UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF NEW YORK

M.C. et al., on behalf of themselves and all similarly situated individuals,

Plaintiffs,

v.

JEFFERSON COUNTY, NEW YORK, et al.,

Defendants.

Case No. 6:22-cv-190 (DNH/ML)

MEMORANDUM OF LAW IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

NEW YORK CIVIL LIBERTIES UNION FOUNDATION

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PRELIMINARY STATEMENT

Plaintiffs and the putative class are people living with a chronic and life-threatening disability: opioid use disorder. They each are or will be detained at the Jefferson County Correctional Facility, where jail officials maintain a routine practice of denying prescribed treatment with agonist medications for OUD, namely methadone and buprenorphine. The inexorable consequence of this practice is that class members, who depend on agonist medications to remain in recovery, are routinely stripped of access to their prescribed treatment when they enter the jail, triggering painful and dangerous withdrawal.

There is no real question that Defendants' denial of agonist medication for OUD violates well established standards of care and medical ethics for treating opioid addiction. Yet jail officials have followed the same reckless practice again and again, abruptly withdrawing prescribed treatment from well over a dozen class members in the past three months alone, many of whom come forward with the filing of this motion to detail the abject suffering they have endured as a result of Defendants' forced termination of their prescribed medication.

Unless this Court intervenes, the scope of this harm will continue to grow during the pendency of this action: A rapidly expanding class of individuals will be denied their prescribed treatment pursuant to Defendants' practice, exposing them to agonizing withdrawal and a substantial risk of death; and those already stripped of their medication will continue to suffer the crushing consequences of lapsed treatment for OUD. Accordingly, Plaintiffs now move for a preliminary injunction permitting members of the putative class to access their prescribed treatment for OUD until this Court can evaluate the lawfulness of the jail's practice.

FACTS

I. Agonist MOUD Is the Standard of Care for OUD.

The opioid epidemic is a national health crisis. Rosenthal Supp. 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://perma.cc/8GU9-828U. The rate of death from opioids has accelerated rapidly during the coronavirus pandemic. Rosenthal Supp. 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. Although the particular form and dosage of methadone or buprenorphine that would be the most effective treatment depends on individual patients' profiles, there is no question that it is medically necessary for patients receiving prescribed treatment with agonist MOUD to continue that treatment. *See id.* ¶¶ 26–27, 32, 45. 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 Health Servs. Admin. ("SAMHSA"),

[1] An agonist medication activates opioid receptors in the brain to relieve withdrawal symptoms and control cravings. Rosenthal Supp. Decl. ¶ 26.

https://perma.cc/GD3Q-RNGH (last updated Mar. 4, 2022). Those who discontinue treatment with MOUD generally return to illicit opioid use. *Medications for Opioid Use Disorder: Treatment Improvement Protocol 63*, SAMHSA, 1-8 (2021), https://perma.cc/YX8W-VUJE [hereinafter SAMHSA, *TIP 63*].

II. Continued Access to Agonist MOUD Is Medically Necessary for Class Members.

For class members, who are prescribed treatment for OUD with agonist medications, continued access to those medications is medically necessary. Rosenthal Supp. Decl. ¶ 45. Forcing a person with OUD to withdraw from effective MOUD treatment, absent significant adverse side effects or contraindications, is exceptionally dangerous and therefore violates the standard of care and medical ethics. *Id.* ¶¶ 35, 38, 45, 48.

Premature termination of MOUD treatment causes extreme pain and dramatically increases the likelihood of relapse, overdose, and death. *See id.* ¶¶ 35–38. Within hours or days of being removed from MOUD, a patient experiences excruciating withdrawal. *Id.* ¶¶ 36–41. Withdrawal precipitates physical symptoms including bone and joint aches, vomiting, diarrhea, insomnia, hypothermia, hypertension, and heart failure, as well as psychological symptoms including depression, anxiety, and suicidal ideation. *Id.* ¶¶ 36–37. These symptoms are so agonizing that people in the throes of withdrawal feel overwhelming drug cravings and become desperate to use opioids to put an end to their suffering. *Id.* ¶¶ 8, 38; *see also, e.g.*, P.M. Decl. ¶ 13 (During withdrawal, "[m]y drug cravings haunt me. I cannot think about anything else no matter how hard I try."); M.L. Decl. ¶ 16 ("Even though I have not used opioids in years, my cravings are all-consuming [during withdrawal]."). As a result, "patients who discontinue [MOUD] generally return to illicit opioid use." SAMHSA, *TIP 63*, 1-8. Over 82% of patients who discontinue methadone treatment relapse to intravenous drug use within one year. *See*

Rosenthal Supp. Decl. ¶ 38. Those who discontinue buprenorphine treatment are similarly likely to relapse. *Id.*

Compounding the heightened risk of relapse is the reduced tolerance to high-dose opioids seen in persons forcibly withdrawn from MOUD. *Id.* ¶ 38. This means that not only are such individuals more likely to be compelled by their cravings to use opioids, but they are also more susceptible to life-threatening overdose with each use. *See id.* Thus, a patient forcibly withdrawn from MOUD is particularly vulnerable to death from overdose. *See id.*

The risks associated with forced withdrawal are especially pronounced in jail settings—during incarceration and following release. *Id.* ¶¶ 38, 40–41, 44. One study found that incarcerated people receiving agonist MOUD treatment were 94% less likely to die during their first four weeks of incarceration than those not receiving treatment. Sarah Larney, *Opioid Substitution Therapy as a Strategy to Reduce Deaths in Prison: Retrospective Cohort Study*, BMJ Open, 5 (2014), https://perma.cc/5AMA-SPFG. Another study revealed 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. Rosenthal Supp. Decl. ¶ 40. 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.* Finally, forcibly removing people from MOUD during incarceration led to a sevenfold decrease in treatment retention following release. *Id.* ¶ 38.

The shockingly high overdose and fatality rates for people denied MOUD during their incarceration illustrate the importance of restoring their treatment. For as long as they go without their prescribed MOUD, these patients remain at a significantly heightened risk of relapse, overdose, and death. *Id.* ¶ 44. Thus, it is critical that they be allowed to resume their treatment with agonist MOUD as soon as possible. *Id.* ¶¶ 44–45.

III. The Jail's Practice of Denying Agonist MOUD Forces Class Members into Harmful Withdrawal.

The jail maintains a practice of denying agonist MOUD treatment to non-pregnant people in its custody, pursuant to which Defendants routinely strip class members of their prescribed, medically necessary treatment. *See, e.g.*, T.G. Decl. ¶¶ 8–12, ECF No. 2-5 (recent forced withdrawal from prescribed methadone); S.C. Decl. ¶¶ 16–18 (same on two recent occasions); J.C. Decl. ¶¶ 8, 11 (same); P.M. Decl. ¶¶ 9, 11 (same); M.S.C. Decl. ¶¶ 1, 11–18, ECF No. 8 (same); J.M. Decl. ¶¶ 8–10 (recent forced withdrawal from prescribed buprenorphine); R.D. Decl. ¶¶ 11, 13 (same); M.L. Decl. ¶ 10 (same); R.G. Decl. ¶¶ 1, 11–14, ECF No. 9 (same); S.G. Decl. ¶¶ 1, 11–14, ECF No. 10 (same); *see also* White Decl. ¶ 6, *P.G. v. Jefferson Cnty.*, No. 5:21-cv-388 (N.D.N.Y. Apr. 29, 2021), ECF No. 19 [hereinafter "White Decl."]. As a result of this practice, people who enter the jail's custody are abruptly and forcibly withdrawn from their agonist MOUD treatment, despite the harmful effects of withdrawal and without regard to their treating physicians' recommendations. *See, e.g.*, S.C. Decl. ¶¶ 11, 18 ("[T]he pain is unexplainable to anyone who has not undergone withdrawal."); J.C. Decl. ¶ 11 (describing withdrawal as "more painful even than when I was literally hit by a truck"); P.M. Decl. ¶ 11 ("The only way to describe withdrawal is hell on earth."); R.G. Decl. ¶¶ 10, 14 ("The withdrawal I underwent each time the jail cut off my treatment was excruciating—both physically and mentally.").

The jail is capable of providing agonist MOUD treatment to people in its custody. It has a policy of providing access to methadone to pregnant people with OUD through an arrangement with the Credo Community Center, an opioid treatment clinic near the jail. *See* White Decl. ¶¶ 5–6. Under that policy, the jail has successfully continued several pregnant people on methadone treatment through Credo without incident. *See Id*. ¶¶ 5–6. In compliance with this Court's orders,

the jail has also had no problems continuing two non-pregnant individuals, including Plaintiff M.C., on their prescribed agonist MOUD within the past year. *See* ECF No. 30 at 10; *P.G.*, 2021 WL 4059409, at *6. But pursuant to the jail's general practice of denying agonist MOUD to non-pregnant people, Defendants routinely require other class members to withdraw from methadone and buprenorphine, exposing them to the certainty of painful withdrawal symptoms as well as a heightened risk of relapse and death. *See, e.g.*, S.C. Decl. ¶¶ 11, 18, 28; J.C. Decl. ¶¶ 11–13; M.L. Decl. ¶¶ 16–17; J.M. Decl. ¶¶ 8–10, 16; T.G. Decl. ¶¶ 10, 16, 19–20.

Defendants have subjected class member after class member—at least a dozen in the last three months alone—to this inhumane practice notwithstanding the class members' repeated and desperate requests for continued access to their prescribed treatment. *See, e.g.*, S.C. Decl. ¶¶ 17–20; J.C. Decl. ¶¶ 8–9; T.G. Decl. ¶¶ 11–12; R.D. Decl. ¶ 11. Even when class members have given the jail every opportunity to accommodate their medical needs by requesting, well in advance of their incarceration, continuation of their prescribed MOUD, Defendants have steadfastly observed their practice of denying treatment. *See* ECF No. 5 ¶¶ 7–9 (jail ignoring accommodation request); M.S.C. Decl. ¶¶ 11–13 (jail forcibly withdrawing prescribed methadone notwithstanding accommodation request a month in advance).

ARGUMENT

Plaintiffs seek preliminary relief from Defendants' practice of abruptly ending the prescribed agonist MOUD treatment of putative[2] class members when they enter the jail.

[2] Although Plaintiffs' motion for class certification remains pending, *see* ECF No. 2, for simplicity's sake, this memorandum refers in some places to the putative class as the "class."

Plaintiffs are entitled to that preliminary relief here.[3] They can make a "strong showing" that cutting off prescribed agonist MOUD treatment during this litigation will subject class members to irreparable—indeed, life-threatening—harm. *A.H. ex rel. Hester v. French*, 985 F.3d 165, 176 (2d Cir. 2021). Plaintiffs also have a "substantial" likelihood of succeeding on their claims that the jail's pervasive practice of denying prescribed agonist MOUD violates class members' rights under the Americans with Disabilities Act ("ADA") and the Constitution. *Id.* And the public interest and balance of equities weigh heavily in Plaintiffs' favor. *See New York v. U.S. Dep't of Homeland Sec.*, 969 F.3d 42, 86 (2d Cir. 2020). Preserving constitutional rights and preventing unlawful discrimination are among our core societal commitments, and preliminary injunctive relief here would mean almost everything for class members' safety, while imposing minimal burdens on the jail.[4]

Presented with circumstances similar to those here, this Court has twice in the past year alone ordered Defendants to provide prescribed agonist MOUD to individuals entering the jail. *See* ECF Nos. 16, 30; *P.G.*, 2021 WL 4059409, at *6. Members of the class, who face

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[3] The Court has authority to issue preliminary injunctive relief to a putative class before certification. *See, e.g.*, *LaForest v. Former Clean Air Holding Co.*, 376 F.3d 48, 56 (2d Cir. 2004) (affirming issuance of preliminary injunction to a then-putative class); *Abdi v. Duke*, 280 F. Supp. 3d 373, 400 (W.D.N.Y. 2017) ("Under appropriate circumstances, a court may grant preliminary injunctive relief in favor of putative class members before class certification, and correspondingly, assess the harm to putative class members when considering the preliminary injunction motion."), *vacated in part on other grounds*, 405 F. Supp. 3d 467 (W.D.N.Y. 2019).

[4] Plaintiffs' requested relief also comports with the Prison Litigation Reform Act's requirements for preliminary injunctive relief in prison conditions litigation. *See* 18 U.S.C. § 3626(a)(2). The relief Plaintiffs seek is narrowly drawn and extends no further than necessary because class members require access to their prescribed MOUD to avoid the harms of withdrawal and potential relapse, overdose, and death. *See* Rosenthal Supp. Decl. ¶¶ 44–45, 49. And the requested injunction is the least intrusive means of affording relief to class members, because it affords Defendants latitude to determine how to provide class members with continued access to their prescribed treatment while confined to Defendants' custody.

substantially identical harms under the same challenged jail practices, are no less entitled to preliminary relief.

I. Class Members Face Irreparable Harm Absent an Injunction.

"The showing of irreparable harm is perhaps the single most important prerequisite for the issuance of a preliminary injunction." *V.W. ex rel. Williams v. Conway*, 236 F. Supp. 3d 554, 589 (N.D.N.Y. 2017) (citation omitted). As almost a dozen declarants in this litigation attest, Defendants' routine practice is to deny prescribed MOUD treatment, forcing class members into excruciating withdrawal, exposing them to a substantially heightened risk of relapse, and endangering their long-term recovery. These consequences are the quintessence of irreparable harm. *See* ECF No. 30 at 7–8 (finding "strong showing" of irreparable harm based on identical factors); *P.G.*, 2021 WL 4059409, at *4 (same).

Acting under the jail's practice, Defendants routinely end prescribed MOUD treatment as soon as class members enter the jail, forcing painful withdrawal. *See, e.g.*, T.G. Decl. ¶¶ 8–9; S.C. Decl. ¶ 10; J.C. Decl. ¶¶ 8, 11; J.M. Decl. ¶¶ 8–10; R.D. Decl. ¶¶ 11, 13–14; P.M. Decl. ¶¶ 9, 11; M.L. Decl. ¶¶ 10, 13; M.S.C. Decl. ¶ 13; R.G. Decl. ¶ 11; S.G. Decl. ¶¶ 11–12. Withdrawal from agonist MOUD is "excruciatingly painful." Rosenthal Supp. Decl. ¶¶ 8, 36; *P.G.*, 2021 WL 4059409, at *4 (recognizing same); *see, e.g.*, M.C. Decl. ¶ 10, ECF No. 2-4 (describing withdrawal as "awful beyond imagination"); S.C. Decl. ¶ 11 (describing withdrawal as "the worst experience of [his] life"). The immediate and extreme pain of forcibly withdrawing class members alone constitutes irreparable harm. *See* ECF No. 30 at 7–8; *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."). And numerous class members report that their symptoms of withdrawal as a result of Defendants' practice have been severe. *See, e.g.*, P.M. Decl. ¶ 11 ("I felt like I was dying and being

tortured."); M.L. Decl. ¶ 16 ("I have haunting nightmares and my mental health is suffering."); M.S.C. Decl. ¶ 14 ("I had heart palpitations, muscle spasms throughout my whole body, severe pain in my neck and upper body, tremors, and anxiety."); J.C. Decl. ¶ 11 ("I've thrown up and defecated all over myself and could not eat or sleep."); J.M. Decl. ¶ 10 ("[I have] cold sweats . . . so bad that no matter how many layers of clothing I put on I cannot feel warm"). The symptoms of agonist MOUD withdrawal are often so intense that they induce suicidality. *See* Rosenthal Supp. Decl. ¶¶ 8, 36–37. These symptoms can persist for weeks or even months. *See id.* ¶ 36; *e.g.*, T.G. Decl. ¶ 16; S.G. Decl. ¶ 19; S.C. Decl. ¶ 27; J.C. Decl. ¶ 12; P.M. Decl. ¶ 13; J.M. Decl. ¶ 16.

Beyond the severe pain of withdrawal, Defendants' practice of denying access to agonist MOUD sets class members up for life-threatening relapse—another form of irreparable harm. *See* ECF No. 30 at 7–8 (finding "strong showing" of irreparable harm based in part on heightened risk of relapse and death resulting from forced methadone withdrawal); *P.G.*, 2021 WL 4059409, at *4 (same); *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"). "[P]atients who discontinue OUD medication generally return to illicit opioid use," SAMHSA, *TIP 63*, 1-8, with the attendant risks of overdose and death, Rosenthal Supp. Decl. ¶¶ 38, 41, 44. Therefore, prematurely ending prescribed methadone or buprenorphine treatment for OUD is exceptionally dangerous and violates the standard of care. Rosenthal Supp. Decl. ¶¶ 35–37; *see*

also SAMHSA, *TIP 63*, 3-92–93. The risk of life-threatening relapse is particularly pronounced given the context here: a jail setting, where contraband opioids are often readily accessible. *See* Hayes Decl. ¶¶ 13, 26, ECF No. 7; Rosenthal Supp. Decl. ¶¶ 38, 40–41; U.S. Dep't of Just. ("DOJ"), *Mortality in Local Jails & State Prisons, 2000–2013*, 7 (2015), https://perma.cc/S5XL-28PY (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 Supp. Decl. ¶ 40.

Besides subjecting class members to painful withdrawal and likely relapse in the near-term, forcibly ending their prescribed treatment endangers their longer-term recovery. *See* Rosenthal Supp. Decl. ¶¶ 38, 48–49. Research confirms that people with OUD who experience forced withdrawal from methadone or buprenorphine while incarcerated are significantly less likely to resume treatment after release. *See* Rosenthal Supp. 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 practices 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, 161–62 (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. Plaintiffs Are Substantially Likely to Succeed on the Merits.

Plaintiffs seek preliminary relief on their claims under the ADA and U.S. Constitution. To obtain that relief, they 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, Plaintiffs can make that showing as to each.

A. Plaintiffs Are Substantially Likely to Succeed on Their ADA Claims.

Plaintiffs are substantially likely to succeed on their disability discrimination claims under Title II of the ADA because Defendants' practice of refusing access to agonist MOUD denies class members meaningful access to the jail's medical services on account of 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, Plaintiffs must show that (1) they are "qualified individual[s] with . . . disabilit[ies]; (2) defendants are subject to the ADA; and (3) Plaintiffs were "denied the opportunity participate in . . . [Defendants'] services, programs, or activities or [Defendants] otherwise discriminated against [them] by reason of [their] disabilit[ies]." *Wright v. N.Y. State Dep't of Corr.*, 831 F.3d 64, 72 (2d Cir. 2016) (citing *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);[5] *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

[5] 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.

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 "[g]eneral prohibitions against discrimination").

1. Class Members Are Qualified Individuals with Disabilities.

The protections of Title II apply to the class because each class member 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," 42 U.S.C. § 12102(1)(A), and includes "drug addiction," 28 C.F.R. § 35.108(b)(2);[6] *see also Reg'l Econ. Cmty. Action Program, Inc. v. City of Middletown*, 294 F.3d 35, 46 (2d Cir. 2002) (recognizing same). Each class member is an "individual with a disability" because class members are diagnosed with OUD, a substance use disorder that "substantially limits" an array of "major life activities," including caring for oneself; 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* ECF No. 30 at 8; Rosenthal Supp. Decl. ¶ 10.

Each class member is a "*qualified* individual with a disability" under the statute because, when detained at the jail, class members meet the "essential eligibility requirements" for the

[6] Title II's protection against discrimination on the basis of "drug addiction" does not protect illegal drug use itself, but does cover any individual who is "participating in a supervised rehabilitation program and no longer engaging in such use," 42 U.S.C. § 12210(a)–(b); and also prohibits a public entity from "deny[ing] health services, or services provided in connection with drug rehabilitation" to an otherwise-eligible individual based on current illegal drug use. 28 C.F.R. § 35.131(b)(1).

jail's medical services. 42 U.S.C. § 12131(2) (defining "qualified individual with a disability"); 28 C.F.R. § 35.104 (same); *see Estelle v. Gamble*, 429 U.S. 97, 103–04 (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." 42 U.S.C. § 12131(1). 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 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, 91 (2d Cir. 2021) (applying Title II to a county jail).

3. The Jail's Practice of Denying Prescribed Agonist MOUD Discriminates against Class Members Based on Disability.

Defendants are discriminating against the class in violation of Title II because their practice of refusing access to agonist MOUD treatment denies class members "meaningful access" to the jail's medical services based on OUD. Pursuant to Defendants' routine practice, individuals who have prescriptions for methadone or buprenorphine are denied access to their medication when they enter the jail, irrespective of their individual medical needs or the danger associated with abrupt, involuntary termination of prescribed agonist MOUD. *See, e.g.*, T.G. Decl. ¶¶ 8–9; S.C. Decl. ¶ 16; J.C. Decl. ¶ 8; J.M. Decl. ¶¶ 8–9; R.D. Decl. ¶ 11; P.M. Decl. ¶ 9; M.L. Decl. ¶ 13; M.S.C. Decl. ¶ 13; R.G. Decl. ¶ 11; S.G. Decl. ¶¶ 11–12. In following this practice, Defendants engage in unlawful discrimination against class members in multiple ways, any one of which suffices to establish an ADA violation.

First, by denying a prescribed, standard treatment for OUD whose continuation is necessary to prevent serious medical harm, Defendants' practice with respect to methadone and

buprenorphine is discriminatory on its face against people with OUD. *See* ECF No. 30 at 8–9 ("[R]efusal to guarantee access to methadone treatment likely violates the ADA"); *P.G.*, 2021 WL 4059409, at *4–5 (same); *Pesce v. Coppinger*, 355 F. Supp. 3d 35, 47 (D. Mass. 2018) (same); *Smith I*, 376 F. Supp. 3d at 159–60 (similar with respect to buprenorphine). In purpose and effect, Defendants' pervasive practice is to single out people with OUD for exclusion from minimally adequate medical treatment at the jail. *See* 28 C.F.R. § 35.130(b)(1)(i) (unlawful to "[d]eny 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 practice would be unthinkable as to any other serious illness: Were class members 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 class members instead have OUD, Defendants' routine practice is to deny 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 . . . [t]hat 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.[7]

Importantly, the Court need not find that ill will towards people with OUD underlies the Defendants' practices to conclude that the jail's pervasive refusal to provide access to agonist MOUD 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. Instead, it would suffice that Defendants' practices reflect mere "apathetic attitudes" towards people with OUD. *See id.* at 296. It is hard to imagine how anything short of apathy towards people with OUD could underlie Defendants' refusal to provide treatment that, for members of the class, is necessary to avoid agonizing withdrawal symptoms and a substantially heightened risk of relapse, overdose, and death.[8] And decades of entrenched stigma that have pervaded societal attitudes towards opioid addiction generally and agonist MOUD treatment specifically, suggest Defendants' practice reflects more than apathy.[9]

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[7] In guidance issued earlier this week, the Department of Justice, charged with enforcing the ADA, explained that a that jail policy prohibiting incarcerated people from taking prescribed MOUD "would violate the ADA." DOJ, *The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery*, 2 (Apr. 5, 2022), https://perma.cc/22BS-Y3L9.

[8] Even were Defendants to proffer a non-discriminatory rationale for denying essential treatment to people with OUD, the sheer irrationality of that practice permits the inference that any conceivable justification 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 medical care decision 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)).

[9] 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://perma.cc/D6QY-T37N (describing stigma towards OUD as "a major driver behind the lack of access to opioid agonist therapy").

Second, setting aside the facially discriminatory nature of the jail's practice of denying agonist MOUD, Defendants' failure to modify that practice to accommodate class members' disabilities 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). 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 274–75 (ADA requires "affirmative accommodations to ensure that facially neutral rules do not in practice discriminate against individuals with disabilities"). Failing to make such modifications to accommodate "the known physical or mental limitations" of people with disabilities violates Title II. 42 U.S.C. § 12112(b)(5)(A);[10] *see also* 28 C.F.R. § 35.130(b)(7)(i). Courts—including this Court—have repeatedly applied this bedrock principle to carceral facilities in finding that failing to provide prescribed MOUD to incarcerated people violates the ADA. *See P.G.*, 2021 WL 4059409, at *4–5; *Smith I*, 376 F. Supp. 3d at 160–61.

Absent modification to the jail's practice of denying agonist MOUD, Defendants foreclose meaningful access to jail medical services for class members, who depend on their prescribed treatment to avoid serious medical harm. Defendants know that individuals requiring such a modification are frequently present at the jail: Jail officials inquire about prescribed medications as part of the intake process. *See* Gemmell Decl., Exs. A–D (jail policies and forms

[10] Section 12112, which relates to the definition of "discrimination," is located in Title I of the ADA, but Title II does not define that term separately and thus may draw the meaning of "discrimination" from Title I. *See Henrietta D.*, 331 F.3d at 273 n.7.

showing Defendants collect medical information at intake including "medical conditions requiring ongoing or immediate treatment," current medications, and "signs of withdrawal"); *e.g.*, S.G. Decl. ¶ 11; J.M. Decl. ¶ 9; P.M. Decl. ¶ 10. They routinely witness the harmful impact of acute withdrawal on the many class members to whom they deny prescribed agonist MOUD. *See, e.g.*, T.G. Decl. ¶ 10 ; S.C. Decl. ¶¶ 11, 18; J.C. Decl. ¶ 11; J.M. Decl. ¶ 10; R.D. Decl. ¶ 13; P.M. Decl. ¶ 11; M.L. Decl. ¶ 16; M.S.C. Decl. ¶ 14; R.G. Decl. ¶ 10; S.G. Decl. ¶ 13. And in repeated instances, class members have explicitly requested modification to the jail's practice of denying agonist MOUD. *See, e.g.*, ECF No. 5 ¶¶ 7–9; M.S.C. Decl. ¶¶ 11–13; Gemmell Decl. ¶¶ 3–6, *P.G.*, No. 5:21-cv-388 (N.D.N.Y. Apr. 29, 2021), ECF No. 16. Yet despite their knowledge of the widespread need for modification to the jail's practice of denying agonist MOUD, Defendants have consistently failed and refused to modify that practice, thereby violating their obligation under Title II to accommodate class members' disabilities.

There is no good reason for Defendants not to have modified their practices to ensure that class members' prescribed treatment does not dangerously lapse. Agonist MOUD is safe and administrable, including in jail settings. *See* Hayes Decl. ¶¶ 9, 12–26. Every day, agonist MOUD is administered securely to incarcerated people throughout the country, including here in New York State. *See, e.g.*, Hayes Decl. ¶¶ 6, 9, 11; O'Neill Inst., *Applying the Evidence*, 8–10 (Oct. 2019), https://perma.cc/WH9G-E4G6; *see also Smith II*, 922 F.3d at 42 (on ADA claim, acknowledging "variety of reasonable alternatives at [jail's] disposal for providing [agonist MOUD]").

Defendants have numerous means at their disposal for ensuring that agonist MOUD can be provided to class members, either onsite at the jail or offsite in the community. *See, e.g.*, ECF No. 23 (Defendants' letter confirming jail's ability to provide methadone treatment via nearby

clinics); Gemmell Decl., Ex. E (Drug Enforcement Administration explaining means by which jails can provide onsite access to methadone and buprenorphine, even without licensure to prescribe those medications); *Become a Buprenorphine Waivered Practitioner*, SAMHSA, https://perma.cc/RWH5-3QXP (last updated Jan 3, 2022) (explaining means, involving training of no more than 24 hours, for obtaining permission to prescribe buprenorphine). And Defendants are demonstrably capable of providing access to prescribed agonist MOUD: They have done so for pregnant people at the jail, *see* White Decl. ¶¶ 5–6, and on other occasions when this Court has so required, *see* ECF Nos. 16, 30; *P.G.*, 2021 WL 4059409, at *6. Their failure to modify the jail's policies and practices to ensure that other class members, too, have meaningful access to their prescribed treatment for OUD violates Title II.

B. Plaintiffs Are Substantially Likely to Succeed on Their Constitutional Claims.

Plaintiffs are also substantially likely to succeed on their claim that Defendants' practice of denying prescribed agonist MOUD violates the Constitution.[11] 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

[11] The putative class is comprised of two subclasses—one each for class members subject to pretrial and postconviction custody, respectively. *See generally* ECF No. 2. These subclasses account for the different constitutional standards that apply to a claim of inadequate jail medical care before and after conviction: for pretrial subclass members, an objective deliberate indifference standard under the Fourteenth Amendment; and for postconviction subclass members, a subjective deliberate indifference standard under the Eighth Amendment. *Compare Charles v. Orange Cnty.*, 925 F.3d 73, 87 (2d Cir. 2019) (requiring that the defendants knew or should have known of a substantial risk of harm), *with Farmer v. Brennan*, 511 U.S. 825, 837 (1994) (requiring actual awareness of that risk). Because Defendants have actual knowledge of the risk of harm their practice poses to class members, *see infra* at 22–23, the distinction between these two standards is largely immaterial here, and this memorandum analyzes the constitutional claims of both subclasses together under the higher, Eighth Amendment standard.

(Steven, J., dissenting). 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)).

Plaintiffs and other class members satisfy both components of this analysis: Their OUD is an objectively serious medical condition; and Defendants' practice of refusing to permit class members to access life-sustaining treatment for OUD is one that Defendants know exposes class members 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 Plaintiffs' lives and that kills thousands of New Yorkers each year, is an objectively serious medical condition. *See* ECF No. 30 at 9; *P.G.*, 2021 WL 4059409, at *5 (OUD "has been recognized as an 'objectively' serious medical condition." (citing *Alvarado v. Westchester Cnty.*, 22 F. Supp. 3d 208, 217 (S.D.N.Y. 2014))).

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) (citation omitted). It is informed by "contemporary standards of decency," *Smith v. Carpenter*, 316 F.3d 178, 187 (2d Cir. 2003), 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 OUD is an objectively serious medical condition. OUD causes cravings for and uncontrollable use of opioids. *See* Rosenthal Supp. 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. Class members are all prescribed agonist medication—either methadone or buprenorphine—that constitutes the standard of care for OUD. *See id.* ¶ 26. If that treatment lapses prematurely, class members face an array of severe withdrawal symptoms as well as a significantly heightened risk of relapse into drug use, overdose, and death—particularly if treatment is ended abruptly. *See id.* ¶¶ 35–38. Because it subjects class members 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)—OUD satisfies the first prong of the deliberate indifference analysis.

2. Enforcing a Practice That Arbitrarily Strips Class Members of Life-Sustaining Medical Treatment Reflects Deliberate Indifference.

Stripping class members of life-sustaining medical treatment for OUD under a pervasive jail practice in disregard of individual medical needs is inconsonant with sound medicine—including broad consensus in the scientific community and the prescribed course of treatment of their treating physicians —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. *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." *Salahuddin*, 467 F.3d at 280. "[A] factfinder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious." *Farmer*, 511 U.S. at 842.

Forcibly withdrawing class members from their current courses of agonist MOUD treatment exposes them to a constellation of serious harms, some of which are the *certain outcome*—not merely a substantial risk—of Defendants' denial of agonist MOUD. *See supra* at 8–10. 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 agonist MOUD treatment, as is Defendants' routine practice. *See* Rosenthal Supp. Decl. ¶ 35.

Defendants know that their practice of denying prescribed agonist MOUD endangers class members. Consensus in the medical community is clear that abruptly ending prescribed agonist MOUD therapy is dangerous. *See id*. ¶¶ 35, 38, 49. 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: Their staff routinely witness the effects of

forced MOUD withdrawal as class member after class member cycles into the jail. *See* ECF No. 5 ¶¶ 18–21; J.M. Decl. ¶ 11 ("[I've asked] officers for my medication and told them how bad my withdrawal is. They responded by calling me a 'whiny ass' and telling me to 'stop complaining.'"); *e.g.*, T.G. Decl. ¶¶ 10, 16; S.C. Decl. ¶¶ 11, 18; J.C. Decl. ¶ 11; P.M. Decl. ¶ 11; M.L. Decl. ¶ 16; R.D. Decl. ¶ 13; M.S.C. Decl. ¶¶ 13–15; R.G. Decl. ¶¶ 10, 14; S.G. Decl. ¶¶ 13, 19. And with respect to a number of current and former class members, including Plaintiff M.C., Defendants have received specific confirmation of the life-threatening harm that will result if Defendants deny access to prescribed MOUD. *See, e.g.*, ECF Nos. 5-1, 5-2. Despite knowing that their practice puts class members in harm's way, the jail continues as a matter of course to deny prescribed MOUD to class members, placing Defendants' deliberate indifference to class members' safety beyond doubt.

As the rate of opioid-related death has continued to skyrocket nationwide, courts around the country—including this Court—have recognized that denying agonist MOUD to people with OUD in their custody can amount to deliberate indifference.[12] *See* ECF No. 30 at 9; *P.G.*, 2021 WL 4059409, at *5 (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"); *see also, e.g.*, *Davis v. Carter*, 452 F.3d 686, 695–96 (7th Cir. 2006) (triable issue of fact on Eighth Amendment claim regarding jail's practice of delaying agonist MOUD treatment for three days); *Foelker v. Outgamie Cnty.*, 394 F.3d 510, 513 (7th Cir. 2005) (triable issue of fact where jail officials knew

[12] DOJ has taken the same position. *See* DOJ, *Investigation of The Cumberland County Jail*, 6–11 (Jan. 14, 2021), https://perma.cc/4W9X-4V83 ("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.").

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 agonist MOUD treatment "ignore[d] and contradict[ed] his physician's recommendations"); *Alvarado*, 22 F. Supp. 3d. at 217 (finding plaintiffs plausibly stated Eighth Amendment claim against jail that denied agonist MOUD treatment). Nothing about the jail's practice of denying agonist MOUD, which forecloses class members 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 treatment for OUD. *Hathaway*, 37 F.3d at 70. There can be no serious disagreement over the importance to class members' safety of preventing prescribed agonist MOUD from lapsing. *See* Rosenthal Supp. Decl. ¶¶ 44–45. 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, 45. Here, preventing a lapse in prescribed MOUD is medically necessary for each class member, and abruptly and arbitrarily discontinuing that treatment at the jail—as is Defendants' routine practice—violates the standard of care and exposes class members unnecessarily to a high risk of withdrawal, relapse, and death. *See* Rosenthal Supp. Decl. ¶¶ 44–45.

Nor does Defendants' practice of denying class members' prescribed treatment involve any medical judgment at all. Treatment for OUD is not a one-size-fits all proposition; it is prescribed based on clinical evaluation of the individual characteristics of each patient's OUD. *See id.* ¶ 33. Yet Defendants' practice of denying prescribed MOUD to class members is not tailored to individual medical needs at all. In fact, the jail's practice is effectively to *ignore* individualized decision-making by medical professionals about appropriate care for OUD,

reflecting deliberate indifference to the medical needs of each class member. *See Pesce*, 355 F. Supp. 3d at 47–48 (granting preliminary injunction on Eighth Amendment claim where jail officials maintained practice of denying methadone "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."); *Alvarado*, 22 F. Supp. 3d at 217 (holding the "uniform[]" denial of MOUD to individuals experiencing opioid withdrawal stated Eighth Amendment claim); *Brooks v. Berg*, 270 F. Supp. 2d 302, 312 (N.D.N.Y.) (finding denial of treatment based on jail policy instead of individualized medical evaluation was 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).[13]

It is hard to imagine what circumstances could justify stripping class members of life-sustaining medical treatment, subjecting them to weeks—if not months—of excruciating physical pain, and exposing them 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 Heavily Favor 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 preliminary injunctive relief Plaintiffs seek.[14]

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[13] Moreover, the jail's mechanical adherence to a practice of denying agonist MOUD is particularly problematic when, in many instances, that practice "ignores and contradicts [the plaintiff's] physician's recommendations." *Pesce*, 355 F. Supp. 3d at 48.

[14] 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.

"[T]he public interest lies with enforcing the Constitution and federal law." *P.G.*, 2021 WL 4059409, at *5 (citing *Paykina ex rel. E.L. v. Lewin*, 387 F. Supp. 3d 225, 245 (N.D.N.Y. 2019)). And particularly given the current opioid epidemic, the public interest is also served by ensuring people with OUD, including class members, 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 life-sustaining medical care. *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 class members will benefit tremendously from access to their prescribed MOUD treatment, Defendants, who are demonstrably capable of making that treatment available to M.C., P.G., and pregnant people, are hardly harmed by a requirement to extend the same access to class members. *See* ECF No. 30 at 9 (recognizing class member "will personally benefit from continuing to receive medically necessary treatment"); *P.G.*, 2021 WL 4059409, at *5 (same).

CONCLUSION

For these reasons, the Court should grant Plaintiffs' motion for a preliminary injunction.

Dated: April 6, 2022
New York, New York

1997). "An exception to the bond requirement" applies in cases, like this one, which "involv[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 v. N.Y. State Bd. of Elections*, 487 F. Supp. 2d 101, 116 (N.D.N.Y. 2006) (waiving bond where case raised "important constitutional and public policy issues").

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