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

S.B.,

Plaintiff,

v. **No. 1:21-cv-00402 KWR-GJF**

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

Defendants.

EMERGENCY MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION AND MEMORANDUM OF LAW

Plaintiff S.B., through her attorneys the American Civil Liberties Union of New Mexico (Lalita Moskowitz and Maria Martinez Sanchez) and the Law Office of Ryan J. Villa (Ryan J. Villa and Katherine Loewe), pursuant to Rules 7 and 65 of the Federal Rules of Civil Procedure seeks emergency injunctive relief requiring Defendants to provide her with continued access to her medically necessary, physician-prescribed medication to treat her opioid use disorder when she is incarcerated in the New Mexico Corrections Department on or before June 9, 2021, and throughout her sentence. She asks that the Court order Defendants to immediately provide her with ongoing methadone maintenance treatment, at a therapeutic dosage already determined to be therapeutic for her by her current medical provider until this Court can rule on a motion for permanent injunctive relief.

Plaintiff requests an expedited briefing schedule due to the on-going harm, and risk of future harm, she is suffering. Plaintiff requests an evidentiary hearing on this matter. In

accordance with Local Rule 7.1(a), Plaintiff contacted Defendants for their position on this motion. Defendants oppose the motion.

INTRODUCTION

Surrounded by myriad examples in her own family and in her community, S.B's life has been plagued by opioid addiction since she was in her twenties. S.B. is finally in active recovery thanks to her life-saving, physician prescribed methadone, one of three FDA-approved medications for addiction treatment (MAT). However, despite having courageously prevailed against a 20-year battle with addiction, S.B. is again in the fight for her life. S.B. comes to this court to ensure that she has access to the *only* effective medication to treat her opioid use disorder throughout her incarceration at the New Mexico Corrections Department (NMCD). But, despite New Mexico being in the middle of a devastating opioid epidemic, Defendants will not even consider methadone as treatment for S.B. Rather, they are subjecting her, like all other non-pregnant prisoners, to their mandatory withdrawal policy. This policy is so well known that public defenders routinely ask for their clients who are on methadone to be remanded to the local jail before starting their NMCD sentence in order to be tapered off of methadone. This practice diminishes life-threatening risks associated with abrupt discontinuation of methadone they would otherwise face in NMCD, but does not reduce the risks associated with untreated opioid use disorder.

Despite the fact that S.B. contacted Defendants and requested a reasonable accommodation excepting her from this blanket mandatory withdrawal policy, NMCD has failed to assure S.B. that they will allow her to stay on her life-saving medication. There is no good reason for denying S.B. her medication. Indeed, NMCD already provides the same treatment for pregnant people in its custody. NMCD policy even requires that Western New Mexico Correctional Facility

(WNMCF) continue to provide methadone to pregnant people entering the facility on methadone, and to have suboxone (buprenorphine) on-site at all times for pregnant people.

NMCD's blanket withdrawal policy is having devastating consequences for S.B. S.B. is currently in an involuntary taper from methadone as she awaits transfer to NMCD. Due to the forced withdrawal from her essential medication, she is experiencing opioid cravings, extreme anxiety, impulses for self-harm, increased depression, and symptoms of post-traumatic stress disorder. S.B. isn't just facing a substantial risk of serious harm, but is experiencing an active, ongoing, and unnecessary harm. Even worse, without her methadone, S.B. faces a dramatically higher risk of relapse, overdose, and even death both during her incarceration and upon release. But methadone is proven to save lives—making death by overdose seven *times* less likely. Therefore, S.B. now moves for preliminary relief enjoining NMCD from enforcing its blanket methadone ban against her until the Court has assessed the mandatory withdrawal policy and blanket ban's lawfulness.

FACTS

A. Opioid Use Disorder is a Serious Medical Condition and a Public Health Crisis.

Opioid Use Disorder (OUD) is a chronic, relapsing brain disorder, the visible symptoms of which include the compulsive use of opioids despite the negative, often horrifying, consequences. Declaration of Bruce Trigg, MD (Trigg Decl.) ¶¶ 5, 7, 48. Legislative Finance Committee, "Health Notes: Substance Use Disorder Treatment and Outcomes in New Mexico," (November 20, 2019) at 3, (hereafter LFC Report);[1] OUD is a "potentially deadly, but treatable chronic illness, not unlike

[1] The LFC report can be accessed at https://www.nmlegis.gov/Entity/LFC/Documents/Health_Notes/Health%20Notes%20-%20Status%20of%20Substance%20Abuse%20Treatment%20and%20Outcomes,%20November%202019.pdf.

diabetes or asthma." LFC Report at 3; Trigg Decl. ¶ 5. NMCD's own medical policies recognize this. *See* Wexford Medical Guideline M-003A at 1 ("The National Institute on Drug Abuse (NIDA) defines addiction as a chronic disease that can be managed and treated successfully."), attached as **Exhibit 1.**[2] Combatting OUD is not a matter of will power—it is a disease that permanently rewires the brain and does not respond to abstinence based program that are common in treating other addictions. Trigg Decl ¶ 12.

In 2017, President Trump declared the opioid crisis, and opioid deaths a national public health emergency.[3] OUD has grown to epidemic proportions, taking the lives of 65,000 people in the United States in the last year alone. Trigg Decl. ¶ 15. Every day, an average of 136 people in the United States die after overdosing on opioids. Id. In 2019, in New Mexico, two out of three overdose deaths involved opioids, with one New Mexican dying due to drug overdose about every fourteen hours.[4] New Mexico has long been hard hit by the opioid crisis and overdose deaths. Bernalillo County, where S.B. lives and is currently incarcerated, is particularly hard hit. Trigg Decl. ¶ 14. Between 1990 and 2018, "[d]rug overdose deaths in New Mexico more than tripled…and are substantially higher than the national trend" with opioids a leading driver of the uptick. LFC Report at 9.

[2] Wexford is the medical vendor for NMCD. Counsel obtained this document from NMCD through the Inspection of Public Records Act.
[3] Trump White House Fact Sheet, "The Crisis Next Door: President Donald J. Trump is Confronting an Opioid Crisis More Severe Than Original Expectations," Nov. 20, 2017, *available at* https://trumpwhitehouse.archives.gov/briefings-statements/crisis-next-door-president-donald-j-trump-confronting-opioid-crisis-severe-original-expectations/.
[4] New Mexico Department of Health, *Drug Overdose Fact Sheet* (Mar. 2021), *available at* https://www.nmhealth.org/publication/view/marketing/2117/

B. MAT is the Standard of Care for Treating OUD.

MAT is the standard of care for treating OUD. Trigg Decl. ¶ 11; LFC Report at 18; *see* Bernalillo County Addiction Treatment Advisory Board, "Standards of Care for the Treatment of Opioid Use Disorder" (Aug. 20, 2018) at 1 (hereafter ATAB Standards).[5] Three FDA-approved medications to treat OUD constitute MAT: methadone, buprenorphine, and naltrexone. Trigg Decl. ¶ 16. Methadone and buprenorphine are categorized as *essential* medications by the World Health Organization.[6]

MAT is medically necessary for people with OUD and gives people with OUD the opportunity to "achiev[e] and sustain[] remission from OUD." ATAB Standards at 1. A broad consensus of major medical, public health, addiction treatment, legal and correctional organizations in the United States support the provision of this evidenced based treatment for OUD. Trigg Decl. ¶ 38. Correctional credentialing organizations, like the National Commission on Correctional Health Care, have recognized MAT as necessary to treat OUD.[7] In recent years, the United States Department of Justice has investigated correctional facilities for violating the ADA and the Eighth and Fourteenth Amendments for not providing MAT.[8]

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[5] The ATAB standards of care can be accessed at https://admin-bernco.sks.com/uploads/files/Behavioral%20Health%20Services/Standards%20for%20Care%20-%20Web.pdf.

[6] National Institute on Drug Abuse, *Effective Treatments for Opioid Addiction* (Nov. 2016) (hereafter NIDA 2016), *available at* https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction (Last visited 4/24/2021).

[7] National Sheriffs Association & National Commission on Correctional Health Care, *Jail-Based Medication-Assisted Treatment* (Oct. 2018), ncchc.org/filebin/Resources/Jail-Based-MAT-PPG-web.pdf

[8] *See, e.g.,* Department of Justice Investigation Letters, attached as **Exhibit 2.** *See also* Department of Justice, "The Department of Justice Alleges Conditions at Cumberland County Jail Violate the Constitution," January 14, 2021 (finding reasonable cause to believe that conditions in NJ violated the 8th and 14th amendment where "inmates faced a heightened risk of self-harm and suicide due to the jail's failure to provide medication-assisted treatment.")

"Methadone is a long-acting opioid that is taken orally. . . once a day to prevent withdrawal symptoms, to decrease cravings for opioids, and at the proper dose, it will block the ability to experience euphoria (a 'high') if an illicit opioid is taken." Trigg Decl. ¶ 20. When prescribed by a doctor effectively treating OUD, methadone "simply makes [patients] feel normal." *Id*. MAT helps patients live normal, productive lives and protects them from the life-threatening effects of illicit opioid use. Trigg Decl. ¶¶ 21. The three medications are *not* interchangeable. Trigg Decl. ¶ 17. A MAT medication that may work for one person, may not work for another. *Id.*

A common misconception, rooted in stigma, is that MAT is simply substituting one addiction for another. Trigg Decl. ¶ 48; LFC Report at 4; *Smith v. Aroostook Cnty*, 376 F. Supp. 3d 146, 160 (D. Maine 2019) (finding defendants' "conduct is consistent with the broader stigma against MAT observed by [a witness], who noted that correctional staff often resist providing MAT because they equate MAT to giving addicts drugs rather than giving people treatment."). This is not the case, rather when MAT is prescribed to treat OUD, the medication restores balance to the brain receptors affected by addiction. Trigg Decl. ¶ 48.[9] Just like medications for other chronic diseases like high blood pressure or diabetes, treatment can last years or even a lifetime. There is no maximum length of treatment. Trigg Decl. ¶ 19 13; ATAB Standards at 3-4.

C. Involuntary Discontinuation of MAT Contradicts the Standard of Care and Puts S.B.'s Life in Severe Danger.

No reasonable medical professional would involuntarily and unilaterally end a patient's methadone treatment. Trigg Decl. ¶ 38. To do so would be highly dangerous. Id. at ¶ 41. When methadone treatment is discontinued, it "results in an 80% or higher relapse rate to illicit opiate

available at https://www.justice.gov/opa/pr/department-justice-alleges-conditions-cumberland-county-jail-violate-constitution

[9] *See also,* NIDA, "Effective Treatments for Opioid Addiction," (Nov. 1, 2019), *available at https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction*

use in the 12 months after discontinuation of treatment." Trigg Decl. ¶ 32. Withdrawal symptoms continue for weeks and months and intense, uncontrollable cravings for opioids can continue for years. Trigg Decl. ¶ 41; Declaration of Kelly Shelton (Shelton Decl.) ¶ 6.

Interrupting MAT has particularly devastating, even deadly, consequences for incarcerated people. One study found that during the two weeks following their release from prison, formerly incarcerated people are 12,900% as likely as non-incarcerated people to die of an overdose.[10] Another found that forcibly removing people from MAT during incarceration led to a seven-fold decrease in treatment retention following release.[11] In contrast, people who receive MAT while incarcerated are 85% less likely to die of a drug overdose within a month of their release.[12] The state of Rhode Island saw a 61% dip in overdose deaths in the year after they implemented their methadone and buprenorphine program in their correctional facilities. Trigg Decl. ¶ 33. This is, in part, 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. Trigg Decl. ¶ 37.

New Mexico's medical experts agree that MAT is critical for those incarcerated. The Governor's Council on Racial Justice Health Subcommittee recommends the provision of MAT in NMCD, explaining that "*[t]his is an urgent issue. People are needlessly dying and being incarcerated.*" *See* Governor's Advisory Council on Racial Justice Health Subcommittee Briefing Memo (Subcommittee), Nov. 18, 2020, Appendix 1, attached as **Exhibit 3** (emphasis original).

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[10] Binswanger, et al., *Release from Prison A High Risk of Death for Former Inmates*, New England Journal of Medicine 336:2 157-165 (2007).

[11] Rich JD, McKenzie M, Larney S. Wong JB. Tran L, Clarke J, *Methadone continuation versus forced withdrawal on incarceration in a combined US prison and jail: a randomized, open-label trial,* Lancet: 386: 350–59 (2015).

[12] Marsden, et al., Does Exposure to Opioid Substitution Treatment in Prison Reduce the Risk of Death After Release? A National Prospective Observational Study in England, Addiction 112, 1408–1418 (2017).

The urgency is such that the Subcommittee recommends NMCD immediately begin to "screen persons in custody. . . for substance use disorders and provide evidence-based care inclusive of all Medication Assisted Treatment (e.g. Naltrexone, Suboxone, or Methadone)." *Id*. at 1.

Denial of MAT can be fatal for people who are still incarcerated. The harsh and undisputed reality is that people in NMCD custody have access to illicit drugs. *See* New Mexico Legislative Finance Committee Quarterly Report Cards, attached as **Exhibit 4**; Plaintiff Decl. ¶ 24. The Legislative Finance Committee provides quarterly report cards showing the percentage of drug tests conducted in NMCD's incarcerated population that came back positive. Of the tests conducted in 2020-2021 reporting period, between 5.6 and 1.7% of tests were positive for drugs. **Exhibit 4.** NMCD also regularly posts pictures of confiscated drugs on its Twitter account. *See, e.g.*, NMCD Twitter [Docs 10-4 through 10-11]. Use of drugs in jails and prisons results 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 life threatening."[13] Trigg Decl. ¶ 46. This is not to mention the increased risk of suicide while incarcerated people go through brutal withdrawal symptoms and then experience severe cravings and brain dysregulation with untreated OUD. Trigg Decl. ¶ 41. Between 2000 and 2013, there were 546 deaths in states prisons due to drug and alcohol intoxication, and 2,577 deaths due to

[13] An example of this is the 2019 death of Carmela Vargas in the Santa Fe County Jail. Ms. Vargas had OUD and the county refused to provide MAT. *The Santa Fe New Mexican* reported that she "had been incarcerated for two months on a probation violation when she died from sepsis related to an infection of her spinal cord and brain stem." Phaedra Haywood, *Family suing over Santa Fe County jail inmate's death*, Santa Fe New Mexican (Feb. 25, 2021), *available at* https://www.santafenewmexican.com/news/local_news/family-suing-over-santa-fe-county-jail-inmates-death/article_b69e5c92-7784-11eb-843f-4fdb80509e6b.html#:~:text=The%20complaint%2C%20filed%20by%20civil,Santa%20Fe%20County%20Jail%20until.

suicide.[14] "Given the well-documented risk of death associated with opioid use disorder, appropriate treatment is crucial." *Smith*, 376 F. Supp. 3d at 150.

Defendants are aware of and understand that MAT is the standard of care for the treatment of OUD. It is set out in the current NMCD medical vendor's policies and procedures for the care of pregnant people. *See* **Exhibit 5.** WNMCFs' policies and procedures even require the facility have suboxone for pregnant people "available at any given time."[15] *See* WNMCF High Risk Pregnancy Procedure at Intake Facility, II(F)(c) (highlighting added), attached as **Exhibit 5.** Defendants have also been informed by the Health Subcommittee of the Governor's Advisory Council for Racial Justice that MAT is the standard of care.[16] Additionally, counsel for S.B. has sent Defendants at least three communications providing information about MAT as the standard of care, that it is medically necessary for S.B., and that she is currently experiencing harm due to NMCD's mandatory withdrawal policy. Loewe Decl. ¶¶ 8-10 Additionally, Defendants are aware of the risk of overdose for people leaving Defendants' custody. Per policy, Defendants provide each individual two doses of the overdose reversing drug naloxone at release, which only treats overdose not OUD itself. Discharge of Inmates with Naloxone, **Exhibit 6**. Nonetheless, Defendants refuse to provide S.B. access to her methadone, evidenced-based, life-saving, FDA-approved care for OUD.

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[14] Margaret Noonan, et al., *Mortality in Local Jails and State Prisons, 2000-2013 – Statistical Tables, United States Department of Justice* (August 2015), *available at* https://www.bjs.gov/content/pub/pdf/mljsp0013st.pdf.

[15] Suboxone is a formulation of buprenorphine. It is buprenorphine plus naltrexone. Buprenorphine is an FDA-approved MAT medication. *See* Wexford Policy, ¶ IV(A)-(B), **Ex.1**

[16] On October 1, 2020, the Health Subcommittee met with Secretary Tafoya Lucero and Mr. Asonganyi and discussed MAT as the standard of care. *See* Public Safety and Law Enforcement Subcommittee and Health Subcommittee Joint Meeting – NOTES at 4-5, excerpts attached as **Exhibit 7.**

D. Methadone is Medically Necessary to Treat S.B.'s OUD and Defendants' Mandatory Withdraw Policy is Already Causing Her Harm and Placing Her at Risk.

S.B. is diagnosed with severe OUD. Plaintiff Decl. ¶ 2; Trigg Decl. ¶ 39. She grew up surrounded by family members using drugs and at ten years old, began using marijuana and cocaine. *Id*. ¶ 22. She wanted a different life, but didn't know how to change. *Id*. She started using heroin in her twenties and quickly became addicted. *Id*. Her addiction "has made it hard to think clearly, stay out of jail and prison, maintain good relationships with [her] family, and lead a stable life." *Id*. ¶ 26.

Approximately two years ago, S.B. sought treatment for her addiction. *Id*. ¶ 3. She went to a methadone clinic in Albuquerque and a physician prescribed her methadone. *Id*. She continued methadone treatment in Colorado without permission to care for her parents with COVID-19, and she is prescribed methadone therapy while incarcerated at MDC. *Id*. ¶¶ 8, 11.

Methadone radically changed S.B.'s life for the better. *Id*. ¶ 3. For the first time in 20 years, she "is able to say [she] is clean from heroin." *Id*. ¶ 13. On MAT, her thinking was clearer, her mental health was better, and she "[could] see an end to using drugs, and an end to being in jail and prison." *Id*. ¶ 3. Before methadone, she "woke up fixing every day," and using heroin throughout the day in a way that was uncontrollable. *Id.* ¶ 4. She was "mostly homeless" and "didn't care about anything except getting a fix from sun up to sun down." *Id.* Staying off of heroin has been a struggle, and she has had some slips, but she has had huge milestones too. *Id.* ¶ 5. She is ready to put that old life behind her, and even today as she sits in jail, her life is 100% better than before methadone. *Id.*

S.B. is a survivor of sexual assault, and she recently lost her father to COVID-19. *Id*. ¶¶ 10, 20. S.B.'s methadone treatment has helped her survive significant traumas in her life. "When

[she] is on [her] methadone dose that works, [she] can experience and work through [her] emotions…process traumatic events…do counseling and talk to [her] advocate." *Id*. ¶ 20. When her dad died, S.B. was sure she would relapse. *Id*. ¶ 12. But because of her methadone, she was able to disregard any thoughts of using. *Id*. She says that "I am proud that, with the help of methadone, I am not using heroin." *Id*. ¶ 5. As S.B. explains, methadone makes her feel "normal." *Id*. ¶ 27 ("Methadone helps me deal with life. It got me functioning, not trying to wake up every day and get a fix. It makes me feel normal."); Trigg Decl. ¶¶ 20-21.

S.B.'s Rape Crisis Center advocate, Kelly Shelton, sees methadone's benefits in S.B.'s life too. She has met with S.B. through the arch of getting on methadone at MDC to being forced to withdraw from it. *See generally* Shelton Decl. Through video visits, Ms. Shelton witnessed S.B. cope in an extremely difficult environment full of trauma triggers—things that activate or increase symptoms of post-traumatic stress disorder. Shelton Decl. ¶¶ 12-14. She describes how S.B. maintained her calm and was insightful in the face of these triggers, and "believe[s] that S.B. was able to maintain her coping skills and not descend into severe trauma symptoms, depression, or suicidal ideation because she was being treated with MAT for her opioid use disorder." *Id.*

"[D]iscontinuing S.B.'s methadone treatment goes counter to the medical standard of care for OUD and will unnecessarily place her health and well-being at risk." Trigg Decl. ¶ 41. Because she is currently being involuntarily tapered off her methadone and is no longer receiving a therapeutic dose, S.B. is already being harmed by NMCD's mandatory withdrawal policy. The withdrawal she is currently experiencing due to being tapered off her MAT is "horrible" and she "wouldn't wish it on anyone." Plaintiff Decl. ¶ 34.

S.B. fears for her life if she cannot continue her methadone treatment in NMCD. Plaintiff Decl. ¶¶ 15, 31. The taper off methadone has been "very hard on [her] physically and emotionally.

Knowing that every day [her] dose will drop and [she] will crave more, and hurt more, and feel the effects of not having the medicine that helps [her] is very hard." *Id*. ¶ 18. "[E]verything feels very overwhelming. [Her] cravings are bad. [She] can't even explain how threatening [her] anxiety gets." *Id*. ¶ 20. Her taper is currently paused at 39 milligrams – or half of the lowest therapeutic dose of methadone. *Id.* ¶ 19; Trigg Decl. ¶ 22 (explaining the therapeutic dose is generally between 80 and 120 milligrams). Her anxiety is heightened knowing that without this Court's intervention, she will be completely tapered off her methadone and transferred to Defendants' custody. *Id*. ¶ 34.

S.B. knows she has "a greater risk of dying in prison because [her] OUD won't be treated." Plaintiff Decl. ¶ 17. S.B. has a history of suicidal thinking and suicide attempts. *Id*. ¶ 21. She has family members who have killed themselves, and who have accidentally overdosed. *Id*. She has seen people overdose in prison and she knows that illicit drugs are available in jail and prison. Plaintiff Decl. ¶¶ 17, 25. She says, "I don't want to die in here or when I am released, but as my dose gets lower I have to remind myself of this." *Id*. ¶ 21. She is scared that if NMCD does not continue her methadone, she "will not be able to control her addiction, the cravings will be too big, and [she] will relapse, and could overdose, and die." *Id*. ¶ 33. She fears that "her depression and anxiety will worsen and [she] could take [her] own life. [She is] scared that [she] will be released and sent right back into the cycle of using and coming in and out of prison." *Id*. ¶ 33.

S.B.'s fears are based in her own experience. After previous incarcerations where her OUD has not been treated, she has gone back to using heroin after release. *Id*.¶ 24. She has overdosed at least thirteen (13) times. *Id*. ¶ 4. She has been hospitalized five times for treatment after an overdose. *Id*. ¶ 4. She is also aware that the drugs in prison and in the community are increasingly dangerous and laced with powerful fentanyl. *Id*. ¶ 16. A friend who she was released from prison with recently overdosed and died. *Id*.

Ms. Shelton shares S.B.'s fears. She describes how S.B.'s nightmares about her abuse are escalating and feel like she is reliving the abuse in real time. Shelton Decl. ¶ 17. The consequences of these "flashbacks" can cause issues "such as self-harm, drug use or relapse to drugs, harm to others, accidental harm to self and others, or an inability to function with daily tasks." Shelton Decl. ¶ 18. Ms. Shelton's "greatest fears are that this MAT withdrawal will result in a continued intensifying of [S.B.'s] trauma and mental health symptoms and a relapse to opioid use, which can endanger S.B.'s life." Shelton Decl. ¶ 23. This suffering, and corresponding harm, is unnecessary. Her medication is available to her in the community and in MDC.

E. Defendants' Mandatory Withdrawal Policy Is Causing Irreparable Harm to S.B. Now.

Defendants do not allow non-pregnant prisoners with OUD to continue physician-prescribed MAT. Counsel for S.B. requested NMCD provide all policies and procedures regarding the provision of MAT and the treatment of OUD in NMCD. The only policies that NMCD provided that allow for MAT are those pertaining to pregnant and lactating women. **Exhibit 1.** NMCD has not provided any policy indicating that MAT is provided to any incarcerated person other than those who are pregnant.

S.B.'s counsel directly asked Defendants multiple times whether they would accommodate S.B.'s disability (OUD) and provide her with MAT during her incarceration. Loewe Decl. ¶¶ 4, 8, 13 and **Exhibit 1 attached thereto (Letters).** Counsel notified Defendants that due to NMCD's policy, S.B. was currently experiencing harm, and that if Defendants agreed to provide MAT, S.B.'s physician would immediately stop her taper. *Id*. Defendants acknowledged counsel's letters, but to date have not provided any substantive response, nor agreed to provide MAT. Loewe Decl. ¶¶ 10-11, and **Exhibit 3 attached thereto (Email thread)**.

Prior to filing the Complaint, counsel again contacted Defendants in an attempt to stop the harm to S.B. and avoid this litigation. Loewe Decl. ¶ 17, **Exhibit 4, p. 9**, **attached thereto.** Counsel emphasized that S.B. was *currently* suffering harm due to NMCD's mandatory withdrawal policy and asked for confirmation whether or not NMCD would provide NMCD with MAT. Defendants replied that they could not make a determination until S.B. was in NMCD custody. Loewe Decl. ¶ 16. Counsel alerted NMCD that we were on the cusp of filing a lawsuit on S.B.'s behalf and asked for clear answers by close of business on April 28, 2021. We received no response. *Id*. ¶ 17. Counsel continued to reach out to Defendants seeking to resolve the issue. *Id*. ¶ 20. S.B.'s involuntary taper is currently paused, however her doctor will not increase it to a therapeutic level due to her NMCD sentence. S.B. Decl. ¶ 19 To date, NMCD has not responded or provided any information indicating that MAT is available to S.B. in NMCD custody.

As a result of Defendants' mandatory withdrawal policy and its inaction as to S.B.'s request for MAT, S.B. is *currently* experiencing the psychological and physical pain of her involuntary withdrawal and reasonably believes that Defendants will continue to place her at risk of unreasonable harm and possibly death by denying her MAT during her incarceration.

ARGUMENT

I. PRELIMINARY INJUNCTIVE RELIEF IS WARRANTED

To be entitled to a preliminary injunction, the moving party:

> must demonstrate (1) that it has a substantial likelihood of prevailing on the merits; (2) that it will suffer irreparable harm unless the injunction is issued; (3) that the threatened injury outweighs the harm that the preliminary injunction may cause the opposing party; and (4) that the injunction, if issued, will not adversely affect the public interest.

Prairie Band of Potawatomi Indians v. Pierce, 253 F.3d 1234, 1246 (10th Cir. 2001); *Winter v. Natural Resources Defense Council*, 555 U.S. 7, 20 (2008). The requirements for a temporary

restraining order are essentially the same. *People's Tr. Fed. Credit Union v. Nat'l Credit Union Admin. Bd.*, 350 F. Supp. 3d 1129, 1138 (D.N.M. 2018).

In two cases nearly identical to this one, courts have granted preliminary injunctive relief requiring correctional facilities to provide MAT throughout the course of an incarceration. *See Pesce v. Coppinger,* 355 F. Supp. 3d 35 (D. Mass. 2018) (finding a jail's mandatory withdrawal policy likely violated the Eighth Amendment and the ADA); *Smith v. Aroostook Cnty*, 376 F. Supp. 3d 146, 158-162 (D. Maine 2019) (finding a jail's mandatory withdrawal policy likely violated the ADA). As in those cases, here, all factors favor granting emergency injunctive relief enjoining Defendants' from applying their mandatory withdrawal policy to S.B.

First, S.B. can prove that Defendants are deliberately indifferent to her serious medical need in violation of the Eighth Amendment. Second, S.B. will show that Defendants' policy, as applied to her, violates the ADA. To obtain the emergency relief sought, S.B. need only show that she is likely to succeed on one of her legal claims.

A. S.B. is Substantially Likely to Succeed in Showing that Defendants are Deliberately Indifferent to Her Serious Medical Need by Denying her Access to her Necessary, Physician-Prescribed Medication in Violation of the Eighth Amendment.

Forcing S.B. off of her physician-prescribed methadone constitutes cruel and unusual punishment in violation of the Eighth Amendment. Because "society takes from prisoners the means to provide for their own needs," they "are dependent on the State for food, clothing, and necessary medical care." *Brown v. Plata*, 563 U.S. 493, 510 (2011). "Just as a prisoner may starve if not fed, he or she may suffer or die if not provided adequate medical care." *Id*. at 510-11. "A prison that deprives prisoners of basic sustenance, including adequate medical care, is incompatible with the concept of human dignity and has no place in civilized society." *Id*. at 511. Thus, prison officials have an affirmative obligation to provide medical care to individuals in their

custody. *See Farmer v. Brennan*, 511 U.S. 825, 832 (1994); *Helling v. McKinney*, 509 U.S. 25, 31-32 (1993); *Estelle v. Gamble*, 429 U.S. 97, 104 (1976).

In the medical care context, "deliberate indifference to [a] serious medical need[ ] of prisoners constitutes the unnecessary and wanton infliction of pain proscribed by the Eighth Amendment." *Estelle,* 429 U.S. at 104 (citation and internal quotation marks omitted); *Mata v. Saiz*, 427 F.3d 745, 751 (10th Cir. 2005). Denial or delay of necessary medical care can amount to deliberate indifference. *Estate of Booker v. Gomez*, 745 F.3d 405, 429 (10th Cir. 2014). "A prison official's deliberate indifference to a substantial risk of serious harm to an inmate violates the Eighth Amendment." *Farmer*, 511 U.S. at 828 (internal quotation marks and citation omitted).

A deliberate indifference claim has an objective and subjective prong. *Estate of Booker*, 745 F.3d at 430. The objective prong is satisfied by showing that the plaintiff's medical need was sufficiently serious. *Farmer*, 511 U.S. at 834; *Sealock v. Colorado*, 218 F.3d 1205, 1209 (10th Cir. 2000). "The subjective component is met if a prison official 'knows of and disregards an excessive risk to inmate health or safety,'" a standard equivalent to recklessness. *Sealock*, 218 F.3d at 1209 (quoting *Farmer*, 511 U.S. at 837).

Here, OUD is a serious medical need. Defendants are aware of S.B.'s serious medical need, and by requiring her to withdraw from her doctor-prescribed medication, and then withholding that medication, Defendants are disregarding the excessive risk to her health and safety. *See Pesce,* 355 F. Supp. 3d at 47.

1. Opioid Use Disorder is an Objectively Serious Medical Condition.

First, OUD is a serious medical need. *See Est. of Jensen by Jensen v. Clyde*, 989 F.3d 848, 859 (10th Cir. 2021) (holding that opioid withdrawal is a serious medical need); *Quintana v. Santa Fe Cty. Bd. of Commissioners*, 973 F.3d 1022, 1033-34 (10th Cir. 2020) (same). A serious medical

need "is one that has been diagnosed by a physician as mandating treatment or one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention." *Hunt v. Uphoff*, 199 F.3d 1220, 1224 (10th Cir. 1999). OUD is a chronic brain disease, which left untreated can lead to severe injury or death. *See* Facts, Sec. A, *supra*; *Smith*, 376 F.Supp.3d at 150 ("People who are engaged in treatment are three times less likely to die than those who remain untreated."). Opioid overdoses alone kill 136 people in the United States every day.[17] MAT is the standard of care for OUD and failure to provide MAT is failure to provide adequate treatment. *See Pesce*, 355 F.Supp.3d at 47-48; Facts, Sec. B, *supra*.

Second, MAT is medically necessary to adequately treat S.B.'s OUD. S.B.'s physicians at MDC, and at methadone clinics in the community, have prescribed methadone to treat her OUD. S.B. Decl. ¶ 3, 8, **Exhibit 2,** attached thereto. For twenty years, she was unable to stop using heroin. *See* Facts Sec. E, *supra*. Only with methadone has she been able to say that she is no longer using heroin, and that she has stayed this way even through recent, significant hardship, like the stress and grief of her father's death. S.B. Decl. ¶ 12. Methadone is an essential medication that "restores balance to the brain circuits affected by addiction."[18] For S.B., methadone "got [her] functioning, not trying to wake up every day and get a fix." Plaintiff Decl. ¶ 28. She may need to take it for the rest of her life to stay in recovery from heroin. Plaintiff Decl. ¶ 35; ATAB Standards at 4.

Discontinuing S.B.'s methadone treatment for non-medical reasons is counter to the standard of care for OUD and unnecessarily places her health and well-being at risk. Trigg Decl. ¶ 41. For S.B., staying on methadone is a matter of life or death. S.B. Decl. ¶ 33; Trigg Decl. ¶ 42.

[17] *See* Opioid Overdose, Centers for Disease Control and Prevention (last reviewed Mar. 17, 2021), https://www.cdc.gov/drugoverdose/epidemic/index.html.
[18] NIDA 2016.

Her advocate attests to S.B.'s decompensation since her methadone taper started, and fears that S.B. will relapse, overdose, and die. Shelton Decl. ¶¶ 21-23.

Defendants' mandatory withdrawal policy directly contradicts the weight of medical authority, is contrary to the medical standard of care for OUD, and will categorically deny S.B. access to adequate medical care. *See* Facts, Sec. B, *supra*. Defendants' practice is to deny MAT to all but pregnant people. This blanket policy violates her constitutional right to individualized care and to adequate care for her serious medical need.

2. Arbitrarily Requiring Withdrawal from Physician-Prescribed Methadone Constitutes Deliberate Indifference.

Prison officials are deliberately indifferent when they subjectively know of and disregard a substantial risk of harm. *Sealock*, 218 F. 3d at 1209. The deliberate indifference standard lies "somewhere between the poles of negligence at one end and purpose or knowledge at the other." *Farmer*, 511 U.S. at 836. The Supreme Court in *Farmer* analogized this standard to criminal recklessness, which makes a person liable when she consciously disregards a substantial risk of serious harm. *Id*. at 836–38. Thus, "[d]eliberate indifference does not require a finding of express intent to harm." *Mitchell v. Maynard*, 80 F.3d 1433, 1442 (10th Cir.1996) (citation omitted). Further, the inquiry does not require that a harm be guaranteed to occur. Rather, deliberate indifference is met where a prison official disregards a substantial risk of harm. *Helling*, 509 U.S. at 34 ("[A] remedy for unsafe conditions need not await a tragic event.").

Further, the relevant inquiry under the deliberate indifference standard is not whether *any* medical care has been provided, but whether *constitutionally adequate* care has been provided. *Estelle*, 429 U.S. at 103-06. (prison officials may not adopt an "easier and less efficacious treatment" that does not adequately address a prisoner's serious medical needs); *Ramos v. Lamm*, 639 F.2d 559, 574 (10th Cir. 1980) (the constitution "requires that the State make available to

inmates a level of medical care which is reasonably designed to meet the routine and emergency health care needs of inmates") (internal quotation marks omitted); *Edwards v. Syder*, 478 F.3d 827, 831 (7th Cir. 2007) (treatment cannot be "blatantly inappropriate"). It is well-established that, while prisoners may not be entitled to any particular treatment of their choosing, medical care in prison cannot be "so cursory as to amount to no treatment at all." *Ancata v. Prison Health Servs., Inc.*, 769 F.2d 700, 704 (11th Cir. 1985); *see also Langford v. Norris*, 614 F.3d 445, 460 (8th Cir. 2010) ("a total deprivation of care is not a necessary condition for finding a constitutional violation"); *Jones v. Muskegon Ctny.*, 625 F.3d 935, 944 (6th Cir. 2010) (prison officials may not avoid liability "simply by providing some measure of treatment").

Defendants' mandatory withdrawal policy is currently inflicting harm on S.B., and more harm is certain if she if required to withdrawal completely from her essential medication for the duration of her incarceration. *See* Facts, *supra*. She is, and will continue to be, at increased risk of harm from relapse, overdose, and death by overdose or suicide. Additionally, because of Defendant's mandatory withdrawal policy, she was remanded to MDC to taper. Declaration of Jennifer Barela (Barela Decl.) ¶¶ 7-8. It will also take weeks for S.B. to taper back up to a therapeutic dose, therefore the harm caused by NMCD's policy is ongoing. Trigg Decl. ¶ 42. While she is at MDC for this medical reason, she is not earning "good time," thus extending her sentence. Barela Decl. ¶¶ 11-13. Because of this, the mandatory withdrawal policy causes her physical and psychological harm, and also deprives her of her liberty.

This court has at least four bases to find that Defendants are subjectively aware of and deliberately indifferent to S.B.'s serious medical need. First, Defendants Tafoya Lucero and Asonganyi were copied on counsel's correspondence which alerted Defendants to S.B.'s OUD and methadone treatment, her current suffering and risk of harm to her – they know that her anxiety

and depression is increasing, that she has a history of suicide and is experiencing impulses for self-harm, that she is a sexual abuse survivor and is experiencing increased trauma symptoms, and that she is craving opioids, and is at risk of relapse, overdose, and death. Loewe Decl. ¶¶ 9, 13, Ex. 4. They are aware that MAT is the standard of care for OUD, and that courts have held that failure to provide MAT to treat OUD poses a serious danger to incarcerated people. *Id*. S.B. has asked Defendants to allow her to continue her doctor-prescribed treatment, which would allow her physician to provide her with a therapeutic dose of methadone and stop her current suffering. They have declined to do so. *See generally*, Loewe Decl.

Second, Defendants Tafoya Lucero and Asonganyi were present at an October 1, 2020 meeting where doctors who treat addiction, informed them that MAT is the standard of care for OUD; advised that incarcerated people with OUD were particularly at risk; and questioned them about whether NMCD provided MAT. **Exhibit 7** (10/1/20 Meeting Notes).

Third, Defendants Tafoya Lucero and Asonganyi participate in creating and approving NMCD policies and overseeing the medical provider. As recently as April 27, 2021, NMCD's website stated that the Defendant Asonganyi's was responsible for overseeing the medical services contract and was responsible for the medical care and addictions treatment of NMCD inmates. Defendants' mandatory withdrawal policy violates the standard of care. The mandatory withdrawal policy also deprives S.B. of her right to individualized assessment and treatment, because even if a cursory assessment is done, MAT is not an option at all. Defendants' disregard S.B.'s serious medical need in favor of a blanket ban on MAT. Defendants' know that overdose and death are risks to people with untreated OUD – because of this, they have a policy to provide overdose education to releasing inmates as well as naloxone, a medication that does not treat OUD, but can be life-saving when overdosing. **Exhibit 6**. Finally, although Defendants do not currently

provide MAT, their contract with the vendor has a provision for it "[a]t such time that NMCD implements MAT." Wexford Contract – MAT, **attached as Exhibit 8.** It includes a provision to "ensure continuity of care." Id.

Fourth, the opioid epidemic's impact on New Mexico is well documented. *See* Facts, *supra*. In 2018, *one-third* of incarcerated people in New Mexico were there for failed drug tests and missed appointments.[19] The Legislative Finance Committee, which Defendants report to, has noted that in 2018 heroin overdose deaths slowed in New Mexico, and attributed this to "[s]tate policies regarding expansion of MAT and naloxone." LFC Report at 14. Between the State DOH which publishes a fact sheet directing people to MAT,[20] LFC reports, and newspaper stories, Defendants are aware of the severity of the opioid epidemic and the necessity for MAT.

This is sufficient for the Court to conclude that Defendants know of the risk created by denying MAT treatment to the people in their care. *See Mata*, 427 F.3d at 752 (explaining that the subjective prong can be shown with circumstantial evidence and that "[a]n official 'would not escape liability if the evidence showed he merely refused to verify underlying facts that he strongly suspected to be true, or declined to confirm inferences of risk that he strongly suspected existed'") (quoting *Farmer*, 511 U.S. at 843).

Thus, the Court has at least four bases to find that Defendants are aware of S.B.'s serious medical need, that they understand that failing to treat that medical need runs counter to the standard of care, that it is already causing her harm and placing her at risk, and that they are

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[19] Legislative Finance Committee, Program Evaluation: Corrections Department - Status of Programs to Reduce Recidivism and Oversight of Medical Services, October, 23, 2018 at 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 May 21, 2021).

[20] *Supra,* footnote 4.

disregarding that risk of harm. *See Pesce*, 355 F. Supp. 3d at 48; *Parish v. Sheriff of Cook Cty.,* 2019 WL 2297464 at *17 (N.D. Ill. May 30, 2019) (finding a jury could reasonably conclude jail officials were deliberately indifferent to a serious need based on practice of tapering detainees off of methadone); Emergency relief is warranted.

A blanket methadone ban is no substitute for an individualized medical judgment. Nor is this a case of mere disagreement with Defendant's considered medical judgment. Rather, it precludes an expert medical judgment from being made in the first place. *See, e.g.*, *Brock v. Wright*, 315 F.3d 158, 166 (2d Cir. 2003) ("Since both [prison doctors] have cited the policy as the reason for their actions . . . the question before us is whether following the policy resulted in deliberate indifference to [the plaintiff's] medical needs."); *Ramos,* 639 F.2d at 575-78 (finding deliberate indifference where non-medical logistical factors, such as insufficient vehicles to transport individuals to appointments interfered with appropriate medical treatment). Indeed, per the blanket withdrawal policy, S.B. cannot be prescribed MAT even if the treating physicians identified her need for it. *See Ramos*, 639 F.2d at 578 (finding deliberate indifference where prisoners were not given access to medical professionals appropriately qualified to evaluate *and* treat their medical needs).

Finally, the blanket methadone ban is *already* causing S.B. substantial harm. This policy is so widely known that public defenders routinely ask for their clients who are on methadone to be tapered off of their methadone at MDC before being transferred to NMCD. *See generally* Barela Decl. S.B. has been involuntarily tapered off methadone due to NMCD's mandatory withdrawal policy. S.B. Decl. ¶ 14. Therefore, hypothetically, even if Defendants change or make an exception to their policy and S.B. is given methadone upon her first day at NMCD, she will still experience ongoing harm and will have to be slowly tapered back up to a therapeutic dose. It is

well established that a delay in treatment can amount to deliberate indifference. *Oxendine v. Kaplan*, 241 F.3d 1272, 1276 (10th Cir. 2001).

B. S.B. is Substantially Likely to Succeed on the Merits of Her ADA Claim.

S.B. is also substantially likely to succeed on the merits of her ADA claim. Defendants violate the ADA by refusing to accommodate her known disability. Defendants' mandatory withdrawal policy and denial of MAT, as applied to S.B., also violates the ADA because it effectively precludes her from meaningful access to medical care available to other incarcerated people and does so on the basis of her OUD.

"Title II of the ADA 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.'" *Robertson v. Las Animas Cnty Sheriff's Dep't*, 500 F.3d 1185, 1193 (10th Cir. 2007) (quoting 42 U.S.C. § 12132). "The ADA 'unmistakably includes State prisons and prisoners within its coverage.'" *Hughes v. Colo. Dep't of Corrections*, 594 F. Supp. 2d 1226, 1241 (quoting *Penn. Dep't of Corrections v. Yeskey,* 524 U.S. 206, 209 (1998); 28 C.F.R. § Pt. 35, App. A (stating the ADA "applies to all state and local detention and correctional facilities."). Courts evaluate 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).

To state a claim under Title II of the ADA, a plaintiff must show that "(1) [s]he is a qualified individual with a disability, (2) who was excluded from participation in or denied the benefits of a public entity's services or programs, or activities, and (3) such exclusion, denial of benefits, or discrimination was by reason of a disability." *Robertson,* 500 F. 3d at 1193 (citing 42 U.S.C. § 12132; *Kiman v. N.H. Dep't of Corr.,* 451 F.3d 274, 283 (1st Cir. 2006)). Each element is satisfied

here. Defendants engage in disability discrimination in at least two ways, either one of which is sufficient to prove an ADA violation: 1) their categorical ban on methadone for non-pregnant people; and 2) their failure to make a reasonable accommodation.

3. S.B. is a Qualified Individual with a Disability.

Individuals with OUD are "qualified individuals with disabilities" under the ADA. *See* 42 U.S.C. § 12210; *Pesce*, 355 F. Supp. 3d at 45. A "disability" is "a physical or mental impairment that substantially limits one or more major life activities." 42 U.S.C. § 12102(1)(A). "Drug addiction" is a recognized impairment. 28 C.F.R. § 35.108(b)(2). S.B.'s OUD is chronic and severe. Plaintiff Decl ¶ 2; Trigg ¶¶ 5, 39-41 ("OUD is a chronic, relapsing brain disorder that is often not able to be cured."). For twenty years, S.B. struggled with OUD and heroin addiction. Plaintiff Decl. ¶ 2. Untreated, S.B.'s OUD "substantially limits" major life activities, such as concentrating, communicating, caring for herself, working, and sleeping. Plaintiff Decl. ¶¶ 4, 20, 26, 34. Prior to being sentenced to NMCD, S.B. was participating in the local jail's methadone treatment program. Plaintiff Decl. ¶ 8. Post-sentencing she was remanded to the jail to taper off physician-prescribed MAT. Plaintiff Decl. ¶ ¶ 14, 30; Barela Decl. ¶ 8. She is currently still enrolled in the jail's methadone program, albeit at an extremely low dose of methadone, and is abstaining from drugs. Plaintiff Decl. ¶¶ 18-19. S.B. is otherwise qualified to receive medical services in Defendants' custody. *See generally Estelle v. Gamble*, 429 U.S. 97, 102-103 (1976) (recognizing constitutional guarantee of medical care to all incarcerated people); 42 U.S.C. § 12131(2) (defining "qualified individual with a disability"); 28 C.F.R. § 35.104, 108 (same).

4. Defendants Violate the ADA by Failing to Accommodate S.B.'s Disability.

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."); *Romero v. Bd. Of Cty. Comm'rs for the Cty.. of Curry*, 202 F. Supp. 3d 1223, 1265 (D.N.M. 2016) ("Discrimination under the ADA may include a defendant's failure to make reasonable accommodations to the needs of a disabled person.") (citing *McCoy v. Tex. Dep't Crim. Justice*, 2006 WL 2331055, at *7 & n. 6 (S.D. Tex. Aug. 9, 2006) ("In the prison context, failure to make reasonable accommodations to the needs of a disabled prisoner may have the effect of discriminating against that prisoner because the lack of an accommodation may cause [them] to suffer more pain and punishment than non-disabled prisoners.")).

Here, S.B. provided Defendants with three formal letters and several additional emails detailing her disability, her medically necessary treatment, the life-threatening effects of being forced to withdraw from this treatment, *and asking Defendants to accommodate her disability*. Loewe Decl. ¶¶ 4, 8-9, 13 and Exhibits attached thereto. *See Fisher v. Glanz*, 2016 WL 1175239, ** 1-2, 9-10, 13, No. 14-cv-678-TCK-PJC (March 24, 2016) (Kern, J.) (allowing ADA claim to proceed where family notified jail employees of individual's disability and need for anti-seizure medication and jail failed to accommodate the disability or provide the medication). Defendants have given no concrete indication that they will reasonably accommodate S.B.'s disability and make MAT available to her during incarceration and as a result she currently does not have access to a therapeutic dose of her essential medication.

Defendants are on notice that S.B. has been diagnosed with opioid use disorder and that she has been prescribed methadone to treat her opioid use disorder. Defendants are on notice that S.B. is being forced to withdraw from methadone based solely on Defendants' mandatory withdrawal policy and refusal to provide MAT. S.B. is currently experiencing harm, harm that could be stopped if Defendants agreed to provide S.B. with this reasonable accommodation. There is no legitimate reason that Defendants cannot provide S.B. with MAT, particularly when it is available to pregnant incarcerated people. Declaration of Edmond Hayes (Hayes Decl.) ¶ 8; Trigg Decl. ¶ 49. Prisons and jails around the country accommodate people with OUD by providing them with MAT.[21] Trigg Decl. ¶¶ 4, 45, Hays Decl. ¶ 9; *see also Smith v. Aroostook Cnty.,* 922 F.3d at 41 (affirming preliminary injunction on plaintiff's ADA claims where defendants had "variety of reasonable alternatives at their disposal for providing [the plaintiff] with her medication in a manner that alleviates any security concerns"). Defendants do not provide any FDA-approved medication for OUD to non-pregnant individuals. Without this reasonable accommodation, S.B. will be denied meaningful access to the public service of medical care provided by Defendants during her incarceration.

5. Defendants Discriminate Against S.B. by Denying her Access to her Essential Medication Based on Her Disability.

Defendants unlawfully discriminate against S.B. by denying her medically necessary methadone on the basis of her disability, thus denying her access to effective medical services that

[21] *See, e.g.*, *Crews* v. *Sawyer*, 20120 WL 1528502 (D. Kan. Jan. 26, 2021) (describing the settlement with the federal Bureau of Prisons to provide buprenorphine to a prisoner who had been taking buprenorphine for 14 months before reporting to a Kansas prison to serve a three year sentence); *DiPierro v. Hurwitz*, No. 19-cv-10495 (filed March 15, 2019) (describing the Bureau of Prisons' agreement to provide methadone-based MAT to a plaintiff sentenced to 366 days, who, like S.B., had his long-term opioid use successfully treated with MAT).

people with other chronic conditions, like diabetes, have access to. *See Rashad v. Doughty*, 4 Fed. Appx. 558, 560 (10th Cir. 2001) (recognizing that "the allegation that a disabled prisoner has been denied services that have been provided to other prisoners may state a claim under the ADA." (citing *McNally v. Prison Health Servs.,* 46 F. Supp. 2d 49, 58 (D. Me. 1999) (concluding that an HIV patient's claim to discriminatory denial of prescription services provided to the general population would state an ADA claim)).

In setting out the elements of ADA claims, the Tenth Circuit looked to *Kiman v. New Hampshire Department of Corrections.,* 451 F.3d 274, 283 (1st Cir. 2006). *See Robertson,* 500 F. 3d at 1193. *Kiman* is instructive here. In *Kiman,* a formerly incarcerated person alleged that the defendant's medical treatment decisions violated the ADA. The court differentiated between disagreements between "reasoned medical judgement" and medical decisions that are "so unreasonable—in the sense of being arbitrary and capricious—as to imply that it was pretext for some discriminatory motive, such as animus, fear, or apathetic attitudes." *Id*. at 284 (internal quotation and citation omitted). The court further explained that a plaintiff could also "argue that her physician's decision was discriminatory on its face, because it rested on stereotypes of the disabled rather than an individualized inquiry into the patient's condition" and was thus unreasonable. *Id*. at 284-85 (internal quotation and citation omitted).

The Tenth Circuit distinguishes "between claims asserted under the ADA that allege that the medical treatment that a plaintiff . . . had access to was inadequate, versus claims alleging that a plaintiff was discriminatorily precluded from access to medical treatment altogether." *Hughes,* 594 F. Supp. 2d at 1241 (compiling cases). Claims alleging that a plaintiff was discriminatorily precluded from access to medical care altogether are sufficient under the ADA. *Id*. at 1241-42 (holding plaintiff stated a claim where he alleged that a prison maintained a policy of assuring

incarcerated people received the mental health treatment they required, but intentionally failed to provide him with mental health treatment). Here, S.B. asserts that the blanket ban on methadone forecloses her access to appropriate and effective medical care altogether.

To prove discrimination, S.B. need only show "benign neglect," rather than active animus. *Alexander v. Choate*, 469 U.S. 287, 295-97 (1985). In enacting the ADA, Congress recognized that disability discrimination was "often the product of . . . thoughtlessness and indifference." *Id*. At 295. Thus, this Court need not find that Defendants are acting with animus when they discriminate by maintaining their mandatory withdrawal policy and denying S.B. access to medical care for OUD altogether. Here, the stigma surrounding MAT and indifference towards people with substance use disorders plays a role in treating MAT differently than other medications for chronic diseases. Hayes Decl. ¶ 24; LFC Report at 1, 4 (explaining that stigma "remains a significant obstacle in broadening access to effective treatment," namely MAT). It would simply be unthinkable for a prison to have a blanket ban on insulin for diabetes. The very purpose of a prison's medical care is to provide adequate medical care, yet this policy requires that they do not provide such care (despite Defendants' capability to do so for pregnant people).

In *Smith*, a nearly identical case, the court relied on *Kiman* when it determined that a correctional facility's blanket policy denying MAT to an individual who requested "her prescribed, necessary medication" was "so unreasonable as to raise an inference that the Defendants denied the Plaintiff's request because of her disability." 376 F. Supp. 3d at 159-60. This Court should reach the same conclusion here. Defendants' mandatory withdrawal policy and blanket denial of MAT to all but pregnant people does not allow for reasoned medical judgement or an individualized inquiry into S.B.'s condition. There is no legitimate medical or security reason to deny S.B. continued access to MAT. Hayes Decl ¶¶ 12-21 (describing how MAT can be safely

administered in a correctional setting). To do so is contrary to medical standards of care. Trigg Decl. ¶¶ 11, 41 (explaining MAT is the standard of care and discontinuing S.B. is counter the medical standard). And there is no legitimate reason to provide MAT to pregnant people, but not to non-pregnant people in the prison for whom MAT is medically necessary. The very fact that MAT is provided to pregnant people obviates any purported security concerns of providing methadone to S.B.

As in *Smith*, Defendants' policy and practice here deny S.B. her "necessary medication because she suffers from OUD" and for no other legitimate reason. 376 F. Supp. 3d at 159. There, the court determined that by denying the plaintiff the only form of treatment effective at managing her disability, defendants denied her "meaningful access to the Jail's healthcare services." *Id.* at 160. The same is true here where Defendants have provided no justification for their mandatory withdrawal policy as applied to S.B. The evidence supports the conclusion that she is being denied her essential medication because of her disability. Additionally, Defendants provide medication for a multitude of other chronic conditions, MAT to a sub-set of pregnant people with OUD, and access to specialty care for other chronic conditions, including off-site care, but deny MAT to non-pregnant people with OUD. Where services are available to people with disabilities, but not a sub-set of people with disabilities, the public entity has a duty to take action to ensure equal access. *See Chaffin v. Kan. State Fair Bd.*, 348 F.3d 850, 857 (10th Cir. 2003) (rejecting "the argument that the ADA requires no more than mere physical access" and stating public entity has a duty to make changes to ensure access is meaningful access) *overruled on other grounds*, *Muscogee Creek Nation v. Pruitt*, 669 F.3d 1159, 1167 n. 4 (10th Cir. 2012); *Randolph v. Rodgers*, 170 F.3d 850, 858 (8th Cir.1999) (holding that a deaf incarcerated person who was physically present at events without an interpreter was not provided meaningful access to services and activities).

Defendants' mandatory withdrawal policy is an outright ban on providing effective treatment consistent with the standard of care for one particular disease. Defendants' deny methadone and buprenorphine – essential medications approved by the FDA to treat a chronic disabling condition – to S.B., but *do* provide essential medications and treatment for other chronic conditions. Methadone has been the *only* medication that has been effective at controlling S.B.'s OUD. It would be unthinkable for Defendants to have a blanket policy requiring people with diabetes to withdraw from their insulin or people with steroid dependent asthma to withdraw from their inhalers. For these reasons, S.B. is likely to prevail on her ADA claim.

B. S.B. is Suffering and Will Continue to Suffer Irreparable Harm if She is Denied Access to MAT While Incarcerated.

A plaintiff suffers irreparable harm "when 'the injury cannot be adequately atoned for in money,' or 'when the district court cannot remedy the injury following a final determination on the merits.'" *Prairie Band of Potawatomi Indians*, 253 F. 3d at 1250 (quoting *American Hosp. Ass'n v. Harris*, 625 F. 2d 1328, 1331 (1980)) (internal citations omitted). It is well established that "[w]hen an alleged constitutional right is involved … no further showing of irreparable injury is necessary." *Planned Parenthood Ass'n of Utah v. Herbert,* 828 F3d 1245, 1263 (10th Cir. 2016) (citing *Kikumura v. Hurley*, 242 F.3d 950, 963 (10th Cir. 2001)).

S.B. is currently suffering irreparable harm. Due to Defendants' deliberate indifference and discriminatory policies, her life saving essential medication is being denied and she is experiencing physical and psychological suffering, which greatly increase her risk of relapse, overdose, and death. Discontinuing her necessary medical treatment places her life and safety at risk right now as she decompensates and craves opioids. In granting S.B.'s motion to proceed anonymously, Magistrate Judge Fourrat recognized that having been tapered off methadone and craving opioids, S.B. is at risk of physical harm. He found "that there is a 'real danger of physical harm' that may

result to her in prison (e.g., being targeted by individuals with drugs) should her identity be known to the public." Order Quashing Order to Show Cause and Granting Motion to Proceed Anonymously at 4 [Doc. 11]. The court's order allowing her to proceed anonymously helps diminish, but does not alleviate, the risk of irreparable harm S.B. is subject to due to Defendants' mandatory withdrawal policy.

Without her medication S.B. is at risk of self-harm, relapse, overdose, and death. Without MAT, S.B. will continue to face set-backs in her recovery. Even if Defendants agreed today to provide MAT to S.B., it would take weeks to bring her back up to a therapeutic dose of methadone, extending the period of current and on-going harm. Trigg Decl. ¶ 42. No amount of money can atone for the suffering that she is experiencing, the loss of her hard-won recovery from heroin, and the risk to her life. By the time the court can hold a full trial on the merits, S.B. will have already suffered irreparable harm.

C. The Public Interest and the Balance of Harms Strongly Favor the Grant of Emergency Injunctive Relief.

The public interest is best served by providing S.B. with medically necessary treatment that will support her in remaining in active recovery. *Pesce*, 355 F. Supp. 3d at 49. First, "[i]t is always in the public interest to prevent the violation of a party's constitutional rights." *Verlo v. Martinez*, 820 F.3d 1113, 1127 (10th Cir. 2016) (internal quotation marks and citation omitted) (affirming district court's grant of preliminary injunction). Additionally, the Legislative Finance Committee has detailed the costs of opioid addiction, death, and related illnesses and traumas. *See generally* LFC Report. The Governor's Advisory Council has urged immediate action to provide MAT to incarcerated people with OUD and reduce the risk of death, illness and recidivism. Allowing S.B. to continue her methadone treatment is consistent with maintaining jail security as there is a reduction in contraband in correctional facilities that provide MAT. Hayes Decl. ¶ 13.

MAT will help S.B. break the cycle of being released from prison, using illegal drugs, and returning to prison. Plaintiff Decl. ¶¶ 23, 33, 35.

The risk of irreparable harm to S.B. greatly outweighs any potential harm claimed by Defendants. The harm S.B. is experiencing now, and will continue to experience as her methadone is discontinued, is concrete and irreversible. In contrast, granting injunctive relief imposes no measurable harm on Defendants. *See Smith*, 376 F. Supp. 3d at 162 (finding that providing plaintiff access to MAT placed little burden on the jail). Defendants already provide MAT to pregnant people. Their policies specifically address how to obtain methadone for pregnant persons. Ex. 1. NMCD could obtain "take home doses" to dispense from their pharmacy. Trigg Decl. ¶ 49.

II. THE RELIEF REQUESTED MEETS THE PLRA'S NEEDS-NARROWNESS-INTRUSIVENESS REQUIREMENTS

The Prison Litigation Reform Act (PLRA) requires that preliminary injunctive relief "be narrowly drawn, extend no further than is necessary to correct the harm the court finds requires preliminary relief, and be the least intrusive means necessary to correct that harm." 18 U.S.C. § 3626(a)(2). Here, the relief requested extends no further than necessary. S.B. needs methadone to avoid the harm of continued withdrawal, the associated suffering, and potential relapse, overdose, and death. *See* Facts, *supra*. Requiring Defendants to provide S.B. with methadone is the only remedy available to prevent the harm. Thus, the relief requested is narrowly drawn. Requiring Defendants to provide S.B.'s essential medication is also the least intrusive means to providing the relief. Defendants already provide MAT for pregnant people. Defendants can determine how to ensure that S.B. receives her medically necessary, constitutionally required treatment, in a non-discriminatory way.

III. THE COURT SHOULD WAIVE THE REQUIREMENT OF A SECURITY UNDER RULE 1-066 NMRA.

Rule 65(c) of the Federal Rules of Civil Procedure requires the party moving for a preliminary injunction to put up a security an amount determined by the court "for the payment of such costs and damages as may be incurred or suffered by any party who is found to have been wrongfully enjoined or restrained…" Rule 65(c) Fed. R. Civ. P. The court has "wide discretion" in setting the amount of bond and may waive the requirement entirely. *See Dominion Video Satellite, Inc. v. Echostar Satellite Corp.*, 269 F.3d 1149, 1158 (10th Cir. 2001); Rule 65(c) Fed. R. Civ. P. In this case, Defendants will suffer no harm from a preliminary injunction. Accordingly, no security should be required. *See, e.g.*, *Winnebago Tribe of Neb. v. Stovall*, 341 F.3d 1202, 1206 (10th Cir. 2003) (no bond necessary where there was no showing of harm from injunction); *Moltan Co. v. Eagle-Picher Indus., Inc.*, 55 F.3d 1171, 1176 (6th Cir. 1995) (no bond necessary where plaintiff had strong likelihood of success on merits).

CONCLUSION

For the foregoing reasons, this Court should (1) issue a Preliminary Injunction requiring Defendants to provide methadone to S.B. throughout her incarceration in NMCD, (2) order an expedited briefing schedule for this motion, and (3) set an evidentiary hearing on this matter.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on this 24th day of May, 2021, a true and correct copy of the foregoing was served electronically via the CM/ECF system to all counsel of record.

/s/ Katherine Loewe
Katherine Loewe