COMMONWEALTH OF MASSACHUSETTS

SUPREME JUDICIAL COURT

FRANKLIN COUNTY NO. SJC-12486

COMMONWEALTH

V.

CAYLA PLASSE

BRIEF OF THE COMMITTEE FOR PUBLIC COUNSEL SERVICES, THE AMERICAN ACADEMY OF ADDICTION PSYCHIATRY, THE AMERICAN CIVIL LIBERTIES UNION OF MASSACHUSETTS, INC., THE ASSOCIATION FOR BEHAVIORAL HEALTHCARE, THE CENTER FOR PRISONER HEALTH AND HUMAN RIGHTS, THE CENTER FOR PUBLIC REPRESENTATION, THE GRAYKEN CENTER FOR ADDICTION MEDICINE AT BMC, THE MASSACHUSETTS ASSOCIATION OF CRIMINAL DEFENSE LAWYERS, THE MASSACHUSETTS SOCIETY OF ADDICTION MEDICINE, PRISONERS' LEGAL SERVICES AS AMICI CURIAE

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutory Provisions

Other Authorities

INTRODUCTION

Cayla Plasse was placed on probation for one year pursuant to a continuation without a finding of guilt for stealing five video games from Walmart. She was found in violation seven times for myriad issues, including positive drugs screens, leaving a treatment program, termination from sober houses, and absconding for thirteen months (Tr. 4-7). Throughout this period of probation, however, she lived in the community for three years without picking up any new criminal charges (Tr. 7).

At the final violation and revocation hearing, the judge imposed a sentence of two years in the house of correction — the maximum permissible under the statute for the underlying crime and more than either party recommended. In imposing the sentence, the judge stated:

> So, I am going to deviate from both recommendations. I'm going to do so not to punish her but to make sure that she gets through a program and is back out on the street safe and alive.

(Tr. 12). The judge thus made clear that he was increasing the term of incarceration for the sole purpose of "treatment" in a house of correction.

Although well-intended, this sentencing decision was unlawful. Judges have no authority to sentence an

offender to a term of incarceration solely for the offender's own welfare. To be sure, sentencing judges are well advised to inform the Sheriff's Office or Department of Correction of an offender's medical or treatment needs. But judges can only *recommend* treatment or placement in a particular correctional facility; they have no power to *require* or ensure that incarcerated offenders who need or might benefit from treatment will in fact receive it. It was thus improper for the judge in this case to increase the defendant's term of incarceration solely for the non-punitive purpose of making sure that she got through a treatment program over which the judicial branch has no control or authority.

Furthermore, in view of the reality of jail and prison life, sentencing an offender to *more* time in order to "help" her reflects a serious misapprehension of the risks that incarceration poses to an inmate's well-being, health, and safety. All jails and prisons are designed to punish, deter, and isolate offenders from society. Although medical and psychiatric treatment may be provided to inmates who are assessed in need, and rehabilitation programs may be available to inmates on a limited basis, jails and prisons are not the same as treatment facilities. To the contrary,

they pose serious risks to a person's emotional and physical well-being, and can actually hinder, rather than help, recovery and treatment.

This Court should therefore make clear that it is impermissible for a sentencing judge to increase an offender's term of incarceration solely for the purpose of seeking to ensure that the offender receives treatment while incarcerated.

ISSUE PRESENTED

Whether, or to what extent, a judge may consider an offender's rehabilitative needs, including factors associated with eligibility for a Department of Correction program, in determining the term of a sentence of incarceration.

INTERESTS OF AMICI

The **Committee for Public Counsel Services (CPCS)**, Massachusetts's public defender agency, is statutorily mandated to provide counsel to indigent persons in criminal proceedings. G.L. c.211D, §5. CPCS submits this brief as amicus curiae in order to assist in the resolution of the above question. It is in the interest of CPCS's clients, and the fair administration of justice, that CPCS's views be presented in order to contribute to this Court's full consideration of the important issue raised in this case.

The **American Academy of Addiction Psychiatry (AAAP)** is the professional membership organization for learning and sharing about the art and the science of Addiction Psychiatry research and clinical treatment. AAAP's mission is to promote evidence-based screening, assessment, and treatment for substance use disorders and co-occurring mental disorders and to translate and disseminate evidence-based research to clinical practice and public policy.

The American Civil Liberties Union of Massachusetts (ACLUM), an affiliate of the national ACLU, is a state-wide nonprofit membership organization dedicated to defending the principles of liberty and equality embodied in the constitutions and laws of the Commonwealth and the United States. Consistent with this mission, ACLUM is concerned about safeguarding the rights of defendants in the criminal justice system.

The **Association for Behavioral Healthcare (ABH)**, located in Needham, Massachusetts, is the leading statewide association with four decades of experience advancing, promoting and preserving community-based mental health and addiction services for individuals and families. ABH creates strategies that positively change public policy through legislative, budgetary and

regulatory advocacy. ABH identifies and impacts emerging issues relating to mental health and addiction treatment services.

The **Center for Prisoner Health and Human Rights** was established in 2005 to act as a hub for the innovative correctional health research and programming occurring at The Miriam Hospital and other research hospitals in RI and around the country. The Center's mission is to improve the health and human rights of justice-involved populations through education, advocacy, and research. Today, the Center's work falls into three core areas: 1) raising awareness at the national and state levels about the healthcare challenges of incarcerated and other justice-involved populations; 2) providing education and training opportunities for college, graduate, and medical students, and encouraging student engagement and leadership in justice issues; and 3) collaborating with local justice system stakeholders to identify and support projects that respond to the intersection of incarceration, recidivism, and public health in the State of Rhode Island.

The **Center for Public Representation (CPR)** is a public interest law firm with offices in Massachusetts and Washington, D.C. For more than 40 years, CPR has

been dedicated to enforcing and expanding the rights of people with disabilities, including those with substance use disorder. CPR uses legal strategies, advocacy, and policy to design and implement systemic reform initiatives to promote their integration and full community participation. Its attorneys have represented individuals with substance use disorder in individual cases in Massachusetts and in class actions in State and Federal courts.

The **Grayken Center for Addiction Medicine at Boston Medical Center (BMC)** strives to become the premier health institution transforming creative programs into groundbreaking clinical care innovations and prevention strategies, driving efforts to end the addiction crisis. The work builds on BMC's long history as one of the most comprehensive and influential treatment centers for addictions in the country, with tailored programs for the spectrum of types of patient and care settings.

The **Massachusetts Association of Criminal Defense Lawyers (MACDL)** is an incorporated association of more than 1,000 experienced trial and appellate lawyers who are members of the Massachusetts Bar and who devote a substantial part of their practices to criminal defense. MACDL is dedicated to protecting the rights

of the citizens of the Commonwealth guaranteed by the Massachusetts Declaration of Rights and the United States Constitution. MACDL seeks to improve the criminal justice system by supporting policies and procedures to ensure fairness and justice in criminal matters. MACDL devotes much of its energy to identifying, and attempting to avoid or correct, problems in the criminal justice system. It files amicus curiae briefs in cases raising questions of importance to the administration of justice.

The **Massachusetts Society of Addiction Medicine (MASAM)** is a statewide medical organization providing education, leadership, and support for physicians, trainees and allied health professionals in support of excellence in care of people with substance use disorders and of access to such care for all.

Prisoners' Legal Services (PLS) is a not-for-profit legal services corporation, founded in 1972, that provides civil legal assistance to people who are incarcerated in Massachusetts state prisons and in the county jails and houses of correction. PLS engages in administrative advocacy, litigation, and public education on behalf of prisoners and their families. PLS has represented individuals with substance use disorder in individual and class action litigation.

ARGUMENT

I. A judge has no authority - statutory or inherent - to impose a term of incarceration solely to "make sure that [an offender] gets through a program."

The judge in this case sentenced Cayla Plasse to the maximum term permissible under the applicable statute, see G.L. c.266, §30(1), as amended through St. 1995, c.297, §9, "not to punish her" but to "make sure" that she would remain behind bars long enough to "get through [a drug treatment] program" run by the Sherriff of Hampden County (Tr. 11-12). This reason is unsound. Judges have no authority to take away a person's liberty *for the purpose of treatment* absent due process protections, including an assessment by an expert.

The Legislature has addressed the circumstance of a drug-addicted individual who poses "a likelihood of serious harm as a result of . . . [an] alcohol or substance use disorder," and has established civil commitment procedures as a mechanism to detain such at-risk individuals for treatment. See G.L. c.123, §35. Confinement may not exceed ninety days and must be in "a facility designated by the [D]epartment of [P]ublic [H]ealth." Id. Males may be confined to a Department of Correction (DOC) facility, "provided, however, that any person so committed *shall be housed and treated*

separately from persons currently serving a criminal sentence." Id. (emphasis added). Women, however, may not be civilly committed to a DOC or jail facility. Id. Critically, an individual may only be detained for drug treatment after a judge has weighed expert testimony from a "qualified physician, a qualified psychologist or a qualified social worker" who has assessed the individual. Id.

Chapter 123A, which authorizes the civil commitment of sex offenders deemed sexually dangerous after completing a term of incarceration for the express purpose of "treatment and rehabilitation," similarly reflects a distinction between punishment and treatment, and the need to rely on expert opinions. The DOC "shall maintain" a designated "correctional institution for the care, custody, *treatment* and *rehabilitation* of persons adjudicated as being sexually dangerous." G.L. 123A, §2 (emphasis added). Notably, such an adjudication "must be based, at least in part, on credible qualified examiner opinion testimony." Green, petitioner, 475 Mass. 624, 625 (2016). Chapter 123A makes evident that a prison term pursuant to a sex offense conviction is punishment for the crime, while civil commitment to a DOC treatment facility pursuant

to G.L. c.123A is intended to rehabilitate. No statute authorizes a judge to order a criminal defendant to jail or prison without an evaluation by a clinical expert for the purpose of treating a substance use disorder (SUD).[1/]

This makes sense. Sentencing judges have no power to insist that an inmate receive or participate in any particular jail or prison program. "Once a sentence is imposed, the executive branch holds the power and responsibility of executing it." Commonwealth v. Cole, 468 Mass. 294, 302 (2014). Although a sentencing judge "can *recommend*" that an offender be placed "in a particular facility or program," Tapia v. United States, 564 U.S. 319, 331 (2011) (emphasis in original), "the place of actual confinement is a matter for the executive branch, subject to the conditions imposed by the Legislature." Sheriff of Middlesex

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[1/]Standards to address substance misuse and addiction, developed by this Court in collaboration with the Trial Court, state that "[c]ourt-ordered treatment should match the party's treatment needs and should be selected on the basis of *expert information about what type of treatment will work best* for the party, with full consideration of public safety." Supreme Judicial Court Standing Committee on Substance Abuse, Standards on Substance Abuse, Standard IX (Apr. 28, 1998) (Standards on Substance Abuse) (emphasis added). The judge in this case did not rely on expert testimony in determining that jail was the type of treatment that would work best for Plasse.

County v. Commissioner of Correction, 383 Mass. 631, 636 (1981). See Commonwealth v. Donohue, 452 Mass. 256, 264 (2008) ("[O]nce a judge has sentenced a defendant, authority over the defendant passes from the judicial branch to the executive branch of government in that the defendant becomes subject to the sheriff's control").

A judge also has no power or control over what programming, if any, a sentenced prisoner may be afforded, as the Legislature has vested the executive branch with the exclusive authority to make such decisions. See G.L. c.124, §1(g) (with respect to prisoners in state custody, the Commissioner of Correction "shall . . . determine at the time of commitment, and from time to time thereafter, the custody requirements and program needs of each person committed to the custody of the department and assign or transfer such persons to appropriate facilities and programs").[2/] See also Ladetto v. Commissioner of Correction, 7 Mass. App. Ct. 1, 1-2 (1979) (judge has no authority to order transfer of defendant from prison

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[2/]Effective January 13, 2019, the statute will require that DOC determine inmates' programming needs "after consultation with the parole board." G.L. 124, §1(g), as amended by St. 2018, c.72, §4. If the Legislature had intended to require that such needs be determined in consultation with sentencing judges, it would have said so.

"to the drug addiction center at [MCI-Bridgewater] for treatment of his drug dependency"). Although Standard X of the Standards on Substance Abuse encourages judges "to recommend a particular treatment program or a particular institution on the mittimus," nothing in the standard suggests that a judge should impose or lengthen a sentence *for the purpose of treatment*; nor could it lawfully do so. Yet that is exactly what the judge did here.

Although otherwise lawful, this sentence — the maximum allowed for the underlying offense — must be vacated because it was imposed for an unlawful reason. See, e.g., Commonwealth v. Henriquez, 440 Mass. 1015, 1015-1016 (2003); Commonwealth v. Coleman, 390 Mass. 797, 798 (1984); Commonwealth v. Sitko, 372 Mass. 305, 313-314 (1977); Commonwealth v. LeBlanc, 370 Mass. 217, 224-225 (1976); Commonwealth v. White, 48 Mass. App. Ct. 658, 663-664 (2000); Commonwealth v. Howard, 42 Mass. App. Ct. 322, 326-327 (1997); Commonwealth v. Lewis, 41 Mass. App. Ct. 910, 910-911 (1996) (all involving sentences imposed for impermissible reasons).

II. Lengthening a term of incarceration solely to provide an offender treatment violates evidence-based best sentencing practices.

Plasse was sentenced to two years in the house of correction for stealing five video games from Walmart. See Commonwealth v. Eldred, 480 Mass. 90, 100-101 (2018) ("disposition of probation does not punish act prompting probation violation proceedings, and arises from 'underlying offense for which a probationary sentence originally was imposed'"),[3/] quoting Commonwealth v. Odoardi, 397 Mass. 28, 30 (1986). Imposing the maximum term of incarceration for the purpose of jail treatment violates best sentencing practices.

The Superior Court's "Working Group on Sentencing Best Practices" sets forth seventeen principles of sentencing. See Criminal Sentencing in the Superior Court: Best Practices for Individualized Evidence-Based

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[3/]Unlike this case, where Plasse was sentenced to two years in a house of correction after a probation revocation hearing, Eldred addressed a judge's authority to detain an individual pending a revocation hearing. Within that context, this Court "conclude[d] that the judge did not abuse her discretion in modifying the defendant's probation to require inpatient treatment," holding "that it was permissible. . . to detain the defendant until an inpatient bed was available." 480 Mass. 90, 104. Eldred did not address a judge's authority to increase a defendant's sentence for the express purpose of treatment in a jail or prison.

Sentencing, 1-3 (2016) (Best Practices).[4/] The second of these principles requires the judge to:

> i. impose a sentence that is *proportionate to the gravity of the offense* or offenses, the harms done to crime victims, and the blameworthiness of offenders;
>
> *ii.* *when reasonably feasible*, impose a sentence that seeks to achieve offender rehabilitation, general deterrence, incapacitation of dangerous offenders, restoration of crime victims and communities, and reintegration of offenders into the law-abiding community, *provided these goals are pursued within the boundaries of proportionality* in section (i) above; and,
>
> iii. render a sentence that is *no more severe* than necessary to achieve the applicable purposes of sections (i) and (ii) above.

Id. at 1 (emphasis added). Imposing a longer term of incarceration for the purpose of "treatment" rendered Plasse's sentence disproportional to the gravity of the

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[4/]Available at https://www.mass.gov/files/documents/2018/01/08/CRIMINAL%20SENTENCING%20IN%20THE%20SUPERIOR%20COURT%203.17.pdf. At the prompting of Chief Justice Gants, working groups organized by the Trial Court began in December 2014 to "collect[] and evaluate[] data and information relating to effective approaches to criminal sentencing." Best Practices at i. District Court sentencing is guided by similar principles, which are based on the Superior Court's Best Practices. Boston Municipal Court and District Court Sentencing Best Practice Principles 1 n.1 (2016). Available at https://www.mass.gov/files/documents/2016/08/pg/dc-bmc-sentencing-best-pratices.pdf

offense, in violation of best practices.[5/]

The Best Practices further make clear that the goal of incarceration is to "reflect society's condemnation" or "incapacitate" the offender. Id. at 7. As a result, in cases in which it is appropriate to incarcerate the offender, factors regarding the offender's background, including his or her "substance use history," are not pertinent because the "purpose of sentencing" in such cases "does not include efforts at rehabilitation." Id. at 7-8. While the probation department should "perform an assessment relating to the criminogenic needs to be addressed" when "a judge is contemplating a term of *probation*," the judge "should not use . . . [that] assessment . . . to determine the length of any incarcerated portion of the *sentence*." Id. at 2 (emphasis added).

Moreover, the National Association of Drug Court Professionals, Adult Drug Court Best Practice

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[5/]The Supreme Court noted in Tapia that indeterminate federal sentencing premised on a "faith in rehabilitation" led to "great variation among sentences imposed by different judges upon similarly situated offenders." 564 U.S. at 324, quoting Mistretta v. United States, 488 U.S. 361, 365 (1989). The same risk of sentencing disparity exists here: Plasse would not have been sentenced to two years in jail if she had committed larceny in a part of the state where the "Howard Street" option did not exist.

Standards, Volume I (2013),[6] advises that incarceration should not be used "to achieve clinical or social service objectives such as obtaining access to detoxification services or sober living quarters." Id. at 38. Research indicates that "jail sanctions produce diminishing returns after approximately three to five days," and that "sanctions of longer than one week were associated with increased recidivism and negative cost-benefits." Id. at 33. While placing individuals "in custody might be appropriate to protect public safety or to punish willful infractions such as intentionally failing to attend treatment sessions . . . in-custody treatment will rarely serve the goals of treatment effectiveness or cost-effectiveness." Id. at 41.

III. Jails and prisons do not provide adequate treatment for SUD and frequently make it worse.

In 2016, the Commonwealth articulated its view that incarceration is antithetical to addiction recovery when it prohibited sending women to MCI-Framingham for civil commitments.[7] Applauding the bill, Governor Baker announced that "women with substance use disorder who are civilly committed . . .

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[6] Available at http://www.nadcp.org/wp-content/uploads/2018/03/Best-Practice-Standards-Vol.-I.pdf.

[7] See G.L. c.123, §35, as amended by St. 2016, c.8, §4.

will have the opportunity to get treatment instead of jail time." "We need to treat substance abuse like the disease it is," then-Senate President Stan Rosenberg said, "and provide access to treatment in an appropriate setting so these women have an opportunity to get on a path to recovery." "Governor Baker Signs Legislation Ending Civil Commitments at MCI-Framingham for Substance Use Disorder" (Jan. 25, 2016).[8/] These comments reflect the reality that incarceration will not solve the addiction crisis because jails and prisons are fundamentally flawed for such a purpose.

A. Treatment for the medical disorder SUD requires individualized treatment planning and evidence-based therapies, which jails and prisons either do not provide or provide inadequately.

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)[9/] characterizes SUD as "an underlying change in brain circuits" leading to "a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related

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[8/]Available at http://www.mass.gov/governor/press-office/press-releases/fy2016/bill-signed-ending-civil-commitment-at-mci-framingham.html.

[9/]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.

problems." Id. at 483.[10/] Triggered by biological, environmental and genetic risk factors, addiction "is considered a brain disorder, because it involves functional changes to brain circuits involved in reward, stress, and self-control, and those changes may last a long time after a person has stopped taking drugs." NIDA, Drugs Brains, and Behavior: The Science of Addiction 4 (2018) (NIDA).[11/] When a person is addicted, the dopamine neurotransmitter system is critically damaged (Add. 4 [Affidavit of Ruth A. Potee, M.D. ¶9]).[12/] Recovery is a process of repairing the broken dopamine system with evidence-based behavioral

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[10/]"For purposes of [the Standards on Substance Abuse], substance abuse is defined as chronic or habitual ingestion of drugs or alcohol to the extent that (i) such use substantially injures a person's health or substantially interferes with his or her social or economic functioning, or (ii) a person has lost the power of self-control over the use of drugs or alcohol. It is a chronic, relapsing disorder requiring ongoing rather than episodic intervention. It is predictable, progressive, symptomatic, and treatable." Standards on Substance Abuse, Introduction.

[11/]Available at https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/soa.pdf.

[12/]Dr. Potee is an addiction specialist, Medical Director of the Franklin County House of Correction, and Medical Director of the Franklin Recovery Center (Add. 1-2 [Potee Aff. ¶1, ¶4]). She has been a speaker on the topic of addiction at multiple training conferences for judges, lawyers, correctional staff, drug court staff, students, teachers, and community members. Id. at ¶1.

therapies and medications, as well as a range of positive experiences, such as building healthy relationships, exercise, work, school, and developing a sense of purpose and accountability (Add. 6 [Potee Aff. ¶14]).

Components of comprehensive addiction treatment include individual counseling, evidence-based behavioral therapies, case management, mutual peer support, and medication (Add. 6-7 [Potee Aff. ¶15]). Effective treatment for SUD is not one-size-fits-all and may require trying multiple clinical modalities and systems of support before finding what works best for the individual. Treatment "should be person-centered and include strength-based approaches, or ones that draw upon an individual's strengths, resources, potential, and ability to recover." U.S. Department of Health and Human Services, Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health 4-16 (2016).[13/] An individual's "age, gender identity, race and ethnicity, language, health literacy, religion/ spirituality, sexual orientation, culture, trauma

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[13/]Available at https://addiction.surgeongeneral.gov/sites/default/files/chapter-4-treatment.pdf.

history, and co-occurring physical and mental health problems" should be considered in tailoring an appropriate treatment plan. Id. Because no single treatment approach helps everyone, "effective matching to individual needs such as vocational or employment skills, family counseling, and mental health services improves the likelihood that [an individual] will successfully complete treatment" and sustain recovery. Substance Abuse and Mental Health Services Administration, Substance Abuse Treatment for Adults in the Criminal Justice System: A Treatment Improvement Protocol (TIP 44), 43 (2005) (SAMSHA TIP).[14/]

Individualized, evidence-based treatment is effectively foreclosed by the many constraints of the correctional environment. Of the 1.5 million inmates who met clinical diagnostic criteria for a substance use disorder in 2006, only 11.2 percent had received any type of professional treatment since admission, with few receiving evidence-based services. Behind Bars II: Substance Abuse and America's Prison Population, The National Center on Addiction and Substance Abuse at Columbia University 40 (2010) (CASA

[14/]Available at https://store.samhsa.gov/shin/content/SMA13-4056/SMA13-4056.pdf.

Report).[15] The availability of trained staff knowledgeable in SUD is also limited. Id. at 43. Most correctional facilities that offer addiction-related services tend to provide "alcohol and other drug education or low-intensive outpatient counseling sessions rather than evidence-based, intensive treatment" that is grounded in research. Id. The existence of a treatment unit does not "necessarily mean that quality care is offered." Id. at 48. See Add. 37 [Affidavit of Michael Cox ¶14])[16] (the DOC's Correctional Recovery Academy "consists of classes in which inmates watch movies about addiction, fill out worksheets, and have superficial conversations" and no "one-on-one therapy").[17]

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[15]Available at https://www.centeronaddiction.org/addiction-research/reports/behind-bars-ii-substance-abuse-and-america's-prison-population.

[16]Mr. Cox was incarcerated from 2007 to 2012 in the Department of Correction after being convicted of mayhem when he was 22 years old (Add. 33 [Cox Aff. ¶1]).

[17]A sizable percentage of Massachusetts state prisoners are unable to access even this type of psychoeducation programming. In 2016, 41% of the inmates whom the Department of Correction determined in need of substance use programming were unable to access it. Department of Correction, Gap Analysis Report 3 (2016). Available at https://www.mass.gov/files/documents/2017/10/16/fy16_gap_analysis_report.pdf. See id. at 2 (defining "gap" as percentage of offenders who did not

(FOOTNOTE CONTINUED ON NEXT PAGE)

At the same time, pharmacological treatments for SUD (often referred to as medication-assisted treatment, or MAT) remain mostly prohibited in Massachusetts jails and prisons (Add. 8 [Potee Aff. ¶18]). This is despite medical consensus that MAT is the standard of care for opioid use disorder, and the research showing that it effectively prevents opioid withdrawal, decreases cravings, and allows the individual to stabilize and function normally. Bruce & Schleifer, Ethical and Human Rights Imperatives to Ensure Medication-Assisted Treatment for Opioid Dependence in Prisons and Pre-trial Detention, 19 International J. Drug Policy 17, 18 (2008). See NIDA at 24 ("Research shows that when treating addictions to opioids . . . medications should be the first line of treatment, usually combined with some form of behavioral therapy

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17/ (FOOTNOTE CONTINUED FROM PREVIOUS PAGE) complete or participate in corresponding core programming to a need area prior to their release"). Of the inmates assessed in need of the CRA, 43% completed the program, 16% terminated before completion, 17% released without being housed in a prison that offered CRA programing, 9% refused to participate, 1% were on a waitlist, and 4% were deemed ineligible. The gaps for Criminal Thinking and Violence Reduction programs were even worse - a shocking 60% and 54%, respectively. Id. See also Add. 37 (Cox Aff. ¶13) (describing long waitlists and limiting opportunities for programming).

or counseling").[18] Although new legislation enacting a program to include MAT in four DOC facilities and a pilot program to include MAT in five counties is an important step forward, see St. 2018, c.208, §§78 and 98, this will address the needs of only a minority of those who are incarcerated.

Finally, integrated services are essential when treating SUD and a co-occurring disorder (e.g., post-traumatic stress disorder), and yet co-occurring disorders are commonly left undiagnosed and untreated while incarcerated. Peters, Wexler & Lurigio, Co-Occurring Substance Use and Mental Disorders in the Criminal Justice System: A Frontier of Clinical Practice and Research, 38 Psychiatric Rehabilitation Journal 1, 2-3 (2015).[19] The majority of substance-addicted offenders have survived physical abuse, sexual abuse, or community violence, yet, "trauma is

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[18]Although the criminal justice system cannot solve the opioid crisis, authorizing MAT in jails and prisons is a health imperative. Allowing the continuation of MAT during incarceration increases the continuation of MAT after release, which in turn decreases the risk of relapse into active addiction. See Rich, et al., Methadone Continuation Versus Forced Withdrawal on Incarceration in a Combined US Prison and Jail: A Randomised Open-Label Trial, 386 Lancet 350, 358 (2015) (copy on file with counsel).

[19]Available at https://www.apa.org/pubs/journals/features/prj-0000135.pdf.

unrecognized, untreated, and exacerbated" in jails and prisons (Add. 7 & 9 [Potee Aff. ¶16, ¶21]). See also Add. 28 (Affidavit of Patricia M. Stacy, MSW, LICSW ¶18).[20/] Research indicates that only one-half of prison inmates and one-third of jail inmates who have a SUD and a co-occurring mental disorder receive treatment to address the co-occurring disorder as part of their addiction-related services. CASA Report at 49.

B. The correctional environment is antithetical to wellness and recovery, and places individuals with SUD at high risk.

Jails and prisons are constructed and administered to punish and deter offenders while housing them away from society. Thus, the "overriding concern" of the correctional setting is "security, not rehabilitation" (Add. 27 [Stacy Aff. ¶12]). "Security staff is focused on maintaining order and must assume each inmate is potentially violent." Miller & Najavits, Creating Trauma-Informed Correctional Care: A Balance of Goals and Environment, 3 European J. of Psychotraumatology 1,

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[20/]Ms. Stacy worked as a mental health clinician in the Department of Correction at Souza-Baranowski Correctional Center from 2012 to 2015 (Add. 23 [Stacy Aff. 1]).

1 (2012) (Miller & Najavits).[21] To achieve the primary goal of security, "[c]orrectional staff receive paramilitary training in combat techniques" (Add. 27 [Stacy Aff. ¶12]). Inmates are routinely subjected to restricted movement and discipline from staff, as well as degrading strip searches. Miller & Najavits at 1. See Add. 33 (Cox Aff. ¶ 3]) ("Like all inmates, I was regularly forced to remove all of my clothing to expose my genitals and body cavities"). The result is a "culture of 'us versus them'" between inmates and staff, which in turn creates "a toxic environment that is especially detrimental to health outcomes and recovery from addiction" (Add. 27 [Stacy Aff. ¶12]).

Instead of a health-promoting environment conducive to engaging in treatment and repairing the broken dopamine system, deprivation is a salient feature of jail and prison life. Access to basic human needs such as exercise, daylight, and good nutrition are restricted (Add. 10 [Potee Aff. ¶23]). See also Add. 36 (Cox Aff. ¶9). Security staff control when inmates are permitted movement out of their cells or dormitories (Add. 10 [Potee Aff. ¶23]). "Positive

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[21]Available at https://doi.org/10.3402/ejpt.v3i0.17246

relationships with family, friends, and children are disrupted and sometimes damaged beyond repair." Id. There is limited opportunity for meaningful work, vocational training, or education (Add. 37 [Cox Aff. ¶13]). See CASA Report at 5 ("While critical to recovery and reduced recidivism, the percentage of inmates participating in education and job training services declined between 1996 and 2006. . . . The participation rate among state inmates . . . declined from 57 percent in 1996 to 45 percent in 2006").

Inmates are forced to manage "anxiety, fear, depression, boredom, and alienation" - all of which can trigger relapse and ongoing substance use (Add. 26 [Stacy Aff. ¶9]). Men's correctional facilities are dominated by a "very rigid culture[] that rewards extreme masculinity and aggression. . . ." National Prison Rape Elimination Commission Report 73 (2009) (PREA). "Violence is a pervasive feature of prison life ... [as men] are aggregated and confined in close and frequently overcrowded quarters characterized by material and social deprivation." Wolff et al., Physical Violence Inside Prisons: Rates of Victimization, 34 Criminal Justice and Behavior 588,

588 (2007).[22/] The hostile and oftentimes dangerous environment requires inmates to rely on survival instincts to manage the complexities of relationships with other inmates and correctional staff, which severely hinders recovery (Add. 34 [Cox Aff. ¶4]).

The danger of sexual assault increases exponentially upon entering prison. Miller & Najavits at 3. See PREA at 3 ("Too often, in what should be secure environments, men, women, and children are raped or abused by other incarcerated individuals and corrections staff"). One former Massachusetts prisoner, who was raped at NCCI-Gardner by three inmates, describes the struggle to manage safety while incarcerated:

> Over the course of five and one-half years in prison, I was regularly confronted with three challenges: (1) aggressive inmates wanting to fight me; (2) lustful inmates soliciting sex; and (3) aggressive COs humiliating me. . . .
>
> I was constantly worried about having enough food to eat, protecting my body, and protecting my mind.

(Add. 34 & 38 [Cox Aff. ¶4, ¶18]). This baseline experience of feeling unsafe makes the correctional environment detrimental to the recovery process, because, as with all medical disorders, "[f]eeling safe

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[22/]Copy of article on file with counsel.

is critical to SUD treatment" (Add. 9 [Potee Aff. ¶20]).

Incarcerated women also face conditions that obstruct their path to recovery. Female inmates who struggle with SUD are frequently the survivors of childhood traumatization, sexual abuse, or sex work. Moloney, van den Bergh & Moller, Women In Prison: The Central Issues of Gender Characteristics and Trauma History, 123 Public Health 426, 427 (2009) (Moloney).[23/] See CASA Report at 47 ("[W]omen with a history of abuse are three times likelier than other women to have an alcohol use disorder during their lifetime and four times likelier to have a drug use disorder"). In addition to SUD, these women commonly struggle with other serious health problems that are inadequately treated and exacerbated by imprisonment, including thoughts of suicide, eating and other mental disorders, gynecological problems, sexually transmitted diseases, and hepatitis.[24/] Moloney at 428. Women with a prior history of sexual assault or domestic violence are at higher risk of being sexually abused while detained and

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[23/]Copy of article on file with counsel.

[24/]"A substantial percentage of those under criminal justice supervision have one or more co-occurring mental disorders in addition to their substance use disorder." SAMSHA TIP at 22.

are more likely to be retraumatized by commonplace prison procedures, such as pat searching. Id. When revictimization occurs in a jail or prison, a woman has no redress, which compounds trauma. Id. at 429. This, in turn, creates a further barrier to recovery.

Finally, it is worth noting that the Best Practices warn that "rather than reducing crime, subjecting low-level offenders to periods of incarceration may actually lead to an increase in crime based on the prisoner's adoption of criminogenic attitudes and values while incarcerated, and based on the legal barriers and social stigma encountered after release." Id. at v-vi, citing Spohn & Holleran, The Effect of Imprisonment on Recidivism Rates of Felony Offenders: A Focus on Drug Offenders, 40 Criminology 329, 347 fig.1 (2002). Indeed, "[c]lose associations with more severely affected offenders can result in the less-severe offender becoming socialized into a criminal and drug-oriented lifestyle through contagion of attitudes and introduction to a criminal social network." SAMSHA TIP at 60. Increasing the likelihood of criminogenic thinking and associations is not only detrimental to SUD recovery, it is the exact opposite goal of our criminal justice system.

CONCLUSION

For the above-stated reasons, the Court should make clear that it is impermissible for a sentencing judge to incarcerate an offender solely for the purpose of providing him or her treatment.

Respectfully submitted,

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August, 2018.

CERTIFICATE OF COMPLIANCE

I, the undersigned counsel for Amici Curiae, hereby certify that the foregoing brief complies with the rules of court that pertain to the filing of briefs, including, but not limited to Mass.R.A.P. 16(a)(6) (pertinent findings or memorandum of decision); Mass.R.A.P. (16)(e) (references to the record); Mass.R.A.P. 16(f) (reproduction of statutes, rules, regulations); Mass.R.A.P. 16(h) (length of briefs); Mass.R.A.P. 18 (appendix to the briefs); and Mass.R.A.P. 20 (forms of briefs, appendices, and other papers).

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ADDENDUM

Statutory Provisions Cited

G.L. c.123, §35

For the purposes of this section the following terms shall, unless the context clearly requires otherwise, have the following meanings:

> "Alcohol use disorder", the chronic or habitual consumption of alcoholic beverages by a person to the extent that (1) such use substantially injures the person's health or substantially interferes with the person's social or economic functioning, or (2) the person has lost the power of self-control over the use of such beverages.
>
> "Facility", a public or private facility that provides care and treatment for a person with an alcohol or substance use disorder.
>
> "Substance use disorder", the chronic or habitual consumption or ingestion of controlled substances or intentional inhalation of toxic vapors by a person to the extent that: (i) such use substantially injures the person's health or substantially interferes with the person's social or economic functioning; or (ii) the person has lost the power of self-control over the use of such controlled substances or toxic vapors.

Any police officer, physician, spouse, blood relative, guardian or court official may petition in writing any district court or any division of the juvenile court department for an order of commitment of a person whom he has reason to believe has an alcohol or substance use disorder. Upon receipt of a petition for an order of commitment of a person and any sworn statements the court may request from the petitioner, the court shall immediately schedule a hearing on the petition and shall cause a summons and a copy of the application to be served upon the person in the manner provided by section twenty-five of chapter two hundred and seventy-six. In the event of the person's failure

to appear at the time summoned, the court may issue a warrant for the person's arrest. Upon presentation of such a petition, if there are reasonable grounds to believe that such person will not appear and that any further delay in the proceedings would present an immediate danger to the physical well-being of the respondent, said court may issue a warrant for the apprehension and appearance of such person before it. If such person is not immediately presented before a judge of the district court, the warrant shall continue day after day for up to 5 consecutive days, excluding Saturdays, Sundays and legal holidays, or until such time as the person is presented to the court, whichever is sooner; provided, however that an arrest on such warrant shall not be made unless the person may be presented immediately before a judge of the district court. The person shall have the right to be represented by legal counsel and may present independent expert or other testimony. If the court finds the person indigent, it shall immediately appoint counsel. The court shall order examination by a qualified physician, a qualified psychologist or a qualified social worker.

If, after a hearing which shall include expert testimony and may include other evidence, the court finds that such person is an individual with an alcohol or substance use disorder and there is a likelihood of serious harm as a result of the person's alcohol or substance use disorder, the court may order such person to be committed for a period not to exceed 90 days to a facility designated by the department of public health, followed by the availability of case management services provided by the department of public health for up to 1 year; provided, that a review of the necessity of the commitment shall take place by the superintendent on days 30, 45, 60 and 75 as long as the commitment continues. A person so committed may be released prior to the expiration of the period of commitment upon written determination by the superintendent of the facility that release of that person will not result in a likelihood of serious harm. Such commitment shall be for the purpose of inpatient care for the treatment of an alcohol or substance use disorder in a facility licensed or approved by the department of public health or the department of mental health. Subsequent to the issuance of a commitment order, the superintendent of a facility may authorize

the transfer of a patient to a different facility for continuing treatment; provided, that the superintendent shall provide notification of the transfer to the committing court. If the department of public health informs the court that there are no suitable facilities available for treatment licensed or approved by the department of public health or the department of mental health, or if the court makes a specific finding that the only appropriate setting for treatment for the person is a secure facility, then the person may be committed to: (i) a secure facility for women approved by the department of public health or the department of mental health, if a female; or (ii) the Massachusetts correctional institution at Bridgewater or other such facility as designated by the commissioner of correction, if a male; provided, however, that any person so committed shall be housed and treated separately from persons currently serving a criminal sentence. The person shall, upon release, be encouraged to consent to further treatment and shall be allowed voluntarily to remain in the facility for such purpose. The department of public health shall maintain a roster of public and private facilities available, together with the number of beds currently available and the level of security at each facility, for the care and treatment of alcohol use disorder and substance use disorder and shall make the roster available to the trial court.

Annually, not later than February 1, the commissioner shall report on whether a facility other than the Massachusetts correctional institution at Bridgewater is being used for treatment of males under the previous paragraph and the number of persons so committed to such a facility in the previous year. The report shall be provided to the clerks of the senate and house of representatives, the chairs of the joint committee on public safety and homeland security and the chairs of the joint committee on the judiciary.

Nothing in this section shall preclude a facility, including the Massachusetts correctional institution at Bridgewater or such other facility as may be designated by the commissioner of correction, from treating persons on a voluntary basis.

The court, in its order, shall specify whether such commitment is based upon a finding that the person

is a person with an alcohol use disorder, substance use disorder, or both. The court, upon ordering the commitment of a person found to be a person with an alcohol use disorder or substance use disorder pursuant to this section, shall transmit the person's name and nonclinical identifying information, including the person's social security number and date of birth, to the department of criminal justice information services. The court shall notify the person that such person is prohibited from being issued a firearm identification card pursuant to section 129B of chapter 140 or a license to carry pursuant to sections 131 and 131F of said chapter 140 unless a petition for relief pursuant to this section is subsequently granted.

After 5 years from the date of commitment, a person found to be a person with an alcohol use disorder or substance use disorder and committed pursuant to this section may file a petition for relief with the court that ordered the commitment requesting that the court restore the person's ability to possess a firearm, rifle or shotgun. The court may grant the relief sought in accordance with the principles of due process if the circumstances regarding the person's disqualifying condition and the person's record and reputation are determined to be such that: (i) the person is not likely to act in a manner that is dangerous to public safety; and (ii) the granting of relief would not be contrary to the public interest. In making the determination, the court may consider evidence from a licensed physician or clinical psychologist that the person is no longer suffering from the disease or condition that caused the disability or that the disease or condition has been successfully treated for a period of 3 consecutive years.

If the court grants a petition for relief pursuant to this section, the clerk shall provide notice immediately by forwarding a certified copy of the order for relief to the department of criminal justice information services, who shall transmit the order, pursuant to paragraph (h) of section 167A of chapter 6, to the attorney general of the United States to be included in the National Instant Criminal Background Check System.

A person whose petition for relief is denied may

appeal to the appellate division of the district court for a de novo review of the denial.

G.L. c.123A, §2

The commissioner of correction shall maintain subject to the jurisdiction of the department of correction a treatment program or branch thereof at a correctional institution for the care, custody, treatment and rehabilitation of persons adjudicated as being sexually dangerous. Said facility shall be known as the "Nemansket Correctional Center". The commissioner of correction shall appoint a chief administrative officer who shall have responsibility for providing personnel with respect to the treatment and rehabilitation of the sexually dangerous persons, consistent with public safety. The commissioner of correction shall have the authority to promulgate regulations consistent with the provisions of this chapter.

G.L. c.124, §1(g) Effective until January 13, 2019

In addition to exercising the powers and performing the duties which are otherwise given him by law, the commissioner of correction, in this chapter called the commissioner, shall:

(g) determine at the time of commitment, and from time to time thereafter, the custody requirements and program needs of each person committed to the custody of the department and assign or transfer such persons to appropriate facilities and programs;

G.L. c.124, §1(g) Effective January 13, 2019

In addition to exercising the powers and performing the duties which are otherwise given him by law, the commissioner of correction, in this chapter called the commissioner, shall:

(g) determine at the time of commitment, and from time to time thereafter, the custody requirements and, after consultation with the parole board, program needs of each person committed to the custody of the department and assign or transfer such persons to appropriate facilities and programs;

G.L. c.266, §30(1),
as amended through St. 1995, c.297, §9

Whoever steals, or with intent to defraud obtains by a false pretence, or whoever unlawfully, and with intent to steal or embezzle, converts, or secretes with intent to convert, the property of another as defined in this section, whether such property is or is not in his possession at the time of such conversion or secreting, shall be guilty of larceny, and shall, if the property stolen is a firearm, as defined in section one hundred and twenty-one of chapter one hundred and forty, or, if the value of the property stolen exceeds $1,200, be punished by imprisonment in the state prison for not more than five years, or by a fine of not more than twenty-five thousand dollars and imprisonment in jail for not more than two years; or, if the value of the property stolen, other than a firearm as so defined, does not exceed $1,200, shall be punished by imprisonment in jail for not more than one year or by a fine of not more than $1,500.

Session Laws, Acts (2018)

CHAPTER 208

An Act for prevention and access to appropriate care and treatment of addiction

SECTION 78. Said chapter 127 is hereby further amended by inserting after section 17A the following 3 sections:-

Section 17B. The commissioner, in consultation with the commissioner of public health, shall offer medication-assisted treatment for opioid use disorder to a state detainee or prisoner at the Massachusetts alcohol and substance abuse center, the Massachusetts correctional institution at Framingham or the South Middlesex correctional center, upon the recommendation of a qualified addiction specialist. The medication-assisted treatment program shall not be required to be administered in any other state correctional facility; provided, however, that the commissioner shall, upon the recommendation of a qualified addiction specialist, offer medication-assisted treatment at the Massachusetts correctional institution at Cedar Junction to: (i) a state detainee or prisoner, including a state detainee or prisoner who was

receiving opioid agonist or partial agonist treatment immediately preceding incarceration, during the first 90 days during which such state detainee or prisoner is serving a sentence, as part of a medically managed detoxification which shall comply with the federal Substance Abuse and Mental Health Services Administration's treatment improvement protocols for detoxification; and (ii) a state detainee or prisoner during the last 90 days during which such state detainee or prisoner is serving a sentence, pursuant to a re-entry treatment plan under section 17C. The Massachusetts alcohol and substance abuse center, the Massachusetts correctional institution at Framingham, the South Middlesex correctional center and the Massachusetts correctional institution at Cedar Junction shall maintain or provide for the capacity to possess, dispense and administer all drugs approved by the federal Food and Drug Administration for use in medication-assisted treatment for opioid use disorder; provided however, that such facilities shall not be required to maintain or provide a drug that is not also a MassHealth covered benefit.

The commissioner shall ensure that each state detainee or prisoner at the Massachusetts alcohol and substance abuse center, the Massachusetts correctional institution at Framingham and the South Middlesex correctional center who is receiving medication-assisted treatment for opioid use disorder, including immediately preceding incarceration or commitment, continues to have such treatment available unless such person voluntarily discontinues the treatment or unless a qualified addiction specialist determines that treatment is no longer medically necessary.

Such facilities shall ensure access to a qualified addiction specialist by a state detainee or prisoner.

Treatment established under this section shall include behavioral health counseling for individuals diagnosed with opioid use disorder; provided, however, that counseling services shall be consistent with current therapeutic standards for these therapies in a community setting.

No incentives, rewards or punishments shall be used to encourage or discourage a state detainee's or prisoner's decision to receive medication-assisted

treatment.

Section 17C. The commissioner shall ensure that, not later than 120 days prior to the expected discharge date of a state detainee or prisoner serving a sentence to a state prison, a state detainee or prisoner shall have access to a qualified addiction specialist who shall conduct an assessment of the state detainee or prisoner. Upon a determination by the qualified addiction specialist that the state detainee or prisoner requires treatment for opioid use disorder, the qualified addiction specialist shall establish a medically appropriate re-entry treatment plan for the state detainee or prisoner, which may include, but shall not be limited to, medication-assisted treatment during the final 90 days of incarceration; provided, however, that if medication-assisted treatment is included in a re-entry treatment plan, such treatment plan shall be provided to the state detainee or prisoner at a facility included in section 17B. A re-entry treatment plan may include any treatment upon discharge that the qualified addiction specialist shall recommend and deem appropriate, which may include, but shall not be limited to, all drugs approved by the federal Food and Drug Administration for use in medication-assisted treatment for opioid use disorder. A re-entry treatment plan shall ensure that a state detainee or prisoner is directly connected to an appropriate provider or treatment site in the geographic region to which the state detainee or prisoner shall reside upon release. The commissioner shall further ensure that, for a state detainee or prisoner with a re-entry treatment plan under this section, the facility shall request reinstatement or apply for MassHealth benefits for the state detainee or prisoner at least 30 days prior to release.

The re-entry treatment plan shall be forwarded to the parole board and may be incorporated into any treatment plan included within the terms and conditions of parole.

Section 17D.(a) Annually, not later than February 1, the commissioner shall report to the house and senate committees on ways and means, the joint committee on mental health, substance use and recovery, the joint committee on public safety and homeland security and the joint committee on the judiciary the

following information for the prior calendar year for each facility included in section 17B: (i) the cost to the facility of providing medication-assisted treatment for opioid use disorder; (ii) the cost to the facility of providing re-entry treatment plans under section 17C; (iii) the type and prevalence of medication-assisted treatment provided for opioid use disorder; (iv) the number of persons in the custody of the facility, in any status, who continued to receive the same medication-assisted treatment as they received prior to incarceration, by medication type; (v) the number of persons in the custody of the facility, in any status, who changed or discontinued medication-assisted treatment for opioid use disorder that they received prior to incarceration, by medication type; (vi) the number of persons in the custody of the facility, in any status, who received medication-assisted treatment for opioid use disorder during the 90 days prior to release, by medication type; (vii) the number of persons in the custody of a facility, in any status, with a re-entry treatment plan that included medication-assisted treatment but did not receive such treatment prior to release; (viii) the number of persons in the custody of the facility, in any status, who received medication-assisted treatment for opioid use disorder who did not receive such treatment prior to incarceration, by medication type; (ix) a summary of facility practices and any changes to those practices related to medication-assisted treatment for opioid use disorder; (x) the number of persons who were connected to treatment after release; (xi) the number of persons who received a re-entry treatment plan under section 17C and were subsequently enrolled in MassHealth upon discharge; provided, however, that the commissioner, the commissioner of medical assistance and the commissioner of public health shall coordinate to provide such information; and (xii) any other information requested by the commissioner related to the provision of medication-assisted treatment for opioid use disorder.

Every 2 years, not later than the April 30, the commissioner of public health shall prepare a report, pursuant to section 237 of chapter 111, regarding outcomes for the medication-assisted treatment programs established under sections 17B and 17C to the house and senate committees on ways and means, the joint committee on mental health, substance use and recovery,

the joint committee on public safety and homeland security and the joint committee on the judiciary. The department of correction shall provide, upon request from the commissioner of public health, information necessary to prepare the report. The report shall, to the extent possible, provide a comparison between the state detainees and prisoners who did not receive medication-assisted treatment for opioid use disorder and those who did, reported separately for each medication type, in order to determine the impact of the treatment programs on the following: (i) retention in treatment after release; (ii) substance use and relapse after release; (iii) rates of recidivism; (iv) rates of nonfatal and fatal overdose; (v) treatment retention after release; and (vi) other outcome measures identified by the commissioner of public health.

....

SECTION 98.(a) Notwithstanding any general or special law to the contrary, there shall be, subject to appropriation, a pilot program for the delivery of medication-assisted treatment for opioid use disorder at the county correctional facilities located in Franklin, Hampden, Hampshire, Middlesex and Norfolk counties. The pilot program shall be implemented by the department of public health, in collaboration with the executive office of public safety and security, the office of Medicaid, and the county sheriffs who have jurisdiction over the county correctional facilities located in Franklin, Hampden, Hampshire, Middlesex and Norfolk counties.

(b) A county correctional facility participating in the pilot program shall:

(1) maintain or provide for the capacity to possess, dispense and administer all drugs approved by the federal Food and Drug Administration for use in medication-assisted treatment for opioid use disorder; provided, however, that a facility shall not be required to maintain or provide a drug that is not also included as a MassHealth covered benefit;

(2) provide medication-assisted treatment to a person in the custody of the facility, in any status, who was receiving medication-assisted treatment for

opioid use disorder through a legally authorized medical program or by a valid prescription immediately before incarceration; provided, however, that treatment shall not be involuntarily changed or discontinued except upon a determination by a qualified addiction specialist, as defined in section 1 of chapter 127 of the General Laws, that the treatment is no longer appropriate;

(3) provide medication-assisted treatment not less than 30 days prior to release to a sentenced inmate in the custody of the facility for whom such treatment is determined to be medically appropriate by a qualified addiction specialist;

(4) provide, as part of the facility's opioid use disorder treatment program, behavioral health counseling, as defined in section 1 of chapter 127 of the General Laws, for individuals consistent with current therapeutic standards for these therapies in a community setting; provided, however, that those standards shall be consistent with the safety and security requirements of the facility;

(5) not use incentives, rewards or punishments to encourage or discourage a person's decision to receive medication-assisted treatment while in the custody of the facility;

(6) make every possible effort to directly connect, prior to release, a person in the custody of the facility who is receiving medication-assisted treatment to an appropriate provider or treatment site in the geographic region in which the person will reside upon release; provided, however, that if such connection is not possible, the facility shall document its efforts in the person's record;

(7) request reinstatement or apply for MassHealth benefits for a person in the custody of the facility who is receiving medication-assisted treatment not less than 30 days before that person's release; and

(8) provide a status report every 6 months, in a format determined by the commissioner of public health, to the secretary of public safety, the commissioner of public health, the joint committee on public safety and homeland security and the joint committee on mental

health, substance use and recovery, which shall include following information: (i) the cost to the facility of providing medication-assisted treatment, behavioral health counseling and post-release case management for opioid use disorder; (ii) the type and prevalence of medication-assisted treatment provided for opioid use disorder; (iii) the number of persons in the custody of the facility, in any status, who continued to receive the same medication-assisted treatment as they received prior to incarceration; (iv) the number of persons in the custody of the facility, in any status, who voluntarily changed or discontinued medication-assisted treatment for opioid use disorder that they received prior to incarceration; (v) the number of persons in the custody of the facility, in any status, who changed or discontinued medication-assisted treatment for opioid use disorder that they received prior to incarceration due to a determination by a qualified addiction specialist; (vi) the number of persons in the custody of the facility, in any status, who received medication-assisted treatment for opioid use disorder during the 30 days before their release; (vii) a summary of facility practices and any changes to those practices related to medication-assisted treatment and behavioral health counseling for opioid use disorder; (viii) a list of program participants, which shall be provided to the department of public health in order to track aggregated outcome data post release; and (ix) any other information requested by the commissioner related to the provision of medication-assisted treatment for opioid use disorder.

(c) A county sheriff with jurisdiction over a county correctional facility participating in the pilot program shall, in consultation with thecommissioner of public health, the secretary of public safety and security, the director of Medicaid, the Association for Behavioral Healthcare, Inc., the Advocates for Human Potential, Inc., and othercounty sheriffs who have jurisdiction over the county correctional facilities participating in the pilot program, develop an implementation plan for the pilot program in their facility. An implementation plan shall consider: (i) best practices for the delivery of medication-assisted treatment and behavioral health counseling for opioid use disorder; (ii) uniform guidelines to ensure the safety and security of correctional facility personnel and people in the custody of the facility during the

administration of medication-assisted treatment and behavioral health counseling; (iii) the projected cost of providing medication-assisted treatment and behavioral health counseling; (iv) health insurance coverage, including Medicaid; (v) protocols for technical medical assistance that may be required by the department of public health, including appropriate personnel and physical space to safely administer medication-assisted treatment; (vi) the availability of appropriate community services after release, including a process for directly connecting a person upon release to an appropriate provider or treatment site in the geographic region in which the person will reside upon release in order to continue treatment; (vii) appropriate metrics for evaluating and tracking pilot program outcomes; and (viii) any other information necessary to implement the pilot program.

The commissioner of public health shall evaluate and approve, pursuant to section 7 of chapter 111E, implementation plans for a pilot program under this section. The commissioner of public health shall send copies of approved implementation plans to the senate and house committees on ways and means, the joint committee on mental health, substance use and recovery and the joint committee on public safety and homeland security not less than 30 days before the implementation of the pilot program.

(d) The pilot program under this section shall be implemented not later than September 1, 2019.

(e) After implementation of the pilot program, the commissioner of public health shall submit a report regarding outcomes for the pilot program not later than September 1, 2020, and annually thereafter for the next 3 years, to the senate and house committees on ways and means, the joint committee on mental health, substance use and recovery and the joint committee on public safety and homeland security. The report shall include, to the extent possible, a comparison between people in custody who did not receive medication-assisted treatment for opioid use disorder and those who did, reported separately for each medication type, in order to determine the impact of the treatment programs on the following: (i) retention in treatment after release, including regions where direct connection to treatment was less likely; (ii) substance use and

relapse after release; (iii) rates of recidivism; (iv) rates of nonfatal and fatal overdose; and (v) other outcome measures identified by the commissioner of public health.

(f) Notwithstanding any general or special law to the contrary, the department of public health shall establish protocols that ensure that medication-assisted treatment provided under this section meets the following criteria: (i) consent provided to receive medication-assisted treatment is voluntarily given by the person in custody; (ii) that consent is recorded on a consent form signed by the person in custody; and (iii) consent is given after a written and verbal explanation of the following information: (A) the nature of federal Food and Drug Administration-approved medication used in substance use disorder treatment, including benefits and risks; (B) available alternative treatment options, including benefits and risks; (C) the need for the person in custody to inform the qualified addiction specialist, as defined in section 1 of chapter 127 of the General Laws, of medical conditions, including pregnancy, and medications that the person in custody is currently taking; (D) acknowledgement that the person in custody may withdraw voluntarily from treatment and discontinue use of medications; and (E) the options following termination of treatment, including detoxification. The department of public health shall establish the protocols not later than March 1, 2019, and shall make the protocols publicly available on its website and forward a copy of the protocols to the joint committee on mental health, substance use and recovery.

(g) The commissioner of public health may promulgate regulations and guidelines necessary to implement the pilot program under this section.

ADDENDUM

Table of Contents

COMMONWEALTH OF MASSACHUSETTS

FRANKLIN COUNTY NO. SJC-12486

COMMONWEALTH

v.

CAYLA PLASSE

AFFIDAVIT OF RUTH A. POTEE, M.D.

I, Ruth A. Potee, M.D., hereby state as follows:

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

2. I am submitting this affidavit to provide the Court with information relevant to whether substance use disorder (SUD) can be effectively treated in jail or prison. I have not treated or met the defendant in this case.

3. For the reasons explained below, imprisonment is an unhealthy environment to send a person for treatment, and incarceration generally exacerbates the course of SUD, even in

places like Franklin County where evidence-based[1] treatment is offered.

4. I am board certified in Addiction Medicine and Family Medicine. In addition to my work with the Franklin County Sherriff's Office, I am Medical Director of the Franklin Recovery Center, Chair of the Healthcare Solutions 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.

5. I trained at Boston University, an international center for addiction medicine, and I have cared for people with

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[1] An intervention is "evidence-based" if it falls into one or more of the following categories: "(1) [t]he intervention is included in a federal registry of evidence-based interventions, such as the National Registry of Evidence-based Programs and Practices (NREPP); or (2) [t]he intervention produced positive effects on the primary targeted outcome, and these findings are reported in a peer-reviewed journal OR, (3) [t]he intervention has documented evidence of effectiveness, based on guidelines developed by the Center for Substance Abuse Prevention and/or the state, tribe, or jurisdiction in which the intervention took place. Documented evidence should be implemented under four recommended guidelines, all of which must be followed." SAMHSA, Center for the Applications of Prevention Technologies. https://www.samhsa.gov/capt/applying-strategic-prevention-framework/step3-plan/defining-evidence-based

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.

6. I have worked with over 500 people with SUD prosecuted in the criminal justice system. At the Franklin County House of Correction, 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.

7. SUD 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."[2] Id. at 483.

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

[2] 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.

9. When a person starts down the path of addiction, the neurochemistry of the brain shifts in ways both dramatic and subtle. 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]

10. 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.

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[3] See the Surgeon General's 2016 report, Facing Addiction: The Surgeon General's Report on Alcohol, Drugs, and Health, Chapter 2, available at https://addiction.surgeongeneral.gov/sites/default/files/chapter-2-neurobiology.pdf

11. The survival part of the brain wants to achieve a sense of normalcy. Non-addicted 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 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.

12. SUD has many definitions but can easily be understood by reference to "the Four C's" – cravings, continued use despite harm, compulsive use, and loss of control.

13. When a person has experienced addiction, even after achieving sobriety for a period of time, a part of the brain can remain preoccupied with the drug. Relapse is extremely common and is one of the reasons that SUD is considered a chronic relapsing disease like depression, diabetes, and obesity. Triggers for relapse cause a cascade of neurotransmitters in the brain to race through the amygdala, hippocampus, and nucleus accumbens. Triggers can include people, smells, stressors, a strong emotion, or an intolerance to emotional or physical discomfort. Cravings for drugs are present for years after stopping.[1]

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[1] See Addendum 13, NEJM Brain Image.

14. In order to recover from SUD, the brain needs to rebuild its broken dopamine system. This takes between 18 and 24 months in most cases.[5] Rebuilding the dopamine system is promoted by engaging in or experiencing these healthy behaviors:

a. developing positive relationships with others (e.g., restoring relationships, falling in love, or having a pet);
b. exercise or physical movement;
c. good mental health treatment;
d. evidence-based medications;
e. engaging in constructive activities like working or going to school;
f. developing a sense of purpose and investment in a community;
g. feeling accountable and respect for one's self; and
h. growing into an adult brain.[6]

15. 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. Components of comprehensive addiction treatment include:

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[5] See Addendum 14, Longitudinal Trends in Recovery, ASAM.

[6] See Addendum 15, "What It Takes to Get Better."

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. medication assisted treatments (MAT) (e.g., buprenorphine, methadone, or naltrexone) to treat opioid use disorder;

d. case management (especially for high risk patients with co-occurring medical, housing and employment needs)[7]; and

e. mutual peer support – e.g. Twelve-Step programming or recovery coaches.

16. The majority of people with SUD prosecuted in the criminal justice system have experienced one or more major life traumas – e.g., family or community violence, including physical or sexual abuse. For this population, trauma-informed care and trauma therapy (EMDR, tapping therapy, mindfulness, meditation, and yoga) are core components of effective SUD treatment.

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

17. Although medical care in jails and prisons is supposed to meet basic standards,[8] treatment for SUD almost never meets the threshold, as facilities do not provide the core components of addiction recovery. By and large, evidence-based treatment (as discussed above) is not offered in Massachusetts jails and prisons. In western Massachusetts, for example, women are first sent to the Western Massachusetts Regional Women's Correctional Center in Chicopee, where they receive limited individual counseling, group therapy, or behavioral health treatment. Inmates often wait for months to attend infrequent Alcoholic Anonymous meetings.

18. Franklin County is the only detention facility in Massachusetts to administer buprenorphine to inmates with an opiate use disorder who desire treatment with medicine. We also offer Vivitrol prior to an inmate's release and we are working to get licensed to use methadone for treatment in the coming year. Additionally, we provide full spectrum behavioral health treatment to address trauma, depression and anxiety, which

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[8] "Institutions, associations, and government agencies issue health related standards and guidelines which are widely used and recognized in the U.S. Standards are authoritative statements that articulate minimal, acceptable or excellent levels of performance or that describe expected outcomes in health care delivery, biomedical research and development, health care technology, or professional health care." National Institute of Health, Collection Development Manual of the U.S. National Library of Medicine 109 (2004). Available at https://www.nlm.nih.gov/tsd/acquisitions/cdm/CDMBook.pdf.

frequently co-occur with SUD. As stated at the outset, however, even in a jail with quality treatment, incarceration generally exacerbates the course of SUD.

19. Jails and prisons are, first and foremost, places of imprisonment. Security concerns always take precedence over and frequently interfere with treatment needs.

20. Feeling safe is critical to effective SUD treatment. People generally do not feel safe when incarcerated. Being removed from one's life situation and forced to acclimate to jail or prison is a highly destabilizing event. Most people with SUD come to jail or prison feeling broken down and worthless. These feelings are exacerbated by the experience of incarceration, which is generally perceived as dehumanizing and degrading. This is counterproductive for building dopamine and is a risk factor for a person with SUD continuing to use or relapsing. People who are already emotionally damaged when they enter jail or prison often dissociate while incarcerated, i.e., they shut down. Dissociating becomes a coping strategy that remains with the person post-incarceration and triggers relapse, as substance use is a highly effective way to become numb and disconnect.

21. Trauma is a major risk factor for developing SUD. In prison or jail, trauma is unrecognized, untreated, and exacerbated.

22. Because so many incarcerated women with SUD have been sexually abused or engaged in sex work (both high-risk factors for SUD), treatment should be in a safe, all-female environment, without male correctional staff. The inherent power structure in jails and prisons is unhealthy for female inmates who have sexual abuse histories because it places men in control, which can lead to further victimization.

23. The building blocks for repairing the broken dopamine system in the brain (see ¶14 above) are, by definition, almost entirely unavailable in jails and prisons. Instead of building positive and healthy relationships, harmful relationships oftentimes occur due to the inherent power dynamic of correctional staff versus inmates. Inmates are confined to cells or units, and physical movement is accordingly limited. Positive relationships with family, friends, and children are disrupted and sometimes damaged beyond repair. There is inadequate mental health treatment, evidence-based therapy, and prescribing. Incarceration does not foster an individual's sense of purpose. There is also little if any engagement in constructive activities and community investment.

24. Building self-esteem and learning to love one's self is critical to recovery. Incarceration fuels the opposite, as most people in jail or prison experience self-loathing.

25. In many jails and prisons, inmates have ready access to illicit substances and continue drug use. When caught for using, inmates are often placed in solitary confinement or terminated from programming. Isolation negatively impacts the course of recovery.

26. Even if forced abstinence is achieved during a period of 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. Compared to the rest of the adult population, the opioid-related overdose death rate is 120 times higher for people released from jails and prisons.[9] Abstinence does not itself repair the broken dopamine system. Thus, even if an inmate with SUD has been abstinent during incarceration, the brain's dopamine system remains broken. Tolerance to the drug is gone and re-exposure to even small amounts of certain drugs can cause a fatal overdose, most often in the first thirty days after returning to society.

27. Having a conviction on one's record and serving a term of incarceration interferes with housing and employment

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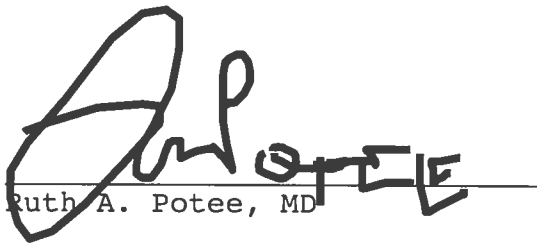
[9] Massachusetts Department of Public Health, An Assessment of Fatal and Nonfatal Opioid Overdoses in Massachusetts (2011-2015) 40-51 (2017), https://www.mass.gov/files/documents/2017/08/31/legislative-report-chapter-55-aug-2017.pdf

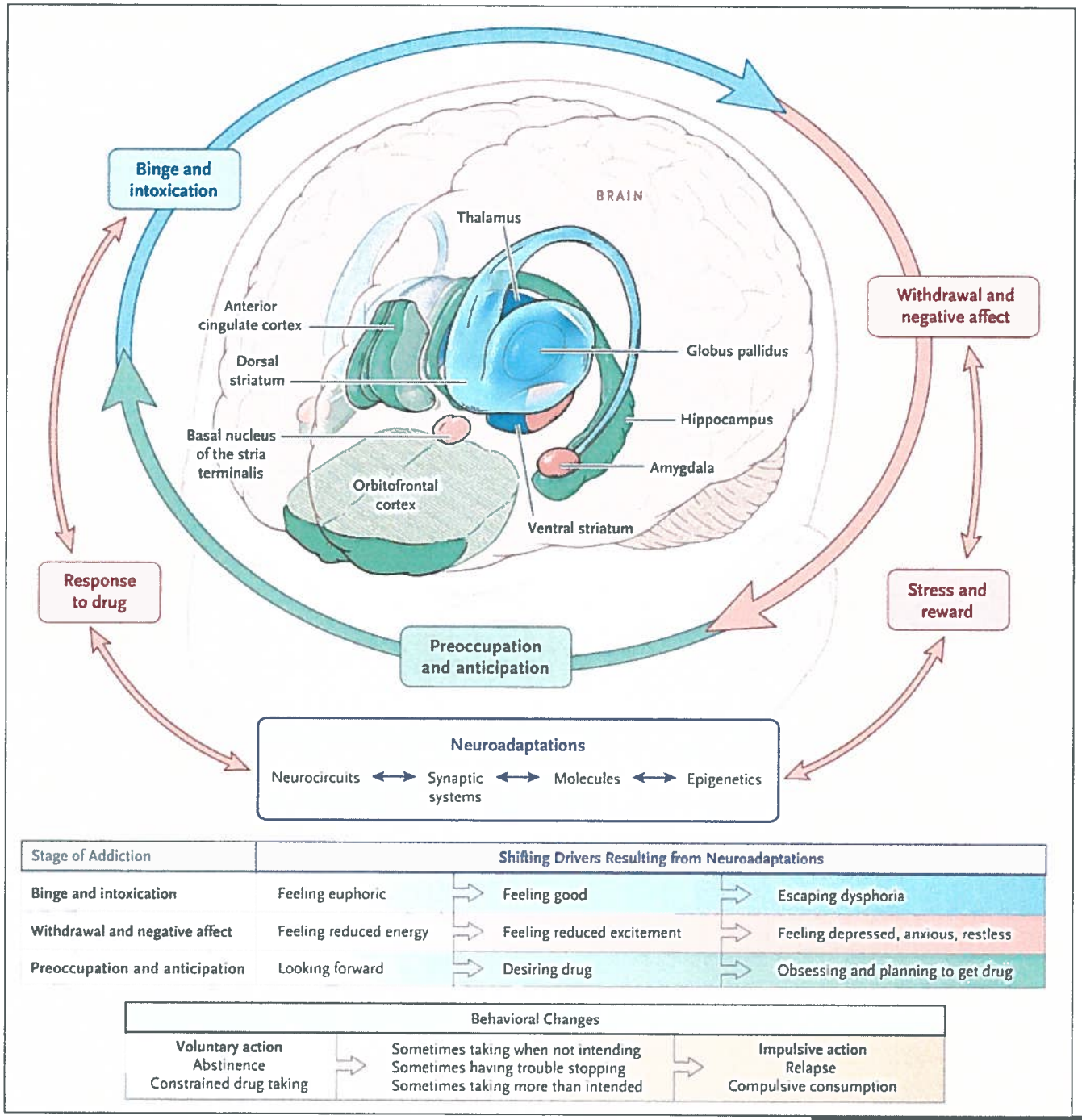
options,[10] and interrupts care with health providers. In other words, returning to the community after imprisonment is a major stressor, which in turn jeopardizes a person's ability to achieve or sustain recovery.

SIGNED UNDER THE PAINS AND PENALTIES OF PERJURY THIS 19 DAY OF AUGUST 2018.



Ruth A. Potee, MD

[10] See Addendum 16 "For formerly incarcerated people looking for jobs, it's worse than the Great Depression," Prison Policy Initiative.



Stage of Addiction	Shifting Drivers Resulting from Neuroadaptations		
Binge and intoxication	Feeling euphoric	Feeling good	Escaping dysphoria
Withdrawal and negative affect	Feeling reduced energy	Feeling reduced excitement	Feeling depressed, anxious, restless
Preoccupation and anticipation	Looking forward	Desiring drug	Obsessing and planning to get drug

Behavioral Changes		
Voluntary action Abstinence Constrained drug taking	Sometimes taking when not intending Sometimes having trouble stopping Sometimes taking more than intended	Impulsive action Relapse Compulsive consumption

Neurobiologic Advances from the Brain Disease Model of Addiction
Nora D. Volkow, M.D., George F. Koob, Ph.D., and A. Thomas McLellan, Ph.D.
N Engl J Med 2016; 374:363-371January 28, 2016

The NEW ENGLAND JOURNAL of MEDICINE

Longitudinal Research: Chestnut Health Systems Studies

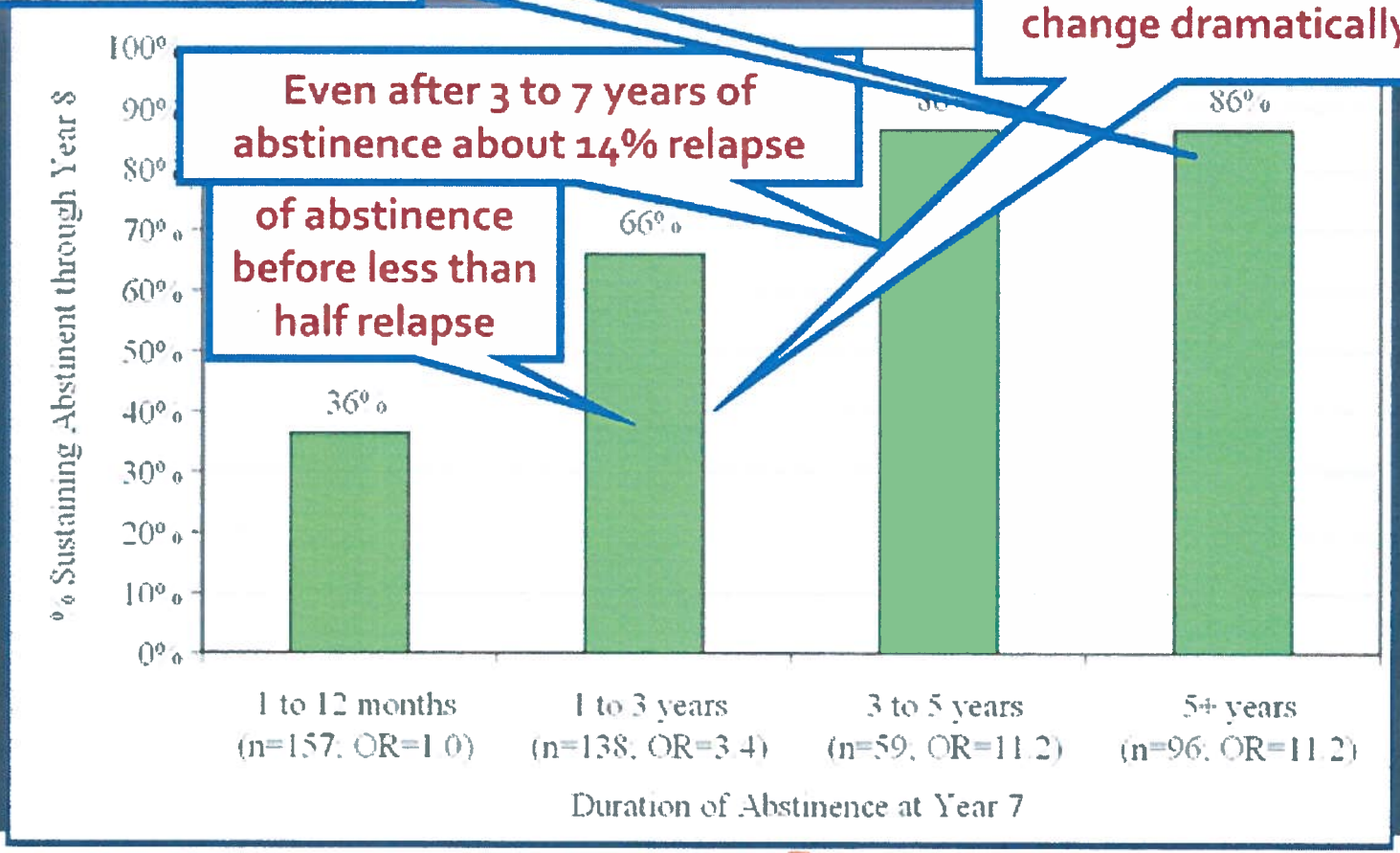
Longitudinal Trends in Recovery

After 5 years – if you are sober, you probably will stay that way.

3+ years of abstinence the odds of relapse change dramatically

Even after 3 to 7 years of abstinence about 14% relapse

of abstinence before less than half relapse



Source: Dennis, Foss & Scott (2007), *Eval. Rev.*

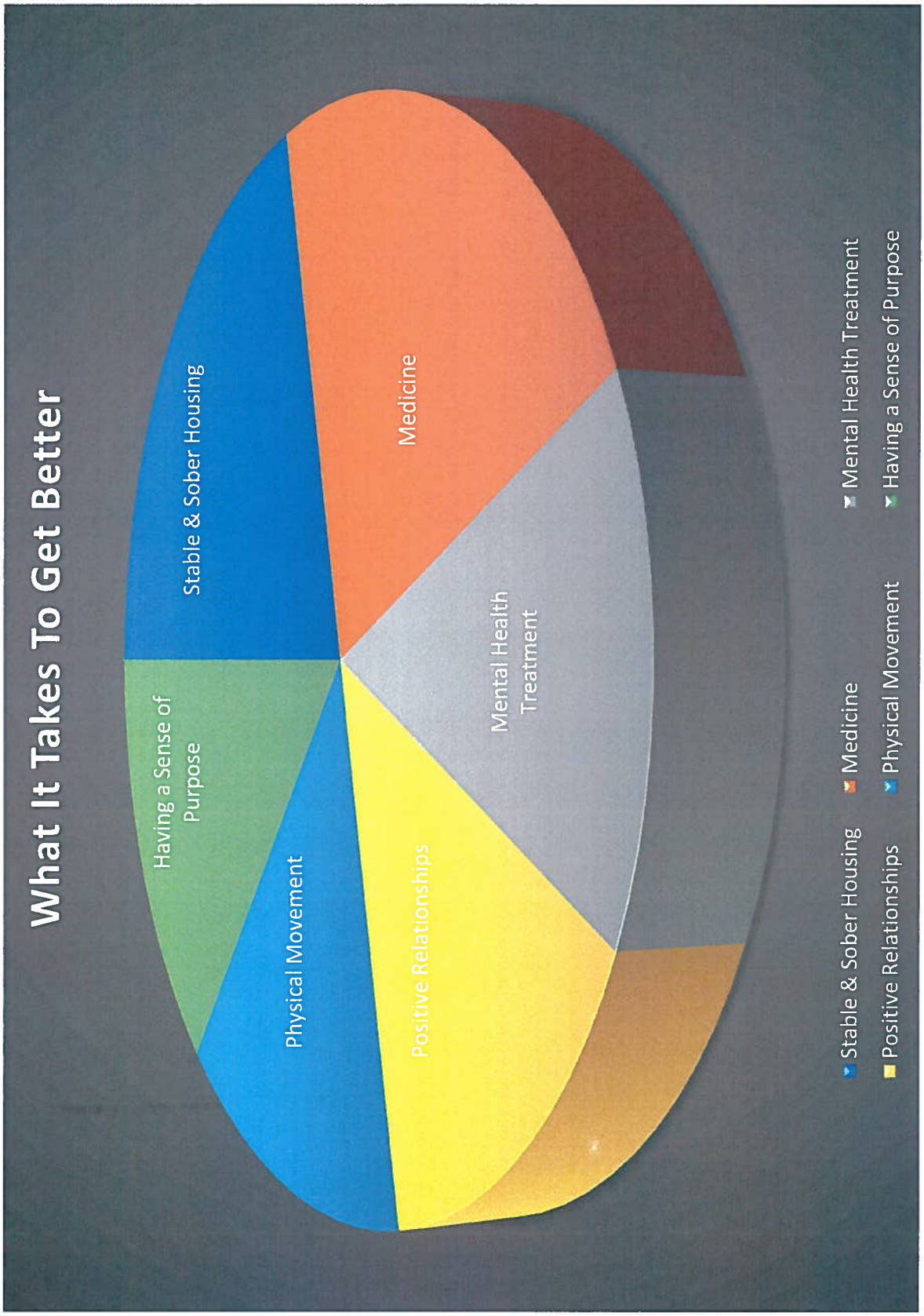

What It Takes To Get Better
Stable & Sober Housing
Medicine
Mental Health Treatment
Positive Relationships
Physical Movement
Having a Sense of Purpose
Stable & Sober Housing
Medicine
Mental Health Treatment
Positive Relationships
Physical Movement
Having a Sense of Purpose

Figure 1. *The unemployment rate of formerly incarcerated people in 2008 (the most recent year for which data are available) was 27.3% (compared to 5.8% in the general public), exceeding even the highest level of unemployment the ever recorded in the U.S. (24.9%), during the Great Depression.*

Ruth Alexandra Potee M.D.

55 Main Street • Northfield, MA 01360 • *phone:* 413-498-0212 • *e-mail:* rupotee@gmail.com

Employment

2010-Present **Valley Medical Group**
Greenfield, MA
Family physician, trustee and shareholder in clinician-owned medical group in the most rural county in Massachusetts. Full scope of Family Medicine with special interest in women's health, pediatrics, addiction treatment, psychiatric illness and pain management.

2012-Present **Pioneer Valley Regional School District**
Northfield, MA
School physician for regional high school and four elementary schools. Curriculum development for nurses, teachers and staff. Training in adolescent care; specifically nutrition, sports supplements, adolescent substance abuse and addiction.

2014-Present **Franklin County House of Corrections**
Greenfield, MA
Medical Director for 300 inmates in Franklin County. Established re-entry plans focusing on substance use disorder. Started medically assisted treatment for inmates with opioid use disorder during incarceration. Established Hepatitis C treatment protocol. Provided training in physiology of addiction to correctional officers, courthouse staff, lawyers, judges, and inmates.

2015-Present **Baystate Franklin Medical Center**
Greenfield, MA
Chair, Department of Medicine
Oversight of largest medical department at a rural hospital. Responsible for credentialing reviews and performance evaluations.

2016 -Present **Franklin First Step Recovery Center**
Greenfield, MA
Medical Director - 64 beds
Acute stabilization, induction to medical treatment, and medically monitored withdrawal of patients addicted to opioids, alcohol, benzodiazepams, and other illicit substances. Modelling alternative pathways of intensive treatment distinct from previous pathways to demonstrate greater efficacy and patient experience. Integrating evidence based treatment models of dialectical behavioral treatment, trauma-informed care, motivational enhancement therapy, acupuncture, mindfulness meditation, and yoga into this state-funded treatment center.

2002-2010 **Assistant Professor of Family Medicine, Boston University and Boston Medical Center**
Family physician in urban hospital-based clinic caring for a large immigrant population. Full scope of family medicine with large volume of pediatric and prenatal care. Special interests in women's health, addiction medicine, and psychiatry. Precepted and taught medical students and residents each day.

2002-2004 **National President, Committee of Interns and Residents – SEIU Local 1957**
Represented 11,000 residents nationwide in efforts to improve patient care and house officer working conditions • New York, NY

1989-1993 **Deputy Director, Ann Richards for Governor**
1990 and 1994 Gubernatorial Campaign • Austin, TX
Designed and managed statewide organization composed of 254 counties. Organized issue campaigns and advised local demographic races statewide. Directed all aspects of grassroots effort, from media analysis to voter targeting and turn-out.

1992 **State Director, Bob Kerrey for President**
1992 Presidential Campaign • New York, NY
Established New York field and ballot access operations for Senator Bob Kerrey. Selected Delegate slates and organized successful statewide petition drive.

Education

1999-2002 **Boston University Department of Family Medicine** • Boston, MA
Three-year residency program in Family Medicine - Chief Resident

1994-1999 **Yale University School of Medicine** • New Haven, CT
M.D. Degree

1992-1993 **Mount Holyoke College** • South Hadley, MA
Intensive post-baccalaureate pre-medical curriculum; cumulative 4.0 GPA

1986-1990 **Wellesley College** • Wellesley, MA
B.A. *cum laude* in Women's Studies (major) and Geology (minor)

Board Certification

2015 - present Diplomate of the American Board of Addiction Medicine
2002 - present American Board of Family Medicine

Honors and Awards

Franklin County Clinician of the Year - 2015 - Massachusetts Medical Society

Boston University School of Medicine AOA Volunteer Clinical Faculty of the year - 2017
Given to one individual who teaches and mentors BU medical students in the community

RECOVER Project Community Award - 2016
Chosen by RP community each year to honor an individual who works to raise knowledge and awareness about addiction and recovery.

The Making A Difference Award Massachusetts Interscholastic Athletic Association - 2016
Recognizes the individual or agency who has made a significant contribution and impact on the lives of students through the development of quality prevention programming that promotes healthy, responsible decision making.

Distinguished Woman of the Year - International Women's Day - The Greenfield Recorder - 2015
One of eight women honored for changing the face of Franklin County

Nominated by medical students for AAFP National Teacher of the Year – American Academy of Family Physicians – 2010

Faculty Preceptor of the Year- 2010 (Boston University Department of OB/Gyn)
Selected by residents

Faculty Preceptor of the Year- 2008 (Boston University Department of Family Medicine)
Selected by residents

Pfizer Teaching Award – American Academy of Family Physicians – 2008
One of fifteen family physicians selected nation-wide

The Leonard Tow Humanism in Medicine Award Nominee (Boston University) – 2007

Miriam Kathleen Dasey Award (Yale University)
Presented to the student who by strength of character, personal integrity, and academic achievement gives promise of fulfilling the ideal of the compassionate physician

NBI Healthcare Foundation Humanism in Medicine Student Award (Yale University)
Honors a graduating student who demonstrates the highest standard of compassion and sensitivity in their interaction with patients

Janet M. Glascow Memorial Achievement Citation (Yale University)

Connecticut Academy of Family Physicians Award (Yale University)

Psychological Study of Social Issues Ward and Research Grant (Yale University)

Farr Research Scholar (Yale University)

Sarah Perry Wood Fellowship (Yale University)

Phillip I. Huffman Preceptorship in Rural Family Medicine (UCSF - Fresno)

Family Practice Interest Group Leadership Award (American Academy of Family Physicians)

Frances Perkins Scholar (Mount Holyoke College)

President, Student Government (Wellesley College)

Vice-President, Student Government (Wellesley College)

Leadership America (Wellesley College)

Activities & Community Service

2015-present	Chair, Department of Medicine - Baystate Franklin Medical Center
2013-present	Co-Chair, Opioid Task Force of Franklin County and North Quabbin
2009-2013	Chair, Community Preservation Committee – Town of Northfield, MA
2007-2014	Chair, Parish Committee, First Parish – Unitarian, Northfield, MA
2007	Chair, Search Committee, First Parish – Unitarian, Northfield, MA
2006-2012	Board Member, Historical Commission, Northfield, MA
2003-2005	Board Member, Abortion Access Project, Cambridge, MA
2002-2004	ACGME Duty Hours Subcommittee, Chicago, IL
2003-2005	Co-Chair, School Site Council, James Michael Curley Elementary School, JP
2000-2005	Community Garden Coordinator – Margaret Wright Memorial Garden, Roxbury
1999-2001	National Treasurer and Vice President, Committee of Interns and Residents – SEIU
1999-Present	Member, Massachusetts Academy of Family Practice
1994-Present	Member, American Academy of Family Practice
1995-1999	Member, Connecticut Academy of Family Practice
1994-1997	Co-Director, Yale Family Practice Interest Group
1994-1995	Volunteer, Prenatal Care Project, New Haven, CT
1993-1994	Patient Partner, Hospice Austin, TX
1992-1993	Volunteer, Baystate Medical Center Emergency Room
1987-1990	State Certified Mediator, Commonwealth of Massachusetts
1988	Camp Director, Appalachian South Folklife Center

Research Experience

1995-1999	"Motherhood and Medicine" (Medical Student Thesis) Department of Epidemiology and Public Health, Yale School of Medicine Thesis Advisor: Dr. Jeannette R. Ickovics.

Publications

Voas, J., K. Allen, and R. Potee. 2016. Communities that Care Coalition provides model for improving community health through clinical–community partnerships: A population health case study. Discussion Paper, National Academy of Medicine, Washington, DC.

http://nam.edu/wp-content/uploads/2016/05/The-communities-that-care-coalition-modelfor-improving-community-health-through-clinical-community-partnerships.pdf.

Watson PY, Potee R, Blalock A. Residents' Work Hours. Correspondence. *New England Journal of Medicine*. 2003 Feb 13;348(7):664-666.

Potee RA. Limiting Residents' Work Hours. Correspondence. *JAMA*. 2002 Dec 18;288(23):2973-4.

Potee RA, Gerber AJ, Ickovics JR. Medicine and motherhood: shifting trends among female physicians from 1922 to 1999. *Academic Medicine*. 1999;74(8):911-919.

Presentations

"Physiology of Addiction", multiple presentation given to schools, hospitals, courts, school nurses, and correctional facilities statewide
2014 - present

"SCOPE of Pain: Risk Mitigation in Pain Management", Boston University, 24 Trainings in Western Mass
June 2013 - present

"Opioid Crisis in America and Our Community", multiple presentations to hospitals, schools, parents and professional organizations throughout Massachusetts
2015

"Controlled Substances, Chronic Pain, and Protecting Patients and Community", December 2010,
Valley Medical Group, Greenfield, MA

"Well Child Care – An Update" Grand Rounds Lecture, August 2009
Department of Family Medicine, Boston University

"Over-the-Counter Medicines" Grand Rounds Lecture, September 2008
Department of Family Medicine, Boston University

"Drugs of Abuse and Outpatient Treatment Modalities" Resident Seminar, November 2007

"Update on Contraception and Reproductive Health" Grand Rounds Lecture, January 2007
Department of Family Medicine, Boston University and August 2010, Valley Medical Group

"School Age Prevention" Grand Rounds Lecture, July 2006
Department of Family Medicine, Boston University

"The History of Boston City Hospital" Noon Conference, July 2006 Dept. of Internal Medicine
Grand Rounds Lecture, December 2001 Department of Family Medicine Grand Rounds, Boston University

"Mifepristone in the Primary Care Setting" Boston Medical Center, December 2002 & November 2003

"Education or Endurance? Ethics and the Debate Over Resident Work Hours", Harvard University Medical School, October 2002

"Motherhood and Medicine: A Retrospective Examination of Women at Yale School of Medicine, 1922-1999." Student Research Day, Yale University School of Medicine; May 1998 and 1999.

"The Art of Breastfeeding." Lecture delivered to third and fourth year medical students and residents. Pittsburgh, PA; New Haven, CT; Boston, MA. Spring 1998

COMMONWEALTH OF MASSACHUSETTS

FRANKLIN COUNTY NO. SJC-12486

COMMONWEALTH

v.

CAYLA PLASSE

AFFIDAVIT OF PATRICIA M. STACY, MSW, LICSW

I, Patricia Stacy, state as follows:

1. I am a Licensed Independent Clinical Social Worker (LISCW). From 2012 to 2015, I worked at Souza-Baranowski Correctional Center (SBCC) as a mental health clinician,[1] carrying a caseload of up to eighty inmate patients. Well over half of my patients had a substance use disorder (SUD). Drug use and addiction were pervasive and many of my patients were actively addicted and using while imprisoned.

2. I am currently the Social Worker Manager at St. Vincent's Hospital in Worcester, Massachusetts, where I supervise a team of eleven social workers providing clinical social work services to patients and families in the acute care

[1] Within the Department of Correction, mental health clinicians may be licensed social workers (like me), licensed mental health clinicians, or psychologists. There is a psychiatrist tasked with diagnosing and prescribing.

setting to meet their medically related social and emotional needs. A significant percentage of my work involves treating patients in the emergency room who have suffered a drug overdose. I have attached my curriculum vitae.

3. I understand that this Court has requested amicus briefs in this case addressing "[w]hether, or to what extent, a judge may consider an offender's rehabilitative needs, including factors associated with eligibility for a Department of Correction (DOC) program, in determining the term of sentence of incarceration."

4. As someone who previously worked as a mental health clinician in the DOC, I am submitting this affidavit to provide the Court with information about mental health treatment — particularly for SUD — in our prison system.

5. I cannot emphasize enough that inmates frequently obtain and use illegal drugs and alcohol ("homebrew") in all of the state prisons. While the DOC has attempted to address this issue, those efforts have focused on punishing inmates caught using and keeping drugs out (e.g., limiting inmate visitors, searching mail, and employing drug-sniffing dogs), rather than addressing the enormous treatment need.

6. Inmates suspected of drug use or addiction are routinely urine-tested. When inmates test positive, they are placed in segregation (i.e., solitary confinement) or locked in

their cells for a period of days and issued a disciplinary ticket. They may also lose privileges (e.g., yard time, visits, or phone calls). This disciplinary response restricts exercise and further distances inmates from their family and friends on the outside. Men who tested positive would have to pay for future drug testing, which meant they would accumulate a financial debt to the DOC. It was my observation that addicted inmates sanctioned for drug use typically did not stop using. Ironically, inmates who meet criteria for severe SUD often incur so many disciplinary tickets that they are reclassified to or remain in maximum security custody at SBCC where the programming is extremely limited and where inmates are typically locked in their cells for twenty hours a day.

7. Even though the vast majority of inmates with an "open" mental health case have a SUD diagnosis per the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), mental health clinicians do not provide treatment for the disorder. To the contrary, when I worked in the DOC, clinicians were told to terminate treatment if other mental health diagnoses were resolved and SUD was the only remaining diagnosis.

8. I worked with numerous men who wanted to stop drug use while incarcerated, but the prison environment made recovery extraordinarily difficult.

9. A respectful and safe environment is essential for medical and clinical treatment. Prison is an adverse environment for recovery because it is psychologically distressing and physically dangerous. Inmates experience stress, shame, and maltreatment, all of which worsen mental health problems (including SUD), as well as physical ailments. I worked in a men's prison, where physical altercations are a regular occurrence and sexual victimization is also an issue. Addicted inmates talked with me about feeling helpless locked in a facility where triggers to use — anxiety, fear, depression, boredom, and alienation — are part of daily life.

10. A significant portion of prison violence is secondary to the drug trade inside. Drug-addicted inmates, in many instances, are preyed upon because they continue using in prison and accumulate debt to other inmates or correctional officers who are selling the drugs. If an inmate cannot pay the debt, he may be physically assaulted by other inmates, or his family may be exploited to pay the debt. If staff become aware of the problem, the addicted inmate will be placed in administrative segregation. Even in segregation, inmates can obtain drugs.

11. Inmates who constantly feel their safety threatened often become hypervigilant. This hypervigilance is carried back home and makes it difficult for formerly imprisoned people to adjust to life in the community. The guardedness required for

prison life significantly interferes with an individual's ability to seek and stay in treatment when released.

12. Prison security, not rehabilitation, is the DOC's overriding concern. Correctional staff receive paramilitary training in combat techniques, and inmates view COs as "cops." The culture of "us versus them" creates a toxic environment that is especially detrimental to health outcomes and recovery from addiction.[2]

13. Mental health and medical professionals have minimal say in the functioning of the environment and are not empowered to make changes – e.g., establishing daily outdoor recreation time – that could enhance mental health and recovery outcomes for inmates.

14. Medications that can help inmates with opioid use disorder stabilize and recover – buprenorphine (i.e. Suboxone) and methadone – are prohibited in the DOC.

15. Spectrum Health Services is the contracted vendor for "substance abuse" programming. Spectrum staff are employed by a

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[2] The hostility between inmates and COs sometimes puts clinicians in the difficult position of witnessing maltreatment and even outright abuse of their patients (the inmates). For many clinicians, reporting abuse to the administration is a frightening experience due to the risk that correctional staff will retaliate against the mental health team. Clinicians (who are employed by a vendor contractor) are "at will" employees who may be fired and walked from the premises with little recourse. Because of the tense environment, staff can themselves experience poor mental health, leading to high turnover, which further undermines inmate treatment services.

separate vendor from mental health and medical staff; they are paid marginal wages, and unlike mental health clinicians, they are not required to have a master's degree or license.

16. Spectrum staff run a variety of psychoeducation classes intended to address substance misuse, criminal thinking, and violence reduction. Psychoeducation is a component of a well-rounded recovery program, but psychoeducation by itself is not treatment.[3]

17. Spectrum runs the Correctional Recovery Academy (CRA), which is a unit within three medium-security and one minimum-security prison (MCI-Concord, MCI-Norfolk, MCI-Shirley Medium, and MCI-Shirley Minimum). Inmates live in the CRA unit for six to nine months. Like the other Spectrum classes, the CRA curriculum is primarily psychoeducation and does not include one-on-one counseling or evidence-based behavioral therapies.

18. There is no formal collaboration between mental health clinicians and Spectrum staff regarding inmate needs. This is problematic, not only because SUD is a complex disorder, but because the vast majority of addicted inmates have survived trauma that requires highly trained and licensed clinicians to safely engage patients in effective, integrated treatment.

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[3] Spectrum's addiction services in the community involve integrated treatment programming that is vastly different from the prison programming.

19. A qualified licensed clinician does not screen or determine who attends "substance abuse" programming or who lives in the CRA. Instead, the decision is made by a DOC employee in the classification department. Consequently, not all inmates placed in a CRA have a SUD, and not all inmates with SUD are placed in a CRA.

20. Unlike treatment of other mental health disorders within the DOC, placement in a CRA is considered a privilege and inmates who complete the program earn good time credits. This is significant because every other DSM-5 diagnosis is treated by mental health clinicians regardless of the inmate's disciplinary status in the prison.

21. Because only a few prisons have CRAs, not all inmates have the opportunity to participate. An inmate may request transfer to a prison with a CRA, only to have classification deny the request. An inmate may request placement in the CRA and not be admitted, or an inmate may be classified to the CRA but choose to opt out. And, as noted above, inmates who repeatedly incur disciplinary tickets for positive drug screens may be prohibited from participating due to their poor institutional record and high classification points.

22. The courts are not involved in determining which inmates in DOC custody receive mental health or medical

treatment, or rehabilitation programming. These decisions are made entirely at the discretion of DOC staff.

SIGNED UNDER THE PAINS AND PENALTIES OF PERJURY THIS 20th DAY OF AUGUST, 2018.

Patricia Stacy MSW, LICSW

Patricia Stacy, MSW, LICSW

Patricia M. Stacy LICSW
17 Shady Lane
Leominster, MA 01453
Home: (978) 516-0529
Mobile: (617) 877-2537
Email: pmm1980@yahoo.com

2016-Present Social Worker Manager/Emergency Room Clinical Social Worker
St. Vincent Hospital Worcester, MA

- Provide clinical social work to patients and families in the acute care setting to meet their medically related social and emotional needs
- Synchronize treatment, recovery, and safe transition from one care environment to another using an interdisciplinary approach
- Ensure coordination of timely discharge planning, including rehab, detox, nursing home, hospice, long term care hospital, and inpatient psychiatric hospital
- Initiate rapid contact with local authorities as needed, including Police Department, Elder Services, and Department of Children and Families
- Recent recipient of Outstanding Service Performance Award as well as multiple "Ace of Hearts" awards

2012-2015 Mental Health Clinician
Souza-Baranowski Correctional Center Shirley, MA

- Managed individual caseload of over 80 incarcerated maximum-security adult males struggling with significant legal issues, personality pathology, substance use disorders, and major mental illnesses
- Utilized de-escalation and motivational interviewing techniques during significant crisis events, such as self-injury, suicide attempts, and gang violence
- Encouraged prosocial coping techniques behavioral management plans to enable patients to work collaboratively with Security Staff as well as Administration

2010-2012 Outpatient Clinician
Lipton Center Community Health Link Gardner, MA

- Managed individual therapy caseload of over 70 children, adolescents, and adults struggling with Depression, Anxiety, Schizophrenia, Bipolar Disorder, Substance Use Disorder, severe aggression and PTSD
- Provided periodic clinical supervision for graduate student interns
- Collaborated with multiple community supports, including DCF, DYS, Office of State Probation, FCT Teams, Mentors, DMH, and local school departments, as well as on-site psychiatrists
- Maintained licensure through trainings while incorporating CBT, DBT, and Motivational Interviewing skills for clients

2011-2012 Emergency Services Clinician (per diem)
Community Health Link Leominster, MA

- Provided immediate comprehensive psychosocial evaluation for clients at local emergency rooms
- Identified best outcome for client, including inpatient hospitalization, outpatient services, and collaborated with community agencies and school departments

2007-2010 Clinical Social Worker, Mental Health Unit
Bureau of Prisons Federal Medical Center Devens, MA

- Active member of Risk Assessment Panel determining whether inmates found Not Guilty by Reason of Insanity were appropriate for release
- Facilitated numerous therapeutic groups, including Reentry, Recidivism, Cognitive Behavioral Therapy, Parenting, Anxiety-Reduction, and unit process groups
- Managed caseload of over 60 mental health inmates, including administering initial psychosocial assessments
- Collaborated with interdisciplinary team for team meetings, treatment team, discharge planning, and crisis intervention
- Cooperated with multiple federal agencies in release preparation planning for inmates with significant mental health requirements

2005-2007 Clinician, Adolescent Girls Unit
Perkins School Lancaster, MA

- Facilitated weekly therapy, group therapy, and family therapy to residential adolescent female population struggling with self-mutilation, substance use, eating disorders, oppositional/aggressive behavioral disorders and trauma victims of physical/sexual/emotional abuse.
- Managed case communication with multiple collaterals including families, DSS, DYS, DOE, legal teams, etc.
- Intervened in crisis situations while encouraging stress reduction techniques.
- Prepared and participated in administrative meetings, such as weekly Team meeting, initial and quarterly conferences, DSS reviews, clinical reviews and psychiatric supervision

Education:
Masters in Social Work - University of New England - Portland, ME 2003 - 2005
BA Human Services - University of Massachusetts - Boston, MA 2001 - 2003

COMMONWEALTH OF MASSACHUSETTS

FRANKLIN COUNTY NO. SJC-12486

COMMONWEALTH

v.

CAYLA PLASSE

AFFIDAVIT OF MICHAEL COX

I, Michael Cox, hereby state as follows:

1. I was incarcerated from 2007 to 2012 in Massachusetts prisons after being convicted of mayhem when I was 22 years old.

2. I am submitting this affidavit about prison life and programming behind the wall for the Court's consideration in connection with the amicus solicitation in this case: "Whether, or to what extent, a judge may consider an offender's rehabilitative needs, including factors associated with eligibility for a Department of Correction (DOC) program, in determining the term of a sentence of incarceration."

3. From the moment I entered prison, I felt degraded. Like all inmates, I was regularly forced to remove all of my clothing to expose my genitals and body cavities to correctional officers (COs). I was forced to live in confined spaces with

dysfunctional strangers. COs would often yell orders at me like I was a dog. Adding to my problems, I am five feet, seven inches tall, have a slight frame, and am quiet and meek by nature. I stood out as a mark and was in survival-mode from day one.

4. Over the course of my five and one-half years in prison, I was regularly confronted with three challenges: (1) aggressive inmates wanting to fight me; (2) lustful inmates soliciting sex; and (3) aggressive COs humiliating me. I was constantly trying to diffuse or avoid these oppressive situations.

5. I was pressured to engage in fights at least twenty times during my incarceration. For example, after I sat in the wrong seat in the chow hall at MCI-Cedar Junction, an inmate threw my food tray on the floor and told me to "kick rocks" or fight for the right to sit in that seat. Another time, at MCI-Concord, a group of inmates went through my court papers while I was in the yard. When I returned to my cell, five inmates entered my cell and held an ad hoc trial. I was told that because I filed counter-charges against the victim in my case, I was a "snitch." They deliberated my fate while I sat in the corner. They considered extorting me for money, beating me, or demanding that I leave the housing unit. When I was incarcerated at NCCI-Gardner, I was attacked while walking up an

unsupervised staircase. My hands were full as I returned from my kitchen job. The inmate who attacked me was upset that I "stole" his gym partner and attempted to teach me a lesson.

6. I was often pressured for sex. When I was held pretrial in jail, I asked to be transferred to a different cell to avoid living with an inmate who was sexually harassing me. Instead of getting a new cellmate, I was moved to solitary confinement for seven weeks. I nearly lost my mind in solitary.

7. Harassment continued once I moved to state prison. While I was housed at MCI-Cedar Junction and working in the kitchen, I was handed a note from a large and aggressive inmate. The note demanded that I perform various sex acts. It also demanded my silence, or he would kill me. By the grace of God, I was transferred to NCCI-Gardner the following morning. The trauma continued at NCCI-Gardner, however, as I was raped there by three large men while in the communal shower.

8. The COs also contributed to the hostile environment. They would often enter our housing units barking orders. They would search our belongings by dumping our property on the ground and ripping our family photos. This was scary and kept me on guard. At other times, COs would humiliate me by making distasteful jokes if I asked for an extra roll of toilet paper or made other simple requests.

9. While in the chow hall, we would often be rushed to scarf down our food. Although the regulations permit inmates ten to fifteen minutes to eat, in practice, COs would want chow to be over as quickly as possible. To achieve this, they would yell at us to hurry up and finish. I would often leave the chow hall without eating all of my food. If I attempted to sneak unfinished food out of the chow hall, I was given a disciplinary ticket.

10. Drugs were widely used by inmates in the prison system. Inmates caught with drugs or who had a positive drug screen were placed in solitary confinement for up to three months. Inmates who tested positive had to pay for future drug tests. This meant that an inmate would incur a debt to the DOC for every urine test he could not afford to pay and the DOC would freeze the inmate's account until the debt was paid off. With a frozen account, an inmate could not make basic purchases (like for hygiene products). The drug tests cost a lot of money and most of the men I knew could not pay the debt. These sanctions were punitive, not rehabilitative, and did not stop men who were addicted from using.

11. During my incarceration, I saw numerous men who had released from prison return back behind the wall.

12. Classification decided who would participate in the Correctional Recovery Academy (CRA), a designated housing unit

that was intended to address criminal thinking and substance use. I was in my third year of prison when I transferred to NCCI-Gardner and was placed in the CRA unit upon my request.

13. While I had no problem getting into the CRA unit, it was incredibly difficult to get involved in other programs and productive activities. I was on a waitlist for two years for the gardening program. I waited three years for the paralegal program and was never accepted. After two years of begging, I was finally permitted to take college courses and participate in the culinary vocational training program. Despite my efforts to engage in different types of work and vocational programs, I was only ever permitted to work in the kitchen.

14. The CRA consists of classes in which inmates watch movies about addiction, fill out worksheets, and have superficial conversations.

15. I did not receive any one-on-one therapy as part of the CRA programming.

16. The CRA model requires that inmates report inappropriate behavior, including innocuous bad attitudes. This was a tone-deaf requirement because the safety of any inmate who complied with it was put at risk.

17. In the CRA classes, I was not allowed to speak about trauma or make connections to how my childhood or life experiences related to my drug use. Even if I had been

permitted to do so, I would not have shared my deepest thoughts. Many inmates did the CRA program just to accrue good time credits and were not interested in personal growth. Inmates who attempted to open up in these groups were made fun of or harassed.

18. The overall environment in the CRA – and in prison generally – was not conducive to personal growth and development to overcome addictions or problematic behaviors. I was constantly worried about having enough food to eat, protecting my body, and protecting my mind.

19. Fortunately, since my release from prison in 2012, I have had a great deal of support and treatment to help me heal from the traumas I experienced in prison. The recovery from what I experienced continues to be a work in progress.

Signed under the pains and penalties of perjury this 17 day of August 2018.

Michael Cox