IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS

CHRISTINE M. FINNIGAN, Plaintiff, v. JAMES MENDRICK, *et al.*, Defendants.	)	Civil Action No. 1:21-cv-00341 Hon. Steven C. Seeger Mag. Sheila M. Finnegan

PLAINTIFF'S SECOND SUPPLEMENTAL STATEMENT

Plaintiff Christine Finnigan, by her attorneys, provides this second supplemental statement in response to the Court's February 19, 2021 order, Dkt. 50, and states as follows:

I. PLAINTIFF'S RESPONSES TO QUESTIONS POSED BY THE COURT

Question 1: What are the side effects of a methadone withdrawal?

Withdrawal from methadone leads to significant physical and psychological symptoms and suffering, increasing the risk of relapse, overdose, and death. Declaration of Ross MacDonald, M.D. ("MacDonald Decl.") Dkt. 28 ¶¶ 11-13; [redacted]. The physical symptoms of withdrawal include extreme muscle pain, abdominal cramps, vomiting, diarrhea, body tremors, body aches, chills, and hot flashes. MacDonald Decl. ¶ 11; [redacted]; Declaration of Mark A. Parrino ("Parrino Decl.") Dkt. 37 ¶ 14. These symptoms can last up to several weeks. MacDonald ¶ 12. Withdrawal also has an intense psychological component that may last indefinitely. *See id.* People who are withdrawing from methadone often have a depressed mood, insomnia, anxiety, and intense cravings. *Id.* ¶ 11; [redacted]; Parrino Decl. ¶ 14. These cravings for opioids during withdrawal are extremely dangerous and can lead to relapse, overdose, and death.

MacDonald Decl. ¶ 13. Following withdrawal, the preoccupation with cravings may continue indefinitely and often leads to compulsive drug seeking and relapse. *Id.* ¶12.

Based on prior experiences with withdrawal from opioids, Ms. Finnigan expects she will suffer from insomnia, severe body aches, and constant sickness if forced to withdraw from methadone. *See* Declaration of Christine Finnigan ("Finnigan Decl.") Dkt. 22 ¶ 9. She describes the feeling of withdrawing as being always at the peak of a panic attack. Supplemental Declaration of Christine Finnigan ("Finnigan Supplemental Decl.") Dkt. 56 ¶ 6. During prior withdrawals, Ms. Finnigan endured unending anxiety, an incessant feeling of impending doom; her thoughts raced, and at times, she had suicidal ideations. *Id*. ¶¶ 5-6; Finnigan Decl. ¶ 24. Ms. Finnigan also describes having intense cravings to use opioids following withdrawal, and a constant preoccupation with how to stop those cravings. Finnigan Supp. Decl. ¶ 7.

Question 2: When do those side effects take effect?

If Ms. Finnigan were forced to withdraw from methadone, she would likely experience withdrawal symptoms within one to two days of taking her last dose (Thursday morning). Supplemental Declaration of Ross MacDonald, M.D. ("MacDonald Supp. Decl.") Dkt. 43 ¶ 7; Parrino Decl. ¶ 14. The negative consequence of withdrawal will worsen with each dose missed and each passing day. MacDonald Supp. Decl. ¶ 7; Parrino Decl. ¶ 13.

Question 3: What are the consequences of a lengthy interruption in methadone treatment?

If Ms. Finnigan does not have access to methadone at the DuPage County Jail, she cannot simply pick up where she left off with treatment following her release, (even if she returns to treatment and has not relapsed or died while incarcerated). [redacted]

[redacted]

[redacted] During these [redacted] weeks or more of re-stabilization, she would continue to experience withdrawal symptoms, including intense cravings, and be at greatly increased risk of relapse and, due to diminished tolerance, overdose and death. [redacted]; Parrino Decl. ¶15; *see* MacDonald Decl. ¶¶ 18-23.

Withdrawing Ms. Finnigan from methadone during her incarceration also makes it less likely she will return to treatment upon release. Research shows that when people who were treated with methadone in the community are forced into withdrawal while incarcerated, they are more than two times *less* likely to return to treatment, compared to those for whom treatment is not interrupted. MacDonald Decl. ¶ 21. On the other hand, individuals able to access methadone while incarcerated are significantly more likely to continue their treatment upon release than those who receive only counseling (or those who receive counseling and with a referral to a methadone clinic post-release); they are also less likely to test positive for illicit opioids. *Id.* ¶ 28.

To understand the impact of interruption in methadone treatment, it is important to recognize that OUD fundamentally changes a person's brain. *Id.* ¶ 10. Opioids bind to receptors in the brain that are crucial to reward and motivation, decision making, and stress regulation. *Id*. ¶¶ 10, 16. Over time, a person becomes tolerant to opioids and needs more and more to function and avoid withdrawal. *Id*. ¶10. Methadone, however, binds to those same receptors without causing euphoria, and, at the proper dose, stabilizes the brain so that reward and motivation,

decision making, and stress regulation are no longer compromised and focused on compulsive drug-seeking. *Id.* ¶¶ 10, 16; Reeves Decl. ¶ 7. When the brain is withdrawn from methadone, there is nothing to bind to those receptors, and the symptoms of OUD, including cravings, are present. *See* MacDonald Decl. ¶¶ 16, 26. This phenomena explains the high risk of relapse, overdose, and death following forced withdrawal. Reeves Decl. ¶ 14. These consequences can be avoided: incarcerated people with OUD who had access to an opioid agonist, like methadone, were 85% less likely to die of an overdose and 75% less likely to die of any cause in the first month after release. MacDonald Decl. ¶ 22.

Currently, however, drug overdose is among the leading causes of death among formerly incarcerated people, with one study showing that people released from prison have a risk of overdose that is 129 times higher than the general population. *Id.* ¶ 15. Defense counsel suggested that this statistic does not apply to Ms. Finningan, because "even should plaintiff not be prescribed methadone . . . in our custody, as soon as she leaves our custody, she would be free to get methadone again. . . ." Transcript of February 19 Status Conference ("Tr.") 46:12-15. Defense counsel's assertion is refuted by all the evidence cited above: forced withdrawal in jail diminishes Ms. Finnigan's likelihood of returning to treatment, and if she does return, she would have a period of re-stabilization over at least two weeks, during which she would have intense cravings and diminished tolerance for opioids, with severe risk of relapse and death.

Question 4: Is it ever medically appropriate to stop a course of methadone "cold turkey"?

Absent "rare circumstances where a life threatening complication has developed," "[i]t is never medically appropriate to abruptly stop methadone treatment for opioid use disorder (OUD) (also known as 'cold turkey')." Second Supplemental Declaration of Ross MacDonald, M.D. ("MacDonald Second Supp. Decl.") ¶ 2. The OUD treatment guidelines from the

American Society of Addiction Medicine ("ASAM Guidelines"), which Defendants agree are authoritative, *see* Defs.' Supp. Reply, Dkt. 53 ¶ 1, state that "abrupt discontinuation of opioids is not recommended," recommend "[u]sing methadone or buprenorphine for opioid withdrawal management . . . over abrupt cessation of opioids," and make clear that "[i]ndividuals entering the criminal justice system should not be subject to forced opioid withdrawal." Exhibit 1 to Fourth Supplemental Declaration of Joseph Longley ("Longley Fourth Supp. Decl."), American Society of Addiction Medicine, *ASAM National Practice Guidelines for the Treatment of Opioid Use Disorder: 2020 Focused Update* ("*ASAM Guidelines*") at 33, 11, 16; *see also* MacDonald Decl. ¶ 26. This is because "[a]brupt cessation of opioids may lead to strong cravings, and/or acute withdrawal syndrome which can put the patient at risk for relapse, overdose, and overdose death." Exhibit 1 to Longley Fourth Supp. Decl., *ASAM Guidelines* at 11.[1]

Even the discontinuation of methadone pursuant to a graduated taper (as opposed to "cold turkey") is appropriate only in limited and "extraordinary" circumstances when a patient is stable in treatment. MacDonald Decl. ¶ 41; Parrino Decl. ¶¶ 17-19. There is "almost never a legitimate reason for a jail to discontinue methadone treatment of someone stable and in recovery. . . ." Parrino Decl. ¶ 19. The extraordinary circumstances where discontinuing methadone may be appropriate include where the individual makes the decision, where there are new medical contraindications for methadone, where there are specific concerns about diversion *by the treated individual* in their current correctional setting, or where it is logistically impossible to arrange for methadone. *Id*. ¶ 18; MacDonald Decl. ¶ 41.

[1] Note that treating withdrawal is not treating OUD: "[O]pioid withdrawal management on its own, without ongoing pharmacotherapy [methadone or buprenorphine], is not an effective treatment for opioid use disorder and is not recommended." Exhibit 1 to Longley Fourth Supp. Decl., *ASAM Guidelines* at 33.

In this case, it is not medically appropriate for Defendants to stop, abruptly or gradually, Ms. Finnigan's methadone treatment. [redacted] None of the extraordinary circumstances that would warrant discontinuing her methadone treatment are present here. *See* Finnigan Decl. ¶¶ 16, 18-19, 26 (Ms. Finnigan is terrified of her treatment being involuntarily ceased and has no desire to change or terminate her treatment with methadone); [redacted]; Tr. 23:21-25, 24:1-18 (acknowledging medical staff at the DuPage County Jail did not identify any contraindications to methadone in reviewing Ms. Finnigan's medical records); *see generally* Defs.' PI Resp. Br., Dkt. 34 (identifying no safety and security concerns around methadone generally or as to Ms. Finnigan).

Even if there was some medical justification for stopping Ms. Finnigan's treatment, which there is not, "tapering of her methadone dose would need to be done very slowly over the course of several months and only with the full cooperation of the patient and guidance of an addiction specialist." MacDonald Supp. Decl. ¶ 2. At Ms. Finnigan's current prescribed methadone dosage, she cannot safely taper off of her medication during the length of her sentence, which is expected to be 30 days. *Id.* ¶¶ 2, 4. It would be "irresponsible" for the Jail to change Ms. Finnigan's "treatment course when [she] . . . would only temporarily be under their care for a short time, especially understanding that changes in methadone dose would only appropriately be made very slowly (typically over the course of months . . .)." *Id.* ¶ 4.[2]

[2] It is also not appropriate for the Jail to change Ms. Finnigan's treatment to a different agonist treatment (buprenorphine) or to a non-agonist treatment (naltrexone). [redacted]; Parrino Decl. ¶ 19; MacDonald Decl. ¶ 41. [redacted]

II. PLAINTIFF'S RESPONSE TO DEFENDANTS' SUPPLEMENTAL STATEMENT

In their Supplemental Reply, Dkt. 53, Defendants grossly misrepresent the standard of care, reference treatment protocols that are outdated and inconsistent with the standard of care, and provide evidence that they *do* have a de facto Mandatory Withdrawal Policy for methadone for non-pregnant persons. Defendants' Supplemental Reply thereby further demonstrates the urgent need for this Court to act to protect Ms. Finnigan's rights.

1. ASAM Guidelines

Defendants correctly identify the ASAM Guidelines as comprising the medical standard of care in treating OUD. Defs' Supp. Reply ¶ 1. Nevertheless, Defendants' selective citation to the ASAM Guidelines is highly misleading.

The section of the ASAM Guidelines cited in the Defendants' Supplemental Reply pertains to an initial evaluation of a patient seeking care from a new community provider, not, as in this case, to a patient who is already stably in care for OUD. MacDonald Second Supp. Decl. ¶ 5. Ms. Finnigan has already been fully assessed by her treating physician. Defendants misrepresent the guidelines as requiring "a provider" to conduct "a complete assessment of the patient," Defs.' Supp. Reply ¶ 1(a), ostensibly to justify their decision to withhold Ms. Finnigan's methadone treatment until after Jail medical staff perform a custodial physical evaluation. But because this assessment has already occurred, and because the Jail is not an OTP, this standard is inapplicable.[3] MacDonald Second Supp. Decl. ¶ 5.

[redacted]

[3] Defendants also cite ASAM language that "confirmation of the [OUD] diagnosis must be obtained by the prescriber before pharmacotherapy for [OUD] commences," Defs.' Supp. Reply ¶ 1(b)(i), as purported support for their insistence that Ms. Finnigan needs an in-person medical evaluation at the Jail before she can receive methadone. Again, however, the "prescriber" is her treating physician who has already verified Ms. Finnigan's need to continue her methadone treatment. The Jail is not an OTP and its

Defendants' strategic use of an ellipsis, Defs.' Supp. Reply ¶ 1(a), also omits a key sentence that states: "*[C]ompletion of all assessments should not delay or preclude initiating pharmacotherapy for opioid use disorder*." Exhibit 1 to Longley Fourth Supp. Decl., *ASAM Guidelines* at 26. The ASAM Guidelines recognize the need to avoid delay, because "patients with opioid use disorder are at risk for significant harm - including overdose and overdose death[.]" *Id.* at 22. Such guidance is consistent with the Illinois Jail Standards, which require continuation of physician-prescribed medications upon confirmation from the prescribing physician. Ill. Admin. Code tit. 20 §701.40(j)(1)–(2); *see* Pl.'s Reply Br. at 4 and 11-12.[4]

Moreover, the ASAM Guidelines include guidance specific to providing MAT in correctional facilities, and these guidelines prioritize the need for continuity of community-initiated OUD care. MacDonald Second Supp. Decl. ¶ 6. The ASAM Guidelines state that "[a]ll FDA approved medications for the treatment of opioid use disorder should be available to individuals receiving healthcare within the criminal justice system[,]" and "[i]ndividuals entering the criminal justice system should not be subject to forced opioid withdrawal. . . . Patients being treated for opioid use disorder at the time of entrance into the criminal justice system should continue their treatment." Exhibit 1 to Longley Fourth Supp. Decl., *ASAM Guidelines* at 62.[5] It is those patients *not yet* in treatment who "should be assessed and offered individualized

---

medical staff cannot prescribe methadone for OUD. *See* Exhibit 1 to Longley Fourth Supp. Decl., *ASAM Guidelines* at 11 ("Methadone can only be provided in opioid treatment programs (OTPs)[.]").

[4] All page numbers refer to internal pagination, not ECF page numbering.

[5] In selectively highlighting portions of the ASAM Guidelines, Defendants imply that because a clinician referring someone to treatment should consider the "treatment setting" and "venue,"perhaps the jail setting justifies discontinuing Ms. Finnigan's methadone treatment. Defs.' Supp. Reply, Dkt. 53 ¶ 1(c)(i-ii). The ASAM Guidelines, however, could not be more clear that "[c]riminal justice staff should coordinate care and access to pharmacotherapy to avoid interruption in treatment" and that forced withdrawal is not within the standard of care. Exhibit 1 to Longley Fourth Supp. Decl., *ASAM Guidelines* at 61.

pharmacotherapy and psychosocial treatment as appropriate[.]" MacDonald Second Supp. Decl. ¶ 6; Exhibit 1 to Longley Fourth Supp. Decl., *ASAM Guidelines* at 62.

Here, Ms. Finnigan's OTP provider has already conducted a full evaluation to diagnose her OUD and has provided relevant information to Defendants to allow them to continue her treatment during her brief incarceration. According to Defendants' own authority, the medical standard of care is that the Jail should continue Ms. Finnigan's methadone treatment without interruption. There is no justification to deny Ms. Finnigan her methadone pending an evaluation by the Jail's physician.[6]

2. NCCHC and BOP

Defendants make a false distinction between a "general" medical standard of care for treating OUD and a "correctional" standard of care. Defs.' Supp. Reply ¶¶ 1-2. The law does not make any such distinction.[7] If anything, the nature of the relationship between a jail health care provider and patient weighs against changing the treatment the patient began in the community because the patient has not voluntarily sought care in jail, has no opportunity to seek a second opinion, and is only temporarily under the jail's care. MacDonald Second Supp. Decl. ¶ 5. At any rate, to the extent Defendants believe the Federal Bureau of Prisons ("BOP") and the National Commission on Correctional Healthcare (NCCHC) set standards for OUD treatment,[8]

[6] Notably, Ms. Finnigan asked that an evaluation be completed before she reports to the jail so that there is no lapse in her treatment, not that an evaluation be avoided altogether. Pl.'s Br. Prelim. Inj., Dkt. 19-1 at 21-22. Consistent with the ASAM Guidelines, she asks that the evaluation not be used as reason to delay or deny her methadone treatment.

[7] There may be some instances where the security concerns affect the way care is implemented, but the standard of care does not change between the community and a correctional setting. *See, e.g., Konitzer v. Frank*, 711 F. Supp. 2d 874 (E.D. Wis. 2010) (analyzing the standard of care for incarcerated people with gender dysphoria, and separately considering the security concerns).

[8] To be clear, Plaintiff does not accept this view. NCCHC is an accreditation agency that sets out minimum processes for accreditation, and BOP is another prison system; the ASAM Guidelines comprise the specific, evidence-based standards for OUD care.

those organizations would fully support Ms. Finnigan's continued OUD treatment during her jail sentence.

The Defendants incorrectly claim that an NCCHC standard "recommends that *medically supervised withdrawal* be implemented for non-pregnant inmates." Defs.' Supp. Reply ¶ 2(a). Nowhere does the cited document, which is a standard and protocol for medically supervising and treating withdrawal and not for the treatment of OUD,[9] recommend forced withdrawal for a patient entering jail on a stable dose of methadone. As relevant here, the NCCHC standard actually states as follows: "The facility has a policy that addresses the management of inmates on medication-assisted treatment (MAT)," and "Inmates entering the facility on MAT have their medication continued, or a plan for medically supervised withdrawal is initiated." Exhibit A to Defs.' Supp. Reply, Dkt. 52-1, 2 ¶¶ 8-9. In the discussion section of the standard, the NCCHC elaborates further: ". . . Patients with opioid use disorders who are released following long-term confinement are at high risk of postrelease death from overdose. This risk can be reduced by continuing MAT (e.g., methadone, buprenorphine or naltrexone) when appropriate or by initiating MAT prior to release." *Id.* at 3; MacDonald Second Supp. Decl. ¶ 8. Thus, the NCCHC does not exclusively advocate medically supervised withdrawal, as Defendants suggest, particularly for a patient stabilized on methadone.

Moreover, NCCHC has published a position statement about treating OUD, "Substance Use Disorder Treatment for Adults and Adolescents." Exhibit 4 to Longley Fourth Supp. Decl. This position statement endorses the "continuation of opioid agonist treatment," particularly for sentences of six months or less, and states that discontinuation of MAT during incarceration is

[9] This is apparent from the title, "Medically Supervised Withdrawal and Treatment" and the standard: "Inmates who are intoxicated or undergoing withdrawal are appropriately managed and treated." Ms. Finnigan should not be put through withdrawal from her medication for addiction treatment.

"not preferred." *Id*. at 4. This is consistent with an October 2018 publication by NCCHC and the National Sheriffs Association stating that "Medication-assisted treatment (MAT)—utilizing the U.S. Food and Drug Administration (FDA)-approved medications methadone, buprenorphine, or naltrexone—is considered a central component of the contemporary standard of care for the treatment of individuals with opioid use disorders." Exhibit 2 to Longley Fourth Supp. Decl. at 5.

Additionally, Defendants cite an outdated and explicitly reversed BOP policy requiring medical detoxification and hold it out as the standard of care. Defs.' Supp. Reply ¶ 2(b). The BOP overturned the very policy that Defendants cite: "The BOP is no longer requiring immediate rapid detoxification of inmates who arrive at our facilities currently receiving MAT for opioid use disorder." Pl.'s Supp. Statement, Dkt. 58 at 1 and Attachment A thereto. The BOP's current policy is unequivocal that people arriving at a BOP facility on methadone "**will be continued** on established treatment plans" so long as it is clinically appropriate. *Id*.

3. OUD Treatment Options at the Jail

Defendants' description of the medications available for OUD at the Jail shows that for non-pregnant people, the Jail only manages the symptoms of opioid withdrawal (including withdrawal caused by the Jail's withholding of effective agonist medication such as methadone) and does not follow the standard of care, which is to actually treat the underlying OUD with MAT. *Cf. Finley v. Huss*, 723 Fed. App'x 294, 298-99 (6th Cir. 2018) (if "[a particular corrections practice] will exacerbate a mental-health disorder, claiming that medication makes it permissible is a little like bandaging a person's broken leg but then taking away his crutches"). Most of the medications Defendants list are appropriate only to treat withdrawal symptoms (e.g., Ativan, Clonidine, Librium, Vistaril, and Doxepin). Defs.' Supp. Reply ¶ 4. Defendants do

include buprenorphine (Suboxone), methadone,[10] and naltrexone (Vivitrol) in their list, but their descriptions of methadone and buprenorphine as medications "purport[ing] to prevent chemical opiate withdrawal altogether," *id*. ¶ 3, *see also id.* ¶ 4 (describing them in similar terms), betrays the stigmatized and medically uninformed view that these medications do not constitute legitimate treatment for OUD. It suggests that Defendants use these medications to mitigate the effects of *withdrawal*, rather than as maintenance to treat *opioid use disorder* itself.

In fact, opioid agonists such as methadone and buprenorphine do not only prevent withdrawal, but also address cravings, prevent illicit opioid use, improve physical and mental health, allow people to resume healthy, functional behaviors and activities, and reduce the likelihood of overdose and death. MacDonald Decl. ¶¶ 16-17; Reeves Decl. ¶¶ 6, 7. Defendants' continued insistence that managing withdrawal symptoms is equivalent to treating OUD is further evidence that the Jail has a de facto Mandatory Withdrawal Policy in lieu of actual treatment.

4. The Jail's Methadone Practices

Despite continually asserting that they do not have a de facto Mandatory Withdrawal policy, the *only* evidence Defendants now provide demonstrates that they do. They do not currently provide methadone to non-pregnant detainees and have not done so since April 12, 2016, nearly five years ago. Defs.' Supp. Reply ¶¶ 5-7. Ms. Finnigan will require one dose of methadone per day for her 30-60 day incarceration, or 30-60 doses of methadone. Defendants have provided just 42 doses of methadone *total* (to five people, pregnant detainees included) in

[10] Defendants inaccurately describe methadone as a "medication taken as a pill," Defs.' Supp. Reply ¶ 4(b), when in fact, it is a tablet that is then dissolved in water and taken in liquid form when used for OUD, MacDonald Decl. ¶ 37, as opposed to for pain.

the past five *years*. *Id.* ¶ 6. This establishes a de facto Mandatory Withdrawal Policy for non-pregnant detainees.

Additionally, the Jail admits that even in the rare instance that it provides methadone, it takes, on average, between 24-48 hours to provide someone methadone. Defs.' Supp. Reply ¶ 6. Methadone is a daily medication, and taking up to 48 hours to provide it means that withdrawal symptoms will start. MacDonald Supp. Decl. ¶ 7.

The Jail's representation that it is not currently providing methadone to anyone because no one is "medically indicated" for it, Defs.' Supp. Reply ¶ 7, is not credible. Opioid abuse is a serious problem in DuPage County, which reported 112 opioid overdose deaths in 2020 alone.[11] There are currently 476 people in the Jail and Sheriff Mendrick recently stated that 80% of them have "addiction issues." Third Supplemental Declaration of Joseph Longley ("Longley Third Supp. Decl.") Dkt. 55 ¶¶ 3, 5 and Exhibit 1 thereto. Defendants' position that methadone is not "medically indicated" for any of the 380 people in his jail who, by their own estimate, have addiction issues, strongly suggests that, other than for pregnant women, the jail never considers methadone to be "medically indicated."

Edmond Hayes, an expert in MAT and corrections, and a steering committee member of the federal government's Justice Community Opioid Innovation Network (JCOIN), reviewed Defendants' assertion that no non-pregnant detainee has been medically indicated for methadone since April 2016. *See generally*, Supplemental Declaration of Edmond Hayes ("Hayes Supp. Decl."). In response, Mr. Hayes states, "This assertion is not credible. . . I regularly meet with jail administrators and public health researchers throughout the nation. In my experience,

[11] The Cty. of DuPage, *Public Safety Announcement: DuPage Overdose Statistics 2020* (Feb. 4, 2020), https://www.dupageco.org/Coroner/Coroner_News/2020/63300/. This webpage is proper for judicial notice. *See Pickett v. Sheridan Health Care Ctr.*, 664 F.3d 632, 648 (7th Cir. 2011) ("We have recognized the authority of a court to take judicial notice of government websites.") (internal citations omitted).

especially with the ongoing nationwide opioid epidemic, *every* jurisdiction I have spoken with has detainees for whom methadone is clinically indicated and necessary." *Id*. ¶ 7. Mr. Hayes explains that in the Franklin County Jail, where he runs an opioid treatment program (OTP), there have been over 104 detainees on methadone since January 1, 2020, with 37 of those continuing a community prescription and 67 starting methadone in the jail. *Id.* ¶¶ 3-5. That jail has an average population of 200, *id.* ¶ 6, which is less than half the size of the DuPage County Jail's current population of 476. Longley Third Supp. Decl. ¶ 5. In Mr. Hayes's experience, "corrections officials who deny detainees access to methadone and other MAT medications do so because they view methadone as not another medication, but rather an illicit drug." Hayes Supp. Decl. ¶ 8.

Ross MacDonald, an expert in correctional health and treating substance use disorders in corrections, states that the fact that Defendants have not provided methadone to a non-pregnant person since 2016, is a "clear pattern of undertreatment of patients requiring methadone," as "it is . . . not plausible that a stably treated patient on methadone has not been booked into…[the DuPage County Jail] in nearly five years." MacDonald Second Supp. Decl. ¶ 9. Dr. MacDonald explains that in his facility there are typically more than 100 patients treated with methadone per day. *Id*. Although the DuPage County Jail is a smaller facility, based on his estimate that at least 15-20% of individuals in jails across the country have OUD, Dr. MacDonald finds it "highly likely that the jail health system has removed countless patients from their methadone treatment" and concludes they "may well do so in the case of Ms. Finnigan." *Id.*

III. CONCLUSION

For these reasons, the Court should grant the Emergency Motion for a Preliminary Injunction and order that Defendants continue Ms. Finnigan's methadone treatment throughout her 30-60 day incarceration.

Dated: February 23, 2021

Respectfully submitted,

CHRISTINE FINNIGAN

By her attorneys,

/s/ Sally Friedman

Sally Friedman*
Rebekah Joab*
LEGAL ACTION CENTER
225 Varick St., 4th Fl.
New York, NY 10014
(212) 243-1313
sfriedman@lac.org
rjoab@lac.org
*Pro hac vice

/s/ Nusrat J. Choudhury

Nusrat J. Choudhury
Camille Bennett
ROGER BALDWIN FOUNDATION OF ACLU, INC.
150 N. Michigan Avenue, Suite 600
Chicago, IL 60601
(312) 207-9740
nchoudhury@aclu-il.org
cbennett@aclu-il.org

/s/ Maggie E. Filler

Maggie E. Filler*
RODERICK AND SOLANGE MACARTHUR JUSTICE CENTER NORTHWESTERN LAW SCHOOL BLUHM LEGAL CLINIC
160 E. Grand Avenue, 6th Floor
Chicago, Illinois 60611
(312) 503-0899
Maggie.filler@macarthurjustice.org
*Pro hac vice

/s/ Joseph Longley

Maria Morris*
Joseph Longley**
AMERICAN CIVIL LIBERTIES UNION NATIONAL PRISON PROJECT
915 15th Street NW Seventh Floor
Washington, DC 20005
(202) 548-6602
mmorris@aclu.org
jlongley@aclu.org
*Pro hac vice
**Pro hac vice; Not admitted in DC; practice limited to federal courts