IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

GEOFFREY PESCE,

Plaintiff,

v.

KEVIN F. COPPINGER, in his official capacity as Essex County Sheriff, AARON EASTMAN, in his official capacity as Superintendent of the Essex County House of Corrections - Middleton,

Defendants.

C.A. No. ________________

DECLARATION OF SHORTA YUASA, MD

Pursuant to 28 U.S.C. § 1746, I, Shorta Yuasa, M.D., declare as follows:

1. My name is Shorta Yuasa. I am a board certified physician in emergency medicine and addiction medicine employed by Lahey Health Behavioral Services (Lahey). In my clinical capacity as his treating physician, I have been working with Geoffrey Pesce since December 2016 to assist with his recovery from opioid use disorder.

2. I received my medical degree from Tufts University School of Medicine in 1994 and have more than 24 years of experience. I completed my residency at the Medical College of Pennsylvania. A copy of my curriculum vitae is attached as Exhibit 1.

3. Between 1997 and 2012 I practiced emergency medicine at Leominster Hospital and Burbank Hospital in Leominster and Fitchburg, Massachusetts; Elliot Hospital and Catholic Medical Center, in Manchester, New Hampshire; and Lowell General Hospital in Lowell, Massachusetts.

4. For the past 6 years, I have focused exclusively on treating patients who struggle with addiction.
5. From 2013 to 2014, I served as the medical director in the residential detoxification unit at Lahey's Tewksbury Treatment Center.
6. Since 2015, I have been the medical director at the methadone outpatient treatment program at Lahey's Danvers Treatment Center. Since 2017, I have also been the medical director for addiction services at Lahey's Boston, Danvers and Tewksbury Treatment Centers. In this capacity, I offer medication-assisted treatment (MAT) with buprenorphine (commonly referred to by the brand name Suboxone®), naltrexone (commonly referred to by the brand name Vivitrol®), and methadone to treat opioid use disorder.
7. As an addiction specialist, I work with patients every day to prescribe and manage treatment programs for opioid use disorder and other forms of substance use disorder. For many patients suffering from opioid use disorder, an essential component of an effective recovery program is the administration of MAT. MAT involves the use of FDA-approved prescription drugs and is typically prescribed in conjunction with counseling, behavioral therapy, and other interventions. This includes prescribing methadone, buprenorphine and naltrexone. The use of MAT is the medical standard of care for the treatment of opioid use disorders.
8. I have treated hundreds of patients with MAT, including methadone, and witnessed the profound effects it can have on people's lives.
9. It is from the perspective of both Geoffrey's treating physician and as a trained addiction specialist that I offer this declaration.
10. I met Geoffrey when I admitted him into Lahey's Danvers Treatment Center in December 2016. I learned that he had been in and out of detox several times, but it had never worked

before, and he was desperate to try something different that might make a difference. That is why he asked to be admitted into the methadone treatment program. I diagnosed Geoffrey with opioid use disorder and prescribed methadone to treat it. In choosing this treatment, I considered, among other things, the length and severity of Geoffrey's active addiction to opioids, as well as his previously unsuccessful attempts to achieve long-term recovery using buprenorphine and naltrexone. Geoffrey told me that he had felt sick on buprenorphine and naltrexone, which is something I have heard from other patients. In my clinical practice, I have found that there are some people for whom buprenorphine and naltrexone simply do not work, and Geoffrey's history suggests that he is one of those people. In such cases, methadone may be the only option to achieve active, long-term recovery.

11. As his treating physician, I have monitored Geoffrey's recovery progress since December 2016. In my opinion, the continued administration of methadone is medically necessary to treat his opioid use disorder.
12. I generally hesitate to use phrases like model patient, but in Geoffrey's case it is entirely appropriate.
13. With the assistance of methadone, Geoffrey has been able to control the symptoms of his addiction for nearly two years. He has always had negative drug screenings at our clinic, and he has not missed a single day of treatment except for the day after he was held overnight in jail after his arrest in July 2018. He is working at a full time job that he enjoys, he is contributing financially to his family, and he is a caring and responsible father to his young son.
14. As an indication of his progress, Geoffrey had earned "take home" privileges for a three-day dosage of methadone, pursuant to an 8-point criteria set out by Federal Regulations: (1) an

absence of recent abuse of drugs or alcohol; (2) regularity of clinic attendance; (3) no serious behavioral problems demonstrated; (4) no known recent criminal activity; (5) stable home environment and relationships; (6) sufficient length of time in treatment; (7) ability to safely store medication at home; and (8) the benefit of reduced attendance outweighs risk of diversion. In July 2018, when Geoffrey was arrested, he was on his way to earning "take home" privileges for an entire week. These are the outcomes we hope to see in all of our patients.

15. When Geoffrey started his methadone treatment, we slowly up-titrated to a "blocking dose" of 120 mg per day. At this dosage, Geoffrey did not suffer from the symptoms of opioid use disorder. He was able to function each day as a parent of a young boy and a hard working machinist without cravings for opioids and did not engage in the types of risky behaviors that were common during his periods of active addiction.

16. Geoffrey remained on this dosage until the summer of 2018. He became concerned that he would not be able to continue his methadone treatment during an upcoming 60-day incarceration at Essex County House of Correction – Middleton (Middleton HOC), and he chose to taper down because he was so concerned about the prospect of having to undergo abrupt withdrawal when he is incarcerated. He ultimately went down to 20 mg per day, at which point he became quite sick. He was sweating all day, suffered from insomnia, and felt fatigued, anxious, unmotivated and depressed. We have increased his dosage back up to 50 mg per day, but I am still concerned that this dosage is too low. In my opinion, Geoffrey's current medical state indicates that he should be taking between 80-100 mg a day to properly treat his opioid use disorder.

17. Despite Geoffrey's progress, in my medical opinion he continues to need methadone as part

of his ongoing recovery and is not ready to be tapered off of his medication. He is still learning coping mechanisms and other skills to help ensure the success of his long-term recovery. That is typical for someone with a history of active addiction as lengthy as Geoffrey's. The length of time a patient remains on methadone is individual and depends on the particular circumstances of the patient. The Substance Abuse and Mental Health Services Administration recommends that methadone treatment lasts at least 12 months but recognizes that some patients may require methadone for years.[1] That is consistent with my experience, where some of my patients have required methadone treatment for 5, 10, or 15 years.

18. My patients have previously served time at Middleton HOC, and it is my understanding that this facility does not provide any MAT. Instead, their withdrawal protocol is limited to the provision of comfort medications that incompletely mask the symptoms of withdrawal rather than using opioid agonists like methadone that go to the heart of withdrawal symptoms Comfort medications do little to stop opioid cravings and they do not remove all of the symptoms of withdrawal, leaving patients in a significant amount of discomfort and vulnerable to relapse. In my opinion, this is the equivalent of forcing patients to "white-knuckle" their withdrawal. I believe it is cruel because patients are so uncomfortable and are therefore at a high risk of relapse. It is for this exact reason that our residential detoxification programs discontinued using protocols that only use comfort medications.

19. In my medical opinion, the only humane way to treat opioid withdrawal is to offer MAT, which is the standard of care.

20. I am very concerned about Geoffrey being incarcerated without being able to continue his prescribed methadone. The sudden, involuntary withdrawal of Geoffrey's methadone

[1] SAMHSA, Methadone, *available at* https://www.samhsa.gov/medication-assisted-treatment/treatment/methadone

treatment will cause severe and needless suffering, jeopardize his long-term recovery and is inconsistent with sound medical practice. From a medical perspective, it is no different than not offering insulin to someone with diabetes when they are incarcerated. Geoffrey's methadone treatment is that important to his physical and psychological health.

21. Without treatment, Geoffrey will suffer from withdrawal and cravings to use opioids when he is sent to Middleton HOC. In my practice, I have personally witnessed the excruciating symptoms experienced by patients undergoing an accelerated methadone detox process. Physically, these patients suffer from severe abdominal cramps, diarrhea, vomiting, tremors, body aches, chills, hot flashes and insomnia. Putting someone in abrupt opioid withdrawal can also trigger significant psychological consequences, including anxiety, depression and in some cases, suicidal thoughts.

22. Forcing Geoffrey to undergo this painful withdrawal is inhumane. It is also extremely dangerous, as it puts him at high risk of relapse. Through my work with formerly incarcerated patients, I am aware that illegal drugs are accessible in jails and prisons. I fear that even though Geoffrey is desperate to remain in active recovery, if someone offers him illegal drugs while he is incarcerated and undergoing withdrawal from methadone, he will be unable to say no.

23. Forced withdrawal will also substantially disrupt Geoffrey's treatment. As an initial matter, it is not uncommon for patients to not return to treatment after incarceration, and that has occurred with many of my patients in the past. For those that do return to treatment, they must effectively start over. In our clinic, patients that have missed only three doses of methadone are required to have their dosage amount cut in half. After five missed days of treatment, the patient is administratively discharged and has to start over again. Even

assuming Geoffrey returns to treatment when he is released — rather than relapsing —he will need to start all over at low dosages. It will take several weeks before Geoffrey is able to achieve a fully therapeutic dose. He will lose all of the progress he has made over the last two years and will be back to square one.

24. Finally, I am particularly concerned that incarcerating Geoffrey without access to the methadone treatment that I have prescribed puts him at a high risk of overdose and death upon his release. Without his methadone treatment, Geoffrey will no longer be in remission from active addiction when he is released, and his tolerance to opioids will be significantly diminished. It is for this reason that one of the most vulnerable times for individuals with opioid use disorder is when they are released from incarceration without access to MAT. I have treated numerous patients who have relapsed, overdosed and died soon after they were released because they were not provided MAT while they were incarcerated.

25. Middleton HOC is less than two miles from the Lahey clinic in Danvers where I currently treat Geoffrey. I fully support Geoffrey continuing his treatment at the Lahey clinic while he is incarcerated. The clinic already serves many residential programs who transport their residents to the clinic every morning to receive their methadone treatment. There would be no disruption if Middleton HOC also transported Geoffrey to the clinic to receive his methadone treatment.

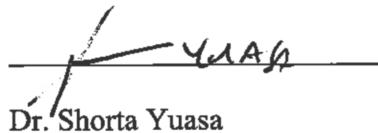
26. In my decades of experience, I have learned that you cannot coerce recovery. Successful long-term recovery requires a sense of autonomy. This includes the ability to have informed consent in, and continued control over, one's own chosen method of treatment. An individual can successfully taper off of methadone only if they do so voluntarily. Forcing someone off of their physician-prescribed medication before they feel ready makes things worse. It adds

extra stress, and opioid addiction causes the area of the brain that handles stress to become maladapted. As a result, individuals suffering from opioid use disorder are particularly ill-equipped to handle stressful situations. Coercing involuntarily withdrawal from methadone in and of itself can therefore cause relapse.

27. At some point, I anticipate Geoffrey will be ready to taper off of his methadone treatment. But in my medical opinion, he is not ready to do so now. Denying Geoffrey his methadone treatment while he is incarcerated at Middleton HOC would deny him medically necessary care. It would be cruel, painful and dangerous, and would put his life at serious risk.

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

Executed on September 18, 2018



Dr. Shorta Yuasa