IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW MEXICO

S.B.,

Plaintiff,

v. **No.**

ALISHA TAFOYA LUCERO,
SECRETARY OF THE
NEW MEXICO CORRECTIONS DEPARTMENT,
WENSCESLAUS ASONGANYI,
HEALTH SERVICES ADMINISTRATOR OF
THE NEW MEXICO CORRECTIONS DEPARTMENT,

Defendants.

COMPLAINT
AND REQUEST FOR EMERGENCY INJUNCTIVE RELIEF

Plaintiff S.B. complains against Defendants New Mexico Corrections Department Secretary Alisha Tafoya Lucero and Health Services Administrator Wensceslaus Asonganyi (collectively, Defendants) as follows:

INTRODUCTION

1. This is a civil rights action challenging the denial of adequate medical care and discrimination based upon a recognized disability by the New Mexico Corrections Department (NMCD), which is overseen by Defendants.

2. The opioid epidemic is devastating communities around the nation, including here in New Mexico. The loss of life has been staggering, killing nearly half a million people in the last 20 years. Nationally, one person dies of an opioid overdose every 8.5 minutes. Like millions of other Americans and thousands of others in New Mexico, S.B. is diagnosed with severe opioid use disorder (OUD). OUD is a chronic, relapsing brain disease that, like many other chronic

diseases such as diabetes or high blood pressure, requires medical intervention for years or sometimes a lifetime. For the last two years, S.B's physicians have prescribed methadone, one of three FDA approved medications for addiction treatment ("MAT" or "medication-assisted treatment," known interchangeably as "medications for opioid use disorder" or "MOUD"), to treat her OUD.

3. MAT uses FDA-approved medications (methadone, buprenorphine, and naltrexone) to treat this chronic brain disease. MAT is the standard of care for OUD. Decades of studies have shown that methadone stabilizes people with OUD both *neurologically* and *socially*. Methadone is a long-acting (taken once a day), legal, safe, orally prescribed, and heavily regulated medication that activates a patient's opioid receptors to suppress cravings and treat opioid withdrawal symptoms.

4. With methadone, for the first time in twenty years, S.B. is able to say she is not using heroin. This is a hard-fought win for her. Methadone has helped her remain off of heroin following recent stressful and traumatic events: the death of her father from COVID-19, a rape, and her current and impending incarceration.

5. S.B. is in active recovery from heroin addiction. She works on her recovery every day. Methadone and counseling are her life-line. She wants to continue her doctor-prescribed treatment for OUD, to stay in recovery, and to stay off of illicit opioids. She wants to break the cycle of incarceration. If she needs to, she will continue this treatment for the rest of her life.

6. Despite an overwhelming scientific consensus that MAT is the standard of care, S.B. is subject to the New Mexico Corrections Department's (NMCD) blanket ban on MAT for anyone other than pregnant incarcerated people. This ban is contrary to the standard of care for

OUD, and is rooted in the outdated stigma that methadone somehow swaps one addiction for another.

7. S.B. is post-conviction and sentenced to time in NMCD. At her sentencing, S.B.'s criminal defense attorney asked the court to issue an order remanding her to MDC to slowly withdraw from methadone prior to her transfer to NMCD custody because NMCD does not provide methadone or any alternative. She is currently incarcerated at the Bernalillo County Metropolitan Detention Center (MDC) for the specific purpose of tapering her off of her methadone. Her transfer is set for June 9 or June 16, 2021. If S.B.'s attorney had not made the request, S.B. would have been forced to immediately withdrawal from methadone upon arrival at NMCD. Even with the involuntary taper, S.B. is currently at substantial risk of serious harm from being removed from her methadone.

8. Right now, S.B. is suffering due to NMCD's blanket ban on methadone. She is no longer receiving a therapeutic dose of methadone. Her thinking is becoming chaotic, her bones hurt, her anxiety is through the roof, she is finding it difficult to control her impulses for self-harm, *and* she is craving opioids. She does not want to use illicit drugs in jail or engage in self-harm. She does not want to relapse, overdose, and possibly die.

9. S.B. is particularly afraid because she has family members who have overdosed and died, she has a history of suicidal thoughts and attempts, and when she was using heroin there were times that she used hoping she would die. She, herself, has overdosed more than thirteen times.

10. Denial of her necessary medical care violates her rights under the Americans with Disabilities Act to be free from discrimination based on her disability.

11. Further, Defendants' deliberate indifference to S.B.'s necessary medication to treat her serious medical condition, to her current suffering, and to the long-term consequence of forced withdrawal from her doctor-prescribed medication, violate S.B.'s right to be free from cruel and unusual punishment in violation of the Eighth Amendment of the United States Constitution.

12. S.B. seeks emergency, preliminary and permanent injunctive relief requiring Defendants to provide her with her medically necessary, physician-prescribed methadone during her incarceration in NMCD to stop her current suffering. Further, she seeks declaratory relief in the form of a declaration that NMCD's blanket ban on MAT is a violation of the ADA and the Eighth Amendment.

PARTIES

13. Plaintiff S.B. is a resident of Albuquerque, New Mexico.

14. Defendant Alisha Tafoya Lucero is the Secretary of the New Mexico Corrections Department, in which capacity she is responsible for the housing and care of inmates in the New Mexico Corrections Department. She is being sued in her official capacity.

15. Defendant Wenceslaus Asonganyi is the Health Service Administrator for the New Mexico Corrections Department's Health Services Bureau, in which capacity he is responsible for overseeing the medical services contract, and is responsible for the medical care and addictions treatment of New Mexico Corrections Department inmates. He is being sued in his official capacity.

JURISDICTION AND VENUE

16. This Court has jurisdiction pursuant to 28 U.S.C. §§ 1331 and 1343. This action seeks to vindicate rights guaranteed by the Eighth Amendment of the United States Constitution, pursuant to 42 U.S.C. § 1983.

17. This action is also brought pursuant to Title II of the Americans with Disabilities Act, 42 U.S.C. §§ 12131-12134.

18. Finally, this Court has further remedial authority under the Declaratory Judgment Act, 28 U.S.C. §§ 2201 and 2202, et seq.

19. Venue lies in the District of New Mexico pursuant to 28 U.S.C. § 1391.

FACTS

A. Opioid Use Disorder is a Life-Threatening Medical Condition and Public Health Crisis.

20. Opioids are a class of drugs that inhibit pain and have euphoric effects. Some opioids, like oxycodone, have widely accepted medical uses, like pain management. Others, such as heroin, are illegal and not used in medicine in the United States. All opioids are highly addictive.

21. Opioid use disorder (OUD) is a chronic, relapsing brain disease that can have deadly consequences. It is characterized by compulsive use of opioids despite negative consequences. Signs of the disorder include craving, increasing tolerance to opioids, the inability to control opioid use, withdrawal symptoms, and a loss of control. It is a progressive disease, meaning it gets worse over time. Without effective treatment, patients with OUD are rarely able to control their use of opioids, often resulting in serious physical harm or premature death, including due to accidental overdose.

22. OUD breaks down the dopamine system necessary for the brain to feel a sense of normalcy and confidence in its own survival. People who are dopamine deficient have difficulty

enjoying life activities and feeling normal, and experience feelings of depression, anxiety, and irritability. Brains that are addicted to opioids produce less than half the dopamine of non-addicted brains.

23. OUD permanently rewires the brain for addiction. People with OUD cannot simply "will" or "reason" their way out of continued opioid use, even when they are aware of the dire consequences and fervently desire to be free from the addiction.

24. Continued use of opioids does not indicate a person lacks willpower, but rather is the predictable outcome of chemical changes in the brain that result in uncontrollable cravings.

25. Opioid addiction has thus proven especially unresponsive to non-medication-based treatment methods, such as abstinence-only and twelve-step programs, which have been popular in treating other addictions such as alcoholism.

26. Like other chronic diseases, OUD often involves cycles of relapse and remission. Rather than a linear progression in which a person attains abstinence from opioid use once-and-for-all, "successful" recovery for OUD is often characterized by sustained periods of abstinence or "active recovery," punctuated by relapses in which the person returns to drug use. These relapses are frequently triggered by an increase in life stressors, a traumatic event, or a lapse in treatment, which causes the person to turn toward illicit drug use.

27. The typical treatment goal for OUD is thus to maximize periods of active recovery and minimize periods of relapse, by ensuring continued treatment and encouraging the use of coping mechanisms and support systems.

28. As a chronic condition, OUD is often incurable, but can be controlled with the use of chronic medication and psychological supports. In essence, it can be treated like other incurable but controllable medical conditions, such as diabetes and high blood pressure.

29. As with other chronic conditions, discontinuation of chronic medication almost always results in return of symptoms. Opioid use disorder often involves cycles of relapse and remission.

30. Opioid use disorder is a national public health crisis and a public health crisis here in New Mexico. In 2018, 63% of drug overdose deaths in New Mexico involved opioids, a total of more than 338 fatalities.[1] That year, New Mexico had the fifteenth highest drug overdose death rate in the United States.[2] Albuquerque has been particularly hard hit.[3]

31. S.B. is very aware of the severity of the epidemic. She has multiple family members and friends who have overdosed and died. She has experienced medical complications and illnesses related to heroin use. She herself has overdosed more than thirteen times and has been hospitalized due to overdose five times. She stopped counting after her thirteenth overdose.

32. Since 2013, the proliferation of fentanyl and other synthetic opioids — an extremely dangerous class of drug — has driven the sharp rise in opioid deaths nationally. The CDC estimates that deaths from fentanyl and other synthetic opioids rose 52% in the past year alone.

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[1]National Institute on Drug Abuse (NIDA), New Mexico: Opioid-Involved Deaths and Related Harms (April 3, 2020) *available at* https://www.drugabuse.gov/drug-topics/opioids/opioid-summaries-by-state/new-mexico-opioid-involved-deaths-related-harms#:~:text=In%20New%20Mexico%2C%2063.0%25%20of,(a%20rate%20of%205.4) (Last visited 4/29/21).

[2] New Mexico Department of Health, "Drug Overdose in New Mexico Fact Sheet," (March 2020), *available at* https://www.nmhealth.org/publication/view/marketing/2117/ (Last visited 4/29/21).

[3] *See also,* Elise Kaplan, "72 Hours in Albuquerque: Life and Addiction in Albuquerque," The Albuquerque Journal (October 25, 2019), *available at* https://abqjournal.exposure.co/72-hours (Last visited 4/29/21).

33. A lethal dose of fentanyl is a tiny fraction of a lethal dose of heroin, as demonstrated in the following figure.

34. Heroin and other illegal opioids are now commonly laced with fentanyl — often without the knowledge of the person using the opioids. As a result, people with OUD who use illegal opioids now face a heightened risk of being unwittingly exposed to lethal doses of fentanyl.

35. Opioid use disorder is more prevalent among incarcerated people than in the general population. Data shows that nearly half of the people in state prisons and jails have a substance abuse disorder (SUD), compared to only 5 percent of non-incarcerated adults.[4] Indeed, the opioid crisis has been a significant driver of mass incarceration.

36. The risk of overdose deaths of individuals with OUD after their release from correctional facilities is at least ten times higher than the general population.[5] In part, this is

[4] Pew Charitable Trusts, "Opioid Use Disorder Treatment in Jails and Prisons: Medication provided to incarcerated populations saves lives," (April 2020), *available at* https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2020/04/opioid-use-disorder-treatment-in-jails-and-prisons (Last visited 4/27/21)

[5] Ingrid A. Binswanger, *Opioid Use Disorder and Incarceration – Hope for Ensuring the Continuity of Treatment*, 380 New England Journal of Medicine 1193-95 (2019); Massachusetts Department of Health, An Assessment of Fatal and Nonfatal Opioid Overdoses in Massachusetts 2011-2015 (Aug. 2017) 49-52, *available at* *https://archives.lib.state.ma.us/bitstream/handle/2452/734807/on1001341902.pdf?sequence=1&isAllowed=y* (Last visited 4/24/21)

because "people with OUD lose [their] increased tolerance while incarcerated due to presumed abstinence and thus are at high risk of overdose in the weeks post-release."[6]

37. Contraband drugs are available in jails and prisons. The dangerous circumstances in which illicit drugs are used can and do result in overdoses, overdose deaths, transmission of blood borne diseases including HIV, hepatitis B and C, heart valve infections, and soft tissue infections that can be extremely serious and even life-threatening.

38. Opioid use disorder also contributes to recidivism rates. In New Mexico, approximately *one-third* of prison admissions are due to failed drug tests and missed appointments.[7] A study by the New Mexico Legislative Finance Committee "found that 67 percent of parolees violate conditions at least once" and 75 percent of those violations "are for failed drug tests or missed appointments."[8]

B. Medication-assisted Treatment is the Standard of Care for Opioid Use Disorder and is the Only Effective Treatment for S.B.

39. Medication for addiction treatment (MAT) is the standard of care for opioid use disorder.

40. MAT uses one of three Food and Drug Administration (FDA) approved medications to treat OUD. These are methadone, buprenorphine (often sold under the brand name suboxone), and naltrexone.

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[6] Pew Report, *supra*.
[7] Legislative Finance Committee, "Program Evaluation: Corrections Department – Status of Programs to Reduce Recidivism and Oversight of Medical Services" (October 23, 2018) 1, available at https://www.nmlegis.gov/Entity/LFC/Documents/Program_Evaluation_Reports/Corrections%20Department%20-%20Status%20of%20Programs%20to%20Reduce%20Recidivism%20and%20Oversight%20of%20Medical%20Services.pdf (Last visited April 24, 2021).
[8] *Id*.

41. The scientific consensus is clear: MAT is the most effective treatment for OUD. Therapy and counseling alone do not have high success rates.[9]

42. Methadone and buprenorphine have been categorized as "essential medications" by the World Health Organization (WHO).[10] The American Medical Association, the American Society of Addiction Medicine, the U.S. Department of Health and Human Services, the U.S. Food and Drug Administration ("FDA"), the National Institute on Drug Abuse, the Office of National Drug Control Policy, and the Substance Abuse and Mental Health Services Administration ("SAMHSA") have all endorsed the necessity of MAT.

43. As the Bernalillo County Addiction Treatment Advisory Board explains, "MAT decreases opioid use, opioid-related overdose deaths, criminal activity, and infectious disease transmission."[11]

44. Not all these FDA-approved MAT medications are equally effective for every patient. Studies show that only two — methadone and buprenorphine — produce longer-term treatment retention, which is the key to effective MOUD treatment.

45. Methadone and buprenorphine are "agonists," which means they activate opioid receptors in the brain to relieve withdrawal symptoms and control cravings. Methadone is a "full agonist," meaning that it fully activates opioid receptors. Buprenorphine is a "partial agonist," meaning that it partially activates opioid receptors. Neither of these medications result in a "high,"

[9] Bernalillo County Addiction Treatment Advisory Board (ATAB), Standards of Care for the Treatment of Opioid Use Disorder (August 20, 2018) 3, available at https://admin-bernco.sks.com/uploads/files/Behavioral%20Health%20Services/Standards%20for%20Care%20-%20Web.pdf (Last visited 4/26/21).

[10] NIDA 2016. November 1. Effective Treatment for Opioid Addiction. NIDA. 2016, November 1. Effective Treatments for Opioid Addiction, available at https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction (Last visited 4/26/21).

[11] *Id*.

but rather return patients back to a steady state where they can feel normal and go about their daily lives.

46. The effect of both methadone and buprenorphine is much milder, steadier, and longer-lasting than drugs such as heroin, fentanyl, or oxycodone. Because methadone and buprenorphine bind to the opioid receptors they stimulate, they block the receptors from being stimulated by more powerful agonists — meaning that patients taking methadone and buprenorphine cannot get the same "high" from illicit drugs like heroin and fentanyl. This trains patients' brains to gradually decrease their response to and interest in opioids, in a process known as "extinction learning."

47. In contrast, naltrexone is an "antagonist." It is considered a second-tier treatment my many addiction treatment physicians. As an antagonist, it blocks opioid receptors without activating them, preventing the euphoric effect of opioids, and thus reducing desire for opioids over time. Naltrexone does not relieve withdrawal symptoms, and in fact can trigger acute and severe withdrawal. That withdrawal is especially severe when a patient has recently taken an opioid agonist or partial agonist. For that reason, medical standards require patients be fully withdrawn from opioids before receiving naltrexone — a process that requires not using opioids for anywhere from three to ten days. Studies have shown that naltrexone treatment produces substantially poorer outcomes in terms of treatment retention than either methadone or buprenorphine. Treatment retention is key for recovery.

48. As with any medication, individual patients have individual responses – one may work better than the other for a particular person. It is noteworthy that the National Commission on Correctional Health Care (NCCHC), which establishes standards for health services in correctional facilities and operates a voluntary accreditation program for institutions that meet

their standards, has made clear that "the specific medication chosen, should be the individual's after consultation with medical and treatment providers, not imposed by a justice or treatment agency."[12]

49. MAT is more efficacious than other treatment options. With respect to incarcerated people, one study found that "[p]articipation in MAT during incarceration has [] been associated with reduced likelihood of in-custody deaths by overdose or suicide and an overall 75 percent reduction in all-cause in-custody mortality."[13]

50. In New Mexico, the provision of MAT to incarcerated people has been identified as an *urgent* issue to stop people from needlessly dying and being incarcerated. The Governor's Council on Racial Justice's Health Subcommittee recommends that all NMCD facilities screen all inmates for OUD, offer all three MAT medications, and begin services within 24 hours of arrival.

51. Detoxification from opioids and the treatment of withdrawal symptoms alone are not effective treatments for OUD and fall below the standard of care. Efforts to "medically manage" forced withdrawal or "detoxify" patients, with non-MOUD pain relievers or otherwise, are not meaningfully effective. Such efforts, also known as detoxification, do not improve long-term outcomes for people with OUD. To the contrary, as SAMSHA confirms, patients who complete medically supervised withdrawal are at a risk of opioid overdose.

[12] NCCHC and National Sheriffs' Association, Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines and Resources for the Field (October 2018) 5, available at https://www.ncchc.org/filebin/Resources/Jail-Based-MAT-PPG-web.pdf (Last visit 4/24/21).

[13] *See Smith v. Aroostook Cty.*, 376 F. Supp. 3d 146, 151 (D. Me. 2019) (adopting the study in findings of fact and issuing preliminary injunction on basis that denial of MAT violated the ADA); *aff'd Smith v. Aroostook Cty.*, 922 F.3d 41 (1st Cir. 2019) (per curium).

52. One study of treatment outcomes from a detoxification facility showed a 29% relapse rate on the day of discharge, a 60% relapse rate after one month, and a success rate of between only 5% and 10% after one year.

53. Involuntary discontinuation of MAT is dangerous. "Clinical evidence consistently shows that when patients discontinue or are taken off MAT for OUD, relapse rates soar and are associated with lethal opioid overdose. For this reason, patients should be encouraged to continue their MAT for as long as possible, including indefinitely."[14]

54. With S.B.'s recent methadone treatment, she has been able to stop using heroin for the first time in twenty years.

55. If she were to continue to be incarcerated at MDC, her treating physcian would have kept her on a therapeutic dose of methadone, and then assisted her into transferring to community methadone treatment upon her release.

56. MAT is the effective and medically necessary treatment for S.B.

57. S.B.'s continued treatment is critical now, and can save her life post-release. One study found that there is a 700% decrease in retention in MAT treatment for those who are forced to withdraw on incarceration.[15] Another study concluded that incarcerated people were 12,900% more likely to die of a drug overdose in the two weeks immediately following incarceration as compared to the general public.[16] Medication continuity saves lives.

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[14] ATAB Standards at 3-4.
[15] Rich JD, McKenzie M, Larney S. Wong JB. Tran L, Clarke J. (2015) Methadone continuation versus forced withdrawal on incarceration in a combined US prison and jail: a randomized, open-label trial. Lancet: 386:350–59.
[16] Ingrid A. Binswanger, et al.," Release from Prison - High Risk of Death for Former Inmates, "New England Journal of Medicine (Jan. 7 2011) *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836121/ (Last visited 4/29/21).

C. Administration of MAT in Correctional Settings is Recommended, Safe and Feasible.

58. The National Commission on Correctional Health Care, in collaboration with the National Sheriffs' Association have published guidelines for the provision of MAT in correctional facilities.[17]

59. The American Correctional Association and the American Society of Addiction Treatment Medicine issued a "Joint Public Correctional Policy on the Treatment of Opioid Use Disorders for Justice Involved Individuals," supporting the use of MAT in correctional settings and recognizing that a 2017 bipartisan Presidential Commission on "Combating Drug Addiction and the Opioid Crisis" has recommended increased usage of …(MAT) in correctional settings."

60. The Department of Justice recently investigated a New Jersey jail for violations of the Eighth and Fourteenth Amendment where the jail fails to provide MAT and has investigated Massachusetts correctional facilities for ADA violations where they failed to continue MAT for people entering custody and who were already prescribed the essential medications.

61. In January 2021, U.S. Department of Justice's Civil Rights Division issued a report concluding that the Cumberland County Jail in Bridgeton, New Jersey, had violated the Eighth and Fourteenth Amendments to the U.S. Constitution by failing to provide MOUD to people in its custody. The report found that inadequate treatment of OUD presented a risk of serious harm and likely caused six of the jail's seven suicide deaths in the period studied. It also found that the jail had been deliberately indifferent to that risk by failing to prescribe MOUD, despite knowing people in its custody had significant heroin usage or obvious symptoms of opioid withdrawal.

[17] National Commission on Correctional Health Care (NCCHC) and National Sheriff's Association, *Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field* (October 2018) *available at* https://www.ncchc.org/filebin/Resources/Jail-Based-MAT-PPG-web.pdf (Last visited 4/29/2021).

62. Bernalillo County was a national leader in bringing its county jail into compliance with the medical standard of care by providing MAT to individuals with OUD in MDC. It has provided methadone since 2006 and recently signed a contract to begin the provision of buprenorphine.

63. In the years since MDC began providing MAT, national consensus has only grown as to the importance of this treatment.

64. In recommending expanded access in jails and prisons to MOUD, including methadone, both the National Commission on Correctional Health Care and the National Sheriffs' Association have emphasized that such access can "[c]ontribut[e] to the maintenance of a safe and secure facility for inmates and staff"; and reduce recidivism, withdrawal symptoms, the risk of post-release overdose and death, and disciplinary problems.

65. S.B. has been treated with methadone in MDC.

66. NMCD has a mandatory withdrawal policy for people on MAT. The exception is for pregnant people who are allowed to start or continue access to their essential medication during their pregnancies. The fact that NMCD provides MAT to some individuals demonstrates that the provision of MAT is not only feasible, but already a part of NMCD's medical care infrastructure.

67. Because of this no-MAT policy, Law Office of the Public Defender routinely requests and secures orders from the Second Judicial District Court (where MDC is located) remanding a person who has been sentenced to NMCD to MDC in order to be tapered off their methadone prior to transfer to NMCD custody. While involuntary tapering is not in accordance with the standard of care, and still places people at substantial risk of serious harm, it saves individuals from the painful and life-threatening experience of sudden and complete withdrawal.

68. The state sentencing court entered such a remand order in S.B.'s case.

69. Other correctional facilities follow the medical standard of care and allow patients to continue MAT during incarceration. Upon information and belief, these include the federal Bureau of Prisons, Rikers Island Correctional Facility (New York), Kings County Jail (Washington State), Orange County Jail (Florida), Vermont's combined prison and jail system, Rhode Island Department of Corrections, New York prisons, and many others.

70. Correctional Facilities in Maine and Massachusetts have been court ordered to provide MAT to individual plaintiffs, and since 2019, the federal Bureau of Prisons has settled at least three lawsuits and agreed to provide MAT to the plaintiffs during their incarceration.

D. Defendants Have a Mandatory Withdrawal Policy for People with OUD Who Enter NMCD's Custody on Doctor-Prescribed MAT.

71. As policy and practice, NMCD categorically and arbitrarily denies all non-pregnant inmates access to MAT for the treatment of OUD. This is true even if MAT has been prescribed by a physician to treat their serious and disabling medical condition – OUD.

72. On March 12, 2021, Plaintiff's counsel sent NMCD's general counsel a letter via e-mail inquiring whether S.B. would receive MAT in NMCD custody. Plaintiff's counsel wrote: "It is my understanding that it is NMCD's policy not to provide MAT to anyone other than pregnant and breast-feeding women. Please correct me if I am wrong and provide me with the accurate information."

73. Defendants' acknowledged receipt of the letter but to date have not provided a substantive response.

74. On March 23, 2021, counsel for plaintiff submitted a public records request for all of NMCD's policies regarding the provision of MAT to inmates and the treatment of OUD.

Counsel received two policies on April 8, 2021, and additional policies and documents on April 23, 2021. The only policies that allowed for the provision of MAT pertained to pregnant women.

75. The "High Risk Pregnancy Procedure" *requires that* Western New Mexico Correctional Facility (WNMCF) *suboxone is available at all times*.

76. Also on March 23, 2021, counsel for plaintiff requested information regarding MAT and NMCD from the office of the Governor. Among the documents received are notes from an October 1, 2021 "Public Safety and Law Enforcement Subcommittee and Health Subcommittee Meeting."

77. Defendants presented at that meeting and answered questions from subcommittee members. The meeting minutes capture this question and answer. Q: "Medicated Assisted Treatment (MAT) . . . is medical assisted [sic] provided? A: "Not currently."

78. Another subcommittee member followed up and was "concerned about standard of care for medication of treatment [sic]. Concerned that opioid treatment is not considered a treatment plan," and asked "where is NM on this issue? With people having to hard detox from methadone." The answer appears to be that there is a question about whether it could be done in New Mexico ("Suboxone and methadone and the like through Medicated Assisted Treatment – can it be done in NM? Is the reality of this program something that makes sense for the state, [its] still in flux.").

79. As set forth above, prisoners with OUD have an increased risk of relapse, overdose, and overdose death in the weeks after release. While in custody, prisoners with OUD are at risk of overdose, overdose death, suicide, and contracting life-threatening illness.

80. Suicide rates are increased for people who are forced to withdraw from MAT.

81. NMCD's policies do provide for specialty and off-site treatment for other serious and disabling medical conditions.

82. NMCD's policies allow for the provision of MAT.

83. The policies explain the steps medical staff can take to obtain methadone for a pregnant person.

84. Individuals in NMCD custody depend on NMCD to provide all medical care.

85. As a result, NMCD provides medically necessary care and accommodations to other individuals in custody, but not to incarcerated people with opioid use disorder (who are not pregnant).

86. That NMCD refuses to provide MAT is so commonly known that the public defenders routinely obtain orders for their clients who are on methadone and sentenced to NMCD to be remanded to MDC to be tapered off their methadone prior to transfer to NMCD to serve their sentences.

E. Without the Court's Intervention, Defendants Will Continue to Deny S.B. Medically Necessary Treatment for her Opioid Use Disorder, Causing Her to Suffer the Effects of Involuntary Withdrawal and Untreated OUD.

87. S.B. is diagnosed with severe opioid use disorder, which is a serious medical condition and a recognized disability under the Americans with Disabilities Act.

88. If untreated, S.B.'s opioid use disorder is likely to result in relapse, overdose, and potentially death.

89. S.B. used heroin for approximately 20 years. She has a history of suicidal thoughts and attempts. She has been forced to withdraw from opiates before and always returned to using heroin.

90. She was 10 years old when she started using drugs.

91. She has family members who have overdosed and died of overdose, and she has overdosed.

92. Methadone treatment helped her stop using heroin. She does not wake up every day thinking about how to get a fix. Today, she can say that she is "clean from heroin."

93. When on a therapeutic dose of methadone, S.B.'s thinking is clearer, she is able to communicate, experience her feelings, participate in counseling and work through her history of trauma, cope with PTSD triggers, maintain relationships with her family, and refrain from self-harm. When on a therapeutic dose of methadone, she does not crave opioids. In sum, methadone is a life-saving and life-changing medication for S.B.

94. Methadone is medically necessary to treat S.B.'s serious medical condition.

95. Methadone has been prescribed by S.B.'s doctors to treat her OUD.

96. She does not want to stop MAT and fears for her health and safety without it.

97. S.B. knows that the heroin today is deadlier because much of it is laced with fentanyl, or is completely fentanyl. She is scared that if she relapses and unknowingly uses fentanyl-laced heroin, she will die. This recently happened to a friend she was released from prison with who died.

98. On March 10, 2021, S.B. was sentenced for absconding from probation. She had been on the community custody program when her mother contracted COVID-19. Fearing her mother would die, she went to Colorado without permission. While there, she enrolled in the local methadone clinic. A physician prescribed her an effective dose of methadone and she participated in counseling. While in Colorado, her father contracted COVID-19 and died. With methadone, S.B. stayed free from heroin use. She would think about using, and then the thought would pass.

99. When she was arrested in Colorado, she was forced to immediately withdraw in the Colorado jail. She experienced brutal withdrawal symptoms: vomiting, diarrhea, extreme anxiety, bone pain, sweats, sleep disruption, depression, and chaotic thinking.

100. Once at MDC her physician re-started her methadone.

101. S.B.is currently serving her sentence at MDC, rather than NMCD, in order to titrate off of her doctor-prescribed medication. While at MDC she cannot earn good time and, as such, her incarceration will be unnecessarily extended.

102. Because of NMCD's unconstitutional policy of refusing to provide MAT, S.B.'s taper had to begin almost immediately after sentencing. She is now below a therapeutic dose and, thus, suffering from intense manifestations of withdrawal.

103. In the community, her therapeutic dose is between 120 milligrams and 140 milligrams. When she returned to MDC in December, the physician restarted her slowly because she had already gone through withdrawal.

104. Generally, a therapeutic dose of methadone is between 80 milligrams and 120 milligrams, though it can be higher in times of stress, like the death of a parent, a traumatic event, or incarceration.

105. At MDC, it is her understanding that she only went up to 80 milligrams because she and the physician both knew she would be going to NMCD and would have to either taper or go through dangerous and immediate withdrawal in NMCD.

106. She experienced eighty milligrams as barely therapeutic for her after 20 years of using heroin, the recent death of her father, a recent rape, and her current and impending incarceration. It kept the opioid cravings at bay, but when she woke in the morning she could feel the need for her medication. She would ache and stay in bed until the methadone nurse arrived.

107. Her dose has been dropping by 1 milligram every day. She asked for a pause on the taper, and it was paused once for about three days.

108. Because she is going to NMCD, the taper has resumed.

109. On April 27, 2021, she received a sub-therapeutic dose of approximately 47 milligrams.

110. As her dose drops daily, her thinking becomes increasingly chaotic, she stays in bed (but is unable to sleep), she has a difficult time controlling her impulses for self-harm, and she is very depressed. Further, she is having a hard time communicating. She says that she "can't even describe how threatening [her] anxiety is. It is through the roof."

111. Consistent with the scientific literature described above, S.B. is craving opioids. She is terrified about what will happen if NMCD does not allow her to continue MAT.

112. NMCD and MDC have confirmed that S.B. will be transferred to NMCD custody on either June 9 or 16, 2021.

113. Upon information and belief, at that time she will no longer have access to MAT.

114. As the date comes closer S.B. becomes increasingly terrified. She is currently in physical and psychological pain due to NMCD's ban on methadone. She can't imagine what will happen to her once she is forced off of her methadone entirely.

115. S.B. is dealing with a recent rape. She regularly meets with a Rape Crisis advocate via video visit.

116. Her advocate has a master's degree in Sociology from the University of Minnesota and a master's degree in Addictions Counseling from the Hazelden Betty Ford School of Addiction Studies, is licensed in Minnesota, and previously practiced as an addictions counselor

for women in community confinement in Minnesota. She is familiar with MAT as the standard of care for OUD and how methadone works on the brain.

117. S.B.'s advocate started meeting with S.B. before she re-started methadone at MDC, during the period of time she was on a therapeutic dose, and now during the withdrawal.

118. Her advocate witnessed S.B. cope with the onslaught of trauma triggers at MDC – screaming inmates, yelling correctional officers, loud music, and a correctional officer kicking in the door to the visitation room. When S.B. was on a therapeutic dose of methadone, she remained calm and insightful even with all of those triggers.

119. As S.B.'s methadone dose drops, her advocate is witnessing her decompensate. S.B. is experiencing strong urges to engage in self-mutilation. Her nightmares and flashbacks are escalating. Her anxiety is out of control and she is having difficulty remaining patient and calm.

120. Her advocate's greatest fear is that without her medically necessary methadone treatment, S.B. will be unable to deal effectively with her trauma and her opioid cravings, and that she will relapse, overdose, and die either by overdose or suicide.

F. Defendants Are on Notice of Plaintiff's Medically Necessary Medication, Her Involuntary Withdrawal Due to Defendants' Policy, and Her Current Suffering, but Have Failed to Take Any Action.

121. On March 12, 2021, counsel sent a letter to Defendants informing them of S.B.'s pending incarceration, her disability, and her serious medical need. Counsel provided background about MAT as the standard of care and requested that Defendants accommodate S.B.'s disability and provide MAT for her serious medical need. Plaintiff's counsel requested a response by March 17, 2021. Counsel did not receive a response, but NMCD's general counsel emailed undersigned counsel, the prosecutor, and the public defender acknowledging the titration order and suggested that the criminal attorneys enter a "do not transport" order until a different case was resolved.

122. On March 23, 2021, S.B.'s counsel wrote to Defendants seeking resolution of the issue and asked whether NMCD would accommodate S.B.'s disability and provide her with MAT during her incarceration. This letter explained that because of NMCD's policy denying MAT, S.B. was currently being forced to withdraw from her essential medication and was already suffering.

123. S.B.'s counsel alerted NMCD that if it agreed to provide MAT, S.B.'s taper could be stopped and she could either have her dose of methadone increased to a therapeutic level, or be switched to buprenorphine.

124. The letter advised that S.B.'s involuntary taper, or medically assisted withdrawal, contravenes the standard of care for OUD. Medically managing a forced withdrawal is not a treatment or accommodation for OUD. It alerted Defendants that requiring S.B. to withdraw from her essential medication placed her at an unreasonable risk of harm and requested a response by close of business March 29, 2021.

125. On March 24, 2021, counsel resent both letters, including Defendant Tafoya Lucero in the correspondence. NMCD General Counsel acknowledged receipt, but provided no substantive response.

126. On March 29, 2021, counsel submitted an informal complaint to NMCD on S.B.'s behalf, grieving the denial of MAT and her forced withdrawal. General counsel responded that NMCD could not accept the complaint because S.B. was not in their custody.

127. S.B.'s condition continued to worsen as her methadone was decreased.

128. On April 22, 2021, counsel sent a third letter to Defendants, including Defendant Tafoya Lucero and Defendant Asonganyi on the correspondence. It asked whether NMCD would provide S.B. with MAT. It notified Defendants of S.B.'s suffering and the unreasonable risk of

harm she was experiencing. It informed Defendants that if they would "confirm that NMCD will provide [S.B.] with methadone during her incarceration, the methadone provider at the county jail would stop her withdrawal and place her on a therapeutic dose of methadone." The letter provided additional background on MAT, OUD, recommendations for its use in settings of incarceration, and case law on the issue. Counsel asked for an immediate response, even after business hours, and no later than close of business on Monday, April 26, 2021.

129. NMCD's General Counsel emailed the same day stating that she would be out of the office on April, 26 and would respond later that week.

130. On April 26, counsel emailed Defendants and their general counsel asking that she call first thing Tuesday morning and explaining that S.B.'s condition is rapidly worsening. Counsel offered to facilitate communication between NMCD and S.B.'s methadone provider and reiterated that if NMCD agreed to provide MAT, S.B.'s involuntary withdrawal would stop.

131. On the night of April 27, 2021, Defendants' General Counsel responded and stated that upon her admission to NMCD custody, S.B. would be evaluated and that an individual plan of care would be determined. The General Counsel provided no assurances that S.B. would be provided MAT at NMCD nor did she even allude to it. She did state Defendants were willing to review any pertinent information in advance.

132. Continuity of care, including the necessity of providing bridge orders for essential medications, is a core tenant of correctional health care.

133. Defendants are on notice that MAT is the standard of care to treat opioid addiction and that incarcerated individuals are at particular risk of harm when forced to withdraw from MAT as Plaintiff's counsel has provided this information with citations to multiple sources.

134. Despite this, Defendants refuse to provide a clear response to whether NMCD will provide S.B. her essential physician-prescribed medication. Defendants do this while on notice that S.B. is currently going through involuntary withdrawal and fears for her life without the medication.

135. Plaintiffs had planned to file this Complaint on the morning of April 28, 2021. In light of NMCD's General Counsel's email on the night of April 27th, plaintiff's counsel emailed Defendants one more time in an attempt to secure S.B.'s medically necessary treatment and to avoid litigation.

136. In her message, Plaintiff's counsel stated that waiting until S.B. arrives at WNMCF to know whether she will be continued on MAT is not sufficient.

137. Counsel reiterated that the only reason S.B. is being involuntary tapered from methadone is because of NMCD's policy and that S.B. is suffering and at risk of harm right now.

138. Counsel stated "[i]f NMCD will agree to accommodate [S.B.'s] disability, she can continue on her essential physician-prescribed medication and we can avoid litigation. The email asked for an answer to the questions by close of business the same day and gave Defendants' counsel's cell number.

139. Defendants did not respond.

COUNT I
Injunctive Relief
Unlawful Discrimination against Qualified Individuals in Violation of the Americans with Disabilities Act

140. The above facts are incorporated as if set forth herein.

141. The New Mexico Department of Corrections, which Defendants oversee, is a public entity subject to the Americans with Disabilities Act (ADA).

142. NMCD is a public entity that provides medical services.

143. Drug addiction is a recognized "disability" under the ADA. *See* 42 U.S.C. §§ 12102 and 12131(2); 28 C.F.R. § 35.108 (the phrase "physical or mental impairment includes, but is not limited to . . . drug addiction…").

144. The ADA applies to people like S.B. who are participating in medication-assisted treatment for MAT.

145. Defendants deny S.B. the benefit of medical services that are available to other incarcerated individuals on the basis of her disability

146. Defendants refuse to provide S.B. with the reasonable accommodation of access to a therapeutic dose of her essential medication – methadone – during her incarceration, and thus discriminate against her on the basis of disability, even though the accommodation for S.B. would not alter NMCD's healthcare program. Upon information and belief, Defendants do not deny medically necessary, physician prescribed medications to other inmates with serious, chronic medical conditions, such as diabetes.

COUNT II

Claim for injunctive relief

Deliberate Indifference to a Serious Medical Need in Violation of the Eighth Amendment

147. The above facts are incorporated as if set forth herein.

148. Defendants, while acting under color of law, deliberately purposefully and knowingly deny S.B. access to necessary medical treatment for opioid use disorder – a recognized serious medical need.

149. Denying S.B. with continued access to a therapeutic dose of methadone is currently causing her physical and psychological pain and suffering, will place her at heightened risk for other serious medical conditions, and may trigger relapse into active addiction, potentially causing overdose, and overdose death.

150. As applied to S.B., Defendant's denial of S.B.'s medically necessary doctor-prescribed essential medication, due to Defendants' mandatory withdrawal policy and refusal to provide MAT, amounts to deliberate indifference to a serious medical need, in violation of the Eighth Amendment's prohibition against cruel and unusual punishment and 42 U.S.C. § 1983.

COUNT III

Claim for declaratory relief

Deliberate Indifference to a Serious Medical Need in Violation of the Eighth Amendment

151. The above facts are incorporated as if set forth herein.

152. The Eighth Amendment guarantees freedom from "cruel and unusual punishment." This includes the right of prisoners to receive necessary medical care for their serious medical needs while incarcerated.

153. Plaintiff is entitled to a declaration that the Defendants' failure to provide her with MAT, the standard of care treatment for OUD, based on non-medical reasons and no individualized assessment, violates the protections afforded by Eighth Amendment.

PRAYER FOR RELIEF

Wherefore, S.B. asks the Court to GRANT the following:

1. Emergency, preliminary, and permanent injunctive relief ordering Defendants to provide S.B. with access to MAT, including a therapeutic dose prescribed by her physician, during her incarceration;
2. A declaratory judgment that Defendant's denial of medically necessary doctor-prescribed essential medication, on the basis of non-medical reasons, amounts to deliberate indifference to a serious medical need is a violation of the Eighth Amendment's prohibition against cruel and unusual punishment;
3. Award S.B. attorney's fees and costs; and

4. Any further relief this Court deems just and proper.

Date: April 29, 2021

Respectfully submitted,

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