EXPERT AFFIDAVIT OF RUTH A. POTEE, M.D.

I, Dr. Ruth Potee, state that the following is true to the best of my knowledge, information, and belief, and that I hold the opinions set forth in this report to a reasonable degree of professional certainty:

1. I am the Medical Director of the Franklin County House of Correction and a specialist in Addiction Medicine. I have been a speaker on the topic of addiction at multiple conferences, including trainings for judges, lawyers, correctional staff, drug court staff, teachers, and community members.

2. I am submitting this affidavit to provide the Court with information concerning the use of medication for addiction treatment (MAT) in patients suffering from opioid use disorder in correctional facilities. I have not treated or met the defendant in this case

3. I am board certified in both Addiction Medicine and Family Medicine. In addition to my work with the Franklin County Sheriff's Office, I am Medical Director of the Franklin Recovery Center, Chair of the Healthcare Solutions Committee of the Opioid Taskforce of Franklin County, and Chair of the Department of Medicine at Baystate-Franklin Medical Center. I am the School Physician for the Pioneer Valley School District, as well as a family physician with Valley Medical Group. For eight years, I worked as an assistant professor of Family Medicine at Boston University, where I did my residency. In 2015, I was named the Franklin County Doctor of the Year by the Massachusetts Medical Society. My curriculum vitae is attached to this affidavit as Exhibit A.

4. From 1999-2002, I trained at Boston University, an international center for addiction medicine, and I have cared for people with addiction every working day since. In my primary care practice, I take care of people who struggle with alcohol, prescribed opioids, heroin, benzodiazepines, cocaine, and methamphetamine. I run a 64-patient drug treatment center where patients come for more intensive interventions.

5. I have worked with over 500 people with various substance use disorders (SUD) prosecuted in the criminal justice system. At the Franklin County House of Correction, approximately 85% of the 250 inmates carry a SUD diagnosis. I train medical students and residents from Boston University, Harvard, and Tufts. I also

train Addiction Medicine Fellows from Boston University who work with me at the jail and the detox facility.

6. SUD, including opioid use disorder, is a brain disease defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) as "a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems."[1]

7. The three primary risk factors for developing a SUD are genetic predisposition, early exposure while the brain is developing, and childhood trauma.

8. When a person starts down the path of addiction, the neurochemistry of the brain shifts in ways both dramatic and subtle.[2] Many neurotransmitters — the "telephone wires" linking different parts of the brain — are impacted by addiction, but the one that is most damaged is dopamine. Dopamine is the chemical in the brain that tells the body to survive: find food, water, and a way to send your DNA forward to create another generation. It is the most ancient and elemental part of the brain and every living creature on the planet has this deeply housed reward center driving survival.[3]

9. With addiction, the damage to the dopamine system triggers a cascading chemical cycle telling the brain that, in order to survive, it needs to continue the addictive behavior because it feels as though its survival depends on it. Despite clear evidence of harm to themselves, people they love, and society, individuals suffering from a SUD have unrelenting perseverative thoughts and compulsion to continue to use the drug. This is driven by the broken dopamine system and seems counter-intuitive until one understands the physiology of the disease.

10. The survival part of the brain wants to achieve a sense of normalcy. Nonaddicted brains have a set dopamine level racing through the synaptic cleft. After exposure to huge dopamine spikes through use of heroin, cocaine, methamphetamines, or another addictive substance, the brain down regulates and stops making enough

---

[1] American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 483 (5th ed. 2013), Exhibit B. The DSM-5 is a comprehensive, authoritative volume that defines and classifies mental disorders based on the work of hundreds of international experts in all aspects of mental health.

[2] Christopher A. Blackwood & Jean Lud Cadet, The Molecular Neurobiology and Neuropathology of Opioid Use Disorder, 2 Curr. Res. Neurobiol. 100023 (2021).

[3] See U.S. Department of Health & Human Services, Facing Addiction: The Surgeon General's Report on Alcohol, Drugs, and Health, 2-5 (2016), available at https://addiction.surgeongeneral.gov/sites/default/files/chapter -2-neurobiology.pdf, Exhibit C.

dopamine. Dopamine levels in the addicted brain are less than half that of the non-addicted brain. In order to achieve homeostasis — i.e., to "feel normal" — the brain needs to continue to use the drug.

11. In order to recover from SUD, the brain needs to rebuild its broken dopamine system. The recovery process for SUD is not one-size-fits-all. A comprehensive assessment of clinical needs (including trauma and co-occurring disorders) by a qualified professional should guide treatment planning to meet the specific needs of the person.

12. Components of comprehensive addiction treatment include: (a) individual counseling with a licensed clinician trained in addiction; (b) evidence-based therapy — e.g. cognitive behavioral therapy (CBT), motivational enhancement therapy (MET), dialectical and behavioral therapy (DBT), eye movement desensitization and reprocessing (EMDR), and acceptance commitment therapy (ACT); (c) case management (especially for high risk patients with co-occurring medical, housing and employment needs)[4]; and (d) mutual peer support — e.g. Twelve-Step programming or recovery coaches.

13. In addition, for most patients suffering from opioid use disorder, an essential component of an effective recovery program is the administration of medication for addiction treatment (MAT), the use of FDA-approved prescription drugs in conjunction with counseling, behavioral therapy, and other interventions. The use of MAT is the medical standard of care for the treatment of opioid use disorders.

14. The medication component of MAT helps to suppress withdrawal, reduce cravings, and prevent users from experiencing a "high" after taking opioids by binding to dopamine receptors and preventing opioids from activating on them. In particular, the opioid agonists buprenorphine and methadone activate the opioid-receptors while binding to them, providing for a steady flow of dopamine to the brain. This conditions the brain away from further illicit opioid use and allows patients to resume healthy, functional behaviors and activities. Buprenorphine and methadone have been clinically proven to reduce opioid use compared to treatment without medication.[5]

---

[4] See SAMSHA, Comprehensive Case Management for Substance Abuse Treatment: Treatment Improvement Protocols (TIP) Series 27 (2015), available at https://store.samhsa.gov/shin/content/SMA15-4215/SMA15-4215.pdf, Exhibit D.

[5] American Society of Addiction Medicine, Advancing Access to Addiction Medications: Implications for Opioid Addiction Treatment, 13–15 (2013), available at http://www.asam.org/docs/defaultsource/advocacy/aaam_implications-for-opioid-addictiontreatment_final, Exhibit

15. Patients who successfully begin their recovery on MAT often need to maintain their course of treatment for many years, and tapering of medication should only be considered as part of a gradual and comprehensive plan established by the patient and physician. Sudden, involuntary withdrawal of medication from such patients for reasons other than medical necessity causes severe and needless suffering, jeopardizes the patient's long-term recovery, and is inconsistent with sound medical practice. Where a patient is on a successful course of medication for opioid addiction, and there are no contraindications or adverse effects warranting discontinuation, it is contrary to prudent professional standards and modern medical science to abruptly withhold treatment from the patient against the patient's will.

16. Despite the overwhelming medical evidence supporting MAT as the standard of care in the treatment of opioid use disorder, MAT is not currently available to the vast majority of incarcerated patients suffering from opioid addiction in Massachusetts. Nearly all jails and prisons in the state currently refuse to provide access to methadone or buprenorphine to inmates, even when the inmate, prior to incarceration, was receiving a successful course of MAT prescribed by his or her treating physician.

17. To my knowledge, methadone and buprenorphine are currently only available to inmates at two detention facilities in Massachusetts. The Franklin County House of Corrections is the only detention facility in the state to administer buprenorphine to inmates with an opioid use disorder. We are working to get licensed to use methadone for treatment in the coming year. In addition, the Massachusetts Correctional Institution in Framingham provides access to methadone for pregnant inmates to avoid the medical risks associated with withdrawal.

18. Unlike the continuity of care typically provided to inmates suffering from other chronic illnesses or mental health conditions that require a continuous course of medications,[6] most inmates in Massachusetts receiving MAT for opioid use disorder prior to incarceration are forced to undergo a rapid "detox" process for

---

E. See also Amanda Spayde-Baker & Jennifer Patek, A Comparison of Medication-Assisted Treatment Options for Opioid Addiction: A Review of the Literature, 34 J. Addict. Nurs. E189 (2023).

[6] For example, it is the policy of the Massachusetts Department of Corrections to allow a patient with a history of psychotropic medications who enters a facility to continue those medications unless there is a specific medical rationale for discontinuing the medication. See Commonwealth of Massachusetts Department of Corrections Health Services Division, Pharmacy and Medications Policy, 103 DOC 661, at § 661.04 (November 2017), available at https://www.mass.gov/files/documents/2017/12/20/661.pdf, Exhibit F.

terminating their medication regimen.[7] In my practice, I have personally witnessed the excruciating symptoms experienced by patients undergoing an accelerated methadone detox process. These patients suffer from severe diarrhea and vomiting, abdominal cramps, restless legs, excessive dehydration, and insomnia. These symptoms can sometimes lead to life threatening complications. Inmates undergoing detox require frequent surveillance and monitoring and are placed on "medical watch" by correctional officers or nursing staff.

19. The disruption of therapy has long-term consequences for inmates during and after their incarceration. In many jails and prisons, inmates may have access to illicit substances, and often resort to drug use when deprived of their medication. When these inmates are caught for using, they are often placed in solitary confinement or terminated from other treatment programs. This isolation further impedes the inmate's prospects for recovery.

20. Moreover, for inmates subjected to forced abstinence during their incarceration, the chemical cascade of cravings to return to drug or alcohol use starts about six weeks prior to release, when addicted inmates start planning how they will use the minute they are released. Abstinence does not itself repair the broken dopamine system. Thus, even if an inmate with opioid use disorder has been abstinent during incarceration, the brain's dopamine system remains broken, and the patient's opioid-seeking behaviors continue.

21. Incarcerated patients who had previously succeeded on methadone are often unable to successfully resume treatment after their release from incarceration. For many patients, the experience of methadone detox discourages them from reinitiating therapy. Moreover, patients whose methadone treatment is interrupted are required to begin their therapy anew at low doses without the benefit of the routine and privileges they had previously established.

22. Moreover, patients subjected to forced abstinence during incarceration lose their opioid tolerance, and can fatally overdose upon re-exposure to even small amounts of certain drugs, especially in the first thirty days after returning to society. The overdose-related fatality rates among recently incarcerated individuals in Massachusetts illustrate this danger. The opioid-related overdose death rate is 120 times higher for people released from jails and prisons compared

[7] This is in contrast to the Massachusetts Department of Correction's stated policy of providing evidence based substance abuse programs and recognition of the importance of providing continuity of care for patients transitioning between programs. See Massachusetts Department of Corrections, Substance Abuse Programs Policy, 103 DOC 445, at § 445.02 (April 2018), Exhibit G.

to the rest of the adult population.[8] In 2015, nearly 50 percent of all deaths among those released from incarceration were opioid-related.[9] The vast majority of these deaths occurred within one month after release.[10]

23. Administration of MAT is both practicable and effective in correctional facilities, as illustrated by its implementation in jails and prisons throughout the country.[11]

24. At the Franklin County House of Corrections, my colleagues and I have successfully administered buprenorphine to inmates since 2016. In particular, the staff at Franklin County have implemented effective strategies to manage the risk of medication diversion. Buprenorphine and all controlled substances are stored in locked cabinets with controlled access. The supply is subject to a "count" with every shift change, along with needles, syringes and scalpels. To prevent patients from "cheeking" or diverting pills, inmates receive their medication in a crushed form, their mouths are inspected before and after administration, and they are required to eat a cracker and drink a glass of water after receiving their medication. Random urinalysis of the inmates population is conducted to ensure that only patients on MAT are receiving buprenorphine.

25. These same strategies can be used for both methadone and buprenorphine, and correctional facilities already have systems in place securing other controlled substances commonly prescribed to inmates, such as benzodiazepines and prescription opioids. Moreover, methadone is most frequently administered in a liquid or dispersible tablet form that deters diversion.

26. MAT has been successfully administered in numerous jurisdictions outside of Massachusetts. For several years, inmates suffering from opioid addiction in correctional facilities throughout Rhode Island and at Rikers Island in New York and King County, Washington have received methadone treatment. There is no evidence that the implementation of MAT at these facilities has been unmanageable or has presented significant security concerns.

---

[8] Massachusetts Department of Public Health, An Assessment of Fatal and Nonfatal Opioid Overdoses in Massachusetts (2011-2015), 50 (2017), available at https://www.mass.gov/files/documents/2017/08/31/legislativereport-chapter-55-aug-2017.pdf, Exhibit H.

[9] Id. at 51.

[10] Id. at 52.

[11] Joel Sprunger et al., Jail-Based Interventions to Reduce Risk for Opioid-Related Overdose Deaths: Examples of Implementation Within Ohio Counties Participating in the HEALing Communities Study, 12 Health & Just. 48 (2024). Lara Cates & Aaron R. Brown, Medications for Opioid Use Disorder During Incarceration and Post-Release Outcomes, 11 Health & Just. 4 (2023).

27. The administration of MAT is not cost-prohibitive. In particular, methadone can be administered for less than a dollar a day per patient. In my estimate, the cost of providing methadone treatment to a patient, particularly for an inmate serving a brief term of incarceration, is dwarfed in comparison to the cost of monitoring and caring for the patient during methadone detox.

28. Moreover, jails and prisons can offer inmates access to methadone without being independently licensed as an opioid treatment program (OTP) by the Federal Drug Enforcement Agency and the Massachusetts Department of Public Health. Instead, a correctional facility can contract with a local OTP to serve as the source of methadone for a jail or prison. There are two versions of this contract: one involves the OTP coming to the facility daily to administer the medicine, the other involves the facility picking up and dispensing the medicine at the facility themselves. The entire Rhode Island Department of Corrections has implemented this approach.

29. After the initial implementation of MAT in 2016, Franklin County saw a 35 percent drop in opioid overdose deaths between 2016 and 2017. We have also generally observed a decrease in behavioral problems and less illicit drug use among inmates. The number of recently incarcerated individuals who died from an overdose dropped from 26 in the first 6 months of 2016 to nine in the first 6 months of 2017.[12] More specifically, between those two study periods, the number of individuals to die from an overdose within the first 30 days after release from incarceration decreased from 10 to 1.[13] 12 These findings are consistent with observations from other studies conducted in other countries.[14]

30. In light of the demonstrated practicability and effectiveness of MAT in inmate populations, there are no reasoned grounds for correctional facilities to deny patients suffering from opioid addiction the same continuity of care provided to patients suffering from other medical conditions requiring medication.

31. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

---

[12] Id. at 405 tbl. I.; see also Joel Sprunger et al., Jail-Based Interventions to Reduce Risk for Opioid-Related Overdose Deaths: Examples of Implementation Within Ohio Counties Participating in the HEALing Communities Study, 12 Health & Just. 48 (2024). Lara Cates & Aaron R. Brown, Medications for Opioid Use Disorder During Incarceration and Post-Release Outcomes, 11 Health & Just. 4 (2023).

[13] Id.

[14] See, e.g. , John 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, I 12 Addiction 1408 (2017), Exhibit J.

Respectfully Submitted

_____

Ruth A. Potee, M.D.