IN THE SUPREME COURT OF OHIO

STATE OF OHIO,	:	
	:	Supreme Court
Plaintiff-Appellee,	:	Case No. 2021-0382
	:	
	:	On Appeal from the Guernsey County
v.	:	Court of Appeals,
	:	Fifth Appellate District
	:	Case No. 20CA000010
VERNON L. YONTZ, II,	:	
	:	
Defendant-Appellant.	:	

BRIEF OF AMICI CURIAE PUBLIC HEALTH SCHOLARS, AND TREATMENT AND RECOVERY ORGANIZATIONS AND PROFESSIONALS, ON BEHALF OF APPELLANT VERNON YONTZ IN SUPPORT OF JURISDICTION

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STATEMENT OF INTERESTS OF AMICI CURIAE

Public Health Scholars

The following *amici curiae* are public health scholars at the Johns Hopkins Bloomberg School of Public Health, Johns Hopkins School of Medicine, and the New York University School of Medicine, with extensive knowledge of the research on addiction treatment and experience in the field of public health: *Joshua M. Sharfstein*, M.D., Professor of the Practice in Health Policy and Management at the Johns Hopkins Bloomberg School of Public Health; *Colleen Barry*, PhD, Professor and Chair of the Department of Health Policy and Management at the Johns Hopkins Bloomberg School of Public Health; *Brendan Saloner*, PhD, Associate Professor in Health Policy and Management at the Johns Hopkins Bloomberg School of Public Health; *Noa Krawczyk*, PhD, Assistant Professor in the Department of Population Health at New York University School of Medicine and core faculty of the Center for Opioid Epidemiology and Policy; *N. Jia Ahmad*, MPH, medical student at the Johns Hopkins School of Medicine; *Yngvild Olsen*, MD, MPH, Assistant Professor of Medicine at Johns Hopkins School of Medicine, Vice President of the American Society for Addiction Medicine, and Medical Director of the Institutes for Behavior Resources in Baltimore, MD.

F. Stuart Leeds, M.S., M.D., and Brian Merrill, M.D., are faculty members at the Boonshoft School of Medicine at Wright State University, with extensive clinical experience and knowledge of the state of medical research on opioid use disorder ("OUD") and medication for opioid use disorder ("MOUD," commonly known as medication assisted treatment, or "MAT").

These *amici* seek to provide the Court with their expertise regarding the evidence supporting the treatment of OUD with MOUD. The views expressed here are those of the *amici curiae* and do not necessarily reflect the views of their organizations.

Treatment and Recovery Organizations and Professionals

The Ohio Association for the Treatment of Opioid Dependence ("OATOD") represents the federally certified and state licensed opioid treatment programs throughout Ohio and is the Ohio affiliate of the American Association for the Treatment of Opioid Dependence. OATOD has an active interest in this litigation because its membership is engaged in policy advocacy and education about the use of MAT as an evidenced-based best practice.

The Ohio Council of Behavioral Health and Family Services Providers ("The Ohio Council") is a statewide trade and advocacy organization representing 160 community-based organizations that deliver prevention, addiction treatment, mental health, and family services throughout Ohio. Its mission is to strengthen Ohio's families and communities by helping members be providers and advocates for high quality and efficient behavioral health and family services. The Ohio Council has a strong interest in this litigation because of its policy advocacy and education to support greater access to addiction services, address stigma, and support a comprehensive continuum of care for Ohioans in need of evidence-based services.

SUMMARY OF THE CASE

Amici curiae hereby adopt the statement of the case and facts set forth in Appellant Vernon Yontz's Memorandum in Support of Jurisdiction.

INTRODUCTION

Opioid use disorder ("OUD") is a chronic brain disease and major driver of the overdose epidemic in Ohio and the nation. The standard of care for treating OUD includes medication for OUD ("MOUD") – an evidence-based treatment that helps people achieve recovery and significantly reduces mortality. The Guernsey County Common Pleas Adult Probation subjected Mr. Yontz to a policy prohibiting one form of MOUD, Suboxone, forcing Mr. Yontz to taper off his prescribed medication. The Fifth District Court of Appeals held that because there was no

evidence that Mr. Yontz failed to comply with the no-Suboxone policy, Mr. Yontz's challenge to the policy was moot. That decision reflects a dangerous misunderstanding of OUD and MOUD. MOUD effectively treats the chronic symptoms of OUD, but does not cure the disease. After forced taper, people still have OUD, may have recurring symptoms, and are at severely increased risk of overdose and death. In such circumstances, it is common—and indeed, encouraged by professional guidelines—for a patient to resume MOUD. Doing so does not indicate that the treatment has failed. On the contrary, it demonstrates the patient's commitment to recovery.

The harm to Mr. Yontz did not end when he completed the forced taper; therefore, his challenge to the blanket prohibition of Suboxone remains live. Every day a person like Mr. Yontz is denied access to the lifesaving, evidence-based, standard of care medication prescribed by their physician, is a day of severely increased risk of overdose and death.

ARGUMENT

I. MOUD TREATMENT, INCLUDING WITH BUPRENORPHINE, IS THE STANDARD OF CARE FOR OUD

A. OUD is a chronic and treatable brain disorder

There is consensus in the scientific community that opioid addiction, diagnosed as OUD, is a chronic and treatable brain disease.[1] The American Society of Addiction Medicine ("ASAM") is the leading professional organization for addiction medicine and has established national practice guidelines for the treatment of OUD.[2] ASAM defines addiction as "a treatable, chronic

[1] *See* National Academies of Science, Engineering, and Medicine, *Medications for Opioid Use Disorder Saves Lives,* at 23 (2019), available at https://www.nap.edu/catalog/25310/medications-for-opioid-use-disorder-save-lives (accessed Mar. 25, 2021).
[2] American Society of Addiction Medicine ("ASAM"), *National Practice Guidelines for the Treatment of Opioid Use Disorder, 2020 Focused Updated*, available at https://www.asam.org/docs/default-source/quality-science/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2 (accessed Mar. 25, 2021).

medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences."[3] Repeated use of opioids results in fundamental changes to brain structure and function, particularly the parts of the brain responsible for reward and motivation, decision-making, and stress regulation. These changes promote compulsive drug use despite adverse consequences and make stopping opioid use difficult.[4] Continued drug use is not a moral failing, but a symptom of OUD itself.

B. Treatment with medication is the standard of care for OUD

Evidence-based treatment for this chronic disease saves lives in Ohio and elsewhere. The standard of care is anchored by MOUD, such as buprenorphine or methadone. Treatment with MOUD is also often referred to as medication-assisted treatment ("MAT") or medication-based treatment ("MBT"). Medications help normalize brain function and decrease symptoms of OUD such as cravings and withdrawal.[5] By relieving cravings, medications can provide space to focus on rebuilding relationships and the other work of recovery. Medications are the central component of successful long-term recovery for many people with OUD and have benefits even without counseling.[6] Conversely, evidence shows that counseling and supportive services without medication are less effective than medication alone or medication combined with these services.[7]

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[3] ASAM, *Definition of Addiction*, at 2 (Sept. 15, 2019), available at https://www.asam.org/docs/default-source/quality-science/asam's-2019-definition-of-addiction-(1).pdf?sfvrsn=b8b64fc2_2 (accessed Mar. 25, 2021); *see also* National Institute on Drug Abuse ("NIDA"), *The Science of Drug Use and Addiction: The Basics* (July 2018), available at https://www.drugabuse.gov/publications/media-guide/science-drug-use-addiction-basics (accessed Mar. 25, 2021) (addiction is "a chronic, relapsing disorder characterized by compulsive drug seeking and use despite harmful consequences, and long-lasting changes in the brain.")

[4] National Academies of Science, Engineering, and Medicine, *supra* note 1, at 23-24.

[5] *Id*. at 34-36.

[6] *Id.* at 48.

[7] *See e.g*., Sarah E. Wakeman et al., *Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder, 3* JAMA NETWORK OPEN 1, 8 (2020); Valerie A. Gruber et al., *A*

The three FDA-approved medications for OUD are buprenorphine, methadone, and extended release naltrexone (brand name, Vivitrol). All, used as prescribed, are safe and do not produce euphoric effects (or a "high"). Buprenorphine has been extensively studied and found to be effective for the treatment of OUD; its stabilizing effects on the brain result in substantially less craving, drug use, and mortality.[8] The most commonly prescribed formulation of buprenorphine is Suboxone, the subject of the ban at issue in this case. Many lay people use the term "Suboxone" to refer to all forms of buprenorphine. This brief uses the more generic term buprenorphine except when referencing the no-Suboxone policy in this case; all properties and treatment outcomes associated with buprenorphine also apply to Suboxone.

C. Resuming treatment after cessation of MOUD may be medically necessary

OUD is a chronic brain disease that leads to significant changes in brain structure and function.[9] In a person with an OUD, these changes to the brain can persist for many years, even after discontinuing opioid use.[10] Medications like buprenorphine stabilize functional changes to the brain caused by OUD and minimize symptoms like cravings. However, they do not permanently reverse the chronic brain changes characteristic of opioid addiction, and people who discontinue medications – by choice or by force – often have recurrent symptoms. In fact, all studies exploring tapering or discontinuing medication show high rates of relapse.[11] People who discontinue treatment with medications often experience cravings or withdrawal – symptoms of

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Randomized Trial of 6-Month Methadone Maintenance With Standard or Minimal Counseling versus 21-day Methadone Detoxification, 94 Drug and Alcohol Dependence 199, 203 (2008).

[8] National Academies of Science, Engineering, and Medicine, *supra* note 1, at 38-39.

[9] *Id.* at 2.

[10] Alan I. Leshner, *Addiction is a Brain Disease, and it Matters*, 278 SCIENCE 45, 46 (1997); Nora D. Volkow et al., *Neurobiologic Advances from the Brain Disease Model of Addiction*, 374 NEW ENGLAND JOURNAL OF MEDICINE 363, 366 (2016).

[11] National Academies of Science, Engineering, and Medicine, *supra* note 1, at 40.

their underlying disease – and may need to restart medication treatment. Resuming MOUD is not a sign of failed treatment or moral weakness, but rather an encouraging sign of a patient's commitment to recovery. Restarting medication after a period of discontinuation is common among patients with OUD, and encouraged by professional guidelines.[12]

D. Treatment with buprenorphine is associated with many positive effects, including a substantially lower risk of fatal overdose and overall mortality

Buprenorphine treatment saves lives, with evidence of a 50 percent or greater reduction in risk of fatal overdose and mortality.[13] Use of prescription buprenorphine decreases illicit opioid use and injection drug use,[14] thus reducing risk of HIV and hepatitis C infection.[15] Buprenorphine treatment also improves quality of life.[16] ASAM concluded that treatment with MOUD led to "decreased mortality, abstinence from opioids, and retention in treatment" and "strong evidence support[s] the superiority" of MOUD over treatment without medication.[17]

Treatment of OUD with medications is especially important in the criminal justice system. Studies show that people who receive methadone or buprenorphine have lower rates of probation

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[12] ASAM, *National Practice Guidelines*, *supra* note 2, at 43.

[13] Luis Sordo et al., *Mortality Risk During and After Opioid Substitution Treatment: Systematic Review and Meta-Analysis of Cohort Studies*, 357 BMJ 1, 4 (2017); *accord* Marc R. Larochelle et al., *Medication for Opioid Use Disorder After Nonfatal Opioid Overdose and Association With Mortality*, 169 Annals of Internal Med. 137, 140 (2018).

[14] National Academies of Science, Engineering, and Medicine, *supra* note 2, at 39; *accord* George E. Woody et al., *HIV Risk Reduction with Buprenorphine-Naloxone or Methadone: Findings from a Randomized Trial*, 66 J. Acquired Immune Deficiency Syndromes 288, 290 (2014).

[15] Georgie J. MacArthur et al., *Opiate Substitution Treatment and HIV Transmission in People Who Inject Drugs: Systematic Review and Meta-Analysis,* 345 BMJ 1, 4 (2012).

[16]Shannon Gwin Mitchell et al., *Changes in Quality of Life following Buprenorphine Treatment: Relationship with Treatment Retention and Illicit Opioid Use*, 42 J. Psychoactive Drugs 149, 154 (2015).

[17] ASAM, *National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use* 23-24 (June 1, 2015), available at https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf (accessed Mar. 25, 21).

revocations, re-arrest, and re-incarceration.[18] Additionally, providing MOUD during incarceration and upon release dramatically reduces the risk of overdose and death.[19] A recent study from Rhode Island found that offering medication treatment in the correctional system and providing connections to continued treatment in the community resulted in a 60 percent decrease in overdose mortality.[20] This is because in the absence of medication treatment, tolerance to opioids decreases, leaving individuals at high risk of overdose if they resume illicit opioid use.[21] With medication treatment, by contrast, individuals are less likely to use illicit opioids.

E. Buprenorphine treatment does not substitute one addiction for another

The policy prohibiting Suboxone here reflects a fundamental misconception that MOUD substitutes one addiction for another. This view is common because both buprenorphine and methadone are opioids. However, while heroin, oxycodone, and other commonly misused opioids are short-acting drugs that create euphoria, buprenorphine and methadone are long-acting medications designed to treat symptoms of addiction, such as craving and withdrawal, without inducing compulsive drug-seeking or euphoria.[22] The use of buprenorphine to treat OUD is

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[18] Elizabeth A. Evans et al., *Criminal Justice Outcomes Over 5 Years After Randomization to Buprenorphine-Naloxone or Methadone Treatment for Opioid Use Disorder*, 114 Addiction 1396, 1400 (2019); C. Brendan Clark, et al., *Methadone maintenance treatment may improve completion rates and delay opioid relapse for opioid dependent individuals under community corrections supervision*, 39 Addict. Behav. 1736, 1740 (2014); *accord* Verner S. Westerberg et al., *Community-Based Methadone Maintenance in a Large Detention Center is Associated With Decreases in Inmate Recidivism*, 70 J. Substance Abuse Treatment 1, 4 (2016); Shanna Farrell-Macdonald et al., *Impact of Methadone Maintenance Treatment on Women Offenders' Post-Release Recidivism*, 20 Eur. Addiction Res. 192, 196 (2014).

[19] Louisa Degenhardt, et al., *The Impact of Opioid Substitution Therapy on Mortality Post-Release from Prison: Retrospective Data Linkage Study*, 109 Addiction 1306, 1312 (2014).

[20] Traci C. Green et al., *Postincarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System*, 75 JAMA Psychiatry 405, 406 (2018).

[21] Elizabeth L.C. Merrall et al., *Meta-Analysis of Drug-Related Deaths Soon After Release from Prison*, 105 Addiction 1545, 1549 (2010).

[22] Thomas R. Kosten & Tony P. George, *The Neurobiology of Opioid Dependence: Implications for Treatment*, 1 SCIENCE & PRACTICE PERSPECTIVE 13, 18 (2002). Suboxone contains

analogous to using insulin to treat diabetes, thyroid hormone to treat hypothyroidism, or a diuretic to treat hypertension. These are all safe medications for the treatment of chronic diseases, that are essential to preserving patients' lives. The misconception that buprenorphine is simply substituting one addiction for another has no grounding in science and undermines effective OUD treatment.

F. Automatically prohibiting buprenorphine for a positive drug test for illicit substances is not medically justified and increases risk of relapse and death

Positive urine test results for illicit substances do not, by themselves, constitute a clinical rationale for discontinuing buprenorphine treatment. The use of illicit opioids while in treatment with buprenorphine may actually suggest that the prescribed dosing is inadequate, and that it should, in fact, be increased.[23] The use of non-opioid substances is not a sign of buprenorphine treatment failure, because buprenorphine effectively treats only OUD – not other substance use disorders. A positive drug test for other substances may be a sign that the patient needs additional social, behavioral, or pharmacological support tailored to these substances. Programs that routinely discontinue treatment for positive urine screens are not following the standard of care.[24]

II. THE OPIOID EPIDEMIC IN OHIO DEMANDS SOLUTIONS BASED IN EVIDENCE – INCLUDING BUPRENORPHINE TREATMENT

Given the enormous toll the opioid epidemic is inflicting in Ohio, the State needs solutions based in evidence, not outdated assumptions and stigma. In 2018, Ohio had the fourth highest rate

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buprenorphine and naloxone, an opioid antagonist. This combination is intended to reduce misuse of the drug by injection because the naloxone (inactive when swallowed) blocks the effects of opioids if it is injected. National Academies of Science, Engineering, and Medicine, *supra* note 1, at 36.

[23] Richard P. Mattick et al., *Buprenorphine Maintenance Versus Placebo or Methadone Maintenance for Opioid Dependence*, COCHRANE DATABASE SYSTEMATIC REVIEW, at 16 (2004)

[24] ASAM, *National Practice Guidelines, supra* note 2, at 43.

of opioid overdose deaths in the country.[25] Its rate of overall drug overdose deaths – 29.6 per 100,000 – was more than double the national average.[26] Ohio opioid overdose death rates have risen in 2020, reaching a 10-year high in the second quarter.[27] Nationally, seventy percent of the more than 70,000 drug overdoses deaths in the United States in 2019 involved opioids, with preliminary evidence indicating an even higher total in 2020.[28]

A. MOUD is recommended by Ohio, national, and international public health, medical, and criminal justice authorities

Given the substantial body of research demonstrating its effectiveness, MOUD – including buprenorphine – is widely endorsed by Ohio, national, and international authorities and are considered the standard of care, including in criminal justice settings. The list of renowned organizations supporting the use of buprenorphine for OUD includes the National Institutes of Health,[29] Centers for Disease Control and Prevention,[30] U.S. Food and Drug Administration,[31]

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[25] NIDA, *Opioid Summaries by State* (Apr. 16, 2020), available at https://www.drugabuse.gov/drug-topics/opioids/opioid-summaries-by-state (accessed Mar. 25, 2021).
[26] NIDA, *Ohio: Opioid-Involved Deaths and Related Harms* (Apr. 3, 2020), available at https://www.drugabuse.gov/drug-topics/opioids/opioid-summaries-by-state/ohio-opioid-involved-deaths-related-harms (accessed Mar. 25, 2021).
[27] Ohio Attorney General, *Record Surges in Opioid Overdoses Prompts AG Yost to Urge Vigilance* (Jan. 11, 2021), available at https://www.ohioattorneygeneral.gov/Media/News-Releases/January-2021/Record-Surges-in-Opioid-Overdoses-Prompts-AG-Yost (accessed Mar. 24, 2021).
[28] NIDA, *Overdose Death Rates* (Jan. 29, 2021), available at https://www.drugabuse.gov/drug-topics/trends-statistics/overdose-death-rates (accessed Mar. 25, 2021).
[29] *See* NIDA, *Effective Treatments for Opioid Addiction* (Nov. 2016), available at https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction/effective-treatments-opioid-addiction (accessed Mar. 25, 2021).
[30] *See* Center for Disease Control and Prevention, *Treat Opioid Use Disorder* (Aug. 23, 2017), available at https://www.cdc.gov/drugoverdose/prevention/treatment.html (accessed Mar. 25, 2021).
[31] *See* U.S. Food and Drug Administration, *FDA Takes New Steps to Encourage the Development of Novel Medicines for the Treatment of Opioid Use Disorder* (Aug. 6, 2018), available at https://www.fda.gov/news-events/press-announcements/fda-takes-new-steps-

Substance Abuse and Mental Health Services Administration,[32] President Trump's Commission on Combating Drug Addiction and the Opioid Crisis,[33] Office of National Drug Control Policy,[34] World Health Organization,[35] U.S. Surgeon General,[36] National Academies of Science, Engineering, and Medicine,[37] and ASAM.[38] A recent consensus report by the National Academies of Sciences, Engineering, and Medicine establishes that "[w]ithholding or failing to have available all classes of FDA-approved medication for the treatment for OUD in any care or criminal justice setting is denying appropriate medical treatment."[39]

Criminal justice agencies and courts also have recommended the use of MOUD. A 2019 report by the National Judicial Opioid Task Force states that "[c]ourts should include medication-based treatment for OUD as part of a comprehensive treatment plan, in all civil and criminal cases*

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encourage-development-novel-medicines-treatment-opioid-use-disorder (accessed Mar. 25, 2021).

[32] *See* Substance Abuse and Mental Health Services Administration ("SAMHSA"), *Treatment Improvement Protocol (TIP) 63: Medications for Opioid Use Disorder for Healthcare and Addiction Professionals, Policymakers, Patients, and Families* (2018), available at https://www.ncbi.nlm.nih.gov/books/NBK535268/pdf/Bookshelf_NBK535268.pdf (accessed Mar. 25, 2021).

[33] *See The President's Commission on Combatting Drug Addiction and the Opioid Crisis* (Nov. 2017), available at https://trumpwhitehouse.archives.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-15-2017.pdf (accessed Mar. 25, 2021).

[34] *See* Office of National Drug Control Policy, *National Drug Control Strategy* (Feb. 2020), available at https://trumpwhitehouse.archives.gov/wp-content/uploads/2020/02/2020-NDCS.pdf (accessed Mar. 25, 2021).

[35] *See* World Health Organization, *Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence* (2009), available at https://www.who.int/substance_abuse/publications/ 9789241547543/en/ (accessed Mar. 25, 2021).

[36] *See* U.S. Department of Health and Human Services ("HHS"), *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health* (2018), available at https://addiction.surgeongeneral.gov/sites/default/files/OC_SpotlightOnOpioids.pdf (accessed Mar. 25, 2021).

[37] *See* National Academies of Science, Engineering, and Medicine, *supra* note 1.

[38] *See* ASAM, *National Practice Guideline, supra* note 17.

[39] National Academies of Science, Engineering, and Medicine, *supra* note 1, at 3.

* *" including during probation.[40] A 2018 report by the National Sheriff's Association and National Commission on Correctional Health Care highlights the benefits of MOUD and strongly cautions against "law enforcement officers, probation and parole agents, judges, and correctional officers" determining whether individuals can take MOUD.[41] Instead, "the decision to obtain medication * * * and the specific medication chosen, should be the individual's, after consultation with medical and treatment providers, *not imposed by a justice * * * agency*."[42] (Emphasis added.)

Ohio government and health organizations have also emphasized the central role of MOUD. The Ohio Council for Behavioral Health and Family Service Providers has noted the need to "make *all* forms of FDA-approved MAT accessible." (Emphasis added.)[43] The Governor's Opiate Action Team called for the State to "encourage the use of medication-assisted treatment," including buprenorphine.[44] The team's report described an initiative spearheaded by the Ohio Department of Mental Health and Addiction Services to increase access to buprenorphine as an important treatment. The Ohio Department of Mental Health and Addiction Services has stated

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[40] National Judicial Opioid Task Force ("NJOTF"), *Convening, Collaborating, Connecting: Courts as Leaders in the Crisis of Addiction,* at 17 (2019), available at https://www.ncsc.org/~/media/Files/PDF/Topics/Opioids-and-the-Courts/NJOTF_Final_Report_111819.ashx (accessed Mar. 25, 2021).

[41] National Sheriffs' Association, *Jail-Based Medication-Assisted Treatment, Promising Practices, Guidelines, and Resources for the Field*, at 8 (Oct. 2018), available at https://www.sheriffs.org/publications/Jail-Based-MAT-PPG.pdf (accessed Mar. 25, 2021).

[42] *Id*.

[43] Ohio Council of Behavioral Health and Family Service Providers, *Policy Solutions for Ohio's Addiction & Mental Health Crisis*, at 10 (July 2018), available at https://obc.memberclicks.net/assets/WhitePaper/Ohio%20Council%20Behavioral%20Health%20Policy%20Solutions%20%20with%20Appendices-brennawin70414.pdf (accessed Mar. 25, 2021). As noted in the summary, the terms MOUD and MAT are often used interchangeably. Both refer to medications, including buprenorphine.

[44] Governor's Cabinet Opioid Team, *Action Guide to Address Opioid Abuse*, at 13 (June 2018), available at https://mha.ohio.gov/Portals/0/assets/ResearchersAndMedia/Combating%20Opiate%20Abuse/Ohio-2018-Action-Guide-to-Address-Opioid-Abuse.pdf?ver=2018-11-29-112926-250 (accessed Mar. 25, 2021).

that "[t]aking medication for opioid addiction is like taking medication to control heart disease or diabetes. Used properly, the medication does NOT create a new addiction." (Emphasis sic.)[45]

B. Diversion of buprenorphine by some people does not warrant its prohibition for all people

Fear of illicit diversion of buprenorphine is often cited as a reason not to provide this evidence-based treatment to anyone. However, evidence suggests that the great majority of people who use buprenorphine without a prescription are doing so not to get "high," but as a self-treatment to avoid withdrawal, to stop using other opioids, or because they could not afford drug treatment.[46] Research has also demonstrated that using non-prescribed buprenorphine is a predictor of seeking treatment.[47] Moreover, courts may implement measures to prevent diversion, such as urine drug tests and pill counts, and respond appropriately to individuals who do divert medication, rather than prohibiting all people from accessing this life-saving medication.

III. DECISIONS ABOUT MOUD MUST BE MEDICALLY BASED

A. OUD treatment should be decided on an individualized basis by patients and their clinicians

As with other chronic medical disorders, decisions about OUD treatment should be tailored to individual patient needs and based on shared decision making between the patient and their clinician. This is why the National Judicial Opioid Task Force has clearly said, "[u]sing medication

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[45] Ohio Dept. of Mental Health and Addiction Services, *Medication-Assisted Treatment*, available at https://mha.ohio.gov/Health-Professionals/About-Mental-Health-and-Addiction-Treatment/Medication-Assisted-Treatment (accessed Mar. 25, 2020).

[46] Zev Schuman-Oliver, et al., *Self-Treatment: Illicit Buprenorphine Use by Opioid-Dependent Treatment Seekers*, 39 J. Substance Abuse Treatment 41, 48 (2010); Alexander R. Bazazi et al., *Illicit Use of Buprenorphine/Naloxone Among Injecting and Noninjecting Opioid Users*, 5 J. Addiction Med. 175, 178 (2011); *accord* Becky L. Genberg et al., *Prevalence and Correlates of Street-Obtained Buprenorphine Use Among Current and Former Injectors in Baltimore, MD*, 38 Addict Behav. 2868, 2871 (2013).

[47] Jennifer J. Carroll et al., *The More Things Change: Buprenorphine/Naloxone Diversion Continues While Treatment Remains Inaccessible*, 12 J. Addiction Med. 459, 461 (2018).

to treat OUD should be a clinically-driven decision between the patient and his or her clinician on an individual basis."[48] Likewise, the U.S. Surgeon General has stated, "tailoring treatment to the patient's specific needs increases the likelihood of successful treatment."[49] Therefore, it is dangerous and contravenes medical standards for courts and probation officials to impose blanket prohibitions on MOUD or otherwise override the clinical judgment of an individual's physician. In fact, the treatment provider that conducted a court-ordered evaluation for Mr. Yontz, recommended that Mr. Yontz continue his treatment with buprenorphine.[50]

B. The length of treatment with buprenorphine is a clinical judgment based on the individual's medical needs

National experts recommend continuing MOUD as long as it is beneficial and that the decision to terminate medication come from the patient. The U.S. Substance Abuse and Mental Health Services Administration ("SAMHSA") of the U.S. Department of Health and Human Services treatment protocols clearly state that "[a]rbitrary time limits on the duration of treatment with OUD medication are inadvisable" and "patients should take buprenorphine as long as they benefit from it and wish to continue." (Emphasis added).[51]

The National Practice Guidelines for ASAM state that "there is no recommended time limit for treatment with buprenorphine * * * Patients and clinicians should not take the decision to terminate treatment with buprenorphine lightly."[52] Finally, the committee of the National Academies of Science, Engineering, and Medicine concluded that, "extending treatment for years allows individuals to increase their opportunities to return to work, to regain their health, to avoid

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[48] NJOTF, *Convening, Collaborating, Connecting*, *supra* note 40, at 15.
[49] HHS, *Facing Addiction in America, supra* note 36, at 17.
[50] *See* 3/23/2020 Motion to Modify Intervention in Lieu of Conviction, p. 2, Exhibit B.
[51] SAMHSA, *Treatment Improvement Protocol (TIP)*, *supra* note 32, at 1-8, 3-67.
[52] ASAM, *National Practice Guideline*, *supra* note 17, at 34.

involvement with the criminal justice system, and to establish supportive networks of non-drug-using individuals.[53] Probation-imposed taper requirements for buprenorphine run counter to the national medical consensus and undermine effective treatment.

C. Requiring individuals to stop treatment with buprenorphine for OUD places them at continued increased risk of relapse and death

The Guernsey County Common Pleas Adult Probation rules require *everyone* on Suboxone to taper off without regard to individualized, clinical evidence.[54] For Mr. Yontz, that meant tapering off Suboxone against the clinical judgment of his own physician and the clinical recommendation of his court-ordered evaluation.[55] Pressure by the criminal justice system to stop MOUD increases the risk of relapse and its attendant consequences and deters people from receiving life-saving treatment. SAMHSA treatment guidelines warn that "[f]orcing a patient to taper off of medication for nonmedical reasons or because of ongoing substance misuse is generally inappropriate."[56] Many studies show that the risk of death increases substantially when patients stop taking MOUD.[57] For example, one study found that the mortality rate for people who have recently stopped medication treatment is nine times higher than it is for people in treatment, and over the span of a year, the mortality rate for people who have stopped medications is at least two times higher.[58] The tapering requirement by Guernsey County Common Pleas Adult Probation

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[53] National Academies of Science, Engineering, and Medicine, *supra* note 1, at 40.
[54] 3/23/29 Motion to Modify Intervention in Lieu of Conviction, Exhibit C.
[55] 3/23/29 Motion to Modify Intervention in Lieu of Conviction, p. 3-4, Exhibits B, C.
[56] SAMHSA, *Treatment Improvement Protocol (TIP)*, *supra* note 32, at 3-88.
[57] Rosie Cornish et al., *Risk of Death During and After Opiate Substitution Treatment in Primary Care: Prospective Observational Study in UK General Practice Research Database*, 341 BMJ 1, 5 (2010); *accord* Thomas Clausen et al., *Mortality Prior To, During and After Opioid Maintenance Treatment (OMT): A National Prospective Cross-Registry Study*, 94 Drug Alcohol Dependence 151, 155 (2008); Sordo et al., *supra* note 13, at 4.
[58] Cornish, *supra* note 57, at 1.

is inconsistent with responsible medical practice and leaves individuals like Mr. Yontz at an increased risk of relapse and death, even after the taper is complete.[59]

CONCLUSION

The forced tapering of Mr. Yontz's standard of care medication subjects him to living with an untreated, chronic disease. He is at ongoing risk of severe harm, including overdose and death. Treatment with Buprenorphine, including Suboxone, is essential even after a forced taper, as the standard of care is to restart treatment when the patient is ready. A community control policy that prohibits buprenorphine hinders successful completion of supervision, undermines public safety, and places individuals like Mr. Yontz at grave risk that continues throughout their supervision.

Respectfully submitted,

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[59] National Academies of Sciences, Engineering, and Medicine, *supra* note 1, at 40.

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CERTIFICATE OF SERVICE

I certify that on March 26, 2021, I filed the foregoing via the Court's electronic filing system, and I served a copy of the brief by e-mail to Lindsey Angler, Guernsey County Prosecutor, at langler@guernseycounty.org, and Carly M. Edelstein, Assistant State Public Defender, at carly.edelstein@opd.ohio.gov.

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