UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF NEW YORK

KOREE WILSON, Plaintiff, v. FULTON COUNTY, NEW YORK; RICHARD C. GIARDINO, as the Sheriff of Fulton, New York; KEITH ACKERKNECHT, as the Captain at Fulton County Correctional Facility; EASTERN MEDICAL SUPPORT LLC; TINA ATTY, as a nurse at Fulton County Correctional Facility; and WILLIS WOOD, as the grievance coordinator at Fulton County Correctional Facility, Defendants.	**COMPLAINT** **JURY TRIAL DEMANDED** Civil Action No. ____________

PRELIMINARY STATEMENT

1. This action seeks to hold a New York county jail and certain of its staff members accountable for their brazen violations of an incarcerated person's legal right to life-saving medication—which defendants withheld again, again, and again.

2. More specifically, Plaintiff Koree Wilson brings this civil rights action challenging the life-threatening and discriminatory denial of medical care he endured while in custody at the Fulton County Correctional Facility ("FCCF"). Defendants Richard C. Giardino, Keith Ackerknecht, Eastern Medical Support LLC, Tina Atty, and Willis Wood were legally obligated to meet the medical needs of people in custody at FCCF. However, Defendants failed to provide adequate medical care for individuals with opioid use disorder ("OUD"), a deadly disease that afflicts millions. Defendants' failure violates the Eighth

Amendment and Fourteenth Amendment to the United States Constitution, the Americans with Disabilities Act ("ADA"), the Rehabilitation Act, and Section 296 of the New York State Human Rights Law, and is redressable under 42 U.S.C. § 1983 and governing case law.

3. In October 2019, Mr. Wilson was diagnosed with OUD, a chronic brain disease which causes uncontrollable cravings for opioids. Mr. Wilson sought help from St. Mary's Healthcare Amsterdam ("St. Mary's"), an opioid treatment program. A St. Mary's physician prescribed him daily doses of methadone, a medication medically proven to alleviate OUD symptoms. Mr. Wilson traveled daily to receive methadone under the supervision of a trained physician before his OUD medication was repeatedly thwarted by the deliberate and/or reckless disregard on the part of FCCF staff.

4. In May 2020, Mr. Wilson was jailed at FCCF for 14 days and was only provided methadone after a several-day delay during which he underwent horrific withdrawal symptoms while begging for his medication. FCCF forced Mr. Wilson to stop taking his OUD medication for this several-day period without any medical justification or even any medical consultation. FCCF did so despite knowing full well about his OUD diagnosis and prescribed medication and his repeated pleas. Mr. Wilson was released from FCCF on May 21, 2020. Upon release, Mr. Wilson returned to the care of St. Mary's, where he resumed OUD medication under the supervision of his physician.

5. On February 23, 2021, Mr. Wilson was again jailed at FCCF and again involuntarily thrust into a medically inappropriate withdrawal because FCCF again deprived him of proper care for his OUD—this time for the full duration of his incarceration. And, once again, Mr. Wilson informed FCCF staff of his OUD diagnosis

and methadone prescription, but again his entreaties fell on deaf ears. Even worse, FCCF staff persistently ignored the direct pleas of Mr. Wilson's mother, legal counsel, and even the pharmaceutical director of Mr. Wilson's treatment program—all of whom reiterated to FCCF staff that Mr. Wilson suffered from OUD and was, as his physician directed, in dire need of OUD medication. Mr. Wilson was released from FCCF on March 23, 2021, after nearly a month of forced withdrawal by FCCF staff.

6. On May 3, 2022, Mr. Wilson was again jailed at FCCF and put through yet another excruciating withdrawal, again because FCCF refused to provide him with his prescribed OUD medication. This time, in light of FCCF's previous violations, on May 6, 2022, counsel explained FCCF's legal obligation to provide methadone to incarcerated individuals who were being treated with methadone upon admission to the facility. FCCF staff, however, shrugged off that request and denied Mr. Wilson his medication for the full five months of his incarceration.

7. FCCF's repeated refusal to provide Mr. Wilson with adequate medical care for OUD not only caused him excruciating pain and risk of relapse and death, but also may have rendered him ineligible to receive the medication when he was transferred to prison. In particular, on October 6, 2022, Mr. Wilson was transferred from FCCF to Mohawk Correctional Facility ("Mohawk"), a New York State-managed prison. Upon information and belief, unlike FCCF, Mohawk provided medication for OUD. However, on information and belief, at the time Mr. Wilson was transferred, Mohawk only offered "medication for opioid use disorder" ("MOUD") to individuals actively receiving MOUD in jail before they arrived. On information and belief, FCCF's prior refusal to provide Mr. Wilson with methadone during his time at FCCF rendered Mr. Wilson ineligible for

methadone medication at Mohawk, thus compounding his needlessly traumatic withdrawal. FCCF's repeated refusal to provide Mr. Wilson with adequate medical care caused him such intense distress that he feared resuming methadone treatment upon release from incarceration, lest he be forced into another excruciating withdrawal at some point in the future.

8. Upon information and belief, FCCF had a practice of denying prescribed medication to people with OUD in its custody, forcing them to painfully withdraw from their methadone medication and suffer through the associated severe and potentially life-threatening harms.

9. For decades, the opioid epidemic has devastated communities across this country. The loss of life has been staggering: more than half a million people dead over 20 years—***more than 25,000 deaths per year on average***.[1] Opioid overdose took the lives of 5,017 New Yorkers in 2021.[2]

10. That startling statistic only worsened since the coronavirus pandemic. Today, one person in the United States dies of opioid overdose every seven minutes.

11. The medical standard of care—in fact the *only* care for OUD recognized by the medical establishment—is MOUD, also known as "medication for addiction treatment" ("MAT"). There are three MOUD medications approved by the Food and Drug Administration ("FDA"): methadone, buprenorphine, and naltrexone. MOUD can be accompanied by other supportive services based on a patient's particular needs. While

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[1] *Understanding the Opioid Overdose Epidemic*, Ctrs. for Disease Control and Prevention (Aug. 8, 2023), https://www.cdc.gov/opioids/basics/epidemic.html.

[2] *New York State Opioid Annual Report 2023*, N.Y. Dep't of Health 24 (2023), https://www.health.ny.gov/statistics/opioid/data/pdf/nys_opioid_annual_report_2023.pdf.

these supportive services are important, these medications primarily drive treatment efficacy. The duration and dosage of MOUD must be based on an individualized consideration of a person's medical needs by a trained medical professional. Much like the medication-based treatment for any other chronic disease, the medically necessary duration of MOUD is generally lengthy and, in some cases, lifelong. Forcibly and abruptly ending someone's MOUD often causes excruciating withdrawal symptoms and puts that patient at heightened risk for relapse, overdose, and death.

12. Jails and prisons throughout the country and within the State of New York provide—or, at least, are legally obligated to provide—MOUD to individuals in their custody. In October 2021, Governor Kathy Hochul signed into law Senate Bill 1795/Assembly Bill 533, requiring New York's jails and prisons to give incarcerated individuals with OUD the option to continue or begin taking MOUD, including their choice of methadone, buprenorphine, and naltrexone (based on their existing prescription or an individualized assessment by an authorized health care professional).[3]

13. FCCF's policy, however, was to withhold this critical medical care. Due to FCCF's policy and practice, Mr. Wilson was forced into multiple acute withdrawals, which Defendants knew or should have known were extremely painful, could lead to life-threatening medical complications and would place Mr. Wilson at a severely increased risk of relapse, overdose, and death.

14. As applied to Mr. Wilson, Defendants' policy and practice was unlawful. Defendants' policy and practice of denying methadone maintenance treatment for OUD

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[3] *Governor Hochul Signs Legislation Package to Combat Opioid Crisis* (Oct. 7, 2021), https://www.governor.ny.gov/news/governor-hochul-signs-legislation-package-combat-opioid-crisis.

reflected deliberate indifference to Mr. Wilson's serious medical needs, to his suffering, and to the long-term consequences of forced withdrawal. Defendants' actions, therefore, violated Mr. Wilson's Eighth and Fourteenth Amendment rights to be free from cruel and unusual punishment. Additionally, Defendants' denial of the necessary medical care violated Mr. Wilson's right, under the ADA and the Rehabilitation Act, to be free from discrimination based on his disability. Likewise, Defendants' denial of the necessary medical care violated Mr. Wilson's rights

15. Mr. Wilson therefore brings this action under 42 U.S.C. § 1983 to enforce his rights under the Eighth and Fourteenth Amendments, under 42 U.S.C. §§ 12131-12134 to enforce his ADA rights, under 29 U.S.C. § 794 to enforce his Rehabilitation Act rights, and under N.Y. Exec. Law § 296 to enforce his New York Human Rights Law rights. He seeks compensatory and punitive damages for the unnecessary and excruciating physical suffering he endured while in Defendants' care.

PARTIES

16. Plaintiff Koree Wilson is a 26-year-old man who resides in Gloversville, New York. He suffers from a disability—opioid use disorder—for which he is prescribed daily treatment with methadone by a trained medical professional.

17. Defendant Fulton County, New York, is a municipal corporation organized under the laws of the State of New York. Fulton County Corrections is a department of Fulton County and operates FCCF.

18. Defendant Richard C. Giardino is the Sheriff of Fulton County. As such, he is the legal custodian of all pretrial detainees and prisoners housed at FCCF and is responsible for the safe, secure, and humane treatment of these residents, including their

medical care. At all relevant times, Defendant Giardino was acting under color of state law. Defendant Giardino is being sued here in his official capacity.

19. Defendant Keith Ackerknecht is the Captain at FCCF. As such, he has policymaking authority over the day-to-day operations of the jail, including its provision of medical care. On information and belief, his duties include overseeing all administrative functions of jail operations, including but not limited to supervising corrections officers and other staff, as well as overseeing detained people's health, care, safety, and discipline. He is fully familiar with the jail's policies, practices, procedures, and regulations. At all relevant times, Defendant Ackerknecht was acting under color of state law. Defendant Ackerknecht is being sued here in his official capacity.

20. Defendant Eastern Medical Support LLC is a corporation headquartered in the State of New York contracted by Fulton County to provide medical care to incarcerated individuals at FCCF. At all relevant times, Eastern Medical Support LLC acted under color of state law by providing medical services and care at FCCF pursuant to an agreement (or agreements) with Fulton County.

21. Defendant Tina Atty was a nurse at FCCF who was involved in the decision not to provide Mr. Wilson with methadone in March of 2021. At all relevant times, Defendant Atty was acting under color of state law. Defendant Atty is being sued in her official capacity here.

22. Defendant Willis Wood was a grievance coordinator at FCCF who failed to respond reasonably to Mr. Wilson's repeated grievance submissions regarding his forced withdrawal. At all relevant times, Defendant Wood was acting under color of state law. Defendant Wood is being sued in her official capacity here.

JURISDICTION AND VENUE

23. This action seeks to vindicate Plaintiff's rights guaranteed by the Eighth and Fourteenth Amendments to the United States Constitution, pursuant to 42 U.S.C. § 1983.

24. This action is also brought pursuant to Title II of the Americans with Disabilities Act, 42 U.S.C. §§ 12131-12134, and Section 504 of the Rehabilitation Act, 29 U.S.C. § 794.

25. This action is also brought pursuant to Section 296 of the New York State Human Rights Law.

26. This Court has original jurisdiction over this action pursuant to 28 U.S.C. § 1331 because this action arises under federal law. Jurisdiction is also authorized pursuant to 28 U.S.C. § 1343(a)(3) and 28 U.S.C. § 1367 with respect to this action's claims under N.Y. Exec. Law § 296.

27. Venue in this Court is proper under 28 U.S.C. § 1391(b) because the events giving rise to this action occurred within this judicial district.

FACTUAL ALLEGATIONS

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

28. Opioids are a class of drugs that work in the brain to produce a variety of effects, including pain relief. Prescription opioids, such as Oxycodone or Vicodin, have accepted medical uses, including managing severe or chronic pain. Other opioids, such as heroin, are illegal and not used in medicine in the United States. All opioids, including

those prescribed for medical use, can cause addiction, also known as opioid use disorder ("OUD").

29. OUD is a chronic brain disease. Symptoms of OUD include uncontrollable cravings for and compulsive use of opioids, decreased sensitivity to opioids, and potentially excruciating withdrawal symptoms. OUD is progressive, meaning it often becomes more severe over time. Without effective treatment, patients with OUD are rarely able to control their use of opioids, often resulting in serious physical harm or premature death, including due to accidental overdose.

30. OUD breaks down the dopamine system necessary for the brain to feel a sense of normalcy and confidence in its own survival. This can cause a dopamine deficiency. People who are dopamine deficient have difficulty enjoying life activities and feeling normal. Instead, they experience feelings of depression, anxiety, and irritability. Brains that are addicted to opioids produce less than half the dopamine of nonaddicted brains.

31. The effects of OUD permanently rewire the brain for addiction. People with OUD cannot simply "will" or "reason" their way out of continued opioid use, even when they are aware of the dire consequences. Continued opioid use does not indicate a person lacks willpower, but rather is the predictable outcome of chemical changes in the brain that result in uncontrollable cravings.

32. OUD has thus proven especially unresponsive to exclusively non-medication-based treatment methods, such as those using only counseling or peer-based approaches, which have been popular in treating other addictions such as alcohol use disorder.

33. Like other chronic diseases, OUD often involves cycles of relapse and remission. Rather than a linear progression in which a person attains abstinence from opioid use once and for all, "successful" recovery for OUD is often characterized by sustained periods of abstinence, or "active recovery," punctuated by relapses in drug use. These relapses are frequently triggered by a lapse in treatment, an increase in life stressors, or a traumatic event, which causes the person to turn to illicit drug use to satisfy cravings. The typical treatment goal for OUD is thus to maximize periods of active recovery and minimize periods of relapse, by ensuring continued treatment and encouraging the use of coping mechanisms and support systems.

34. OUD is an epidemic in the United States and a public health crisis. The incidence of OUD has skyrocketed since the late 1990s. Between 1999 and 2020, the number of annual opioid overdose deaths nationwide increased more than eightfold. Since 1999, more than 600,000 people in the United States have died from opioid overdose.[4]

35. The COVID-19 pandemic, which produced enormous grief, anxiety, and feelings of isolation, has further accelerated these trends. In the one-year period from April 2020 to April 2021, the opioid epidemic claimed more than 75,673 lives in the United States—an increase of almost 35% from the previous year.[5]

36. The opioid epidemic has not spared New York. In this state, the number of annual opioid overdose deaths increased almost sixfold between 2000 and 2020. New

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[4] *Managing the Opioid Crisis in North America and Beyond*, 399 The Lancet 495 (Feb. 2, 2022), https://doi.org/10.1016/S0140-6736(22)00200-8.

[5] *Drug Overdose Deaths in U.S. Top 100,000 Annually*, Ctrs. for Disease Control and Prevention (Nov. 17, 2021), https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm.

York State Department of Health ("DOH") estimates that 5,388 New Yorkers died of opioid overdose in 2022.[6]

37. According to the DOH, in 2021, 848 people died of opioid overdose in this judicial district alone.[7]

38. Since 2013, the proliferation of fentanyl and other synthetic opioids—an extremely dangerous class of drug—has been the primary driver of the sharp rise in opioid deaths. The Centers for Disease Control and Prevention ("CDC") estimates that deaths from fentanyl and other synthetic opioids rose approximately 24% from 2020 to 2021 alone.[8] A lethal dose of fentanyl is a tiny fraction of a lethal dose of heroin.

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

B. Broad Scientific Consensus Confirms That MOUD Is Necessary to Treat OUD

40. As the opioid epidemic ravages communities across the United States, medical science has provided hope by demonstrating that overdose deaths are preventable with effective treatment.

41. Broad consensus in the medical and scientific communities confirms that MOUD is effective—and in fact necessary—to treat OUD. The American Medical Association, the American Society of Addiction Medicine, the U.S. Department of Health

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[6] *New York State Opioid Annual Report 2023*, N.Y. Dep't of Health (2023) 24, https://www.health.ny.gov/statistics/opioid/data/pdf/nys_opioid_annual_report_2023.pdf.

[7] *Id.* at 114-15.

[8] *U.S. Overdose Deaths in 2021 Increased Half as Much as in 2020*, Ctrs. for Disease Control and Prevention (May 11, 2020), https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/202205.htm.

and Human Services, the FDA, the National Institute on Drug Abuse, the Office of National Drug Control Policy, and the Substance Abuse and Mental Health Services Administration ("SAMHSA") have all endorsed the necessity of MOUD.[9] SAMHSA has explained: "just as it is inadvisable to deny people with diabetes the medication they need to help manage their illness, it is also not sound medical practice to deny people with OUD access to FDA-approved medications for their illness."[10]

42. New York State health agencies have similarly embraced the importance of MOUD. DOH, the Office of Mental Health, and the Office of Addiction Services and Supports all recognize MOUD as necessary to treat OUD. In a letter to all state-licensed mental health clinics, the New York State Office of Mental Health explained that "MAT reduces overdose deaths, rates of [emergency department] visits and hospital stays, costs to payers and families, and improves quality of life with the potential for contribution to the community," and clinics and hospitals "can contribute to mitigating the Opioid Epidemic" by "[o]ffering [MOUD] to all patients identified as having OUD."[11]

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[9] *See generally 2023 Overdose Epidemic Report*, Am. Med. Ass'n (2023), https://www.ama-assn.org/system/files/ama-overdose-epidemic-report.pdf; *National Practice Guideline for the Treatment of Opioid Use Disorder*, Am. Soc'y of Addiction Med. (Dec. 18, 2019), https://sitefinitystorage.blob.core.windows.net/sitefinity-production-blobs/docs/default-source/guidelines/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2; *Many Medicaid Enrollees with Opioid Use Disorder Were Treated with Medication; However, Disparities Present Concerns*, U.S. Dep't of Health and Hum. Servs. (Sept. 2023), https://www.oig.hhs.gov/oei/reports/OEI-BL-22-00260.pdf; *Information About Medication-Assisted Treatment (MAT)*, U.S. Food & Drug Admin. (May 23, 2023), https://www.fda.gov/drugs/information-drug-class/information-about-medication-assisted-treatment-mat; *Medications to Treat Opioid Use Disorder*, Nat'l Inst. on Drug Abuse (June 2018), https://nida.nih.gov/sites/default/files/21349-medications-to-treat-opioid-use-disorder.pdf; *National Drug Control Strategy*, Off. of Nat'l Drug Control Pol'y (2022), https://www.whitehouse.gov/wp-content/uploads/2022/04/National-Drug-Control-2022Strategy.pdf; *Federal Guidelines for Opioid Treatment Programs*, Substance Abuse and Mental Health Servs. (Jan. 2015), https://store.samhsa.gov/sites/default/files/guidelines-opioid-treatment-pep15-fedguideotp.pdf.

[10] *Medications for Opioid Use Disorder*, Substance Abuse and Mental Health Servs. (2021), https://www.rcorp-ta.org/sites/default/files/2022-03/PEP21-02-01-002.pdf.

[11] *Opioid Use, Prevention, and Treatment of Opioid Use Disorder in Patients with Mental Illness*, N.Y. Off. of Mental Health (June 18, 2018), https://omh.ny.gov/omhweb/bho/docs/opioid_use_mental_illness.pdf.

43. The two most recent presidential administrations have also embraced the importance of MOUD. Under President Biden, SAMHSA has identified MOUD as "life-saving, evidence-based treatment" that "Americans with [OUD] need and deserve."[12] And in November 2017, President Trump's Commission on Combating Drug Addiction and the Opioid Crisis likewise acknowledged the efficacy of MOUD and the need to expand its availability to patients.[13]

44. Treatment of OUD often includes counseling and other behavioral therapies, but MOUD is the primary driver of treatment efficacy. MOUD decreases opioid use, reduces the risk of relapse and overdose death, and improves treatment retention. Treatment retention is crucial for treating OUD because the longer a patient stays in treatment, the less likely they are to relapse. Studies have shown that MOUD also decreases the likelihood of involvement in the criminal legal system and infectious disease transmission, and improves patients' ability to maintain positive family relationships and employment.

45. The FDA has approved three medications for treating OUD: methadone, buprenorphine, and naltrexone. Not all of these medications are equally effective for every patient. Studies show that only two—methadone and buprenorphine—produce longer-term treatment retention, which is the key to effective MOUD treatment.

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[12] *HHS Releases New Buprenorphine Practice Guidelines, Expanding Access to Treatment for Opioid Disorder*, Substance Abuse and Mental Health Servs. Admin. (Apr. 27, 2021), https://www.samhsa.gov/newsroom/press-announcements/202104270930.

[13] Chris Christie et al., *Report of the President's Commission on Combating Drug Addiction and the Opioid Crisis*, The President's Commission on Combating Drug Addiction and the Opioid Crisis (2017), https://trumpwhitehouse.archives.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-15-2017.pdf.

46. Methadone and buprenorphine are "agonists," which means they activate opioid receptors in the brain to relieve withdrawal symptoms and control cravings without causing the euphoria that is associated with other types of opioids. Methadone is a "full agonist," meaning that it fully activates opioid receptors, resulting in a stronger opioid effect. Buprenorphine is a "partial agonist," meaning that it partially activates opioid receptors.

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

48. Because they act on opioid receptors without causing euphoria while also satisfying cravings, both methadone and buprenorphine have been designated as "essential medicines" by the World Health Organization.[14] In fact, it is virtually undisputed within the medical community that agonist MOUD is the most effective treatment for OUD.

49. Treatment for OUD—like treatment for other chronic diseases such as insulin for diabetes—is often lengthy. As SAMHSA has recognized, there is no maximum recommended duration for treatment with MOUD. And ending MOUD treatment

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[14] *Opioid Agonist Pharmacotherapy Used for the Treatment of Opioid Dependence (Maintenance)*, World Health Org., https://www.who.int/data/gho/indicator-metadata-registry/imr-details/2718#:~:text=Methadone%20and%20buprenorphine%20have%20a,maintenance%20treatment%20of%20opioid%20dependence.

prematurely is exceptionally dangerous. It triggers painful withdrawal symptoms that markedly increase the risk of relapse into opioid use, overdose, and death.

50. The symptoms of withdrawal from MOUD are crushing. They include bone and joint aches, nausea, vomiting, diarrhea, fever, excessive sweating, hypothermia, hypertension, tachycardia, depression, anxiety, dysphoria, insomnia, and suicidal ideation. These symptoms can last for weeks or months, and can lead to life-threatening complications—even apart from the risk of relapse and overdose—including pneumonia and fatal dehydration.

51. In addition to the considerable discomfort and medical dangers associated with withdrawal from MOUD, unsupervised and sudden MOUD withdrawal can perpetuate drug-seeking behavior and preclude engagement in appropriate treatment in patients with OUD.

52. When treatment with MOUD must be discontinued, due to a patient's wishes or medical necessity, it is crucial to taper methadone and buprenorphine as slowly as possible to avoid severe withdrawal symptoms. That process of tapering often lasts several months, or even multiple years, and must be done under close medical supervision.

53. Forcing a person with OUD to withdraw from effective MOUD treatment, absent significant side effects or contraindications, violates medical standards of care. And doing so abruptly heightens the risk of acute withdrawal and is even more dangerous.

54. Efforts to "medically manage" forced withdrawal or "detoxify" patients, with non-MOUD pain relievers or otherwise, are not meaningfully effective. Such efforts, also known as detoxification, do not improve long-term outcomes for people with OUD.

To the contrary, as SAMHSA confirms, even "[p]atients who complete medically supervised withdrawal are at a risk of opioid overdose."[15]

55. One study of treatment outcomes from a detoxification facility showed a 29% relapse rate on the day of discharge, a 60% relapse rate after one month, and a success rate of between only 5% and 10% after one year.[16]

C. Allowing Access to MOUD Is Particularly Important, and Is Feasible, in Carceral Settings

56. Providing MOUD is especially critical in carceral settings, where people with OUD face a dramatically heightened risk of relapse, overdose, and death in the weeks immediately following release.

57. A large proportion of incarcerated people have OUD. Approximately 85% of people in jails and prisons have a history of substance use,[17] and 18.9% of sentenced people in local jails nationwide self-report that they regularly used opioids prior to incarceration.[18]

58. One study found that incarcerated people are 12.7 times as likely to die of drug overdose in the two weeks immediately following release as compared to the general public.[19]

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[15] *Federal Guidelines for Opioid Treatment Programs*, Substance Abuse and Mental Health Servs. 25 (Jan. 2015), https://store.samhsa.gov/sites/default/files/guidelines-opioid-treatment-pep15-fedguideotp.pdf.

[16] Genie L. Bailey et al., *Perceived Relapse Risk and Desire for Medication Assisted Treatment Among Persons Seeking Inpatient Opiate Detoxification*, 45 J. of Substance Abuse Treatment 302, 302 (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4874241/pdf/nihms-782511.pdf.

[17] *Criminal Justice DrugFacts*, Nat'l Institutes of Health – National Institute on Drug Abuse, https://nida.nih.gov/publications/drugfacts/criminal-justice (last visited Feb. 22, 2023).

[18] Joane Csete, *Criminal Justice Barriers to Treatment of Opioid Use Disorders in the United States: The Need for Public Health Advocacy*, 109 Am. J. Pub. Health 419, 419 (2019), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6366485/pdf/AJPH.2018.304852.pdf.

[19] Elizabeth Needham Waddell et al., *Reducing Overdose After Release from Incarceration (ROAR): Study Protocol for an Intervention to Reduce Risk of Fatal and Non-Fatal Opioid Overdose Among Women After*

59. Access to MOUD plays a critical role in reducing death in incarcerated populations and yields positive results in the carceral setting.

60. As the Presidential Commission on Combating Drug Addiction and the Opioid Crisis concluded in 2017, treatment with MOUD is "correlated with reduced risk of mortality in the weeks following release" for people with OUD in jails and prisons.[20]

61. One large study of individuals with OUD who were released from prison found that, in the first month after their release, those receiving MOUD were 75% less likely to die of any cause and 85% less likely to die of drug poisoning.[21] Another study found that incarcerated people receiving agonist MOUD treatment were 94% less likely to die during their first four weeks of incarceration than those not receiving that treatment.[22]

62. A study of the first year of the Rhode Island Department of Corrections' MOUD program found that 86% of individuals receiving MOUD continued treatment one year after their release.[23] The program reduced post-release deaths by 60% and all opioid-related deaths in the state by more than 12%.[24] In addition, because the program provided

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Release from Prison, 8 Health and Justice 1, 2 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7349469/pdf/40352_2020_Article_113.pdf.

[20] Chris Christie et al., *Report of the President's Commission on Combating Drug Addiction and the Opioid Crisis*, The President's Commission on Combating Drug Addiction and the Opioid Crisis 72 (2017), https://trumpwhitehouse.archives.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-15-2017.pdf.

[21] Stillwell J. 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 1408–18 (2017) https://onlinelibrary.wiley.com/doi/epdf/10.1111/add.13779; *accord* Needham Waddell et al., at 3.

[22] Sarah E. Wakeman, *Why It's Inappropriate Not to Treat Incarcerated Patients with Opioid Agonist Therapy*, 19 AMA Journal of Ethics 922, 923 (2017), https://journalofethics.ama-assn.org/article/why-its-inappropriate-not-treat-incarcerated-patients-opioid-agonist-therapy/2017-09.

[23] Rosemary A. Martin et al., *Post-Incarceration Outcomes of a Comprehensive Statewide Correctional MOUD Program: a Retrospective Cohort Study*, 18 The Lancet Regional Health – Americas 1, 1 (2022), https://www.thelancet.com/action/showPdf?pii=S2667-193X%2822%2900236-8.

[24] *Id.* at 2.

much needed treatment to people with OUD, the prevalence of illicit opioids in prison decreased.

63. Withholding MOUD without a clinical reason to do so is always dangerous but is especially so for incarcerated individuals with OUD, who are especially likely to relapse and die upon release.

64. Incarcerated individuals with OUD who are not provided with MOUD are nearly seven times as likely to die of drug poisoning in the first month after release than those who are given MOUD.

65. As both the National Commission on Correctional Health Care and the National Sheriffs' Association have recognized, "correctional withdrawal . . . actually increases the chances the person will overdose following community release due to loss of opioid tolerance."[25]

66. The National Academy of Sciences, Engineering, and Medicine has observed that the "transition out of criminal justice settings is the time when users are most likely to overdose on opioids," and concluded that access to MOUD for incarcerated people is crucial to avoiding relapse, improving treatment retention, and lowering transmission of infectious diseases through illicit drug use.[26]

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[25] *Over-Jailed and Un-Treated: How the Failure to Provide Treatment for Substance Use in Prisons and Jails Fuels the Opioid Epidemic*, Am. Civ. Liberties Union 9 (2021), https://www.aclu.org/wp-content/uploads/legal-documents/20210625-mat-prison_1.pdf (quoting *Jail-Based Medication-Assisted Treatment: Promising Practices, Guideline, and Resources for the Field*, Nat'l Sheriffs' Ass'n and Nat'l Comm'n on Correctional Health Care 9 (2018), https://www.sheriffs.org/publications/Jail-Based-MAT-PPG.pdf).

[26] *Opportunities to Improve Opioid Use Disorder and Infections Disease Services: Integrating Responses to a Dual Epidemic*, Nat'l Acads. Scis., Eng'g, and Med. 106 (2020), https://www.ncbi.nlm.nih.gov/books/NBK555809/pdf/Bookshelf_NBK555809.pdf

67. Even when it does not lead to immediate overdose upon release, withholding MOUD from incarcerated people has a broadly destabilizing effect on treatment, decreasing the likelihood of continuing MOUD after release from jail or prison.[27]

68. Both the National Commission on Correctional Health Care and the National Sheriffs' Association have publicly recognized that "forced detoxification of prescribed opioid medication[] such as methadone can undermine an individual's willingness to engage in [MOUD] in the future, compromising the likelihood of long-term recovery."[28]

69. As one study of Bronx patients published in the Journal of Substance Abuse Treatment found, forcible removal from methadone during incarceration led to "severe withdrawal," which "contributed to a subsequent aversion to methadone and adversely affected future decisions regarding engagement in [MOUD treatment]."[29]

70. Given the serious risks that OUD poses for incarcerated people, it is no surprise that an array of governmental authorities and medical and professional associations require or recommend that jails and prisons provide long-term maintenance MOUD to those in their custody.

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[27] Alissa Haas et al., *Post-Incarceration Outcomes for Individuals Who Continued Methadone Treatment While in Connecticut Jails*, 2014–2018, 227 Drug and Alcohol Dependence 1, 2 (2021), https://pubmed.ncbi.nlm.nih.gov/34371235/.

[28] *Jail-Based Medication-Assisted Treatment*, *supra*, at 21.

[29] Jeronimo A. Maradiago et al., *"I Kicked the Hard Way. I Got Incarcerated." Withdrawal from Methadone During Incarceration and Subsequent Aversion to Medication Assisted Treatments*, 62 J. Substance Abuse Treatment 1, 1 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4888768/pdf/nihms748846.pdf.

71. In recent years, the U.S. Department of Justice ("DOJ") has consistently taken the position that access to MOUD is required in both carceral settings and court programs. Repeatedly, the DOJ has confirmed that MOUD is the standard of care for treatment of OUD and that denying access to MOUD can constitute unlawful disability discrimination.

72. In April 2022, the DOJ Civil Rights Division published guidance entitled "The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment and Recovery."[30] The guidance states unequivocally that a jail's blanket ban on MOUD for people receiving MOUD prior to incarceration violates the ADA: "A jail does not allow incoming inmates to continue taking MOUD prescribed before their detention." The jail's blanket policy prohibiting the use of MOUD would violate the ADA.[31]

73. The U.S. Attorney for the Southern District of New York noted in a 2017 letter to the New York State Attorney General that MOUD "is a safe and widely accepted strategy for treating opioid disorders," with "broad support [] among medical and substance use experts."[32] The letter instructed that "the Sullivan [County] family court and Sullivan surrogate's court should ensure that their policies and practices with respect to individuals participating in [MOUD] . . . are consistent with ADA requirements."[33]

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[30] *The Americans with Disabilities Act and the Opioid Crisis: Combatting Discrimination Against People in Treatment or Recovery*, U.S. Dep't of Justice Civil Rights Division (2022), https://archive.ada.gov/opioid_guidance.pdf.

[31] *Id.* at 2.

[32] Letter from the Department of Justice, United States Attorney for the Southern District of New York to New York State Office of the Attorney General regarding Medication-Assisted Treatment and the ADA (October 3, 2017), https://lac.org/wp-content/uploads/2018/02/DOJSDNY-ltr-to-OCA-10.3.17.pdf.

[33] *Id.*

74. In 2018, the U.S. Attorney for Massachusetts concluded "that all individuals in treatment for OUD, regardless of whether they are incarcerated persons or detainees, are already protected by the ADA, and [] the [Massachusetts Department of Correction] has existing obligations to accommodate this disability."[34]

75. In the past two years, DOJ has reached multiple settlements requiring local jails and prisons to provide MOUD to individuals in their custody. On November 4, 2022, DOJ reached an agreement with the Lexington-Fayette Urban County Government's Department of Community Corrections in Kentucky to ensure that incarcerated individuals who take MOUD can remain on their medication while in custody at the Fayette County Detention Center, as required by the ADA.[35] One month later, DOJ and the Big Sandy Regional Jail Authority in Kentucky agreed to ensure that individuals who take MOUD can remain on their medication while in custody at the Big Sandy Regional Jail, as required by the ADA.[36] On May 1, 2023, the United States District Court for the District of New Jersey issued a consent decree requiring the Cumberland County Jail to provide MOUD following findings of reasonable cause to believe that its failure to provide MOUD, together with its failure to offer adequate mental health and suicide prevention measures,

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[34] Letter from Andrew E. Lelling, United States Attorney, to David Solet, General Counsel, Executive Office of Public Safety and Security and Jesse Caplan, General Counsel, Executive Office of Health and Human Services (March 16, 2018).

[35] Press Release, Carlton S. Shier, IV, United States Attorney, Eastern District of Kentucky, U.S. Attorney's Office Announces Agreement to Ensure Access to Medications for Opioid Use Disorder at Fayette County Detention Center (Nov. 8, 2022), https://www.justice.gov/usao-edky/pr/us-attorney-s-office-announces-agreement-ensure-access-medications-opioid-use-disorder.

[36] Press Release, Carlton S. Shier, IV, United States Attorney, Eastern District of Kentucky, U.S. Attorney's Office Announces Agreement to Ensure Access to Medications for Opioid Use Disorder at Big Sandy Regional Detention Center (Dec. 4, 2023), https://www.justice.gov/usao-edky/pr/us-attorneys-office-announces-agreement-ensure-access-medications-opioid-use-disorder.

violated the 8th Amendment.[37] And on November 30, 2023, DOJ reached an agreement with Allegheny County to require MOUD in the Allegheny County Jail.[38] And in November 2019, the federal Bureau of Prisons issued guidance requiring that all its facilities provide continuing MOUD to people in their custody when clinically appropriate.

76. DOJ's settlements also extend to courts that prohibited MOUD. On January 31, 2024, DOJ entered into a settlement with the Unified Judicial System of Pennsylvania, resolving a lawsuit charging the entire court system and several of its trial courts with violating the ADA by prohibiting MOUD among people under community supervision.[39] Less than two years before, DOJ entered into a settlement with the Massachusetts Trial Court following allegations that drug courts in Massachusetts were violating the ADA by discriminating against individuals with OUD.[40]

77. DOJ's Adult Drug Court Discretionary Grant Program, a grant program that provides financial and technical assistance to state and local drug court initiatives, also requires grantees to permit the use of MOUD.[41]

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[37] Press Release, United States Attorney's Office, District of New Jersey, Justice Department Reaches Settlement with Cumberland County Addressing Conditions at County Jail (May 17, 2023), https://www.justice.gov/usao-nj/pr/justice-department-reaches-settlement-cumberland-county-addressing-conditions-county#:~:text=The%20proposed%20consent%20decree%2C%20which,treatment%2C%20where%20clinically%20indicated%2C%20to.

[38] U.S. Dep't of Justice, *Settlement Agreement between The United States of America and Allegheny County*, DJ No. 204-64-172 (2023), https://www.justice.gov/d9/2023-12/settlement_agreement-allegheny_county_jail.pdf.

[39] Settlement Agreement, *United States* v. *Unified Jud. Sys. of Penn.*, ECF No. 55-1 (2024) No. 22-cv-709 (MSG).

[40] *Settlement Agreement between the United States and The Massachusetts Trial Court*, U.S. Dep't of Justice (2022), https://www.justice.gov/usao-ma/pr/us-attorney-s-office-settles-disability-discrimination-allegations-massachusetts-trial.

[41] *FY 2023 Adult Treatment Court Discretionary Grant Program*, U.S. Dep't of Justice 5 (2022), https://bja.ojp.gov/funding/O-BJA-2023-171509.pdf.

78. In December 2021, the U.S. Attorney for Massachusetts reached a settlement with the Massachusetts Parole Board to resolve claims that the Parole Board had violated the ADA by failing to provide individuals on parole with their prescribed MOUD medication.[42] The settlement requires the Parole Board to ensure that parole applicants with OUD and no active MOUD prescription are assessed by a qualified addiction specialist, who may prescribe any of the three FDA-approved forms of MOUD deemed to be an appropriate treatment based on the assessment.

79. The National Commission on Correctional Health Care and the National Sheriffs' Association have also come out strongly in favor of access to MOUD in jails and prisons, calling MOUD "a central component of the contemporary standard of care for the treatment of individuals with [OUD]," and concluding "all individuals with OUD should be considered for [MOUD]."[43]

80. The American Society of Addiction Medicine, the leading professional society in the country on addiction medicine, also recommends treatment with MOUD for people with OUD in the criminal justice system.[44]

81. And SAMHSA identifies making medication available to detained and incarcerated people as one of the remaining challenges in fighting the opioid crisis.[45]

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[42] U.S. Dep't of Justice, *Settlement Agreement between the United States of America and Massachusetts Parole Board*, DJ No. 204-36-241 (2021), https://www.justice.gov/d9/case-documents/attachments/2021/12/14/settlement_agreement_-_u.s._v._the_massachusetts_parole_board.pdf.

[43] *Jail-Based Medication-Assisted Treatment*, *supra*, at 5, 9.

[44] *National Practice Guideline for the Treatment of Opioid Use Disorder*, Am. Soc'y of Addiction Med. 16 (2020), https://sitefinitystorage.blob.core.windows.net/sitefinity-production-blobs/docs/default-source/guidelines/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2.

[45] *Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings*, Substance Abuse and Mental Health Servs. Admin. 48 (2019), https://store.samhsa.gov/sites/default/files/treatment-criminal-justice-pep19-matusecjs.pdf.

82. Ensuring the robust access to the MOUD treatment that these agencies and organizations support is both feasible in and beneficial to carceral settings.

83. In recommending expanded access in jails and prisons to MOUD, including methadone, both the National Commission on Correctional Health Care and the National Sheriffs' Association have emphasized that such access can "[c]ontribut[e] to the maintenance of a safe and secure facility for inmates and staff," and reduce recidivism, withdrawal symptoms, the risk of post-release overdose and death, and disciplinary problems.[46] That recommendation is borne out by the experience of correctional administrators at facilities nationwide, including here in this judicial district.

84. After implementing a comprehensive MOUD program at the Albany County Correctional Facility ("ACCF") in 2019—including access to agonist treatment for OUD with methadone and buprenorphine—Sheriff Craig Apple said of the program, "In the first three months, we saw a reduction in diversion and recidivism. And it was saving lives. It's a no-brainer."[47]

85. Providing comprehensive access to treatment for MOUD with agonist therapy is strikingly inexpensive, even in facilities like the ACCF. According to Sheriff Apple, the total cost of providing MOUD to the first 110 program participants at ACCF was about $30,000[48]—far cheaper than other medical care that jails routinely provide, such as cancer treatment and kidney dialysis.

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[46] *National Practice Guideline for the Treatment of Opioid Use Disorder, supra,* at 5.

[47] Regina LaBelle et al., *Applying the Evidence: Legal and Policy Approaches to Addressing Opioid Use Disorder in the Criminal Justice and Child Welfare Settings*, Georgetown Univ. L. Ctr. O'Neill Inst. for Nat'l & Global Health Law 5 (2019), https://www.opioidlibrary.org/wp-content/uploads/2020/05/Applying-the-Evidence-Report-1_OUD_CJS.pdf.

[48] *Id.* at 16.

86. In recognition of the importance of providing MOUD to incarcerated people, in October 2021, Governor Hochul signed a law requiring all New York State jails and prisons to provide access to MOUD—including methadone and buprenorphine. The law took effect in October 2022 and reflects New York State's commitment to combatting the overdose crisis.[49]

87. Numerous jails and prisons throughout the country also allow incarcerated individuals to continue with MOUD treatment during incarceration—not only due to the DOJ settlements noted above, but also due to private litigation, state law mandates like that in New York, and the recognition that MOUD saves lives and reduces crime. In fact, according to a January 2023 report from the White House on Substance Use Treatment in Correctional Settings, "[a] growing number of correctional facilities are implementing programs that offer medications for opioid use disorder."[50]

D. Mr. Wilson Was Diagnosed with Opioid Use Disorder and Prescribed MOUD

88. Mr. Wilson is diagnosed with OUD, a serious medical need and recognized disability. His OUD substantially limits and has limited one or more of his major life activities, including neurological and brain function, caring for himself, and interacting with others.

89. Mr. Wilson developed OUD at the age of 17, when he was diagnosed with and hospitalized for pancreatitis in 2015. As part of his pancreatitis treatment and pain

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[49] The law that applies to jails is N.Y. Mental Hyg. Law § 19.18-c (2022) and the law that applies to prisons is N.Y. Correct. Law § 626 (2022).

[50] *ONDCP Releases Report on Substance Use Treatment in Correctional Settings to Save Lives, Reduce Costs*, White House Office of Nat'l Drug Control Policy (2023), https://www.whitehouse.gov/ondcp/briefing-room/2023/01/09/ondcp-releases-report-on-substance-use-treatment-in-correctional-settings-to-save-lives-reduce-costs/#:~:text=A%20growing%20number%20of%20correctional,are%20achieving%20their%20desired%20outcomes.

management at the hospital, Mr. Wilson was prescribed opioids. Mr. Wilson became dependent on opioids for pain management and eventually turned to illegal opioids.

90. Mr. Wilson's use of illegal opioids continued until October 2019. During that time, Mr. Wilson overdosed twice, both times while living with his mother, Tami Marshall. Determined to keep her son alive, Ms. Marshall searched for a treatment program for Mr. Wilson, and in October of 2019, Mr. Wilson began treatment for his OUD at St. Mary's, where he received methadone, counseling, and other services.

91. Methadone must be taken daily. St. Mary's was approximately a 20-minute drive from Mr. Wilson's home, but despite the distance, Mr. Wilson kept up with his treatment and visited St. Mary's every day for his methadone and counseling services. Mr. Wilson continued methadone treatment at St. Mary's without interruption until May 7, 2020.

E. In May 2020, after a Several Day Delay, FCCF Provided Methadone to Mr. Wilson

92. On May 7, 2020, Mr. Wilson was arrested and booked at FCCF.

93. Shortly after booking, Mr. Wilson told jail staff that he was enrolled at St. Mary's where he received daily methadone treatment to address his OUD. Mr. Wilson asked for his medication.

94. On May 11, 2020, Mr. Wilson was seen by jail medical staff for a physical. Mr. Wilson told staff that, pre-incarceration, he took a daily dose of 90 mgs of methadone. The following day, Mr. Wilson signed a Medication Assisted Treatment Program Agreement. Not until a few days later did Mr. Wilson begin receiving his prescribed dose of methadone onsite at FCCF. He was inexplicably told not to speak about his medication to any correction officers or other incarcerated persons at FCCF.

95. Mr. Wilson was released from FCCF on May 21, 2020 and continued to receive MOUD treatment at St. Mary's.

F. Despite Providing Mr. Wilson Methadone in 2020, in February 2021, FCCF Refused Mr. Wilson His Life-Saving Methadone

96. On February 23, 2021, Mr. Wilson began serving a 28-day sentence at FCCF.

97. The next day, Mr. Wilson's mother Tami Marshall, contacted St. Mary's to inquire whether, despite his arrest, Mr. Wilson had been brought in for his medication dosing. Ms. Marshall was informed by medical staff at St. Mary's that Mr. Wilson had not been brought in.

98. Later that day, St. Mary's Director of Pharmacy, Kathleen Chestnut, called FCCF to inform staff that Mr. Wilson was taking methadone and would experience withdrawal if his medication did not continue. Defendant Tina Atty, a nurse at FCCF, answered Ms. Chestnut's call. On information and belief, Defendant Atty told Ms. Wilson that FCCF was not providing Mr. Wilson with any medical treatment, including methadone.

99. Following her call with Ms. Chestnut, Defendant Atty placed Mr. Wilson on "15 minute checks" for possible withdrawal. Defendant Atty did not administer methadone or schedule Mr. Wilson to be brought to St. Mary's for his medication.

100. Shortly after her phone call with St. Mary's, Defendant Atty received a call from Ms. Marshall, requesting information on FCCF's policy for providing methadone treatment during Mr. Wilson's incarceration. Defendant Atty told Ms. Marshall that "these medications are not given here at the facility at this time." Ms. Marshall pleaded with Defendant Atty, stating that "this is my son's life you are talking about and [it's] not a

laughing matter." Defendant Atty told Ms. Marshall that "the facility at this time does not have the capability of providing these types of medications safely" and that "there is no physician to prescribe" or "enough medical staff to provide the medication safely." Ms. Marshall again pleaded with Defendant Atty, asking her whether she was "just gonna let him withdraw." Defendant Atty informed Peter Watrobski, a lieutenant at FCCF, about the call.

101. Sometime later that day, Nurse Susan Iliff conducted an intake of Mr. Wilson. During the intake, Mr. Wilson told Nurse Iliff that he was on methadone, explained that he had received methadone during his previous incarceration at FCCF, and requested methadone because he was beginning to experience withdrawal symptoms, including excessive perspiration and suicidal thoughts. Mr. Wilson also told Nurse Iliff about a recent call with his mother in which Mr. Wilson said that he intended to hang himself. Nurse Iliff rejected Mr. Wilson's request for treatment and told him that FCCF no longer provided methadone. Nurse Iliff instead merely stated that he would be placed on constant supervision and reported the conversation to Sergeant Cheryl Mykel.

102. On February 25, 2021, Mr. Wilson met with a social worker, Sierra Bailey. Mr. Wilson explained to Ms. Bailey that he was going through withdrawal and that FCCF officials denied his requests for methadone and another medication that he took for depression.

103. Despite Mr. Wilson's pleas, FCCF continued to deny his methadone requests, forcing him into further withdrawal. Throughout his forced withdrawal, Mr. Wilson repeatedly communicated to FCCF staff that his withdrawal symptoms were

escalating, including that he was experiencing amplified anxiety, racing pulse, difficulty eating and sleeping, and the feeling of needing to bang his head against a wall.

104. Despite acknowledging his withdrawal, FCCF staff did not provide Mr. Wilson with MOUD. Instead, to treat some of the symptoms of his forced withdrawal, and not his underlying MOUD, Mr. Wilson was provided ibuprofen, Benadryl, and clonidine—medications that are inconsistent with the standard of care for treating withdrawal or OUD and were woefully inadequate replacements for methadone.[51] And these already inadequate medications were only provided for five days despite his requesting those medications be continued because his withdrawal symptoms were continuing.

a. FCCF Denied Mr. Wilson's Grievance Despite His Multiple Appeals and Continued to Subject Him to Forced Withdrawal

105. On March 2, 2021, Mr. Wilson filed a grievance with FCCF, stating that he had "been in treatment for a year & half [and] take[s] 90 mgs of methadone" and that he believed that FCCF's refusal to give him his medication was "against [his] rights."

106. On March 4, 2021, Mr. Wilson's grievance was denied by Defendant Willis Wood, FCCF's grievance coordinator, because "the medical department does not feel the necessity to place inmate Wilson on either [requested] medication at this time."

107. Mr. Wilson appealed this decision to the Chief Administrative Officer promptly.

108. On the same day, Mr. Wilson's legal counsel, Rebekah Joab of Legal Action Center, sent a letter to Defendant Richard C. Giardino, the Sheriff of Fulton County, demanding that FCCF provide Mr. Wilson with methadone and to put an end to his forced

[51] Guidelines for Managing Substance Withdrawal in Jails: A Tool for Local Government Officials, Jail Administrators, Correctional Officers, and Healthcare Professionals, Department of Justice – Bureau of Justice Assistance 79 (2023), https://bja.ojp.gov/doc/guidelines-managing-substance-withdrawal-jails.pdf.

withdrawal. The letter made clear that Mr. Wilson has had "severe withdrawal symptoms, including anxiety, racing pulse, and difficulty eating."

109. On March 5, 2021, a nurse at FCCF requested to see Mr. Wilson because he was "withdrawing from 90 mg of methadone from 2 years of treatment," and "[c]an't keep anything down [and] ha[s]n't ate [sic] in 10 days." Despite his deteriorating condition, on information and belief, the nurse told Mr. Wilson that he was "not going to get those meds for w/d again."

110. On March 8, 2021—13 days after Mr. Wilson entered into defendants' custody—Defendant Atty drafted a memo noting that Defendant Keith Ackerknecht, who was the Captain at FCCF, came to medical "stating 'we need to find a way to give K. Wilson his Methadone we got a letter from attorney and the disabilities act- can you call and see what can be done if anything.'" Recognizing FCCF's grossly inadequate response to Mr. Wilson's medical needs, Defendant Atty called St. Mary's to "figure out what if anything can be done" to aid Mr. Wilson through his withdrawal. Defendant Atty's call was returned by Ms. Chestnut, who stated that "the inmate has been [discontinued] from the database from missing well over 7 doses" and that she recommended Mr. Wilson "come to the clinic upon release." Defendant Ackerknecht was made aware of this conversation, but, on information and belief, took no further steps to address Mr. Wilson's forced withdrawal. Upon information and belief, St. Mary's could not continue Mr. Wilson on the same dose he had been prescribed prior to his incarceration and would have needed to begin him on a lower dose and observe him daily. Upon information and belief, Defendants did not offer to transport Mr. Wilson to St. Mary's daily or otherwise seek an alternative way for Mr. Wilson to receive MOUD.

111. On March 10, 2021, six days after filing his initial grievance and appeal, FCCF's Chief Administrative Officer again denied Mr. Wilson access to methadone. In jail records responding to Mr. Wilson's appeal, FCCF's Chief Administrative Officer stated that "St. Mary's Addiction Services will not endorse medication[-]assisted treatment."

112. Mr. Wilson promptly appealed the grievance further to the Citizen's Policy and Complaint Review Council.

113. On or around March 23, 2021, Mr. Wilson was released from FCCF. He received no methadone during his 28 days of incarceration. Ironically, the terms of his probationary release included abstaining from illicit drugs—a requirement made more difficult due to Defendants' denial of methadone while incarcerated.

114. Upon his release, Mr. Wilson resumed methadone treatment at St. Mary's. However, because FCCF had forced Mr. Wilson to withdraw from methadone for almost a full month, he was required to resume methadone treatment at substantially lower dosage than the 90 mgs of methadone he was prescribed before his sentence. The forced withdrawal and the subsequent reduced dosage of methadone therefore subjected Mr. Wilson to an increased risk of relapse into opioid use, overdose, and death. Meanwhile, Mr. Wilson was grieving the loss of his father and struggling to remain in active recovery.

G. In May 2022, Mr. Wilson Was Denied Methadone at FCCF for a Second Time and FCCF's Denial Caused Him to be Ineligible for Methadone at Mohawk Correctional Facility

115. On May 3, 2022, Mr. Wilson was incarcerated at FCCF for violating his probation. Mr. Wilson was, once again, not provided with methadone by FCCF and underwent another agonizing forced withdrawal. Although Mr. Wilson did not request

methadone or file grievance reports because his previous experience at FCCF had demonstrated the futility of any MOUD requests.

116. Mr. Wilson's legal counsel sent another demand letter to Defendant Giardino on May 6, 2022 setting forth FCCF's legal obligation to provide methadone. Despite the letter, nothing changed, and FCCF continued to deny Mr. Wilson his methadone.

117. On October 6, 2022, Mr. Wilson was transferred to Mohawk Correctional Facility ("Mohawk") to serve out the remainder of his sentence. At Mohawk, Mr. Wilson was asked whether he would like to be provided MOUD through Mohawk's treatment program. However, shortly after arriving, on information and belief, Mr. Wilson learned that he was ineligible for the program because he had already withdrawn from methadone for over five months. On information and belief, at the time Mr. Wilson was transferred to Mohawk, an individual must have been actively taking methadone upon arrival at Mohawk to be eligible to participate in its MOUD program.

118. In other words, FCCF not only forced Mr. Wilson to withdraw from methadone but also caused him to be ineligible for Mohawk's MOUD program for a substantial period following his admission to that facility.

119. Being denied methadone at FCCF also raised fears for Mr. Wilson that if he restarted MOUD at Mohawk, at any time, he could be forced to withdraw again. This fear kept Mr. Wilson from resuming MOUD treatment while at Mohawk. Mr. Wilson thus served the majority of his 14–month sentence at Mohawk without vital medicine Mr. Wilson takes to survive.

H. FCCF's Practice of Denying Methadone and Forcing Withdrawal Caused Serious Harm to Mr. Wilson

120. FCCF claims to have a policy of "provid[ing] necessary health care, including medical, dental, and mental health services, to all confined inmates." As part of that policy FCCF states that "[m]edical staff will be aware of inmates with special medical problems and the associated signs and symptoms. . . . The facility physician will ensure all medical staff is aware of procedures to provide emergency medical care to any such inmate." And "[n]o non-medical staff member will deny an inmate access to treatment or evaluation of medical or mental health problems."

121. Despite these bold claims, FCCF did not have any policies on treatment for opioid use disorder, opioid withdrawal, or policies for any substance use disorder.

122. FCCF's deliberate indifference in its care of incarcerated individuals with MOUD resulted from the policy and custom of outright denying methadone treatment to any non-pregnant individual who needed it. Defendants were well aware of the risks of methadone withdrawal both psychologically and physically and were repeatedly made aware of, and exacerbated, Mr. Wilson's forced withdrawal.

123. Defendants' denial of methadone maintenance treatment for Mr. Wilson's OUD has caused him excruciating and traumatizing physical and psychological suffering. Defendants' actions exposed Mr. Wilson to a substantial risk for other serious medical harms, lowered his tolerance to opioids, and exposed him to a heightened risk of relapse into active addiction, potentially resulting in overdose and death.

CLAIMS FOR RELIEF

FIRST CLAIM

Violation of Title II of the Americans with Disabilities Act

124. Plaintiff hereby incorporates by reference the allegations contained in each and every preceding paragraph, as if fully set forth herein.

125. Plaintiff is a qualified individual with a disability. Drug addiction is a "disability" under the ADA. *See* 42 U.S.C. §§ 12102 and 12131(2); 28 C.F.R. § 35.108 (the phrase "physical or mental impairment includes, but is not limited to . . . drug addiction, and alcoholism."). Because Mr. Wilson suffers from OUD (an impairment) that substantially limits his major life activities, including neurological and brain function, caring for himself, and interacting with others, he is an individual with a disability. Mr. Wilson also has had a record of impairment—OUD. Therefore, Mr. Wilson is an individual with a disability within the meaning of the ADA. 42 U.S.C. § 12102.

126. Additionally, Mr. Wilson is a "qualified individual with a disability" because he met the essential eligibility requirements for FCCF's medical services by virtue of his being incarcerated at FCCF.

127. FCCF, which is overseen and/or run by Defendants, is a "public entity" subject to the ADA. 42 U.S.C. § 12131(1). FCCF's medical services are also subject to the ADA because they constitute "services, programs, or activities of a public entity." 42 U.S.C. § 12132.

128. Mr. Wilson was denied the opportunity to participate in or benefit from the defendant's services, programs, or activities because FCCF denied Mr. Wilson his

medically prescribed methadone—a health service—forcing him to experience severe and excruciating withdrawal symptoms.

129. By denying a prescribed, standard medication for OUD, the continuation of which was necessary to prevent serious medical harm, FCCF's practice with respect to methadone was discriminatory on its face against people with OUD. FCCF's pervasive practice was to single out people with OUD for exclusion from necessary medical treatment at the jail. On information and belief, Defendants do not deny medically necessary, physician-prescribed medications to other incarcerated persons with serious, chronic medical conditions, such as diabetes.

130. FCCF's failure to modify its practice of denying methadone to accommodate Mr. Wilson's disability additionally violated Title II of the ADA. Failing to make such modifications to accommodate "the known physical or mental limitations" of people with disabilities like Mr. Wilson violated Title II of the ADA. 42 U.S.C. § 12112(b)(5)(A).

SECOND CLAIM

Violation of Section 504 of the Rehabilitation Act

131. Plaintiff hereby incorporates by reference the allegations contained in each and every preceding paragraph, as if fully set forth herein.

132. Plaintiff is a qualified individual with a disability. Because Mr. Wilson suffers from OUD (an impairment) that substantially limits his major life activities, including neurological and brain function, caring for himself, and interacting with others, he is an individual with a disability. Mr. Wilson also has had a record of impairment—OUD. Additionally, Mr. Wilson is an "otherwise qualified individual with a disability"

because he met the essential eligibility requirements for the FCCF's medical services by being an incarcerated person at FCCF.

133. FCCF, which is overseen and/or run by Defendants, is a public entity. FCCF's medical services are subject to the Rehabilitation Act because it is a "program or activity receiving Federal financial assistance." 29 U.S.C. § 794(a).

134. Mr. Wilson was denied the opportunity to participate in or benefit from the Defendants' services, programs, or activities because FCCF denied Mr. Wilson his medically prescribed methadone—a health service—forcing him to experience severe and excruciating withdrawal symptoms.

135. By denying a prescribed, standard treatment for OUD, the continuation of which was necessary to prevent serious medical harm, FCCF's practice with respect to methadone was discriminatory on its face against people with OUD. FCCF's pervasive practice was to single out people with OUD for exclusion from necessary medical treatment at the jail. On information and belief, Defendants do not deny medically necessary, physician-prescribed medications to other incarcerated persons with serious, chronic medical conditions, such as diabetes.

136. FCCF's failure to modify its practice of denying methadone to accommodate Mr. Wilson's disability additionally violated the Rehabilitation Act.

THIRD CLAIM

Violation of the Eighth Amendment to the United States Constitution

137. Plaintiff hereby incorporates by reference the allegations contained in each and every preceding paragraph, as if fully set forth herein.

138. Defendants, while acting under color of state law, deliberately, purposefully, and knowingly denied Mr. Wilson access to necessary medical treatment for his OUD, which is a serious medical need.

139. Defendants' refusal to provide methadone to Mr. Wilson was pursuant to a pervasive practice of denying methadone to incarcerated individuals with OUD and forcing them to withdraw. Defendants were repeatedly made aware that Mr. Wilson had an OUD, that he regularly took methadone to treat his OUD, and that he required continued doses to treat his OUD and to prevent withdrawal. Even when Mr. Wilson began to suffer severe symptoms of withdrawal and continued to beg for his methadone, Defendants refused to provide methadone.

140. Denying Mr. Wilson access to methadone maintenance treatment for his OUD caused him excruciating forced withdrawal and physical and psychological suffering. Defendants' deliberate indifference exposed him to an inevitable lowered tolerance to opioids as well as a substantial risk for other serious medical harms, and a heightened risk of relapse into active addiction, overdose, and death.

141. As applied to Mr. Wilson, Defendants' failure to adhere to standards of care amounts to deliberate indifference to a serious medical need, in violation of the Eighth Amendment's prohibition against cruel and unusual punishment.

FOURTH CLAIM

Violation of the Fourteenth Amendment to the United States Constitution

142. Plaintiff hereby incorporates by reference the allegations contained in each and every preceding paragraph, as if fully set forth herein.

143. While Mr. Wilson was a pretrial detainee, Defendants, while acting under color of state law, deliberately, purposefully, and knowingly denied Mr. Wilson access to necessary medication for treatment of his OUD for several days.

144. Defendants were repeatedly made aware that Mr. Wilson had an OUD, that he regularly took methadone to treat his OUD, and that he required continued doses to prevent withdrawal. Despite this knowledge, Defendants did not provide Mr. Wilson with methadone for several days while he was a pretrial detainee, forcing him to experience severe psychological and physical withdrawal symptoms and forcing him into a lower dosage of methadone when he resumed treatment.

145. Defendants' deliberate indifference exposed Mr. Wilson to a substantial risk for other serious medical harms, lowered his tolerance to opioids, and caused a heightened risk of relapse into active addiction, overdose, and death.

146. As applied to Mr. Wilson, Defendants' failure to adhere to standards of care amounts to deliberate indifference to a serious medical need, in violation of the Fourteenth Amendment's prohibition against punishment for pretrial detainees.

FIFTH CLAIM

Violation of New York State Human Rights Law

147. Plaintiff hereby incorporates by reference the allegations contained in each and every preceding paragraph, as if fully set forth herein.

148. Plaintiff suffers from OUD, an impairment that results from a neurological condition that prevents the exercise of his normal bodily functions, including neurological and brain function, caring for himself, and interacting with others, and is demonstrable by medically accepted clinical techniques. As such, Plaintiff is a person with a disability

within the meaning of Section 292(21) of the New York State Human Rights Law, N.Y. Exec. Law § 292(21).

149. By denying a prescribed, standard treatment for OUD, the continuation of which was necessary to prevent serious medical harm, FCCF's practice with respect to methadone was discriminatory on its face against people with OUD. FCCF's pervasive practice was to single out people with OUD for exclusion from necessary medical treatment at the jail. On information and belief, Defendants do not deny medically necessary, physician-prescribed medications to other incarcerated persons with serious, chronic medical conditions, such as diabetes.

150. Defendants are subject to the requirements of Section 296 of the New York State Human Rights Law, and their conduct as alleged in the Complaint violates Section 296 of the New York State Human Rights Law.

REQUEST FOR RELIEF

WHEREFORE, Plaintiff requests that this Court:

a. Assume jurisdiction over this action;

b. Declare that Defendants' conduct as alleged in the Complaint violates Plaintiff's rights under:

   i. Title II of the ADA;

   ii. Section 504 of the Rehabilitation Act;

   iii. The Fourteenth Amendment to the United States Constitution;

   iv. The Eighth Amendment to the United States Constitution; and

   v. Section 296 of the New York State Human Rights Law.

c. Award compensatory damages, including, but not limited to those for past and future pecuniary and non-pecuniary losses, physical and mental pain, humiliation, discomfort, fear, anxiety, loss of enjoyment of life, loss of liberty, privacy, and sense of security and individual dignity, and other non-pecuniary losses;

d. Award punitive damages for all claims as allowed by law in an amount to be determined at trial;

e. Award Plaintiff his reasonable attorneys' fees and costs; and

f. Grant any further relief that the Court may deem just and proper.

DEMAND FOR JURY TRIAL

Pursuant to Rule 38(b) of the Federal Rules of Civil Procedure, Plaintiff demands a jury trial as to all issues triable by a jury.

Dated: New York, NY
February 22, 2024

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