3; Rosenthal Decl. ¶¶ 48–50. His treating physician has specifically advised against forcibly ending M.C.'s methadone therapy because doing so would "put him at greater risk of dangerous overdose." Pisaniello Decl. ¶ 5; *see also* Rosenthal Decl. ¶¶ 48–50 (increased risk of relapse). The risk of relapse is particularly pronounced given M.C.'s impending entry to jail, a setting where contraband opioids are often readily accessible. *See* Decl. of Edmond Hayes ("Hayes Decl.") ¶¶ 13, 26; U.S. DEP'T JUSTICE, MORTALITY IN LOCAL JAILS & STATE PRISONS, 2000–2013, 7 (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.

Besides subjecting M.C. to painful withdrawal and likely relapse in the near-term, forcibly ending methadone therapy endangers his longer-term recovery. Rosenthal Decl. ¶¶ 50, 54, 55; Pisaniello Decl. ¶ 5. 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. (Smith I)*, 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 decrease in post-release resumption of treatment, with lack of treatment in turn being associated with increased risk of overdose and death"), *aff'd*, *(Smith II)* 922 F.3d 41 (1st Cir. 2019).

II. M.C. Is Substantially Likely to Succeed on the Merits.

M.C. 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, M.C. can make that showing as to each.

A. M.C. Is Substantially Likely to Succeed on His ADA Claims.

M.C. 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 on account 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. To establish a prima facie violation of Title II, M.C. 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);[4] *Henrietta D.*, 331 F.3d at 279 (broad construction afforded to ADA considering its remedial purpose). The 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 273 (citing *Alexander*, 469 U.S. at 301). And courts look to the ADA's implementing regulations in interpreting Title II's meaningful access requirement. *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 against discrimination").

1. M.C. Is a Qualified Individual with a Disability.

The protections of Title II apply to M.C. 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). M.C. is

[4] 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.

[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, like M.C., is "participating in a supervised rehabilitation program and no longer engaging in such use." 42 U.S.C. § 12210(a)–(b); *see also* Pisaniello Decl. ¶¶ 3–4.

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 function[s]," including neurological and brain function. 42 U.S.C. §§ 12102(1), (2); *see also* Rosenthal Decl. ¶ 10; M.C. Decl. ¶¶ 2, 8.

M.C. 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." *See 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); *Hamilton v. Westchester Cnty.*, 3 F.4th 86 (2d Cir. 2021) (applying Title II against county jail).

3. The Jail's Blanket Methadone Ban Discriminates against M.C.'s Disability.

Defendants are discriminating against M.C. in violation of Title II because their blanket treatment ban denies him "meaningful access" to the jail's medical services based on his OUD. Pursuant to the ban, individuals who have prescriptions for methadone or buprenorphine are denied access to this medication when they enter the jail, without regard to its medical necessity.

See Gemmell TRO Decl. ¶¶ 18–22; *e.g.*, M.S.C. Decl. ¶ 13; T.G. Decl. ¶¶ 8–9; R.G. Decl. ¶ 11; S.G. Decl. ¶¶ 11–12. In enforcing this ban against M.C., 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 M.C. and many others with his disability, Defendants' ban discriminates on its face against people with OUD. *See P.G.*, 2021 WL 4059409, at *4–5 (concluding categorical "refusal to guarantee access to methadone treatment likely violates the ADA"). In purpose and effect, the ban singles out M.C. 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 M.C. 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 M.C. instead

[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 M.C., for whom treatment with agonist MOUD is necessary.

Nor does the fact the jail provides access to *other*, non-agonist MOUD—namely naltrexone—but not methadone, satisfy Defendants' obligation to M.C. under Title II. A medication completely distinct from methadone will not afford meaningful access to jail medical care to M.C., for whom methadone specifically is necessary. *See* Rosenthal Decl. ¶¶ 42, 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))).

has OUD, Defendants' ban not only permits, but actually *requires* Defendants to deny M.C. 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 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 treatment that, for M.C. and many others, is medically necessary.[7] And

[7] Even were Defendants to proffer a non-discriminatory rationale for denying essential treatment to people with OUD, the sheer irrationality of their blanket ban on agonist MOUD 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).

decades of entrenched stigma that have pervaded societal attitudes towards opioid addiction generally and agonist MOUD treatment specifically, suggest the ban reflects more than apathy.[8]

Second, regardless of whether the blanket ban is itself discriminatory, Defendants' refusal to modify it to accommodate M.C.'s disability independently violates Title II. *See* 28 C.F.R. § 35.130(b)(7)(i); *P.G.*, 2021 WL 4059409, at *4–5 (finding plaintiff substantially likely to succeed on merits of Title II failure-to-accommodate claim under virtually identical facts).

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—including in this district—have held that failure to accommodate a disability by providing MOUD to incarcerated people violates the ADA. *See P.G.*, 2021 WL 4059409, *4–5; *Smith I*, 376 F. Supp. 3d at 161; *Pesce v. Coppinger*, 355 F. Supp. 3d 35, 47 (D. Mass. 2018).

---

[8] Stigma towards OUD remains a formidable barrier to patients' accessing necessary treatment, including in the criminal justice system. *See* Hayes Decl. ¶ 28 ("[H]aving worked for years in corrections, it has been my experience that corrections officials who deny detainees access to methadone and buprenorphine medications do so because they view methadone and buprenorphine as not another medication, but rather an illicit drug"—a "view . . . contrary to the science and rooted in stigma."); 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").

Here, M.C.'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* at 3–4 (describing medical necessity of methadone to treat M.C.'s OUD). Thus, on February 24, 2022, through counsel, M.C. sent a letter to the Jefferson County Attorney requesting that, as an accommodation for M.C.'s disability, Defendants alter their policies and practices to permit him to continue methadone treatment at the jail. *See* Gemmell TRO Decl., Ex. A. That letter was supported by a letter from M.C.'s treating physician at Credo confirming M.C.'s diagnosis with OUD and identifying daily methadone therapy as "medically necessary treatment" without which M.C. will "experience severe and extended withdrawal symptoms" placing him at "a greater risk of dangerous overdose and jeopardiz[ing] his recovery from opioid use in the long term." *Id.*, Ex. B. The letter sought confirmation from Defendants by February 28, 2022 that M.C. would be permitted to access continued methadone treatment at the jail. *See id.*, Ex. A. Despite the urgency of M.C.'s disability accommodation request, Defendants failed and refused to grant the request by February 28; and, as of the filing of this motion, they have not responded to the request.[9] *See* Gemmell TRO Decl. ¶ 9.

There is no good reason for Defendants not to have granted M.C.'s request to continue medically necessary treatment for his disability. Methadone therapy is safe, administrable, and affordable, including in a setting like the jail. Hayes Decl. ¶¶ 9, 12–26; *see* NATIONAL COUNCIL

[9] The Court has good reason to believe the jail would end M.C.'s methadone treatment even if Defendants *had* responded. Recently, Defendants deferred decision on an almost identical accommodation request by the NYCLU on behalf of M.S.C., stating they would "happ[ily]" address M.S.C.'s request for continued access to methadone when he entered the jail. *See* Gemmell TRO Decl. ¶ 11. Instead, jail officials abruptly terminated M.S.C.'s prescribed methadone treatment upon his incarceration, exposing him to severe withdrawal. *See* M.S.C. Decl. ¶¶ 10–18; Gemmell TRO Decl. ¶ 12.

FOR BEHAVIORAL HEALTH, *Medication Assisted Treatment for Opioid Use Disorder in Jails and Prisons: A Planning and Implementation Toolkit* 17 (2020), https://www.thenationalcouncil.org/wp-content/uploads/2020/09/MAT_in_Jails_Prisons_Toolkit_Final_12_Feb_20.pdf (listing various ways in which jails and prisons can provide MOUD access). 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 generally* Hayes Decl. (explaining how methadone has been securely administered in carceral settings); *see also Smith II*, 922 F.3d at 42 (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 permit pregnant people at the jail to receive methadone treatment through Credo—precisely the same access to treatment they would now deny to M.C. *See* White Decl. ¶¶ 5–6. This fact undermines any conceivable reason for denying the same access to M.C., and conclusively establishes that their refusal to grant M.C.'s disability accommodation request is discriminatory and violates Title II.

B. M.C. Is Substantially Likely to Succeed on His Constitutional Claim.

M.C. is also substantially likely to succeed on his claim that Defendants' blanket methadone ban violates the Eighth Amendment. The Eighth Amendment's prohibition on cruel and unusual punishment creates an "obligation [for the government] to provide medical care for those whom it is punishing by incarceration." *Estelle*, 429 U.S. at 103. Not every denial of custodial medical care rises to constitutional proportions. *See id.* at 116 n.13. But the Supreme

Court has long recognized that "deliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain'" that the Eighth Amendment proscribes. *See id.* at 104 (quoting *Gregg v. Georgia*, 428 U.S. 153, 173 (1976)). The Eighth Amendment's deliberate indifference standard includes both objective and subjective prongs: "First, the alleged deprivation must be, in objective terms, 'sufficiently serious.' Second, the defendant must act with a sufficiently culpable state of mind." *Chance v. Armstrong*, 143 F.3d 698, 702 (2d Cir. 1998) (quoting *Hathaway v. Coughlin*, 37 F.3d 63, 66 (2d Cir. 1994)).

M.C. satisfies both components of this analysis: His OUD is an objectively serious medical condition; and Defendants' refusal, under a blanket policy, to permit him to access life-sustaining treatment for OUD is one that they know exposes him to life-threatening harm.

1. OUD Is a Serious Medical Condition.

As courts throughout the Second Circuit recognize, OUD, a chronic brain disease that has wreaked havoc in M.C.'s life and that kills thousands of New Yorkers each year, is an objectively serious medical condition.[10] *See P.G.*, 2021 WL 4059409, *5 (OUD "has been recognized an 'objectively' serious medical condition." (citing *Alvarado v. Westchester Cnty.*, 22 F. Supp. 3d 208, 217 (S.D.N.Y. 2014))); *Messina v. Mazzeo*, 854 F. Supp. 116, 140 (E.D.N.Y. 1994) (same).

The serious medical needs standard contemplates "a condition of urgency such as one that may produce death, degeneration, or extreme pain." *Hathaway v. Coughlin*, 99 F.3d 550, 553 (2d Cir. 1996). It is informed by "contemporary standards of decency," *Smith*, 316 F.3d at

[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).

187, and incorporates factors such as "[t]he existence of an injury that a reasonable doctor or patient would find important and worthy of comment or treatment; the presence of a medical condition that significantly affects an individual's daily activities; or the existence of chronic and substantial pain." *Chance*, 143 F.3d at 702 (cleaned up).

Applied here, these factors make clear M.C.'s OUD is an objectively serious medical condition. OUD causes cravings for and uncontrollable use of opioids. *See* Rosenthal Decl. ¶¶ 10, 14. 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." *Id.* ¶ 11. M.C.'s physician has prescribed daily methadone therapy to treat his OUD. Pisaniello Decl. ¶¶ 3–4. That treatment is the standard of care for OUD and "medically necessary" for M.C. *See id.* ¶ 3; Rosenthal Decl. ¶¶ 26, 48–50. If his treatment ends now, M.C. faces an array of severe withdrawal symptoms as well as a significantly heightened risk of relapse into drug use, overdose, and death. *See* Pisaniello Decl. ¶ 5; Rosenthal Decl. ¶¶ 49–50, 54; M.C. Decl. ¶¶ 10–13. Because it subjects him to harms of precisely the sort contemplated under the serious medical need standard—"death, degeneration [and] extreme pain," *Hathaway*, 99 F.3d at 553 (cleaned up)—M.C.'s OUD satisfies the first prong of the deliberate indifference analysis.

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

Stripping M.C. 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 the specific recommendation of his treating physician—and reflects Defendants' deliberate indifference.

Deliberate indifference under the Eighth Amendment "is a mental state equivalent to subjective recklessness, as the term is used in criminal law." *Salahuddin v. Goord*, 467 F.3d 263,

280 (2d Cir. 2006) (citing *Farmer v. Brennan*, 511 U.S. 825, 839–40 (1994)). Deliberate indifference requires more than negligence, but less than conduct undertaken "for the very purpose of causing harm." *Farmer*, 511 U.S. at 835. To be deliberately indifferent in the Eighth Amendment context, a jail official must be aware of and disregard a substantial risk of serious harm to the plaintiff. *See Salahuddin*, 467 F.3d at 280 (citing *Farmer*, 511 U.S. at 835, 842). "Awareness" requires the official "both [to] be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and . . . [to] draw the inference." *Farmer*, 511 U.S. at 837. A harm need not be "surely or almost certainly [to] result" in order for the risk to be considered "substantial." *See Salahuddin*, 467 F.3d at 280 (citing *Farmer*, 511 U.S. at 835, 842). "[A] factfinder may conclude that a prison official knew of a substantial risk from the very act that the risk was obvious." *Farmer*, 511 U.S. at 842.

Forcibly withdrawing M.C. 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* at 7–10. 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 M.C.'s treatment with methadone, as Defendants' policy requires. *See* Rosenthal Decl. ¶ 35.

Defendants know that their blanket ban endangers M.C. 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, Defendants are on notice of the harmful consequences of denying access to prescribed MOUD to M.C.: Their staff routinely witness the effects of forced MOUD withdrawal as putative class members cycle into the jail. *See* Gemmell TRO Decl. ¶¶ 18–21; *e.g.*, M.S.C. Decl. ¶¶ 13–15; T.G. Decl. ¶¶ 10, 16; R.G. Decl. ¶¶ 10, 14; S.G. Decl. ¶¶ 13, 19. And with respect to M.C. in particular, Defendants have received specific confirmation from M.C.'s treating physician of the life-threatening harm that M.C. will suffer if Defendants do not afford him continued access to his "medically necessary" methadone treatment for OUD. *See* Gemmell TRO Decl., Exs. A, B. Despite knowing that their methadone ban puts M.C. in harm's way, Defendants have refused to confirm they will not deny methadone treatment to M.C., placing their deliberate indifference to M.C.'s safety beyond doubt.

As the rate of opioid-related death has continued to skyrocket nationwide, courts around the country—including in this district—have recognized that denying methadone maintenance therapy to people with OUD in their custody can amount to deliberate indifference.[11] *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 v. Outgamie Cnty.*, 394 F.3d 510, 513 (7th Cir. 2005) (triable issue of fact where jail officials knew appellant was experiencing methadone withdrawal); *Pesce*, 355 F. Supp. 3d at 47–48 (granting preliminary

[11] The Department of Justice has taken the same position. *See* 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.").

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. 3d. at 217 (plaintiffs plausibly stated Eighth Amendment claim against jail that denied methadone maintenance therapy); *see also P.G.*, 2021 WL 4059409, at *6 (granting preliminary injunction on Fourteenth Amendment where Defendants were "on notice that refusing access to . . . medically necessary [methadone] treatment expose[d] the plaintiff to serious risk of harm to his health."). Nothing about the jail's blanket methadone ban, which forecloses M.C. 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 M.C.'s treatment. *Hathaway*, 37 F.3d at 70. There can be no serious disagreement over the importance of methadone treatment to M.C.'s continued safety. *See* Pisaniello Decl. ¶ 5; Rosenthal Decl. ¶¶ 48–50; 54. Broad consensus exists that a person in recovery from OUD should not be forced to discontinue agonist MOUD treatment involuntarily, barring a specific and unusual medical reason. *See id.* ¶¶ 35, 38. Here, methadone is medically necessary for M.C. and his treatment provider warns that M.C.'s methadone therapy should not be discontinued at the jail. *See* Pisaniello Decl. ¶¶ 5–6; *accord* Rosenthal Decl. ¶¶ 48–50, 54. Doing so would violate the standard of care and expose him unnecessarily to a high risk of withdrawal, relapse, and death. *See* Rosenthal Decl. ¶¶ 48–50, 54; Pisaniello Decl. ¶ 5.

Nor does ending M.C.'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. *Id.* M.C.'s physician has determined that methadone is medically necessary based on an individualized evaluation of M.C.'s clinical profile. *See* Pisaniello Decl. ¶ 3; *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 M.C.'s medical needs. *See Alvarado*, 22 F. Supp. 3d at 217 ("uniform" denial of MOUD to individuals experiencing opioid withdrawal stated Eighth Amendment claim); *see also Pesce*, 355 F. Supp. 3d 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, as here, the policy "ignores and contradicts [the plaintiff's] physician's recommendations." *Pesce*, 355 F. Supp. 3d at 48; *see also* Pisaniello Decl. ¶¶ 3–6; Gemmell TRO Decl., Ex. B.

The creation of blanket policies like Defendants' agonist MOUD 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 prescribed agonist MOUD were sound policy as a general matter—and it is not—the particularities of M.C.'s illness warrant a departure from that practice. *See* Pisaniello Decl. ¶¶ 4–5 (noting, in light of the severity of M.C.'s OUD and his correspondingly high methadone dosage, that forced methadone withdrawal would expose him to particularly "severe and extended withdrawal symptoms"). Defendants' failure to take M.C.'s individual needs into account in enforcing their methadone ban reflects deliberate indifference.

It is hard to imagine what circumstances could justify stripping M.C. 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.

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 N.Y. v. Kosinski*, 987 F.3d 267, 278 (2d Cir. 2021) (citation omitted). Here, the balance of equities and the public interest support granting the temporary and preliminary injunctive relief M.C. seeks.[12]

[12] 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 M.C. would not cause "any significant monetary losses."

"[T]he public interest lies with enforcing the Constitution and federal law." *P.G.*, 2021 WL 4059409, at *5 (citing *Paykina*, 387 F. Supp. 3d at 245). And particularly given the current opioid epidemic, the public interest is also served by ensuring people with OUD, including M.C., 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 ban on necessary medical care against M.C. *See N.Y. 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. Civil Liberties Union v. Ashcroft*, 322 F.3d 240, 247 (3d Cir. 2003))). And while M.C. "will personally benefit from continuing to receive medically necessary treatment," *P.G.*, 2021 WL 4059409, at *5, Defendants are hardly harmed by the requirement that M.C. be afforded continued access to the very same treatment they already provide to the plaintiff in *P.G.* and to pregnant people at the jail, *see id.*; White Decl. ¶¶ 5–6.

CONCLUSION

For all these reasons, the Court should grant Plaintiff's motion for temporary and preliminary injunctive relief.

Dated: March 2, 2022
New York, New York

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'y 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").

NEW YORK CIVIL LIBERTIES UNION FOUNDATION

/s/ Antony P. F. Gemmell
Antony P. F. Gemmell, #700911
Terry T. Ding, #702578
Molly K. Biklen, #515729
125 Broad Street, 19th Floor
New York, New York 10004
Telephone: 212-607-3320
Facsimile: 212-607-3318
agemmell@nyclu.org

Counsel for Plaintiffs