UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF NEW YORK

P.G., Plaintiff, v. JEFFERSON COUNTY, NEW YORK, et al., Defendants.	Case No. 5:21-cv-388 (DNH/ML)

SUPPLEMENTAL DECLARATION OF RICHARD N. ROSENTHAL, M.D.

Pursuant to 28 U.S.C. § 1746, I, Richard N. Rosenthal, M.D., declare as follows:

1. I submit this declaration to supplement my earlier declaration in support of Plaintiff P.G.'s motion for a preliminary injunction. In preparing this declaration, I reviewed the medical records of P.G.'s opioid use disorder (OUD) treatment, including records from the current provider of his methadone treatment, Credo Community Center. I also reviewed the declaration that P.G. submitted describing his OUD and the treatments he has received for it.

2. It continues to be my opinion, based on P.G.'s records and declaration, that maintenance of his methadone treatment is medically necessary. Of the many different treatments he has tried, methadone therapy is the only one that has been effective in controlling his cravings for opioids and relieving his withdrawal symptoms. Removing him from methadone would be dangerous and violate the standard of care because it would subject him to severe withdrawal and drastically increase his risk of relapse and overdose. A study conducted by two leading authorities on OUD showed that the effects of withdrawal from methadone are frequently more severe than the effects of withdrawal from heroin, and include such agonizing symptoms as bone and joint aches, vomiting, diarrhea, insomnia, hypothermia, hypertension,

depression, anxiety, and desperation.[1] P.G. has previously experienced severe withdrawal on multiple occasions and a life-threatening overdose after he was removed from his medication for OUD (MOUD) while incarcerated.

3. Forcibly removing P.G. from methadone treatment would violate the standard of care even if it were done through medical detoxification. Forced withdrawal—with or without medication to mitigate the effects of withdrawal—is not medically appropriate because it disrupts the patient's treatment, increases their risk of relapse, and reduces their tolerance to high-dose opioids. Put another way, forced withdrawal jeopardizes patients' recovery and makes them more likely to overdose and die. Patients with OUD who are forcibly withdrawn from MOUD while incarcerated are at higher risk for overdose and overdose fatality after release.[2]

4. That P.G. has been maintaining a subtherapeutic dosage of methadone in recent months does not suggest forced withdrawal would be medically appropriate. Although P.G. had previously been maintained at a dosage of 140mg per day, he is currently receiving a much lower dosage of 60mg per day. He is at a subtherapeutic dosage not because his treating physician has determined it is necessary, but rather because P.G. fears being cut off from his medication while incarcerated. In my experience, this is a common resort of patients on MOUD who anticipate being removed from their medication, which reflects their desperation to mitigate the painful withdrawal symptoms they will suffer when removed. Nevertheless, reducing even P.G.'s subtherapeutic dosage to zero would subject him to severe withdrawal symptoms and

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[1] *See* Ex. 1, Michael Gossop & John Strang, *A Comparison of the Withdrawal Responses of Heroin and Methadone Addicts During Detoxification*, 158 Brit. J. Psychiatry, No. 5, at 697–99 (1991).

[2] *See* Ex. 2, Jeannia J. Fu et al., *Forced Withdrawal From Methadone Maintenance Therapy in Criminal Justice Settings: A Critical Treatment Barrier in the United States*, J. Substance Abuse Treatment, 44(5), at 502–05 (2013).

significantly increase his risk of relapse, overdose, and death.

5. P.G.'s records and declaration further indicate that his remaining at a subtherapeutic dosage is not sustainable. While on a subtherapeutic dosage he has been experiencing painful withdrawal symptoms and cravings for opioids. As a result, he has had to steadily increase his dosage over the past few months from 30mg to 60mg per day, despite his effort to remain at as low a dosage as possible. At his current dosage of 60mg he still experiences cravings. The longer P.G. feels compelled to stay at a subtherapeutic dose, the more he is at risk of relapsing.

6. Other medications that are referenced in Defendants' opposition papers, such as Mylanta, Vistaril, and clonidine, would not be effective for P.G. To begin with, those medications are not substitutes for methadone because they are not treatments for OUD. Instead, they are medications sometimes used to attempt to mitigate the effects of withdrawal from OUD medications. But there is no medical basis to withdraw P.G. from his methadone treatment. Moreover, those medications at most will be marginally effective in managing P.G.'s most acute withdrawal symptoms in the very short term. Given that P.G. has chronic withdrawal symptoms and opioid cravings, he will remain at high risk of relapse and overdose without methadone treatment, regardless of whether he is given Mylanta, Vistaril, or clonidine.

7. Fundamentally, no measures aimed at managing P.G.'s withdrawal would adequately mitigate the risks of relapse, overdose, and death that results from interrupting his methadone treatment. Without ongoing methadone therapy, P.G. will continue to experience cravings for opioids and withdrawal symptoms, both while incarcerated and after he is released.

8. P.G.'s use of illicit drugs on a few isolated occasions while he has been receiving methadone treatment does not indicate that continued treatment with methadone is unnecessary.

Like many other chronic diseases, OUD often involves cycles of relapse and remission, and the goal of treatment is to maximize periods of active recovery while minimizing periods of relapse. That P.G. has not completely ceased using drugs while receiving methadone reflects the severity of his condition and underscores the acute need to maintain his treatment. His records confirm that relapses have been very infrequent when he has been receiving a therapeutic dosage of methadone—far less frequent than his relapses while receiving other medications or non-medication treatment for OUD.

9. The only medical basis for forcibly discontinuing the administration of methadone to a patient, like P.G., who is in active recovery on the treatment is contraindications for methadone. As recognized by the American Society of Addiction Medicine, there are only four such contraindications: (1) where the patient has a known hypersensitivity to methadone (an abnormal response by the immune system to methadone); (2) where the patient experiences respiratory depression (an insufficient breathing rate and volume); (3) where the patient has acute bronchial asthma (a condition that typically causes recurrent episodes of acute shortness of breath) or hypercapnia (an elevated level of carbon dioxide in the bloodstream); and (4) where the patient has known or suspected paralytic ileus (a condition where the motor activity of the bowel is impaired due to something other than a physical obstruction).[3] P.G.'s medical records indicate that he presents none of these contraindications. Accordingly, there is no medical basis for discontinuing his treatment.

10. A physical examination is not needed to determine that the continuation of P.G.'s methadone treatment is medically necessary and appropriate. P.G. has been prescribed

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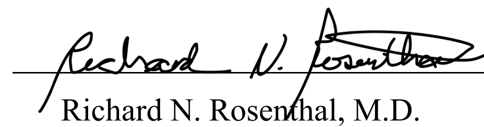
[3] *See* Ex. 3, American Society of Addiction Medicine, *National Practice Guideline for the Treatment of Opioid Use Disorder*, at 30 (2020).

methadone as treatment for his OUD by a specialist in addiction medicine, has been and is currently responding well to that treatment, and has not experienced adverse side effects. Confirmation from the current treating physician of P.G.'s diagnosis, medication, and dosage is sufficient to continue his treatment.

Dated: May 26, 2021
Stony Brook, NY



Richard N. Rosenthal, M.D.