IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MAINE

BRENDA SMITH, Plaintiff, v. AROOSTOOK COUNTY and SHAWN D. GILLEN, Defendants.	CIVIL NO. 18-cv-00352-NT

PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION, WITH INCORPORATED MEMORANDUM OF LAW

Pursuant to Rules 7 and 65 of the Federal Rules of Civil Procedure, Plaintiff, Brenda Smith, moves this Court for a Preliminary Injunction to prevent Defendants, Aroostook County and Chief Deputy Shawn Gillen, from denying her necessary medical care to treat her opioid use disorder, and otherwise discriminating against her on the basis of disability, when she reports to Aroostook County Jail on January 14, 2019.

RELATED CASE

Plaintiff, Brenda Smith, first filed a motion substantially similar to this one on September 6, 2018, seeking an order compelling Defendants to provide her with buprenorphine or an equivalent medication approved by her personal physician, or an order delaying her incarceration until this case was decided. Shortly after Ms. Smith filed her Motion, she was able to come to an agreement delaying her surrender date from September 7, 2018 to October 22, 2018. Plaintiff had sought a delay to October 22, 2018 because, as this matter is substantially similar to *Zachary Smith v. Fitzpatrick*, 1:18-cv-288-NT, it was Plaintiff's belief that the Court's judgment in a then-scheduled hearing on October 2-4, 2018 would provide guidance for Ms. Smith's case.

However, Mr. Smith's case ultimately settled.[1] Plaintiff subsequently sought and received a further delay of her surrender date from October 22, 2018 to January 14, 2019.

INTRODUCTION

Plaintiff Brenda Smith suffers from opioid use disorder. Opioid use disorder is a chronic brain disease that can be deadly – an average of more than one Mainer dies per day of an opioid overdose. The medical care for opioid use disorder is medication-assisted treatment ("MAT"), including treatment with methadone or buprenorphine. For years, Ms. Smith has used MAT—specifically, physician-prescribed buprenorphine—to keep her opioid use disorder in remission. Treatment with MAT enables Ms. Smith to live free from the devastating symptoms of addiction.

However, on January 14, 2019 Ms. Smith must report to the Aroostook County Jail, where MAT is prohibited for all inmates except for pregnant women. Because she is not pregnant, these policies will force Ms. Smith into withdrawal from her physician-prescribed buprenorphine treatment, absent an order from this Court. Without access to buprenorphine, Ms. Smith will suffer painful and psychologically damaging withdrawal and will be at a greater risk for relapse into addiction, potential overdose, and death.

Ms. Smith meets all of the elements for preliminary injunctive relief. First, Ms. Smith is likely to succeed on the merits of her case. Commander Clossey, administrator of the Aroostook County Jail, has been notified of Ms. Smith's condition and the importance of maintaining her prescribed medication-assisted treatment. Despite this notice, representatives of the Aroostook County Jail have notified Ms. Smith's counsel that she will not have access to buprenorphine while incarcerated. This refusal amounts to discrimination on the basis of disability in violation

[1] After resolving Zachary Smith's case, undersigned attorneys from the ACLU of Maine, who served as counsel to Mr. Smith, joined as co-counsel in this case.

of the Americans with Disabilities Act, and deliberate indifference to a serious medical condition in violation of the Eighth Amendment.

Further, Ms. Smith will suffer immediate and irreparable harm absent an injunction. Unless enjoined, Defendants' policies will force Ms. Smith into acute withdrawal and cause her severe and immediate physical and psychological pain, and could also trigger the long-term effects of remission, overdose, and death.

Finally, the balancing of harms and public interest prongs support preliminary injunctive relief. Providing Ms. Smith with her physician-prescribed medication would not harm Defendants in any way, but the harms to Ms. Smith from withholding that medication would be devastating. Moreover, Defendants' policies worsen the already deadly opioid crisis in the state by triggering relapse and increasing the risk of overdose. The public interest favors enjoining these policies as applied to Ms. Smith.

FACTS

I. MAT Is the Appropriate Treatment for Opioid Use Disorder

Opioid use disorder is a chronic brain disease that presents a serious public health crisis in Maine. Fellers Decl. ¶ 3, 5.[2] An average of 1.14 people per day in Maine died of opioid overdoses in 2017—an 11 percent increase over the previous year. Fellers Decl. ¶ 5; MacDonald Decl. ¶ 8.[3] Among other risk factors for opioid use disorder, genetics accounts for 40 to 60 percent of a person's vulnerability, and adverse childhood experiences presents additional risk. Fellers Decl. ¶¶ 9-10. Symptoms of opioid use disorder include "craving, increasing tolerance to opioids, withdrawal symptoms, and a loss of control." Fellers Decl. ¶ 3. Without treatment or

[2] The Fellers Declaration is attached as Attachment B.

[3] The MacDonald Declaration is attached as Attachment D.

other recovery, patients diagnosed with opioid use disorder are often unable to control their use of opioids. Fellers Decl. ¶ 4. Complications of OUD include overdose and death. MacDonald Decl. ¶ 8.

The standard of care for opioid use disorder is MAT (medication-assisted treatment), which refers to an opioid treatment that combines medication and counseling. Fellers Decl. ¶¶ 11-12; MacDonald Decl. ¶ 5. "[M]ost patients need [MAT] to achieve long-term recovery." Fellers Decl. ¶ 11. The primary medications used in MAT are methadone and buprenorphine, which have both been approved by the U.S. Food and Drug Administration for the treatment of opioid use disorder. Fellers Decl. ¶ 12. Both buprenorphine and methadone "have been clinically proven to reduce opioid use more than (1) no treatment, (2) outpatient treatment without medication, (3) outpatient treatment with placebo medication, and (4) detoxification only." Fellers Decl. ¶ 16. Leading authorities, including the American Medical Association, the American Psychiatric Association, and the American Academy of Family Physicians, support treatment with buprenorphine. Fellers Decl. ¶ 18. Treatment with MAT produces "dramatically superior" results compared to other treatment options, "with studies showing improved retention in treatment, abstinence from illicit drugs, and decreased mortality." Fellers Decl. at ¶ 13; MacDonald Decl. ¶¶ 19-32.

MAT is feasible in the correctional setting and has been safely administered in jails across the country. MacDonald Decl. ¶ 33; Hayes Decl. ¶¶ 8-9.[4]

II. Ms. Smith's Medical History

Ms. Smith suffers from opioid use disorder that requires ongoing treatment with MAT. MacDonald Decl. ¶ 17. She currently takes a maintenance dose of 8 mg of buprenorphine twice

[4] The Hayes Declaration is attached as Attachment C.

per day, and is under the care of Dr. David Conner, who prescribes her medication. Smith Decl. at ¶¶ 11-12.[5] Given Ms. Smith's history of maintenance treatment on buprenorphine, forcing Ms. Smith to withdraw from MAT (A) would cause dangerous and painful withdrawal symptoms, (B) would place her at greater risk of relapse into active symptoms of opioid use disorder, and (C) would increase the risk of a dangerous or deadly overdose upon her release from jail. MacDonald Decl. ¶ 17.

Ms. Smith also suffers from the co-occurring diagnosis of bipolar disorder, placing her at greater risk of a complex withdrawal, with potential side effects including suicidal ideation and decomposition. MacDonald Decl. ¶ 18. Indeed, Ms. Smith previously suffered painful and debilitating symptoms during a prior seven-day withdrawal in York County Jail years ago, during which period she was denied her withdrawal medication and suffered greatly. Smith Decl. at ¶¶ 16-18.

Around the same time, another woman incarcerated with Ms. Smith was forced into withdrawal during her sentence and died of an overdose on the day she was released. Smith Decl. ¶ 19. Ms. Smith is terrified of going through a longer period of withdrawal and is even more afraid of the potentially deadly consequences of relapse. Smith Decl. at ¶¶ 24-25.

III. Defendants' Policies Would Cause Ms. Smith Irreparable Harm

Ms. Smith will be forced to report to jail for a 40-day sentence on January 14, 2019, Smith Decl. ¶ 14, where current policies forbid methadone and buprenorphine, except for pregnant inmates. Aroostook County Jail Opiate Withdrawal Protocol at 2 (hereinafter "ACJ Opiate Protocol").[6] Withholding medication from a patient with opioid use disorder generally

[5] The Smith Declaration is attached as Attachment A.

[6] The ACJ Opiate Protocol is attached as Attachment F.

triggers symptoms of withdrawal and increases risk for relapse into active addiction. MacDonald Decl. ¶ 9. Both withdrawal and relapse are serious and potentially dangerous medical conditions. MacDonald Decl. ¶ 9. For example, withdrawal has serious physical and psychological effects, including bone and joint aches, vomiting, diarrhea, excessive sweating, hypothermia, hypertension, tachycardia (elevated heart rate), and severe psychological symptoms like depression, suicidal ideation, and decompensation.[7] Fellers Decl. ¶¶ 24-25.

"Forced withdrawal is not medically appropriate for patients being treated with MAT," like Ms. Smith. Fellers Decl. ¶ 26. Even after several weeks of painful withdrawal, patients with opioid use disorder do not return to their pre-diagnosis baseline, often relapsing into active symptoms of addiction. MacDonald Decl. ¶¶ 11, 25; Fellers Decl. ¶ 26. Relapse into active opioid use disorder is potentially life-threatening, and can result in overdose and death, either during incarceration or after release. MacDonald Decl. ¶¶ 12-14. "Death is three times as likely for people out of treatment versus when in treatment." Fellers Decl. ¶ 26.

ARGUMENT

"A plaintiff seeking a preliminary injunction must establish that he is likely to succeed on the merits; that he is likely to suffer irreparable harm in the absence of preliminary relief; that the balance of equities tips in his favor; and that an injunction is in the public interest." *Winter v. Natural Resources Defense Council*, 555 U.S. 7, 20 (2008). In this case, the facts show that Ms. Smith is likely to succeed on the merits of her statutory and constitutional claims; that she will be irreparably harmed by Chief Deputy Gillen's refusal to provide her with necessary medical care;

[7] In the psychological sense, "decompensation refers to a patient's inability to maintain defense mechanisms in response to stress, which can result in uncontrollable anger, delusions, mania, and other dangerous symptoms." Fellers Decl. ¶ 25.

and that the balance of hardships as well as the public interest strongly favors the issuance of the injunction. Further, the facts show that Defendants' conduct cannot be justified by any medical or penological concern, and that it is instead the product of discrimination against and deliberate indifference towards Ms. Smith's ongoing and serious medical condition.

I. Ms. Smith Is Likely to Succeed on the Merits of Her Statutory and Constitutional Claims

Ms. Smith is likely to prevail on her arguments that Defendants' policies violate the Americans with Disabilities Act ("ADA"), 42 U.S.C. §12132, and the Eighth Amendment to the United States Constitution, U.S. Const. Amend. VIII. There can be no dispute that Ms. Smith's severe opioid use disorder qualifies as a disability under the ADA, and as a serious medical condition requiring treatment under the Eighth Amendment. Defendants' refusal to provide medically necessary treatment—even when prescribed by a physician—reflects discrimination and stigma against opioid use disorder in violation of the ADA. It also reveals deliberate indifference of a serious, and potentially deadly, disease, in violation of the Eighth Amendment. Each of these points is discussed in further detail below.

A. Ms. Smith Is Likely to Succeed on the Merits of Her ADA Claim

Ms. Smith is likely to succeed on the merits of her claim that denying her access to medical services because she suffers from substance use disorder constitutes unlawful discrimination under the ADA. The ADA prohibits a "public entity" from discriminating against a qualified individual with a disability on the basis of that disability. 42 U.S.C. § 12132. As an instrumentality of state and local government, Aroostook County Jail qualifies as a "public entity." 42 U.S.C. § 12131(1)(B); *Pa. Dep't of Corrections v. Yeskey*, 524 U.S. 206, 210 (1998).

In order to state a claim against a public entity under Title II of the ADA, a plaintiff must allege three elements: "(1) that he is a qualified individual with a disability; (2) that he was either

excluded from participation in or denied the benefits of some public entity's services, programs, or activities or was otherwise discriminated against; and (3) that such exclusion, denial of benefits, or discrimination was by reason of the plaintiff's disability." *Buchanan v. Maine*, 469 F.3d 158, 170–71 (1st Cir. 2006) (quoting *Parker v. Universidad de Puerto Rico*, 225 F.3d 1, 5 (1st Cir. 2000)). Each of those elements is satisfied here.

1. **Ms. Smith Is a Qualified Individual with a Disability**

Ms. Smith suffers from a severe and chronic disability, but nonetheless remains qualified to receive medical services in jail for that disability. Individuals who are diagnosed with substance use disorders and are in recovery are "qualified individuals with disabilities" under the ADA. *See* 42 U.S.C. §§ 12102, 12131(2). The term "disability" includes "a physical or mental impairment that substantially limits one or more major life activities of such individual." 42 U.S.C.A. § 12102. As a chronic brain disease, opioid use disorder "substantially limits" major life activities such as caring for oneself, eating, learning, reading, concentrating, thinking, communicating, and working. *See* 42 U.S.C. § 12102(2)(A).[8]

By regulation, "[t]he phrase physical or mental impairment includes . . . drug addiction, and alcoholism." 28 C.F.R. § 35.108(b)(2); *see also Bragdon v. Abbott*, 524 U.S. 624, 633 (1998); *Jones v. City of Boston*, 752 F.3d 38, 58 (1st Cir. 2014). "Unquestionably, drug addiction constitutes an impairment under the ADA." *A Helping Hand, LLC v. Baltimore Cnty., Md.*, 515 F.3d 356, 367 (4th Cir. 2008). Although the ADA does not protect individuals who are current active users of illegal drugs, it does apply to individuals like Ms. Smith who are participating in a

[8] In the alternative, prior cases have considered whether "with respect to the "actual disability" prong, the United States Department of Justice has construed drug addiction as a *per se* disabling impairment pursuant to the ADA." *CRC Health Grp., Inc. v. Town of Warren*, No. 2:11-CV-196-DBH, 2014 WL 2444435, at *10 (D. Me. Apr. 1, 2014). Such a theory provides additional support for holding Ms. Smith to be disabled under the ADA.

supervised drug rehabilitation program.[9] *See* 42 U.S.C. § 12210(a) & (b); *Thompson v. Davis*, 295 F.3d 890, 896 (9th Cir. 2002); *Collings v. Longview Fiber Co.*, 63 F.3d 828, 831-32 (9th Cir. 1995).

Despite her disability, Ms. Smith is otherwise qualified to receive the benefits of healthcare during her incarceration. Jail officials have an affirmative obligation to provide prisoners with the necessities of life, including medical care. *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); *see also Reed v. McBride*, 178 F.3d 849, 852 (7th Cir. 1999) (stating that when a state "so restrains an individual's liberty that it renders him unable to care for himself," government must provide basic human needs such as medical care) (quoting *Helling*, 509 U.S. at 34). As courts across the country have consistently held, the constitution "imposes a duty upon states to provide adequate medical care to incarcerated individuals." *Boyce v. Moore*, 314 F.3d 884-89 (7th Cir. 2002); *Brown v. Plata*, 563 U.S. 493, 510 (2011). Consistent with that obligation, Maine law guarantees that any person in Maine residing in a correctional or detention facility has a right to adequate professional medical care and adequate professional mental health care. 34-A M.R.S.A. §3031(2); 03-201 C.M.R. Ch. 1, § IIa(K) ("Medical And Mental Health Services"). In sum, medical care is a service provided by jails, which cannot be withheld on the basis of disability. *Yeskey*, 524 U.S. at 210 (citing, *e.g.*, *Hudson v. Palmer*, 468 U.S. 517, 552 (1984); *Olim v. Wakinekona*, 461 U.S. 238, 246 (1983)).

[9] Furthermore, the statute specifically prohibits denying individuals "health services, or services provided in connection with drug rehabilitation, on the basis of the current illegal use of drugs if the individual is otherwise entitled to such services." 42 U.S.C. § 12210(c). Considering that medical services and associated "drug rehabilitation" must be provided even to individuals experiencing current illegal drug use, such services surely must also be provided to Ms. Smith, who has been in remission for years.

As of January 14, 2019, Ms. Smith will be a prisoner in custody of Aroostook County. Smith Decl. ¶ 14. As such, she will be an individual qualifying for medical services by a public entity, and, thus, eligible under Title II of the ADA. *See also* Aroostook Cnty Jail – Policy & Proc. at No. F-310 (hereinafter "ACJ Policy & Proc.") (stating that inmates are eligible for medical services).[10]

2. Defendants' Policies Discriminate Against Ms. Smith Because of Her Disability

Despite their obligation to provide medical care to all inmates, Defendants have a policy of refusing to provide MAT to patients with opioid use disorder (except for pregnant women). This policy violates the ADA by discriminating against individuals with opioid use disorder, and by withholding reasonable accommodation for opioid use disorder. *See Nunes v. Mass. Dep't of Correction*, 766 F.3d 136, 144–45 (1st Cir. 2014) (citations omitted).

As an initial matter, discrimination against opioid use disorder is serious and widespread. For example, a Maine town impermissibly targeted disabled individuals suffering from drug addiction when it "expressly singled out methadone clinics for less favorable zoning treatment[.]" *CRC Health Grp., Inc. v. Town of Warren*, No. 2:11-CV-196-DBH, 2014 WL 2444435, at *10 (D. Me. Apr. 1, 2014) (recommended decision).[11] In another case in May 2018, the U.S. Attorney's office for the District of Massachusetts settled an ADA lawsuit against a nursing facility that refused to accept a patient who was being treated for opioid use disorder.[12]

[10] ACJ Policies & Proc. is attached as Attachment E.

[11] *See also MX Grp. Inc. v. City of Covington*, 293 F.3d 326, 344 (6th Cir. 2002) ("[T]he blanket prohibition of all methadone clinics from the entire city is discriminatory on its face ."); *Bay Area Addiction Research & Treatment, Inc. v. City of Antioch*, 179 F.3d 725, 729, 735 (9th Cir.1999) (holding that a zoning ordinance barring the operation of any new substance abuse clinics, including methadone clinics, within 500 feet of residential areas was discriminatory on its face); *Habit Mgmt., Inc. v. City of Lynn*, 235 F.Supp.2d 28, 29 (D. Mass. 2002) (holding that a prohibition on methadone clinics within two miles of any school was discriminatory on its face).

[12] *U.S. Attorney's Office Settles Disability Discrimination Allegations at Skilled Nursing Facility*, UNITED STATES ATTORNEY'S OFFICE FOR THE DISTRICT OF MASSACHUSETTS (May 10, 2018), https://www.justice.gov/usao-

As explained in by the U.S. Attorney Andrew E. Lelling, the opioid epidemic is a deadly public health crisis, and "now more than ever, individuals in recovery must not face discriminatory barriers to treatment."[13] In another example from March 2018, the Department of Justice initiated an ADA investigation into the Massachusetts Department of Corrections, arising from the state's failure to treat prisoners with opioid use disorder "whose disability, prior to confinement, has been identified as requiring Medication-Assisted Treatment (MAT)."[14] As the letter explained, "all individuals in treatment" for opioid use disorder are "protected by the ADA, and [the Massachusetts Department of Corrections] has existing obligations to accommodate this disability." *Id.*

In this case, likewise, Defendants are obliged to provide inmates with appropriate medical treatment, yet refuse to do so for patients with opioid use disorder. Aroostook County Jail ensures that inmates "have access to and receive medical services necessary for maintaining their physical health," and that "[e]ach facility shall provide inmates with medical and mental health services." ACJ Policy & Proc. F-310. Yet Defendants refuse to apply these general policies to prisoners with opioid use disorder, for which MAT is the appropriate treatment. MacDonald Decl. ¶ 5; Fellers Decl. ¶¶ 12-13. Instead, they preclude prisoners with opioid use disorder from obtaining MAT (except for pregnant women). *See* ACJ Opiate Protocol at 2. By policy, Aroostook County Jail does "not use opioid, or opioid replacements," and instead implements a withdrawal procedure. *Id.*

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ma/pr/us-attorney-s-office-settles-disability-discrimination-allegations-skilled-nursing; *see also* Settlement Agreement, United States v. Charwell Operating, LLC, https://www.ada.gov/charlwell_sa.html.

[13] *Id.*

[14] *Investigation of the Massachusetts Department of Correction Pursuant to the Americans with Disabilities Act*, United States Attorney for the District of Massachusetts (Mar. 22, 2018), https://d279m997dpfwgl.cloudfront.net/wp/2018/03/20180322172953624.pdf (last visited Nov. 5, 2018).

Forced withdrawal is not appropriate treatment for opioid use disorder, and instead has painful and potentially deadly consequences. MacDonald Decl. ¶¶ 9-10, 22, 27-28; Fellers Decl. ¶ 26. For patients being treated with MAT, forced withdrawal "disrupts their treatment plan, increases the risk of relapse into active addiction, and makes patients more likely to suffer from overdose and potential death." *See* Fellers Decl. ¶ 26.[15]

Defendants prohibit MAT despite having clear policies on the secure storage and administration of controlled substances, like buprenorphine. Specifically, Aroostook County Jail mandates secure storage and inventory of scheduled medications, requiring such medication to "be stored in a separate locked box within the medication cart," to "be counted" before and after the medication pass, to be "signed" by an officer, and to be confirmed by the Shift Supervisor at the beginning and end of each shift. ACJ Policy & Proc. F-313(D)(3). Despite these clear policies, Defendants refuse to provide buprenorphine (a controlled substance) to patients with opioid use disorder. There is no reason why Defendants cannot apply these secure procedures to buprenorphine, and thereby continue Ms. Smith's MAT treatment.

By refusing MAT to Ms. Smith, Defendants discriminate against her in three distinct ways. *First*, Defendants' policies single out opioid use disorder for discriminatory treatment by refusing to provide appropriate care—MAT—and instead requiring forced withdrawal for this disability. *See Nunes*, 766 F.3d at 144–45 (describing the "disparate treatment" theory of discrimination); *CRC Health Grp.*, 2014 WL 2444435, at *5. *Second*, Defendants impermissibly treat MAT (and opioid use disorder) differently than treatment for other disabilities, like asthma,

[15] *See also* President's Commission on Combating Drug Addiction and the Opioid Crisis, Final Report. 72 (2017), https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf (last visited Nov. 5, 2018) (stating "MAT has been found to be correlated with reduced risk of mortality in the weeks following release and in supporting other positive outcomes"). Notably, a survey cited in the President's Commission Report found that "nearly 55% of jail security personnel agreed with the statement that "people who overdose on heroin get what they deserve." *Id.*

diabetes, or any other chronic health condition requiring regular medication. *See, e.g.*, *Iwata v. Intel Corp.*, 349 F. Supp. 2d 135, 14849 (D. Mass. 2004) (citing *Olmstead v. L.C.*, 527 U.S. 581 (1999)) (stating that Defendants violate the ADA by discriminating "amongst classes of the disabled"). *Finally*, Defendants' policies improperly withhold reasonable accommodation for opioid use disorder because MAT is necessary for disabled prisoners to maintain a baseline level of health during and after incarceration. *Nunes*, 766 F.3d at 144–45.[16]

Substance use disorder is no less serious than other chronic conditions like diabetes. Fellers Decl. ¶¶ 3-4. To the contrary, opioid use disorder is a serious chronic illness that has triggered a state and national crisis of overdose deaths. *See* MacDonald Decl. ¶¶ 5, 8. Moreover, it is a disease with a recognized medical treatment: MAT. *Id.* Yet Defendants have decided to either pretend that both the condition and the treatment do not exist, or that people like Ms. Smith who suffer from substance use disorder are not entitled to treatment. But, whether characterized as the denial of accommodation or discrimination against people with a specific disability, the conclusion is the same—Defendants' actions violate the ADA.

B. **Plaintiff is Likely to Succeed on the Merits of Her 8th Amendment Claim**

Ms. Smith is likely to succeed on the merits of her Eighth Amendment claim that denying her medication to treat opioid use disorder while she is incarcerated constitutes cruel and unusual punishment. Prison officials have an affirmative obligation under the Eighth Amendment to provide prisoners with the necessities of life, including medical care. *Farmer v. Brennan*, 511 U.S. 825, 832 (1994); *Helling v. McKinney*, 509 U.S. 25, 31-32 (1993); *Estelle v. Gamble*, 429

[16] Defendants' decision to provide MAT for pregnant women indicates that Defendants understand that MAT is a safe, effective treatment for opioid use disorder that does not present a danger to other inmates. It also indicates that Defendants have the means and resources, including trained staff and internal protocols, to provide MAT to incarcerated patients with opioid use disorder. The fact that Ms. Smith is not currently pregnant does not provide a meaningful reason to refuse the treatment that she needs.

U.S. 97, 104 (1976). As courts across the country have consistently held, the Eighth Amendment "imposes a duty upon states to provide adequate medical care to incarcerated individuals." *Boyce v. Moore*, 314 F.3d 884-89 (7th Cir. 2002).

To prevail in a constitutional challenge to inadequate medical care, a prisoner must show both that the risk of harm to the prisoner is objectively "serious" and that the defendant was subjectively "deliberately indifferent" to the risk of harm. *Farmer*, 511 U.S. 834 (noting the objective and subjective components of the standard for "deliberate indifference" claims). However, a prisoner "does not have to await the consummation of a threatened injury" or "await a tragic event" to obtain injunctive relief. *Id.* at 845 (citations and internal quotation marks omitted). Moreover, a successful plaintiff "need not show that a prison official acted or failed to act believing that harm actually would befall an inmate; it is enough that the official acted or failed to act despite his knowledge of a substantial risk of serious harm." *Id.* at 842.

1. **Substance Use Disorder is a Serious Illness Under the Objective Prong**

Opioid use disorder is a serious and potentially deadly disease that qualifies as an "objectively serious illness" under the Eighth Amendment. *See* MacDonald Decl. ¶¶ 8-9. A medical need "is sufficiently serious when "it is one that society considers so grave that it violates contemporary standards of decency to expose anyone unwillingly to that risk." *Helling*, 509 U.S. at 36. It is a risk that "today's society chooses not to tolerate." *Id.* The substantial risk need not pose an immediate, present threat to health and safety; threats to future wellbeing are equally actionable. *Id.* at 33-34.

Although in an earlier generation, when MAT was relatively new, courts were reluctant to hold jails accountable for providing only limited access to such therapy, courts have more recently extended liability to cover "inordinate delay" in access to MAT. *Compare, e.g., Inmates*

of Allegheny Co. Jail v. Pierce, 612 F.2d 754, 761 (3rd Cir. 1979) (refusing to find "deliberate indifference" where jail provided six days of methadone treatment in jail), *with Davis v. Carter*, 452 F.3d 686, 695-96 (7th Cir. 2006) (finding no dispute of the objective seriousness of delaying inmates access to their properly prescribed methadone treatment).

There were two significant developments in those intervening years: First, the Supreme Court announced its decisions in *Helling v. McKinney* in 1993 and *Farmer v. Brennan* in 1994, clarifying the extent of a jail officials' obligation to prevent harm, including medical harm. *See Helling*, 509 U.S. at 36 (recognizing that the Eighth Amendment protects against future harms as well as present harms); *Farmer*, 511 U.S. at 836 (clarifying that jail officials violate the Eighth Amendment when they recklessly disregard the risk of medical harm).

Second, MAT has gained greater recognition as a safe, effective tool for fighting drug addiction. *See, e.g.*, U.S. Food and Drug Administration; *Subutex and Suboxone Approved to Treat Opioid Dependence* ("Subutex and Suboxone have been studied in over 2,000 patients and shown to be safe and effective treatments for opiate dependence.") (*available at* http://www.fda.gov/Drugs/DrugSafety) (last accessed April 7, 2010); *see also* MacDonald Decl. ¶¶ 19-32; Fellers Decl. ¶¶ 20-21.

Under the more recent (and controlling) caselaw, opioid use disorder plainly qualifies as an objectively serious medical condition. A condition is objectively serious if "a reasonable doctor or patient would find [it] important and worthy of comment or treatment. . . [or if it] significantly affects an individual's daily activities [or if it causes] chronic and substantial pain." *Guiterrez v. Peters*, 111 F.3d 1364, 1373 (7th Cir. 1997) (citations and internal quotations omitted). Similarly, a medical need is serious if failing to treat it "could result in further significant injury or the 'unnecessary and wanton infliction of pain.'" *Id.* (citation omitted). The

seriousness of a condition may also be evidenced by the fact that it was "diagnosed by a physician as mandating treatment[.]" *Id.* (citation omitted).

Applying these principles here, Ms. Smith currently manages her symptoms of opioid use disorder with physician-prescribed buprenorphine. *See* Smith Decl. ¶ 11; MacDonald Decl. ¶¶ 12-13, 17. If forced to discontinue the treatment, she would suffer serious, potentially life-threatening complications. *See* MacDonald Decl. ¶¶ 9-10, 22, 27-28; Fellers Decl. ¶ 26. Numerous courts have found that withholding MAT in similar circumstances can pose an objectively serious risk of harm. *See Davis v. Carter*, 452 F.3d 686, 696 (7th Cir.,2006) (finding "no dispute" that failure to provide methadone to an inmate on a timely basis poses an objectively serious risk of harm); *Foelker v. Outgamie County*, 394 F.3d 510, 513 (7th Cir. 2005) (holding that symptoms of withdrawal from methadone are serious); *Messina v. Mazzeo*, 854 F. Supp. 116, 140-141 (E.D.N.Y. 1994) (refusing to dismiss cruel and usual punishment claim based on denial of access to methadone). Ms. Smith's condition thus satisfies the objective prong of the Eighth Amendment.

2. **Refusing to Provide Buprenorphine to Ms. Smith Constitutes Deliberate Indifference.**

A prisoner with an objectively "serious medical need," like opioid use disorder, is entitled to care "at a level reasonably commensurate with modern medical science and of a quality acceptable within prudent professional standards." *See Kosilek v. Spencer*, 774 F.3d 63, 114 (1st Cir. 2014) (citing *DeCologero*, 821 F.2d at 43). In this case, it is "well established" that MAT "mitigates the risk of death" from opioid use disorder. MacDonald Decl. ¶ 15-16. "There is medical consensus that [MAT] is effective at reducing opioid and other drug use and improving physical and mental health for people with opioid use disorder." *Id.* ¶ 16. MAT "also reduces the likelihood of overdose and death that is associated with opioid use disorder." *Id.*

The suffering that Ms. Smith will endure if her buprenorphine is abruptly discontinued is as unnecessary as it is horrific. Not only is forced withdrawal painful and potentially dangerous, but it places the patient at risk of relapse into active opioid use disorder and makes her "more likely to suffer from overdose and potential death." MacDonald Decl. ¶ 27-30. The Defendants need not engage in any particular heroics to prevent this harm. Ms. Smith is only asking that Defendants do something that they do every day for thousands of prisoners: ensure her timely access to necessary medical care, without which she will experience substantial physical and psychological suffering. *See* Smith Decl. ¶ 16-18; MacDonald Decl. ¶¶ 17-18. She only asks to be treated for this purpose as if she were pregnant—in which case Defendants would provide her medication. Defendants know the risk facing Ms. Smith, and they have the capacity to avoid it. The Constitution will not tolerate their deliberate indifference to it.

Finally, Defendants are not permitted, consistent with the requirements of the Eighth Amendment, to say that they provided *some* medical care and, therefore, they cannot be required to provide more care. *See Berry v. Peterman*, 604 F.3d 435, 441 (7th Cir. 2010) (choice of "easier and less efficacious treatment" for severe tooth pain can amount to deliberate indifference). Accordingly, the fact that Defendants have a protocol to provide *some* treatment for the pain of withdrawal, ACJ Opiate Protocol 1-2, is not determinative. Otherwise, prisons and jails could evade liability simply be providing an aspirin to every prisoner who requests medical care. In denying Ms. Smith access to MAT for her opioid use disorder, Defendants have drawn an arbitrary line that cannot be justified with reference to any valid medical or penological interest.

3. Plaintiff Will Suffer Immediate Irreparable Injury If Defendants Withhold MAT During Her Incarceration.

Plaintiff will suffer immediate and irreparable harm if Defendants do not provide her with MAT to treat her opioid use disorder during her incarceration. "'Irreparable injury' in the preliminary injunction context means an injury that cannot adequately be compensated for either by a later-issued permanent injunction, after a full adjudication on the merits, or by a later-issued damages remedy." *Rio Grande Cmty. Health Ctr., Inc. v. Rullan*, 397 F.3d 56, 76 (1st Cir. 2005).

The loss of constitutional rights, such as the right to adequate health care while incarcerated awaiting trial, qualifies as irreparable harm. Courts generally presume irreparable harm when certain core constitutional rights are violated. *See, e.g., Touchstone v. McDermott*, 234 F.3d 1133, 1159 n.4 (11th Cir. 2000).

Further, the dangerous withdrawal symptoms and risk of relapse constitute irreparable harm sufficient to justify preliminary injunctive relief. *See* MacDonald Decl. ¶ 9-10, 12. Money damages or a future injunction could not remedy either a shortened life span or the pain and suffering from increased symptoms. *See Chambers v. NH Prison*, 562 F. Supp. 2d 197, 202 (D.N.H. 2007) (denial of ready access to dental care caused irreparable harm); *Farnam v. Walker*, 593 F. Supp. 2d 1000, 1013 (C.D. Ill. 2009) (delay of treatment for a lung infection constitutes irreparable injury due to reduction in life expectancy and negative impact on quality of life).

4. The Balance of Harms Strongly Favors the Grant of Emergency Injunctive Relief.

With regard to the balance of the harms, any administrative concerns associated with providing MAT have been successfully managed in many correctional facilities across the country. MacDonald Decl. ¶ 32. By contrast, we cannot risk more overdoses and deaths from

failure to treat opioids use disorder. *See* MacDonald Decl. ¶ 8; Fellers Decl. ¶ 5. The irreparable, and potentially permanent, harm suffered by Ms. Smith absent relief greatly outweighs any potential budgetary or administrative harm claimed by Defendants—especially in light of the fact that Defendants already provide this medication to pregnant inmates. Unlike the imminent pain and psychological distress that Ms. Smith would suffer absent the injunction, any cost to Defendants from providing MAT would be minimal. *See, e.g.*, Fellers Decl. ¶ 22 (stating methadone and buprenorphine are "cost effective"). And, in any event, Defendants cannot deny healthcare based on budgetary restrictions. *See, e.g. Boswell v. Sherburne Cty.*, 849 F.2d 1117, 1123 (8th Cir. 1988).

Nor would Defendants suffer any cognizable administrative harm from the requested relief. The typical penological justification for denying prisoners MAT is that buprenorphine and methadone could be diverted and used illicitly. But these concerns can be effectively managed through proper administration and other protocol, as is has been in correctional facilities throughout the country. Hayes Decl. ¶¶ 8-9; MacDonald Decl.¶ 33. Furthermore, Defendants already provide MAT to qualifying pregnant female prisoners, and they would suffer little additional harm from providing MAT to Ms. Smith for only 40 days.

At the end of the day, contraband in jails is an age-old problem. Even with their existing policy of withholding MAT, Defendants cannot guarantee that heroin, fentanyl, and other illicit drugs will be unavailable in prison. *See* MacDonald Decl. ¶ 13. Given that reality, forcing Ms. Smith to withdraw from MAT is potentially life-threatening. *Id.* ¶¶ 13-14. Withdrawal could cause Ms. Smith to relapse into active addiction, to gain access to illicit drugs (without the ability to control her use), and to overdose because of her decreased tolerance. *Id.* ¶¶ 11-14, 21-23. Ms. Smith's interest in safety outweighs any proffered penological interest.

5. The Public Interest Favors Emergency Injunctive Relief.

The public interest also supports granting preliminary injunctive relief. "Surely, upholding constitutional rights serves the public interest." *Newsom Albemarle Cnty. Sch. Bd.*, 354 F.3d 249, 261 (4th Cir. 2003); *Carey v. Klutznick*, 637 F.2d 834, 839 (2d Cir. 1980); *Reinert v. Haas*, 585 F. Supp. 477, 481 (S.D. Iowa 1984) (the public is "always well served by protecting the constitutional rights of all of its members."). Furthermore, granting injunctive relief would represent an important step forward in treating the deadly opioid crisis. *See, e.g.*, Hayes Decl. ¶ 7 (finding reduced opioid deaths after implementing MAT program in jail). This step, moreover, would be consistent with maintaining jail security, as demonstrated by the success in implementing MAT programs in correctional settings across the country. *See* MacDonald Decl.¶¶ 7, 33-35; Hayes Decl. ¶¶ 8-16. Indeed, Defendants already safely offer MAT for pregnant women. Taking these factors together, injunctive relief is in the public interest.

CONCLUSION

For these reasons, we respectfully request that the Court issue a preliminary injunction requiring Defendants to provide Ms. Smith with MAT during her 40-day incarceration.

Dated: November 5, 2018

Respectfully Submitted,

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CERTIFICATE OF SERVICE

The undersigned certifies that she has electronically filed this date the foregoing PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION, WITH INCORPORATED MEMORANDUM OF LAW with the Clerk of the Court using the CM/ECF system, which will send notification of such filing to all counsel of record. This filing is available for viewing and downloading from the ECF system.

Dated: November 5, 2018

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