**UNITED STATES DISTRICT COURT**
**FOR THE WESTERN DISTRICT OF MICHIGAN**
**SOUTHERN DIVISION**

CYRUS PATSON,

Plaintiff,

Case No.:
Hon.:

v.

GRAND TRAVERSE COUNTY, MICHIGAN; THOMAS J. BENSLEY, in his official capacity as Sheriff of Grand Traverse County; MICHAEL SHEA, in his official capacity as Undersheriff of Grand Traverse County; and CHRIS BARSHEFF, in his official capacity as Administrator of Grand Traverse County Correctional Facility,

Defendants.
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**VERIFIED COMPLAINT**
**AND REQUEST FOR EMERGENCY INJUNCTIVE RELIEF**

Plaintiff Cyrus Patson complains against Defendants Grand Traverse County, Grand Traverse County Sheriff Thomas J. Bensley in his official capacity, Grand Traverse County Undersheriff Michael Shea in his official capacity, and Grand Traverse County Correctional Facility Administrator Chris Barsheff in his official capacity (collectively, "Defendants") as follows:

**PRELIMINARY STATEMENT**

1. This civil rights action challenges Defendants' denial of medically necessary treatment for opioid use disorder ("OUD") at Grand Traverse County Correctional Facility ("the Jail").

2. The opioid epidemic has been devastating communities for decades, and its reach continues to grow at an exponential rate. In 1999, 118 people in Michigan died from opioid overdoses. By 2018, that number had grown to 2,036.[1] Nationally, opioid overdoses are the leading cause of death for Americans under 50 years old.[2] In 2019, 70,630 people died from drug overdoses—and 70% of those deaths involved an opioid.[3] Every day, 136 people die from an opioid overdose—equivalent to one person every 10.5 minutes.[4]

3. The medical condition that is often referred to colloquially as "opioid addiction" is known clinically as opioid use disorder ("OUD"). OUD is a chronic brain disease characterized by the persistent use of opioids despite the harmful consequences of their use.[5] Overdose and death are significant risks of opioid use.[6]

4. Medication for opioid use disorder ("MOUD"), sometimes called medication for addiction treatment ("MAT"), is widely regarded as the standard of care for the treatment of OUD. MOUD "is a comprehensive approach that combines FDA-approved medications with counseling and other behavioral therapies to treat patients with opioid use disorder."[7] MOUD is

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[1] *Opioid Resources*, STATE OF MICH., https://www.michigan.gov/opioids/ (last visited Oct. 27, 2021) (hereinafter, "State of Michigan, *Opioid Resources*")
[2] Maya Salam, *The Opioid Epidemic: A Crisis Years in the Making*, N.Y. TIMES (Oct. 26, 2017), https://www.nytimes.com/2017/10/26/us/opioid-crisis-public-health-emergency.html?.?mc=aud_dev&ad-keywords=auddevgate&gclid=CjwKCAjwzOqKBhAWEiwArQGwaJEdok3IbMjIldHH4DFezNuPhMrlqksi33Be0sFwGMp4WkL7IrpLkBoCiaAQAvD_BwE&gclsrc=aw.ds.
[3] *Opioid Overdose: Understanding the Epidemic*, CTRS. FOR DISEASE CONTROL AND PREVENTION (last reviewed Mar. 17, 2021), https://www.cdc.gov/opioids/basics/epidemic.html (hereinafter "CDC, Understanding the Epidemic").
[4] *Id*.
[5] *Opioid Use Disorder*, YALE MED., https://www.yalemedicine.org/conditions/opioid-use-disorder (last visited Oct. 27, 2021) (hereinafter, "Yale Med., *Opioid Use Disorder*").
[6] *Id*.
[7] FDA News Release, Food & Drug Admin., FDA Approves First Generic Versions of Suboxone Sublingual Film, Which May Increase Access to Treatment for Opioid Dependence (June 14, 2018), https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm610807.htm.

the *only* effective treatment for OUD. Attempting to treat OUD without medication or through "cold turkey" withdrawal is not effective and is not a medically appropriate method of treatment.[8]

5. Forcing someone who is currently successfully treated using MOUD to undergo withdrawal from their medication causes immediate and excruciating symptoms in the short-term, and massively increases the chances of a subsequent relapse and the resulting medical hazards, including a greatly heightened risk of fatal overdose.[9]

6. Despite scientific consensus about the critical role of MOUD in treating opioid addiction, decades of entrenched stigma continue to serve as a systemic barrier to this life-saving treatment. While science tells us MOUD is vital to recovery, pervasive stigma towards people with OUD continues to be a substantial barrier to treatment.[10]

7. Defendants—Grand Traverse County, and county officials who are responsible for the operations and oversight of the Jail—are reinforcing precisely such stigma by failing to provide Suboxone as a matter of policy and practice to all peoplepeople who are incarcerated in the facility for more than a very short amount of time.

8. Plaintiff Cyrus Patson is a 20-year-old resident of Traverse City who has severe OUD, for which his physician prescribes twice-daily Suboxone as treatment. This has allowed him to make great progress in managing his OUD. He attends counseling regularly and has

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[8] Marc A. Schuckit, *Treatment of Opioid-Use Disorders*, 375 NEW ENG. J. MED. 357 (2016) (hereinafter, Schuckit, "*Treatment of Opioid-Use Disorders*").

[9] AM. SOC'Y OF ADDICTION MED., THE ASAM NATIONAL PRACTICE GUIDELINE FOR THE TREATMENT OF OPIOID USE DISORDER: 2020 FOCUSED UPDATE, 33 (Dec. 18, 2019), *available at* https://www.asam.org/docs/default-source/quality-science/npg-jam-supplement.pdf(hereinafter "ASAM National Practice Guideline")

[10] Scott E. Hadland et al., *Stigma Associated with Medication Treatment for Young Adults with Opioid Use Disorder: A Case Series,* 13 ADDICTION SCI. & CLIN. PRAC. 15 (2018).

developed healthy hobbies. He works on and rides dirt bikes, and works on small engines. He is even working on the engine for a truck that he will be using when he is able to drive again. He has also reconnected with his family. None of this would have been possible without the Suboxone that his physician prescribes.

9. Mr. Patson anticipates being sentenced to detention at the Jail on November 12, 2021. Without intervention by this Court, Defendants will strip Mr. Patson of his prescribed treatment, disregarding sound medicine, including the broad consensus in the scientific community and the express judgment of his treating physician.[11] The effects of sudden, forcible withdrawal from Suboxone will be immediate and excruciating, and will subject Mr. Patson to a heightened risk of death.[12] Indeed, Defendants have previously forced Mr. Patson to undergo such a painful and forced withdrawal during a prior stay in the Jail despite his treating physician's explicit pleas that he receive proper treatment, and despite state court orders advising the Jail to provide treatment as recommended by his physician.

10. The denial of necessary medical care violates Mr. Patson's constitutional right to be free from cruel and unusual punishment as guaranteed by the Eighth Amendment to the United States Constitution and his right to be free from discrimination based upon his disability as guaranteed by the Americans with Disabilities Act ("ADA").

11. Mr. Patson seeks emergency, preliminary, and permanent relief to require Defendants to provide him with adequate medical care and prevent suffering. Specifically, he seeks declaratory relief and a temporary, preliminary, and permanent injunction requiring

[11] Declaration of Dr. Kelly Clark (hereinafter "Clark Decl.") ¶ 22.
[12] *Id*. at ¶¶ 17-18.

Defendants to provide him with access to his medically necessary, physician-prescribed Suboxone during the course of his incarceration at the Jail.

**PARTIES**

12. Mr. Patson is a 20-year-old man who resides in Traverse City, Michigan. He has a disability, OUD, for which he is prescribed daily treatment with Suboxone. Mr. Patson faces imminent detention at the Jail.

13. Defendant Grand Traverse County, Michigan ("the County"), is a political subdivision of the State of Michigan that can be sued in its own name. The County is responsible for all acts of the Grand Traverse County Sheriff's Office. The Grand Traverse County Sheriff's Office oversees and administers the Jail and is responsible for the custody and care of all persons detained or incarcerated there.

14. Defendant Thomas J. Bensley is the elected Sheriff of Grand Traverse County. He is the legal custodian of all people confined to the Jail and is responsible for the safe, secure, and humane treatment of these residents, including their medical care. He has final policymaking authority with regard to the Jail. At all relevant times, Defendant Bensley was and is acting under color of state law. Defendant Bensley is sued in his official capacity.

15. Defendant Michael Shea is the Undersheriff of Grand Traverse County. He is responsible for operating the Jail and is responsible for the safe, secure, and humane treatment of the people confined to the Jail. At all relevant times, Defendant Shea was and is acting under color of state law. Defendant Shea is sued in his official capacity.

16. Defendant Chris Barsheff is the Administrator of the Grand Traverse County Correctional Facility. He has control and supervision of the Jail's employees and budget. At all

relevant times, Defendant Barsheff was and is acting under color of state law. Defendant Barsheff is sued in his official capacity.

## JURISDICTION AND VENUE

17. This Court has jurisdiction under 28 U.S.C. § 1331 and 1343. This action seeks to vindicate rights guaranteed by the Eighth Amendment to the United States Constitution, under 42 U.S.C. § 1983. This action is also brought under Title II of the Americans with Disabilities Act, 42 U.S.C. §§ 12131–12134.

18. Venue lies in the Western District of Michigan under 28 U.S.C. § 1391.

## FACTS

### A. Opioid Use Disorder Is a Life-Threatening Medical Condition and a Public Health Crisis.

19. Opioids are a class of drugs that inhibit pain and have euphoric side effects.[13] Some opioids, such as oxycodone, have accepted medical uses, including managing severe or chronic pain. Others, such as heroin, are not generally used in medicine in the United States, but are sold on the black market. All opioids are highly addictive.

20. OUD is a chronic brain disease. Symptoms of OUD include uncontrollable cravings for and compulsive use of opioids, decreased sensitivity to opioids, and potentially excruciating withdrawal symptoms.[14] OUD is progressive, meaning it often becomes more severe over time.[15] Without effective treatment, patients with OUD are frequently unable to control their use of opioids, often resulting in serious physical harm or death, including due to accidental overdose.[16]

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[13] Yale Med., *Opioid Use Disorder, supra*.
[14] *Id*., *supra*.
[15] Declaration of Dr. Richard N. Rosenthal (hereinafter "Rosenthal Decl.") ¶ 12.
[16] *Id*.

21. OUD permanently rewires the brain for addiction. People with OUD cannot simply "will" or "reason" their way out of continued opioid use, even when they are aware of the dire consequences.[17] Continued use does not indicate a person lacks willpower, but rather is the predictable outcome of chemical changes in the brain that result in uncontrollable cravings.

22. Opioid addiction has thus proven especially unresponsive to non-medication-based treatment methods, such as abstinence-only and twelve-step programs, which have been popular in treating other addictions such as alcoholism.[18]

23. Like other chronic diseases, OUD often involves cycles of relapse and remission.[19] Rather than a linear progression in which a person attains permanent abstinence from opioid use, "successful" recovery for OUD is often characterized by sustained periods of abstinence of "active recovery," punctuated by relapses in which the person returns to drug use. These relapses are frequently triggered by an increase in life stressors, a traumatic event, or a lapse in treatment, which causes the person to turn toward illicit drug use.[20] The typical treatment goal for OUD is thus to maximize periods of active recovery and minimize periods of relapse, by ensuring continued treatment and encouraging the use of coping mechanisms and support systems.

24. OUD is an epidemic in the United States and a public health crisis. The incidence of OUD has skyrocketed since the late 1990s. Between 1999 and 2017, the number of annual

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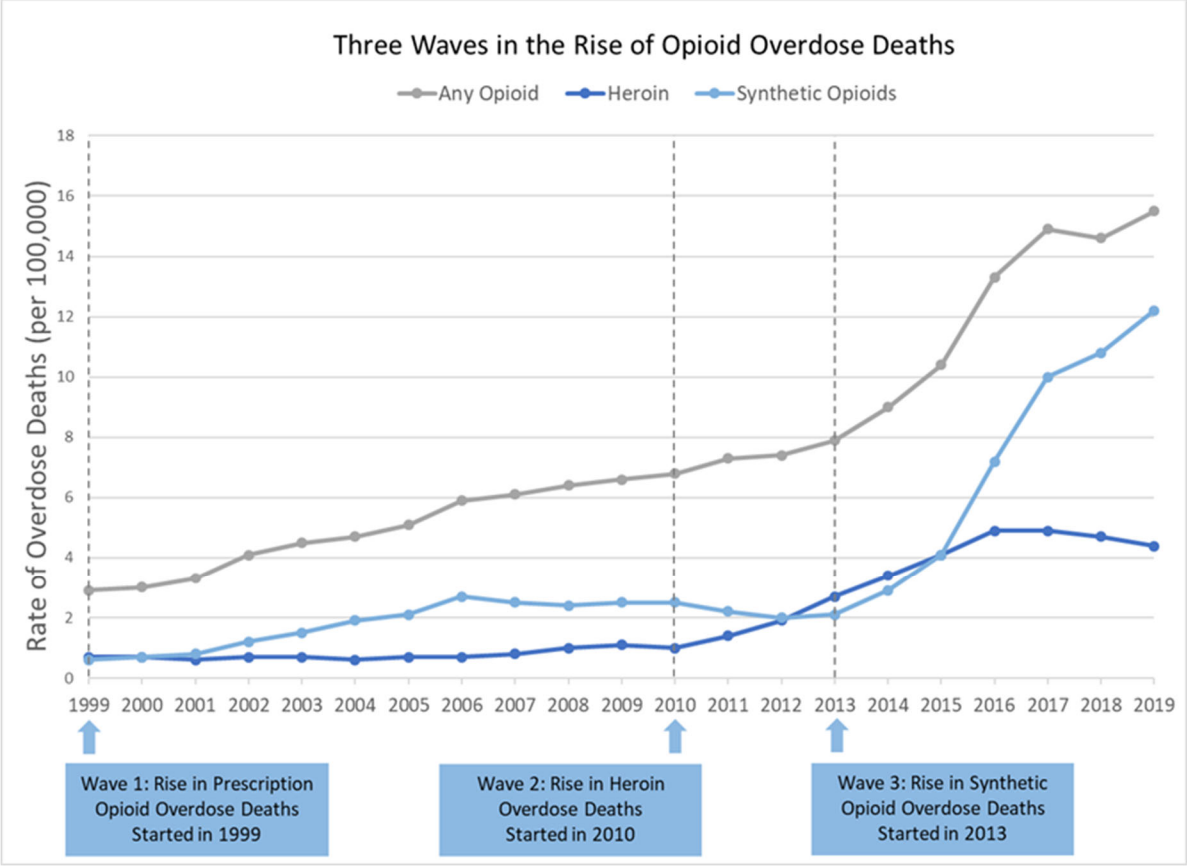
[17] *Biology of Addiction*, *Drugs and Alcohol Can Hijack Your Brain*, NEWS IN HEALTH (Oct. 2015), https://newsinhealth.nih.gov/2015/10/biology-addiction.
[18] Schuckit, *Treatment of Opioid-Use Disorders*, *supra*.
[19] DIAGNOSTIC & STAT. MANUAL OF MENTAL DISORDERS (American Psychiatric Association, 5th ed. 2013) (hereinafter "DSM V").
[20] Rajita Sinha, *Chronic Stress, Drug Use, and Vulnerability to Addiction*, 1141 ANNALS N.Y. ACAD. SCI. 105 (2008).

opioid overdose deaths nationwide increased nearly sixfold. As shown below,[21] since 1999, nearly 450,000 people in the United States have died from opioid overdose:




25. The current COVID-19 pandemic, which has produced enormous grief, anxiety, and feelings of isolation, has further accelerated these trends. In the one-year period ending December 2020, 69,710 people died from drug overdoses involving an opioid, compared with 50,963 in 2019.[22]

[21] CDC, *Understanding the Epidemic*, *supra*.
[22] Julie Steenhuysen & Daniel Trotta, *U.S. Drug Overdose Deaths Rise 30% to Record During Pandemic*, REUTERS U.S. (July 14, 2021, 6:30 PM), https://www.reuters.com/world/us/us-drug-overdose-deaths-rise-30-record-during-pandemic-2021-07-14/.

26. The opioid epidemic has not spared Michigan. From 1999 to 2018, deaths from opioid overdoses in Michigan increased from 118 to 2,036.[23] In 2020, Michigan reported 2,684 overdose deaths.[24] In a 2019 study partly authored by a County health official, opioid deaths in the County were found to have "dramatically increased in the past 5 years . . . . Since 2009, the number of opioid overdose deaths has quintupled."[25]

27. Since 2013, the proliferation of fentanyl and other synthetic opioids—an extremely dangerous class of drug—has been the primary driver of the sharp rise in opioid deaths. As illustrated below,[26] a lethal dose of fentanyl is a tiny fraction of a lethal dose of her oin:


28. Heroin and other illegal opioids are now commonly laced with fentanyl—often without the knowledge of the person using the opioids. As a result, people with OUD who use

[23] State of Michigan, *Opioid Resources*, *supra*.
[24] *Opioid Resources, Data*, STATE OF MICH., https://www.michigan.gov/opioids/0,9238,7-377-94655---,00.html (last visited Oct. 27, 2021).
[25] Wendy Hirschenberger et al., *Grand Traverse County Substance Use Assessment*, 46 (May 1, 2019), https://www.gtcountymi.gov/DocumentCenter/View/11468/GTCO-Substance-Use-Assessment-2019-Final.
[26] Allison Bond, *Why Fentanyl is Deadlier than Heroin, in a Single Photo*, STAT NEWS (Sep. 29, 2016), https://www.statnews.com/2016/09/29/why-fentanyl-is-deadlier-than-heroin.

illegal opioids, especially those who are undergoing MOUD treatment and suffer a brief relapse, now face a heightened risk of being unwittingly exposed to lethal doses of fentanyl.[27]

**B. Broad Scientific Consensus Confirms That MOUD Is Necessary to Treat OUD.**

29. Medical science has provided hope by demonstrating that overdose deaths are preventable with effective treatment.

30. Broad consensus in the medical and scientific communities confirms that MOUD, also known as "medication for addiction treatment" or "MAT," are effective—and in fact necessary—to treat OUD. The American Medical Association, the American Society of Addiction Medicine, the U.S. Department of Health and Human Services, the U.S. Food and Drug Administration ("FDA"), the National Institute on Drug Abuse, the Office of National Drug Control Policy, and the Substance Abuse and Mental Health Services Administration ("SAMHSA") have all endorsed the necessity of MOUD.[28]

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[27] *Id*.

[28] Barbara L. McAneny, *Landmark Deal on Medication-Assisted Treatment A Model for Nation,* AM. MED. ASS'N (Jan. 7, 2019), https://www.ama-assn.org/about/leadership/landmark-deal-medication-assisted-treatment-model-nation; AM. SOC. OF ADDICTION MED., *Policy Statement on Access to Medications for Addiction Treatment for Persons Under Community Correctional Control* (Jan 20, 2021), *available at* https://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2021/01/25/access-to-medications-for-addiction-treatment-for-persons-under-community-correctional-control (hereinafter "ASAM, Policy Statement on Access to MAT"); *How Do Medications Treat Opioid Addiction?*, U.S. DEP'T OF HEALTH & HUM. SERVS. (Sep. 1, 2000), https://www.hhs.gov/opioids/treatment/medications-to-treat-opioid-addiction/index.html; *Information About Medication-Assisted Treatment (MAT)*, FOOD & DRUG ADMIN. (Feb. 14, 2019), https://www.fda.gov/drugs/information-drug-class/information-about-medication-assisted-treatment-mat; *Opioid Use Disorder Affects Millions*, NAT'L INST. ON DRUG ABUSE (Nov. 2016), https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction (hereinafter, "Nat'l Inst. on Drug Abuse, *Opioid Use Disorder Effects Millions*"); *MAT Medications, Counseling, and Related Conditions*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (Sep. 15, 2021), https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions#medications-%20used-in-mat. (hereinafter "SAMHA, *MAT, Counseling, and Related Conditions*")

31. Michigan government agencies also recognize that MOUD is necessary to treat OUD. In 2019, Governor Whitmer and the Michigan Opioids Task Force announced that they would eliminate barriers to treatment for OUD by removing requirements to obtain prior authorization for MOUD in the Medicaid program.[29] In doing so, the Governor and the Task Force explained that MOUD "is the gold standard for treating individuals with opioid use disorder, leading to significantly better outcomes."[30] Likewise, the Michigan Department of Corrections (MDOC) has acknowledged that the benefits of providing MOUD include fewer cases of contraband introduction, less illicit substance abuse, fewer incidents of violence, and better post-release results.[31] Marti Kay Sherry, administrator for the MDOC's Bureau of Health Care Services, recognized that "[m]edication-[a]ssisted [t]reatment, along with additional substance abuse treatment services, increases the likelihood of long-term recovery, reducing the chance of recidivism."[32]

32. The two most recent presidential administrations have also embraced the importance of MOUD. In November 2017, President Trump's Commission on Combating Drug Addiction and the Opioid Crisis acknowledged the efficacy of MOUD and the need to expand its availability to patients.[33] Under President Biden, the Office of National Drug Control Policy has

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[29] Press Release, Michigan.gov, Governor Whitmer, Michigan Opioids Task Force Announce Efforts to Combat Opioid Epidemic, Cut Opioid Deaths in Half (Nov. 14, 2019), https://www.michigan.gov/som/0,4669,7-192-29942_34762-512430--,00.html (hereinafter "Press Release, Michigan Opioids Task Force").

[30] *Id*.

[31] CORRECTIONS CONNECTION, *Ending Addiction: Michigan Department of Corrections Launches Medication-Assisted Treatment at Correctional Facilities*, 3-6 (Feb. 25, 2020), *available at* https://www.michigan.gov/documents/corrections/CC_FebruaryNewsletter2020_682036_7.pdf (hereinafter, "Corrections Connection, *Ending Addiction*").

[32] *Id*. at 4.

[33] THE PRESIDENT'S COMM'N ON COMBATING DRUG ADDICTION AND THE OPIOID CRISIS, FINAL REPORT, 15, 70 (Nov. 1, 2017), https://trumpwhitehouse.archives.gov/sites/whitehouse.gov

likewise identified MOUD as "evidence-based treatment" that "researchers, health care systems, and payers need to develop, scale up, and support."[34]

33. Treatment with MOUD typically consists of medication combined with counseling and other behavioral therapies, but medication is the primary driver of efficacy.[35] MOUD decreases opioid use, reduces the risk of relapse and overdose death, and improves treatment retention.[36] Treatment retention is crucial for treating OUD because patients are less likely to relapse the longer they stay in treatment. Studies have shown that MOUD also decreases the likelihood of criminal activity and infectious disease transmission, and improves patients' ability to maintain family relationships and employment.[37] Although MOUD is typically a comprehensive approach, the medication piece is the most critical and impactful, and should be provided even when counseling and other behavioral therapies are not available.[38]

34. The FDA has approved three medications for treating OUD: methadone, buprenorphine, and naltrexone.[39] Not all these medications are equally effective for every

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/files/images/Final_Report_Draft_11-15-2017.pdf (hereinafter "President's Commission on Combatting Drug Addiction, Final Report")

[34] *The Biden-Harris Administration's Statement of Drug Policy Priorities for Year One*, EXEC. OFF. OF THE PRESIDENT, OFFICE OF NAT'L DRUG CONTROL POL'Y (2021) https://www.whitehouse.gov/wp-content/uploads/2021/03/BidenHarris-Statement-of-Drug-Policy-Priorities-April-1.pdf.

[35] Richard N. Rosenthal, *Medication for Addiction Treatment (MAT)*, 44 AM. J. DRUG & ALCOHOL ABUSE 273 (2018); *Medications for Opioid Use Disorder Improve Patient Outcomes*, PEW (Dec. 17, 2020), https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2020/12/medications-for-opioid-use-disorder-improve-patient-outcomes.

[36] Nora D. Volkow et al., *Medication-Assisted Therapies—Tackling the Opioid-Overdose Epidemic*, 370 NEW ENG. J. MED. 2063, 2064 (2014).

[37] *Id*.

[38] Rosenthal Decl. ¶ 26.

[39] SAMSHA, *MAT Medications, Counseling, and Related Conditions*, *supra*.

patient. Studies show that only two—methadone and buprenorphine—produce longer-term treatment retention, which is the key to effective MOUD treatment.[40]

35. Methadone and buprenorphine are "agonists," which means they activate opioid receptors in the brain to relieve withdrawal symptoms and control cravings.[41] Methadone is a "full agonist," meaning that it fully activates opioid receptors, resulting in a stronger opioid effect.[42] Buprenorphine is a "partial agonist," meaning that it partially activates opioid receptors.[43] In commercially available treatments, buprenorphine is most commonly combined with naloxone, an opioid antagonist that serves as an abuse deterrent in the medication. The most common brand name for this formulation is Suboxone, which is available in both sublingual tablet and sublingual film form.[44]

36. The effect of both methadone and buprenorphine is much milder, steadier, and longer-lasting than drugs such as heroin, fentanyl, or oxycodone. Because methadone and buprenorphine bind to the opioid receptors they stimulate, they block the receptors from being stimulated by more powerful agonists—meaning that patients taking methadone and buprenorphine cannot get the same "high" as they would from illicit drugs like heroin and fentanyl.[45] This trains patients' brains to gradually decrease their response to, and cravings for, opioids.

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[40] NAT'L INST. ON DRUG ABUSE, MEDICATIONS TO TREAT OPIOID USE DISORDER RESEARCH REPORT: HOW EFFECTIVE ARE MEDICATIONS TO TREAT OPIOID USE DISORDER? (Jun. 2018), *available at* https://www.drugabuse.gov/publications/research-reports/medications-to-treat-opioid-addiction/efficacy-medications-opioid-use-disorder.
[41] *Id*.
[42] *Medication Assisted Recovery: Pharmacological Treatment*, INDIAN HEALTH SERV., https://www.ihs.gov/opioids/recovery/pharmatreatment/ (last visited Oct. 27, 2021) (hereinafter, "Indian Health Serv., *Medication Assisted Recovery*").
[43] *Id*.
[44] Declaration of Edmond Hayes (hereinafter, "Hayes Decl.") ¶ 5 n. 1.
[45] Nat'l Inst. on Drug Abuse, *Opioid Use Disorder Effects Millions*, *supra.*

37. Because they act on opioid receptors without presenting the same risk of overdose, both methadone and buprenorphine have been designated as "essential medicines" by the World Health Organization.[46]

38. Unlike buprenorphine and methadone, naltrexone is an "antagonist," which means it blocks opioid receptors without activating them, preventing the euphoric effect of opioids, and thus reducing desire for opioids over time.[47] In patients who have already responded well to buprenorphine or methadone, it is medically inappropriate to provide naltrexone as a substitute. This is because patients' responses to medications for OUD vary significantly based on their individual profiles. The severity of a patient's OUD may affect the relative effectiveness of each different medication. For example, a patient with severe OUD (such as Mr. Patson) may require a medication that produces a stronger opioid effect (like a full agonist) to fully suppress opioid cravings as compared with a patient who suffers from more mild OUD.[48] Naltrexone also does not relieve withdrawal symptoms, and in fact can trigger acute and severe withdrawal. That withdrawal is especially severe when a patient has recently taken an opioid agonist or partial agonist such as buprenorphine. For that reason, medical standards require that patients be fully withdrawn from other forms of MOUD medication before receiving naltrexone—a process that requires undergoing withdrawal prior to switching to naltrexone.[49]

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[46] WORLD HEALTH ORG., WORLD HEALTH ORGANIZATION MODEL LIST OF ESSENTIAL MEDICINES, 22ND LIST 52, 60 (2021), *available at* https://apps.who.int/iris/bitstream/handle/10665/345533/WHO-MHP-HPS-EML-2021.02-eng.pdf.

[47] Indian Health Serv., *Medication Assisted Recovery*, *supra*.

[48] Rosenthal Decl. ¶ 34.

[49] S.H. Boyce & Armstrong, J. Stevenson, *Effect of inappropriate Naltrexone Use in a Heroin Misuser*, 20 EMERGENCY MED. J., 381 (2003).

39. Studies have also shown that naltrexone treatment produces substantially poorer outcomes in terms of treatment retention than either methadone or buprenorphine.[50] Treatment retention is crucial for MOUD because length of treatment is positively correlated with outcomes: The longer a patient stays in treatment, the better the treatment outcome. Because methadone and buprenorphine are better able than naltrexone to keep patients in treatment for longer periods, they are the standard of care for OUD, particularly among patients with severe OUD.[51]

40. Treatment with MOUD is necessarily individualized and depends on a patient's unique profile. Some patients may do well on any form of MOUD; some may find that only one provides effective treatment without significant adverse side effects. An MOUD that effectively treats one person may be completely ineffective, and thus dangerous, for another. Accordingly, switching a patient from one form of MOUD that is currently working for that patient without significant side effects is medically contraindicated.[52] SAMHSA has also highlighted that "dosing and schedules of pharmacotherapy must be individualized" to effectively treat a patient's MOUD.[53]

41. Like other chronic disorders, OUD can be lifelong.[54] There is no maximum recommended duration for treatment with MOUD. MOUD medications are safe to use for life.[55]

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[50] Nat'l Inst. on Drug Abuse, *Opioid Use Disorder Effects Millions*, supra.
[51] Rosenthal Decl. ¶ 33.
[52] *Id.* at ¶ 35.
[53] SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., MEDICATIONS FOR OPIOID USE DISORDER FOR HEALTHCARE AND ADDICTION PROFESSIONALS, POLICYMAKERS, PATIENTS, AND FAMILIES: TREATMENT IMPROVEMENT PROTOCOL 63 (Updated 2020), ES-5, *available at* https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-006.pdf.
[54] *Opioid Use Disorder*, AM. PSYCHIATRIC ASS'N (Nov. 2018), https://www.psychiatry.org/patients-families/addiction/opioid-use-disorder.
[55] SAMSHA, *MAT Medications, Counseling and Related Conditions*, *supra*.

42. Ending MOUD treatment prematurely is exceptionally dangerous. It triggers painful withdrawal symptoms that markedly increase the risk of relapse into opioid use, overdose, and death.[56]

43. Withdrawal from MOUD medication causes symptoms including bone and joint aches, vomiting, diarrhea, insomnia, excessive sweating, hypothermia, hypertension, tachycardia (elevated heart rate), and psychological symptoms like depression, anxiety, and desperation. Apart from the risk of relapse and overdose, other life-threatening complications such as pneumonia and fatal dehydration can occur.[57] The uncontrolled pain and psychological distress that results from withdrawal can also lead to suicidal ideation—that is, a patient experiencing suicidal thoughts—if not properly treated.[58]

44. If treatment with MOUD must be discontinued, it is crucial to taper methadone and buprenorphine as slowly as possible to avoid severe withdrawal symptoms. The process of tapering must occur slowly while the patient is closely monitored, and can take several months.[59]

45. Forcing a person with OUD to withdraw from effective MOUD treatment, when the patient is not experiencing significant side effects or contraindications from the treatment, violates the standard of care.[60] Further, doing so abruptly heightens the risk of acute withdrawal and is even more dangerous.[61]

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[56] Shane Darke et al., *Yes, People Can Die from Opiate Withdrawal*, 112 ADDICTION, 199 (2016).
[57] *Id.*
[58] U.S. DEP'T OF JUST., INVESTIGATION OF THE CUMBERLAND COUNTY JAIL (Jan. 14, 2021) 6, *available at* https://www.justice.gov/opa/press-release/file/1354646/download (hereinafter "DOJ, Investigation of Cumberland County Jail").
[59] ASAM National Practice Guideline, *supra*.
[60] Rosenthal Decl. ¶ 37.
[61] ASAM National Practice Guideline, *supra*.

46. Efforts to "medically manage" forced withdrawal or "detoxify" patients, using non-MOUD pain relievers or otherwise, are not effective. Such efforts, also known as detoxification, worsen long-term outcomes for people with OUD. detoxification is not only ineffective, it is dangerous because it increases overdose risk.[62]

### C. Allowing Access to MOUD Is Feasible in Correctional Settings and Is Particularly Important in Them.

47. Providing MOUD is especially critical in carceral settings, where people with OUD face a dramatically heightened risk of relapse, overdose, and death in the weeks immediately following release.[63]

48. A large proportion of incarcerated people have OUD. More than half of people in prison have been diagnosed with a substance use disorder, and 15% of those in jails and prisons have OUD.[64] In Michigan, more than 20% of incarcerated people have been identified as having OUD.[65]

49. One study found that, in the two weeks following release from prison, formerly incarcerated people in the state of Washington ran a risk of death that is 12.7 times greater than residents of Washington who had not been incarcerated.[66] The leading cause of death among that group was overdose.[67] Another study found that "[t]he opioid overdose death rate is 129

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[62] Edward V. Nunes & Matisyahu Shulman, *Commentary on Stein et al. (2020): Whither Detoxification in the Face of the Opioid Epidemic?* 115 ADDICTION 95 (2019).
[63] Ingrid A. Binswanger et al., *Mortality After Prison Release: Opioid Overdose and Other Causes of Death, Risk Factors, and Time Trends from 1999 to 2009*, 159 ANNALS OF INTERNAL MED. 592 (2013).
[64] Nora Volkow, *Nora's Blog: The Importance of Treating Opioid Use Disorder in the Justice System*, NAT'L INST. ON DRUG ABUSE (July 24, 2019), https://www.drugabuse.gov/about-nida/noras-blog/2019/07/importance-treating-opioid-use-disorder-in-justice-system.
[65] Corrections Connection, *Ending Addiction*, *supra*, at 4.
[66] Ingrid A. Binswanger et al., *Release from Prison–A Higher Risk of Death for Former Inmates*, 356 NEW ENG. J. MED. 157 (2007).
[67] *Id*.

times higher for those recently released from incarceration compared to the rest of the adult population."[68] The same study found that "[o]pioid-related deaths among persons recently released form incarceration have increased 12-fold between 2011 and 2015," and, "[i]n 2015, nearly 50% of all deaths among those released from incarceration were opioid-related."[69]

50. People who have recently been released from incarceration without treatment will have a high risk of return to opioid use upon release, and presumably will have reduced opioid tolerance due to a period of nonuse. This exposes them to a higher risk of overdose if they relapse, as they no longer have the tolerance to the same dose of opioids as before the period of forced withdrawal.[70]

51. In 2017, President Trump's Commission on Combating Drug Addiction and the Opioid Crisis found that, "[i]n the weeks following release from jail or prison, individuals with or in recovery from [OUD] are at elevated risk of overdose and associated fatality."[71] The Commission further found that treatment with MOUD is "correlated with reduced risk of mortality in the weeks following release and in supporting other positive outcomes."[72]

52. Access to MOUD plays a critical role in reducing death in incarcerated populations and yields positive results in the carceral setting. A 2016 national study in England regarding the use of MOUD in jails and prisons found that MOUD "was associated with a 75%

[68] Rosenthal Decl. ¶ 42.
[69] *Id*.
[70] SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., SAMHSA OPIOID OVERDOSE PREVENTION TOOLKIT (revised 2018) 1, *available at* https://store.samhsa.gov/sites/default/files/d7/priv/sma18-4742.pdf.
[71] President's Commission on Combatting Drug Addiction, Final Report, 1-2, *supra*.
[72] *Id*.

reduction in all-cause mortality and 85% reduction in fatal drug-related poisoning in the first month after release."[73]

53. One study in Rhode Island observed a 60.5% reduction in opioid-related post-incarceration overdose deaths one year after a prison-based MOUD program was piloted.[74] In addition, implementing an MOUD program has been shown to decrease drug trafficking in carceral settings because demand for contraband is lowered.[75]

54. Withholding MOUD without a clinical reason is always dangerous, but it is especially dangerous for incarcerated individuals who have OUD, because they are especially likely to relapse and die upon release.

55. In October of 2018, the National Commission on Correctional Health Care and the National Sheriffs' Association jointly released a guide on practices and guidelines for jail-based treatment for OUD.[76] In doing so, they noted that MOUD "is considered a central component of the contemporary standard of care" for the treatment of individuals with OUD.[77] Further, they warned that "correctional withdrawal alone actually increases the chances the person will overdose following community release due to loss of opioid tolerance."[78]

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[73] John Marsden et al., *Does Exposure to Opioid Substitution Treatment in Prison Reduce the Risk of Death After Release? A National Prospective Observational Study in England*, 112 ADDICTION, 1408 (2017).
[74] Takeo Toyoshima et al., *The Evolving Medicolegal Precedent for Medications for Opioid Use Disorder in U.S. Jails and Prisons*, 49 J. AM. ACAD. PSYCHIATRY AND L. ONLINE (2021).
[75] Hayes Decl. ¶ 20.
[76] *See, generally* NAT'L SHERIFFS' ASS'N & NAT'L COMM'N ON CORR. HEALTH CARE, JAIL-BASED MEDICATION ASSISTED TREATMENT: PROMISING PRACTICES, GUIDELINES, AND RESOURCES FOR THE FIELD (Oct. 2018), *available at* https://www.sheriffs.org/publications/Jail-Based-MAT-PPG.pdf (hereinafter "NCCHC & NSA, Jail-Based Medication Assisted Treatment")
[77] *Id.* at 5.
[78] *Id.* at 9.

56. Recognizing the serious risks that OUD poses for incarcerated people, multiple governmental authorities and medical and professional associations have required or recommended that jails and prisons provide maintenance MOUD to those in their custody.

57. In recent years, the U.S. Department of Justice ("DOJ") has consistently taken the position that access to MOUD is required in both carceral settings and court programs. The DOJ has repeatedly confirmed that MOUD is the standard of care for treatment of OUD and that denying access to MOUD constitutes unlawful disability discrimination.[79]

58. The DOJ's Adult Drug Court Discretionary Grant Program, which provides financial and technical assistance to state and local drug court initiatives, also requires grantees to permit the use of MOUD.[80]

59. In 2018, Andrew Lelling, the U.S. Attorney for the District of Massachusetts initiated an investigation into the Massachusetts Department of Corrections for denying people access to MOUD. In doing so, he warned that "all individuals in treatment for OUD, regardless

[79] Press Release, Dep't of Just., U.S. Atty's Off., Dist. of Mass., U.S. Attorney's Office Settles Disability Discrimination Allegations at Skilled Nursing Facility (May 10, 2018), https://www.justice.gov/usao-ma/pr/us-attorney-s-office-settles-disability-discrimination-allegations-skilled-nursing; Alison Knopf, *Department of Justice Tells State Attorney General: ADA Protects People on MAT*, ADDICTION TREATMENT F. (Apr. 17, 2018), https://atforum.com/2018/04/department-of-justice-tells-state-attorneys-general-ada-protects-people-on-mat/; *DEA Supports the Use of Medication Assisted Treatment for Opioid Use Disorder: Message for DATA Waived Practitioners and Those Eligible to Become DATA Waived*, DIVERSION CONTROL DIV., https://www.deadiversion.usdoj.gov/pubs/docs/mat.htm (last visited Oct. 27, 2021); U.S. DEP'T OF JUST., *FY 2021 Budget Request: First Step Act*, *available at* https://www.justice.gov/file/1246146/download.

[80] DEP'T OF JUST., *Adult Drug Discretionary Grant Program FY 2018 Competitive Grant Announcement* 12 -13 (June 5, 2018), *available at* https://bja.ojp.gov/sites/g/files/xyckuh186/files/media/document/BJA-2018-13601.PDF.

of whether they are inmates or detainees, are already protected by the ADA, and [] the [Department of Corrections] has existing obligations to accommodate this disability."[81]

60. In 2021, the DOJ's Civil Rights Division issued a report concluding that the Cumberland County Jail in Bridgeton, New Jersey, had violated the Eighth and Fourteenth Amendments to the U.S. Constitution by failing to provide MOUD to people in its custody.[82] The report found that inadequate treatment of OUD presented a risk of serious harm and likely caused six of the jail's seven suicide deaths in the period studied.[83] It also found that the jail had been deliberately indifferent to that risk by failing to prescribe MOUD, despite knowing people in its custody had significant heroin usage or obvious symptoms of opioid withdrawal.[84]

61. The American Society of Addiction Medicine, the leading professional society in the country on addiction medicine, also recommends treatment with MOUD for people with OUD in the criminal justice system.[85]

62. SAMHSA has also recognized that MOUD should be expanded in criminal justice settings.[86]

63. Ensuring the robust access to MOUD treatment that these agencies and organizations support is both feasible in, and beneficial to, carceral settings. In recommending expanded access in jails and prisons to MOUD, both the National Commission on Correctional

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[81] Letter from Andrew E. Lelling, United States Attorney, District of Massachusetts, to David Solet and Jesse Caplan, General Counsels for the Executive Office of Health and Human Services (Mar. 16, 2018), *available at* https://d279m997dpfwgl.cloudfront.net /wp/2018/03/20180322172953624.pdf.
[82] DOJ, Investigation of Cumberland County Jail, *supra,* at 22.
[83] *Id.* at 9-10.
[84] *Id.*
[85] ASAM, Policy Statement on Access to MAT, *supra.*
[86] SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., MEDICATION-ASSISTED TREATMENT (MAT) IN THE CRIMINAL JUSTICE SYSTEM: BRIEF GUIDANCE TO THE STATES, *available at* https://store.samhsa.gov/sites/default/files/d7/priv/pep19-matbriefcjs_0.

Health Care and the National Sheriffs' Association have emphasized that such access "[c]ontribut[es] to the maintenance of a safe and secure facility for inmates and staff"; and reduces recidivism, withdrawal symptoms, the risk of post-release overdose and death, and disciplinary problems.[87] Additionally, comprehensive drug treatment programs in jails are associated with reduced system costs.[88]

64. Correctional facilities in Michigan have also recognized the necessity of providing MOUD treatment. In 2019, the Michigan Department of Corrections (MDOC) launched a pilot program, providing MOUD in three of its facilities with the goal of expanding treatment to all of its facilities by 2023.[89]

65. The Monroe County Sheriff's Office has achieved a proper standard of medical care for opioid addiction by providing MOUD. Sheriff Troy Goodnough reasoned, "It's the right thing to do . . . We need to give them the opportunity to be productive members of society."[90] In this judicial district, Kent County Correctional Facility provides MOUD to people with OUD. Undersheriff Chuck DeWitt explained, "Everyone should have medical treatment and, as law enforcement officials, we should not dictate what course that treatment needs to take."[91]

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[87] NCCHC & NSA, Jail-Based Medication Assisted Treatment, at 5.
[88] *Id*.
[89] Press Release, Michigan Opioids Task Force, *supra*.
[90] Kara Vensel, *Monroe County Jail Awarded Gold Standard of Medical Care*, MONROE NEWS (Sept. 17, 2021), https://www.monroenews.com/story/news/2021/09/17/monroe-county-jail-awarded-gold-standard-medical-care/8339564002/.
[91] Susan Samples, *Kent County Jail Expands Program to Fight Opioid Abuse*, WOOD TV 8 (Jan. 20, 2020), https://www.woodtv.com/news/target-8/kent-county-jail-expands-program-fighting-opioid-abuse/.

66. Numerous other Michigan counties provide some form of MOUD in their jails, including Eaton, Oakland, and St. Clair.[92]

67. As recognized by these authorities, OUD is a chronic relapsing condition that requires medically appropriate treatment just like other chronic diseases. Once patients start on MOUD, they need to be maintained on that treatment under medical supervision. Any other course of action—including forced withdrawal—is not supported in the medical community and subjects patients to excruciating and unnecessary withdrawal symptoms and elevated risk of relapse and death.

68. Defendants' own practice of providing Suboxone for people who are incarcerated on a short-term basis demonstrates the feasibility of ensuring access to such treatment for people who are incarcerated long-term.

### D. Defendants Have and Will Deny Mr. Patson Medically Necessary Treatment for His OUD.

69. Mr. Patson has battled severe OUD since early 2020. He first sought treatment in November 2020, and was prescribed Suboxone by his physician, Dr. Kelly Clark. Like many other people who battle OUD, he had a brief period of relapse. However, by May of 2021, Mr. Patson had achieved early remission by regularly using his physician-prescribed Suboxone.

70. Alongside Mr. Patson's OUD, he also battles numerous co-occurring disorders. These include major depression, anxiety, and post-traumatic stress disorder. He also has a history of suicide attempts. These co-occurring disorders have been exacerbated when Mr.

[92] Sarah Cwiek, *St. Clair County Jail Joins Small but Growing Ranks of Jails Offering Addiction Medication*, MICH. RADIO (May 9, 2019), https://www.michiganradio.org/health/2019-05-09/st-clair-county-jail-joins-small-but-growing-ranks-of-jails-offering-addiction-medication.

Patson was not treating his OUD, and will again be exacerbated if Mr. Patson is denied treatment.[93]

71. Dr. Clark began prescribing Suboxone Mr. Patson's OUD in April 2021. By May 2021, he had achieved early remission by taking Suboxone regularly. Both Mr. Patson and Dr. Clark recognize that when Mr. Patson is treating his OUD, he does not engage in the risky behaviors that have resulted in his criminal history. When he is being treated, he goes to support group meetings every night, sees a counselor regularly, and actively looks for work.

72. On June 9, 2021, Mr. Patson's course of treatment was disrupted when he was incarcerated at the Jail for a bond violation. Defendants refused to continue MOUD, and refused to provide him with Suboxone during the course of his stay. Defendants persisted in their refusal even after Mr. Patson's criminal defense attorney obtained an order requiring that Mr. Patson continue his treatment.

73. On June 11, 2021, Mr. Patson's grandmother contacted Dr. Clark's office and informed her that Mr. Patson had been incarcerated and that the Jail was denying him his Suboxone. Dr. Clark contacted the jail and spoke with a nurse. Dr. Clark stressed that it was urgent and necessary that Mr. Patson continue his treatment. The nurse told Dr. Clark to send a letter. Dr. Clark sent a letter the same day, stating that Suboxone had been life saving for Mr. Patson and that it would be dangerous to stop his treatment.

74. On June 12, 2021, the Jail gave Mr. Patson one dose of Suboxone. The following day, Mr. Patson slept through medical rounds, and it is therefore unknown if he would have been offered Suboxone that day. After waking up, Mr. Patson requested his Suboxone and it was

[93] Clark Decl. ¶ 5.

denied to him. At that point, the Jail discontinued providing him with Suboxone, but continued to provide him with his other medications as prescribed.

75. After the Jail discontinued his medically necessary Suboxone treatment, Mr. Patson began experiencing withdrawal symptoms immediately and told his grandmother that his mental status was deteriorating. He had stomach cramps and could not eat or sleep. His grandmother became worried and contacted Dr. Clark.

76. On June 15, 2021, Dr. Clark made contact with the Jail's attending physician Dr. Ann Kuenker. Dr. Kuenker is allocated one hour per week to see everyone at the Jail who needs medical attention.[94] On information and belief, Dr. Kuenker does not specialize in and has no particular training or expertise in the treatment of substance use disorders. Dr. Clark again explained to Dr. Kuenker that it was medically necessary for Mr. Patson to continue his Suboxone therapy. Rather than addressing why the Jail refused Suboxone to Mr. Patson, Dr. Kuenker began the conversation by discussing Mr. Patson's criminal record. She also asked Dr. Clark to verify that she had sent the June 11 letter, claiming it looked "photoshopped." Dr. Clark confirmed that she had sent the letter and again stressed that Mr. Patson must receive his Suboxone treatment.

77. On June 17, 2021, Dr. Kuenker left a message for Dr. Clark, stating that Mr. Patson's bond had been set at a high amount, which rendered it unlikely that he would be released soon. Accordingly, Dr. Kuenker advised Dr. Clark, the Jail would not provide him with Suboxone. Without providing any medical explanation, Dr. Kuenker stated that Mr. Patson would not be permitted to take Suboxone during a long term stay in the Jail.[95]

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[94] Tr. Def.'s Mot. Hr'g at 31, People v. Phillips, No. 21-5283-FY-1 (86th Dist. Ct. Grand Traverse Cnty. July 24, 2021).
[95] Clark Decl. ¶10.

78. The facility instead implemented its "detox protocol," which consists of a complete denial of MOUD treatment. Instead, patients are provided with nothing more than Gatorade and over-the-counter pain medications like Tylenol to combat the excruciating symptoms of withdrawal from MOUD.

79. Mr. Patson's withdrawal symptoms worsened. He was restless, but every movement he made was painful. His bones felt like they were bruised. He was sweating and freezing at the same time and could not sleep. He had no appetite, just diarrhea and vomiting. He was in excruciating pain.[96] During a video visit, he told his grandmother that he thought he should kill himself while he was in the Jail.

80. Mr. Patson's grandmother alerted Dr. Clark, who became extremely concerned because she was aware of his co-occurring mental health disorders. Dr. Clark wrote another letter explaining that Mr. Patson was a high-risk individual with a history of suicide attempts, and that he needed to continue his OUD treatment because his mental health would continue to decline without it. In case the Jail continued to deny Suboxone, Dr. Clark even offered to prescribe Sublocade, an injectable buprenorphine formula administered once a month, in the alternative. If Mr. Patson were not being forced to withdraw from Suboxone, there would have been no cause or necessity for him to receive a Sublocade injection.

81. In response, the Jail placed Mr. Patson into isolation because Jail staff had concluded that he presented a suicide risk. However, Jail staff refused to provide Mr. Patson with what he really needed: His MOUD treatment. This is despite Dr. Clark's letters to staff,

[96] Mardi Link, *Rough Recovery: Courts, Jails Slow to Adapt to Best-Practices for Addiction Treatment*, REC. EAGLE (Sep. 26, 2021), https://www.record-eagle.com/news/rough-recovery-courts-jails-slow-to-adapt-to-best-practices-for-addictiontreatment/ article_74712076-1be3-11ec-820f-4792954ccbe2.html.

advising them that continued Suboxone treatment was necessary to combat Mr. Patson's declining mental health, including the risk of suicidal ideation.

82. On June 23, 2021, Mr. Patson's grandmother alerted Dr. Clark that the Jail had placed Mr. Patson into isolation. Dr. Clark wrote another letter, again stating that Mr. Patson's opioid withdrawal was affecting his mental health and that the isolation was making it worse. She asked the Jail to place Mr. Patson into the general population, and again asked that he be put back on his necessary Suboxone treatment.

83. On June 24, 2021, the pharmacist at the Jail called Dr. Clark and advised her that she would prescribe Sublocade if Dr. Clark could transport the medication to the facility. The Jail also advised Dr. Clark that it was not able to store Sublocade and would not be either able or willing to provide it themselves. Dr. Clark was aware that there are strict laws about controlled substances, so she left a message with a Drug Enforcement Agency ("DEA") diversion agent to make sure this was acceptable before proceeding.

84. While Dr. Clark was waiting for return contact from the DEA diversion agent, she began to coordinate with the Jail regarding the prescription for Sublocade. She then learned that the Jail wanted her to leave the medication in a drop box and that she would not be permitted to administer the injection herself. This troubled Dr. Clark because administering Sublocade incorrectly can cause serious harm or death.

85. Subsequently, Dr. Clark's pharmaceutical representatives advised her that the plan violated regulations about the transportation of Sublocade and that doing so would place her medical license at risk. She left two more messages for the DEA agent to determine whether anything could be done. Dr. Clark received no call back. At that point, having learned that the Jail refused to follow her instructions that Mr. Patson be given Suboxone during his

incarceration, and not being able to alleviate Mr. Patson's suffering by providing Sublocade, Dr. Clark reluctantly informed the Jail that she had no choice but to defer to the Jail's medical team.

86. By the time Mr. Patson was released, he had suffered a significant relapse in all of his co-occurring disorders. After he was released, he promptly resumed care with Dr. Clark, who began treating him with Suboxone again. He has been successful at keeping his OUD in remission because of this. He has not used illegal drugs while on Suboxone. Unfortunately, he has not recovered from the relapse in his co-occurring disorders. While he awaits sentencing, Mr. Patson has been participating in a partial hospitalization program for his depression, anxiety, and suicidal ideations. As a result of these lasting consequences of his forced withdrawal, he has not been able to resume employment since his release.

**E. Defendants Categorically and ArbitrarilyDenies MOUD for OUD.**

87. As a matter of policy and practice, Defendants categorically and arbitrarily denies people who are incarcerated long-term access to MOUD, except for pregnant people, even if MOUD has been prescribed by a physician as medically necessary treatment. Defendants have no apparent plans to alter this policy for the foreseeable future.

88. MOUD treatment, such as Suboxone and methadone, is "not allowed" in the Jail, because it "does not fit with the present program of jail and treatment."[97] Defendant Bensley rationalized that the correctional facility is ". . .a jail[,] [] not a hospital, [] not a mental health facility."[98] Defendant Bensley has not wavered from this position, and recently confirmed that

[97] Sheri McWhirter, *Prescribed Recovery: Medication-Assisted Treatment Used to Combat Addiction*, REC. EAGLE (Nov. 11, 2018), https://www.record-eagle.com/news/local_news/prescribed-recovery/article_1c220e17-c383-5740-8a76-657e8927894e.html.

[98] Mardi Link, *Attitudes, Funding Keep MAT Out of Area Jails*, REC. EAGLE (Oct. 26, 2019), https://www.record-eagle.com/news/local_news/attitudes-funding-keep-mat-out-of-area-jails/article_a65b27dcec5e-11e9-ba64-1fa4acb9df2f.html.

the Jail would not provide Suboxone, even when a state court judge indicated his expectation that Mr. Patson would receive MOUD treatment during his prior stay in the Jail. In doing so, Defendant Bensley stated, "[t]hese were sentencing orders to the defendants, not to the jail. It's pretty simple—don't go to jail. And if you do, you'll be treated by the medical professionals we hire."[99]

89. Mr. Patson anticipates being sentenced to the Jail on November 12, 2021. Without judicial intervention, Defendants will again subject Mr. Patson to their compulsory-withdrawal policy and he will be forced to withdraw from his Suboxone again.

90. As explained above, incarcerated people with OUD have a heightened risk for relapse and overdose, with risk of overdose and death especially high in the first weeks immediately following release. Accordingly, Defendants' policies have already once forced Mr. Patson into a dangerous and potentially life-threatening withdrawal. If Defendants' practices are not immediately enjoined, Mr. Patson will again be subjected to forced withdrawal and the concomitant risks to his immediate and long-term health.

91. Mr. Patson's OUD is a serious medical need and a recognized disability. If untreated, it is likely to result in relapse and potentially a fatal opioid overdose, among other things.

92. Suboxone is medically necessary for the treatment of Mr. Patson's serious medical condition.

93. On October 8, 2021, Mr. Patson's criminal defense counsel sent a letter to Defendant Bensley, informing him of Mr. Patson's serious medical need and requesting

[99] Mardi Link, *Repeat Ruling: Sheriff, Not Courts, Control the Jail*, REC. EAGLE (Aug. 1, 2021), https://www.record-eagle.com/news/repeat-ruling-sheriff-not-courts-control-the-jail/article_8d024b02-f21b-11eb-9e20-2f12b4b22f6e.html.

assurance that Mr. Patson will be provided with MOUD, specifically including his physician-prescribed doses of Suboxone, during his time at the Jail. The letter requested a response by October 15, 2021. As of this filing, Mr. Patson's counsel has received no response.

94. Defendants have been informed of Mr. Patson's diagnosis multiple times and advised of the risk of serious harm or death should he continue to be denied medical treatment. However, it is evident that they will not provide such treatment while he is incarcerated in their facility.

**COUNT I – 42 U.S.C. § 1983 AND THE EIGHTH AMENDMENT**
**(Deliberate Indifference to Serious Medical Need in Violation of the Eighth Amendment)**

95. The foregoing allegations are re-alleged and incorporated herein.

96. Defendants, while acting under color of state law, will deliberately, purposefully, and knowingly deny Mr. Patson access to necessary medical treatment for his OUD, which is a serious medical need.

97. Denying Mr. Patson access to his prescribed dosage of Suboxone will cause him physical and psychological suffering, will expose him to heightened risk for other serious medical conditions, and could trigger relapse into active addiction, potentially resulting in overdose and death.

98. As applied to Mr. Patson, the denial of treatment by Defendants amounts to deliberate indifference to a serious medical need, in violation of the Eighth Amendment's prohibition against cruel and unusual punishment and 42 U.S.C. § 1983.

**COUNT II – AMERICANS WITH DISABILITIES ACT**
**(Unlawful Discrimination Against Qualified Individuals with Disabilities)**

99. The foregoing allegations are re-alleged and incorporated herein.

100. The Jail, which is overseen by Defendants, is a public entity subject to the ADA.

101. Drug addiction is a "disability" under the ADA. *See* 42 U.S.C. §§ 12102 and 12131(2); C.F.R. § 35.108 (the phrase "physical or mental impairment includes, but is not limited to . . . drug addiction, and alcoholism.")

102. The ADA applies to people, like Mr. Patson, who suffer from OUD.

103. Defendants have denied and will deny Mr. Patson the benefits of the Jail's medical programs on the basis of his disability by denying him treatment for OUD.

104. Defendants will refuse to make a reasonable accommodation for Mr. Patson by providing him with access to his prescribed dosage of Suboxone during his incarceration, thereby discriminating against him on the basis of disability, even though accommodation would in no way alter the nature of the healthcare program. Defendants do not deny medically necessary, physician-prescribed medications to people with other serious, chronic medical conditions, such as diabetes, which is illustrated by Defendants' own willingness to provide Mr. Patson with all of his other prescribed medications.

**PRAYER FOR RELIEF**

Mr. Patson asks this Court to GRANT the following relief:

1. Emergency, preliminary, and permanent injunctive relief ordering Defendants to provide him with access to MOUD, including the Suboxone dosage prescribed by his physician (or an equivalent generic drug combination), during his incarceration;

2. Declaratory relief;

3. Award Mr. Patson his attorneys' fees and costs; and

4. Any further relief this Court deems just and proper.

Respectfully submitted,

*/s/ Syeda Davidson*
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*Attorneys for Plaintiff Cyrus Patson*

Dated: October 28, 2021

**UNITED STATES DISTRICT COURT**
**FOR THE WESTERN DISTRICT OF MICHIGAN**
**SOUTHERN DIVISION**

CYRUS PATSON,

Plaintiff,

Case No.:
Hon.:

v.

GRAND TRAVERSE COUNTY, MICHIGAN; THOMAS J. BENSLEY, in his official capacity as Sheriff of Grand Traverse County; MICHAEL SHEA, in his official capacity as Undersheriff of Grand Traverse County; and CHRIS BARSHEFF, in his official capacity as Administrator of Grand Traverse County Correctional Facility,

Defendants.
_____/

**DECLARATION OF KELLY J. CLARK, M.D.**

Pursuant to 28 U.S.C. § 1746, I, Kelly J. Clark, M.D., declare as follows:

1. I am a physician at Munson Medical Center in Traverse City Michigan. I have been employed there for 14 years.

2. I received my M.D. from St. George's University School of Medicine in 2007 and have practiced medicine for 14 years. I completed my residence in Family Medicine at Munson Medical Center in 2010 and completed a fellowship at Michigan State University in Academic Medicine in 2011. I am board certified in Family Medicine.

3. My practice includes treating people who have been diagnosed with substance use disorder, including opioid use disorder (OUD). OUD is a chronic brain disease which is a subset of substance use disorder. Often, a person who has OUD has a co-occurring disorder. A co-

occurring disorder is the existence of another mental health disorder (such as anxiety or depression) alongside a substance use disorder (such as OUD).

4. Co-occurring disorders can be difficult to diagnose and treat. The standard of care for individuals with co-occurring disorders is integrated treatment that addresses both the mental health disorder and the substance use disorder. Failing to treat the substance use disorder exacerbates the co-occurring disorders. The standard of care for people who have been diagnosed with OUD is a multidisciplinary program that includes treatment with medication in addition to counseling and other treatment. Medication for treatment of OUD ("MOUD") includes methadone and buprenorphine. In my years of practice, I have treated dozens of people with MOUD.

5. I have been treating Cyrus Patson since 2013. Mr. Patson was diagnosed with severe OUD in November of 2020. In addition, he battles major depression (severe), generalized anxiety disorder, and post-traumatic stress disorder. I determined, after considering Mr. Patson's individual clinical profile and all available treatment options, that buprenorphine/naloxone is the necessary medication for his OUD. The brand name for this medication is Suboxone. The goal of buprenorphine treatment is to eliminate withdrawal symptoms and provide the patient with a maintenance dosage for long-term stability.

6. As with all chronic disorders, it is common for people with OUD to experience periods of relapse and remission. Mr. Patson had a brief period of relapse after beginning treatment, but by May of 2021 he had achieved remission of his OUD using Suboxone. He is currently taking a maintenance dosage. His dosage is a sublingual film of buprenorphine-naloxone 8mg/2mg twice a day, for a total of 16 mg of buprenorphine and 4 mg of naloxone daily.

7. Suboxone has been an effective treatment for Mr. Patson. It has helped reduce his cravings for opioids, allowing him to make substantial progress in managing his opioid use disorder. He does not engage in the types of risky behaviors that occurred during his periods of active addiction. There have been no significant adverse side effects from Mr. Patson's Suboxone treatment.

8. In May of 2021, Mr. Patson's OUD had been in early remission for approximately one month. He was aware that he might be incarcerated at the Grand Traverse Correctional Facility ("the Jail") and was concerned that the Jail would not provide him with Suboxone. He was extremely worried about having to withdraw from the medication while incarcerated, which is understandable, because the symptoms of withdrawal are excruciating. He wanted to begin to taper off the Suboxone in case he was incarcerated. I explained to him that I strongly recommended against any taper or other interruption in Mr. Patson's therapy — including his Suboxone — because he was at severe risk of relapse and mortality so early in his remission. In my experience and based on medical research, tapering medications like Suboxone should not even be considered until the patient has been stable for 6 – 13 months.

9. On June 11, 2021, I received a telephone call from Mr. Patson's grandmother. She advised that Mr. Patson was incarcerated in the Jail and was not being provided with his prescribed Suboxone. I called the Jail to stress that it was urgent and necessary for Mr. Patson to continue his MOUD treatment. The nurse I spoke with instructed me to write a letter explaining that Mr. Patson needed his medication.

10. The same day, I wrote a letter advising that Mr. Patson was under supervised medical treatment for severe OUD and that he required Suboxone therapy. I explained that he had been successful with this life-saving treatment and that it would be a tragedy to stop it.

11. On June 14, 2021, Mr. Patson's grandmother called me and informed me that the Jail gave Mr. Patson one dose of Suboxone, but refused to give him any more. I called and spoke with Dr. Ann Kuenker, the Jail's attending physician, on June 15, 2021. I told Dr. Kuenker that it was medically necessary for Mr. Patson to stay on his Suboxone therapy. Dr. Kuenker responded by attempting to discuss her understanding of the particulars of Mr. Patson's criminal case, which is irrelevant to the issue of whether he needs his medication. Dr. Kuenker also wanted me to verify that my June 13, 2021 letter was real because she claimed that it "looked photoshopped." I verified that I had sent the letter and again stressed that Mr. Patson needed to continue his Suboxone treatment. Dr. Kuenker stated that she agreed, and so I understood that Mr. Patson would receive the medication.

12. On June 17, 2021, I received a message from Dr. Kuenker. She stated that Mr. Patson's bond hearing had taken place, and that his bond was set at a high amount, which rendered it unlikely that he would be released soon. Because of this, the Jail took Mr. Patson off of Suboxone because "he cannot stay on it long term while in jail." Dr. Kuenker did not explain why. She noted that the Jail had implemented its "detox protocol."

13. On June 21, 2021, I learned Mr. Patson was experiencing stomach cramps from withdrawal, and because of these he was not sleeping or eating. He reported increasing obsessive and hopeless thoughts to his grandmother, telling her that he thought that he should kill himself. Mr. Patson's grandmother became alarmed and contacted me. I was extremely concerned because I was aware that he had a history of multiple suicide attempts. I wrote another letter to the Jail explaining that Mr. Patson was a high-risk individual with a history of suicide attempts, and that he needed to continue his MOUD treatment because his mental health would decline without it. I offered to prescribe an alternative; injectable buprenorphine formula

called Sublocade if the Jail still refused to provide Suboxone. Sublocade only needs to be injected once per month.

14. Instead of providing either Suboxone or Sublocade in response to my letter, the Jail placed Mr. Patson into isolation because they concluded that he presented a suicide risk. He reported that he was not sleeping, he had diarrhea and sweats, and that his anxiety was increasing. Mr. Patson's grandmother alerted me to this development on June 23, 2021.

15. The same day, I wrote another letter to the Jail clarifying that Mr. Patson was not actively suicidal, but that his opioid withdrawal was affecting his mental health. I also explained that the effects of being placed into isolation were affecting his mental health. I asked that the Jail place him into the general population and allow him to be treated with his medication.

16. On June 24, 2021, the physician at the Jail contacted me and advised that Sublocade could not be stored there, but that if I could transport the Sublocade to the Jail, Mr. Patson could receive it. I called and left a message for a Drug Enforcement Agency (DEA) diversion agent to make sure this plan was acceptable, because there are strict laws about controlled substances. I also contacted Dr. Kuenker, who explained that the Jail's nurse manager would contact me to coordinate the Sublocade injection.

17. I then learned that the Jail would not allow me to administer the Sublocade myself. Rather, I was directed to place the Sublocade into a drop box at the Jail and that "control would notify" Amy Booms, the RN manager at the Jail, who would be responsible for administering it after the drop-off. This caused me great concern, because incorrectly administering Sublocade could cause serious harm or death. Further, my pharmaceutical representative contacted me and told me that the plan violated regulations about the transportation of Sublocade, which would place my medical license at risk, and which would

cause the pharmaceutical company to sever its relationship with me. I left two more messages for the DEA agent after this to determine whether there was anything that could be done and received no call back. At that point, I had no choice but to defer to the medical team at the Jail until Mr. Patson was released.

18. When Mr. Patson was released, he started his Suboxone therapy again. Recent drug screens reflect that he is not using illegal drugs. He has already expressed stress and anxiety about being on the correct dose and then being forced to withdraw again. It is common for patients who anticipate being forcibly withdrawn to want their dosage lowered to reduce the effects of withdrawal when it occurs. However, as I noted above, reducing his dosage at this critical moment in his treatment plan is dangerous for Mr. Patson and is not an acceptable medical course of action.

19. Suboxone is medically necessary for Mr. Patson. Discontinuing Mr. Patson's treatment is not clinically indicated. I know of no medical reason to discontinue his treatment. Involuntarily withdrawing Mr. Patson from his treatment is medically contraindicated and would be particularly dangerous.

20. If Mr. Patson is again abruptly withdrawn from Suboxone, he will experience an acute withdrawal. The immediate physical symptoms of that withdrawal will likely include severe body aches, nausea, shaking, sweating, dizziness, dehydration, and vomiting. Forced withdrawal also has the potential for serious psychological effects, especially for people with co-occurring disorders like Mr. Patson. Withdrawal from Suboxone could lead to Mr. Patson decompensating, which means he will experience a dramatic loss in defense mechanisms and in the ability to cope, resulting in progressive personality disintegration. Decompensation can, in turn, lead to delusional behavior, mania, catatonia, loss of appetite, or uncontrollable anger.

21. The long-term effects of withdrawal from Suboxone also includes a higher risk of relapse, overdose, and death upon release or in jail if Mr. Patson were to obtain opioids there because Mr. Patson's OUD will no longer be in remission, he will be craving opioids, and his tolerance to narcotics will be reduced or gone. To minimize the risk of serious long-term harm to Mr. Patson, he must not be abruptly taken off his medication if he is incarcerated or on probation.

22. In my informed medical opinion, denying Mr. Patson his medically necessary Suboxone during any incarceration or probation period is barbaric and inhumane. It is no different than withholding necessary medication for other chronic diseases like diabetes and coronary artery disease. Mr. Patson has relied upon his medication to successfully treat a serious and deadly chronic disease.

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

Executed on October 26, 2021

Kelly J. Clark, M.D. 10/26/2021

**UNITED STATES DISTRICT COURT**
**FOR THE WESTERN DISTRICT OF MICHIGAN**
**SOUTHERN DIVISION**

CYRUS PATSON,

Plaintiff,

Case No.:
Hon.:

v.

GRAND TRAVERSE COUNTY, MICHIGAN; THOMAS J. BENSLEY, in his official capacity as Sheriff of Grand Traverse County; MICHAEL SHEA, in his official capacity as Undersheriff of Grand Traverse County; and CHRIS BARSHEFF, in his official capacity as Administrator of Grand Traverse County Correctional Facility,

Defendants.
_____/

**DECLARATION OF EDMOND HAYES**

Pursuant to 28 U.S.C. § 1746, I, Edmond Hayes, declare as follows:

1. I am an expert in corrections, and, more specifically, in safely implementing medication for opioid use disorder ("MOUD" or, alternatively "medication for addiction treatment" or, "MAT") in correctional settings. I currently serve as Assistant Superintendent at the Franklin County Sheriff's Office in Greenfield, Massachusetts. In that role, I am the Director of Treatment and Programming, which incorporates supervision and administration of the federal- and state-certified opioid treatment program in the Franklin County House of Correction and Jail.

2. The opioid treatment program in the Franklin County jail provides MOUD to detainees with opioid use disorder ("OUD"). Among other duties, I manage and develop

the MOUD program, supervise employees who are part of the MOUD program, and provide policy advice. Part of my job is to consider and address security risks to staff and detainees, and to administer treatment programs in ways that minimize those risks.

3. I have overseen the opioid treatment program in the Franklin County jail since 2015.

4. My curriculum vitae is attached as Appendix A.

5. I am a steering committee member of the Justice Community Opioid Innovation Network ("JCOIN"), a project of the National Institutes of Health. Through my work in the JCOIN project, I regularly meet with jail administrators and public health researchers throughout the nation. In my experience, especially with the ongoing nationwide opioid epidemic, every one of the dozens of jurisdictions I have spoken with has detainees on a regular basis for whom buprenorphine[1] is clinically indicated and necessary.[2]

6. Given my experience in Franklin County, I have been asked to consider and provide my opinions with regard to the feasibility and necessity of the administration of MOUD in the Grand Traverse County Jail in Michigan. For the reasons described below, in my expert opinion there is no reason such treatment cannot be provided, and doing so is urgent for the health and well-being of incarcerated people in the Jail.

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[1] Buprenorphine is an opioid agonist that treats, OUD. The most common formulation of buprenorphine is through the more widely known brand, "Suboxone." Suboxone combines buprenorphine along with naloxone, an opioid antagonist that serves as an abuse deterrent in the medication. Instead of the brand name Suboxone, Franklin County jail's opioid treatment program uses a generic formulation of buprenorphine/naloxone that provides the same ratio of each substance as Suboxone and comes in a tablet form and that is pharmacologically identical to Suboxone. All references in this declaration to Franklin County's protocols for administering buprenorphine refer to this generic tablet that contains both buprenorphine and naloxone.

[2] *See* https://heal.nih.gov/research/research-to-practice/jcoin

7. Franklin and Grand Traverse Counties have similar populations—both overall and in their jails specifically. Both counties are federally designated rural counties that are eligible for Rural Health Grants from the federal Health Resources and Services Administration.[3] Franklin County is a relatively small county, with an estimated 70,000 people living here. Since the pandemic began, the Franklin County Jail's current daily population is approximately 140 detainees, down from 200 before the pandemic. My understanding is that Grand Traverse County is also relatively small, with an overall population around 95,000 and a daily jail population around 170 detainees.[4]

8. Franklin and Grand Traverse County also share in common that they are located in states that have been significantly impacted by the opioid epidemic, with high rates of fatal opioid overdoses.[5] A 2019 study documented a rise in 200% of OUD-related deaths in Grand Traverse County over a two year period between 2015 and 2017.[6]

9. Even in a small facility like ours, there are many detainees for whom MOUD, like buprenorphine and methadone are medically necessary. In the six month period between March 1, 2021 and September 30, 2021, the Franklin County jail's opioid treatment program screened 508 persons for potential treatment. 272 persons where screened to have an opioid use disorder (53.5%). Of those 272 persons, 35 arrived at the jail with an existing prescription to buprenorphine that was maintained and 34 additional

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[3] https://www.hrsa.gov/sites/default/files/hrsa/ruralhealth/resources/forhpeligibleareas.pdf

[4] https://www.record-eagle.com/news/jail-officials-will-look-for-new-mental-health-provider/article_c89f0ac0-778b-11eb-aded-4f4985756842.html

[5] https://www.drugabuse.gov/drug-topics/opioids/opioid-summaries-by-state

[6] https://www.gtcountymi.gov/DocumentCenter/View/11468/GTCO-Substance-Use-Assessment-2019-Final

persons met criteria for buprenorphine and were induced on the medication per their request. Additionally, 30 individuals arrived to the facility during this time period with an existing prescription to methadone and 63 met criteria for this medication and were induced on this medication, per the inmate's request. Of the 508 inmates screened for treatment during this time period, approximately 13% had an existing medical prescription for opioid use disorder.

10. Based on these experiences and the size of the Grand Traverse County Jail, it is very likely that there are dozens of people in the Grand Traverse County Jail who have also needed MOUD treatment over the last several years. Public reporting confirms that this is true.[7]

11. It is my understanding that the Grand Traverse County Jail does not currently have a program or policy in place for providing or continuing MOUD medication for people who are incarcerated there, except for people who are staying in the Jail for a very short period of time. There is no legitimate justification for a jail being able to provide MOUD to short-term detainees, but not to other people.

12. Based on my experience overseeing the administration and implementation of a MOUD program in the Franklin County jail, it is my opinion that buprenorphine and other forms of MOUD can be safely and effectively administered in the correctional setting.

13. Since 2016, the Franklin County jail has offered MOUD to inmates entering the jail to maintain their active, pre-incarceration prescriptions of buprenorphine. In 2018, the Franklin County jail expanded to an induction program, in which incoming inmates are evaluated for opioid use disorder and treated with MOUD as appropriate. From the

[7] https://www.record-eagle.com/news/local_news/attitudes-funding-keep-mat-out-of-area-jails/article_a65b27dc-ec5e-11e9-ba64-1fa4acb9df2f.html

inception of the program in 2015 until the present, I have overseen the administration, implementation, and security of the MOUD program. In that role, I have seen the transformative effect that medical treatment through MOUD can have on the lives of detainees afflicted with OUD. Detainees are more emotionally regulated, there are fewer disciplinary issues, and security staff do not have to deal with irritable detainees who are going through brutal withdrawal symptoms. Everyone is better off.

14. I am aware that some correctional facilities cite the risk of diversion and related security concerns as reasons not to provide MOUD to detainees. However, in my opinion, the risk of diversion does not justify withholding MOUD in jails and prisons because there are many different ways to reduce that risk to a minimal level.

15. I understand that drug trafficking is a problem in many jails and prisons. However, implementing the MOUD program in Franklin County jail has actually decreased trafficking in MOUD medications because demand for contraband is lower. This supports the idea that providing properly prescribed medication as part of an MOUD program in prison does not increase trafficking of the prescribed substances.

16. The Franklin County jail has developed effective procedures to address the risk of diversion. The procedure that we use at the Franklin County jail is described in EXHIBIT 2, titled "Dispensing Protocol for Medically Assisted Treatment (MAT) of Opioid Use Disorder." The dispensing protocol includes safeguards such as:

a. Using multiple security staff to support the medical personnel in administering the medication;

b. the security staff must follow the direction of the medical personnel;

c. Inmates are instructed to talk or manipulate medication with the tongue or

make mouth movements during the medication distribution period. Inmates are also instructed to sit on their hands or keep their hands down, by their sides;

d. Using a medication formulation of crushed buprenorphine tablets, the medication is placed under the inmates tongue to absorb sublingually;;

e. Using a flashlight, the nurse will perform a visual mouth check to ensure the medication remains under the tongue;

f. A nurse or a member of the security staff continues to monitor the detainee for 15–18 minutes after administration;

g. After this time has passed, the nurse will complete a final mouth check with a flashlight to determine if the crushed sublingual medication has fully dissolved.

h. Inmates are then escorted individually, with their hands behind their back, to a bathroom by the officer;

i. Medical staff will instruct the inmate to begin a mouth rinse and spit the residue out, and then have the inmate eat one package of saltine crackers, and repeat rinse and spit;

j. The inmate is instructed to use their fingers to open and expose their upper and lower lip, under their tongue and do a complete finger sweep of their mouth. Inmates then wash their hands.

k. Prior to returning to the housing unit, the officer shall conduct another mouth and hand check. If the inmate salivates onto any part of their jumpsuit, that piece of clothing is removed and replaced.

17. I communicate with the nurse and the correctional officers who

administer MOUD medication, and they report that they are able to effectively perform the procedures listed in Exhibit 2.

18. In addition to these procedures, Franklin County jail also implements urinalysis tests to ensure compliance with the MOUD program.

19. Although I am aware of instances where detainees attempted to divert the medication by spitting some of the medication onto their clothes, it has been very easy for medical and corrections personnel to catch these attempts. These attempts happen infrequently and are generally unsuccessful. One of the reasons this is so rare is because detainees need to take their prescribed dose to suppress the painful effects of opioid withdrawal. Part of the protocol described in Exhibit 2 instructs officers to check each detainee before returning them to their unit, and, "[i]f the detainee salivates onto any part of their jumpsuit, that piece of clothing will be removed and replaced." Exhibit 2 #6 ¶ 2.

20. Using the procedures described in Exhibit 2, there has been very little diversion of medication from the MOUD program in Franklin County jail. The net result has been that since the MOUD program began in the Franklin County Jail, there has been less contraband within the facility. Additionally, based on my knowledge of practices in other correctional facilities, I believe that these procedures would be effective in preventing diversion in other correctional facilities.

21. In short, it is my opinion that the above procedures can effectively prevent diversion of buprenorphine and other agonist medications used in MOUD.

22. The decrease in trafficking due to the MOUD program is especially important at a time when illicit fentanyl, which can be deadly even in tiny and nearly untraceable doses, is available. Therefore, it is especially

important that people with OUD have access to their MOUD so they are not experiencing intense cravings and withdrawal symptoms that may lead them to use fentanyl or fentanyl-tainted substances while incarcerated.

23. Additionally, having worked for years in corrections, it has been my experience that corrections officials who deny detainees access to buprenorphine and other MOUD medications do so because they fail to recognize that MOUD is medication, rather than illicit drugs. This view is contrary to the science and rooted in stigma. Many officials view MOUD as a privilege to be withheld as a punishment, rather than the lifesaving medication that it is. Officials do not withhold lifesaving medications for other chronic diseases like diabetes, high blood pressure, or cancer.

24. I am providing this declaration in my personal capacity, not as a representative of Franklin County Sheriff's Office. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

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

Executed on October 27, 2021

Edmond Hayes

# HAYES APPENDIX A

# Edmond Hayes

(413) 346-7434 ehayes@fcso-ma.us
57 Crescent St. Apt 1, Northampton, MA 01060

## WORK EXPERIENCE

**Consultant,** *Community Resources for Justice, Transitions from Jail to Community Project (2018 – 2019)*
*Crime & Justice Institute, Boston, MA*
Technical assistance provider for correctional institutions to develop evidence-based reentry programming.

**Assistant Superintendent,** *Franklin County Sheriff's Office*
*Franklin County House of Corrections, Greenfield, MA (2013 – present)*
Director of Treatment and Programming. Director of Opioid Treatment Program. Program Management & Development. Employee supervision. Grant-writing, grant management. Community organization partnership & outreach. Quality assurance. Media Relations. Policy Advisement.

**Adult Education Program Director,** *Franklin County Sheriff's Office*
*Franklin County House of Corrections, Greenfield, MA (2010 – 2013)*
Employee supervision. Grant-writing, grant management. Program Planning & Development. Reintegration counseling. Community organization partnerships & outreach.

**Adult Education Program Coordinator,** *Hampden County Sheriff's Department*
*Hampden County House of Corrections, Ludlow, MA (2009 – 2010)*
Grant-writing, grant management. Employee supervision. SMARTT database management. Program planning & Development. Reintegration counseling. Community organization partnerships & outreach.

**Adult Basic Education Instructor,** *Hampden County Sheriff's Department*
*Hampden County House of Corrections, Ludlow, MA (2007 – 2009)*
Instructor for literacy and pre-G.E.D. classes. Lesson planning. Curriculum development. B.E.S.T. Plus certified (English as a second language assessment tool). Library supervision.

**Adult Basic Education Instructor/Transitions Counselor,** *The Literacy Project at the Pioneer Valley Adult Learning Center, Northampton, MA (2006 – 2008)*
Managed Northampton GED program. Outreach. Grant writing. Transitions counseling for students to assist with goal setting/meeting. Management of D.E.S.E. grant. Case management. Event programming. Volunteer supervisor.

## EDUCATION

**College of the Holy Cross,** Worcester, MA
B.A., Music and Biology
**Fitchburg State University,** Fitchburg, MA 21 credits completed toward a M.Ed. in Teaching and Curriculum Development
**Westfield State University,** Westfield, MA currently enrolled in MSW program

## PUBLICATIONS & RECOGNITION

- "Making it Plain: A Town Hall Discussion around COVID & the Incarcerated," https://www.youtube.com/playlist?list=PLg8loYXuxhpz8A4UOsn8k9Quwwr-GbVWs (2021)

- Donelan, C., Hayes, E., Potee, R., Schwartz, L., Evans, L. (2020). Covid-19 and treating incarcerated populations for opioid use disorder. *Journal of Substance Abuse Treatment.* https://doi.org/10.1016/j.jsat.2020.108216
- Bureau of Justice Assistance, Franklin County Sheriff's Office named national demonstration site in Peer Mentor Comprehensive Opioid, Stimulant, and Substance Abuse Program. (COSSAP) FCSO will provide technical assistance to other jails and prisons about operating an MOUD program. (2020).
- Evans E, Hayes E. (2020). A criminal justice-engaged research collaborative: Findings and lessons learned from Western Massachusetts. Community Engagement and Research Symposia. https://doi.org/ 10.13028/5w0c-vv51. Retrieved from https://escholarship.umassmed.edu/chr_symposium/2020/ program/8
- National Institute of Drug Abuse (NIDA), Ed Hayes named Justice Community Opioid Innovation Network (JCOIN) Scholar, (2020).
- Hayes, E. Substance Abuse Mental Health Service Administration, Opioid Response Network. (2020). *Linkages to care Franklin County, MA response to the opioid crisis: A Program of Sheriff Christopher J. Donelan.* Retrieved here: https://opioidresponsenetwork.org/MOUDCorrections.aspx
- National Reentry Resource Center, Council of State Government (2017). Contributor to "*Collaborative Comprehensive Case Plans - Addressing Criminogenic Risk and Behavioral Health Needs."* Retrieved from https://csgjusticecenter.org/nrrc/collaborative-comprehensive-case-plans/
- National Reentry Resource Center (2017). Contributor to "A Five Level Risk and Needs System: Maximizing Assessment Results in Corrections through the Development of a Common Language" Retrieved from https://csgjusticecenter.org/wp-content/uploads/2017/01/A-Five-Level-Risk-and-Needs-System_Report.pdf
- Council of State Governments (2016). Contributor to "Developing Sustainability: Success Stories from the Field," https://csgjusticecenter.org/wp-content/uploads/2016/09/8.30.16_Finding-Sustainability-Webinar.pdf

**MEDIA**

- Associated Press, "Jails Slowly Loosen Resistance to Addiction Meds," August 7, 2018. https://www.apnews.com/c594ad1b9a3a4dcd8b3bcf30bc1a4157
- 22News: WWLP "Franklin County Jail helps Inmates Recover from Drug Addictions," June 26, 2018. https://www.wwlp.com/news/local-news/franklin-county/franklin-county-jail-helps-inmates-recover-from-drug-addictions/1265713304
- CNN "A Rehab Jail for Heroin Addicts," June 21, 2018. https://www.cnn.com/videos/us/2018/12/04/rehab-jail-for-heroin-addicts-beme.beme
- Ozy.com: See Beyond. "Can This Small Town Lead America in Fighting the Opioid Crisis," April 18, 2018. https://www.ozy.com/fast-forward/can-this-small-town-lead-america-in-fighting-the-opioid-crisis/85534
- Boston Globe, "Some Jails are Aiding the Addicted." March 29, 2018. https://www.bostonglobe.com/metro/2018/03/29/county-jails-also-receive-inmates-with-addiction-and-some-offer-opioid-medication-treat/dnb1M74zzAwzRjOe3sD4pJ/story.html

**COMMUNITY ENGAGEMENT**

- Justice Community Opioid Innovation Network Steering Committee (2019-present)
- Co-chair Human Trafficking and Sexual Exploitation Task Force (2019-present)
- Board of Directors, Community Health Center of Franklin County (2018-present)
- Greenfield Community College Advisory Board for the Criminal Justice Program (2017-present)
- Chair of Transitions from Jail to Community Task Force (2014-present)
- Greenfield Community College Advisory Board for Civic Engagement (2013-2015)
- President, Massachusetts Correctional Education Association (2012-2013)
- Elected to Directors' Council for Massachusetts Adult Education Programs (2009-2011)

- Selected by Dept. of Elementary & Secondary Education for Advisory Board for Special Education in Institutional Settings (2010-2013)
- Volunteer: Northampton Interfaith Shelter (2005-2007), The Literacy Project (2004-2006), The Shang Shung Institute for Preservation of Tibetan Culture (Board member 2010-2014)

# HAYES EXHIBIT 1

*Commonwealth of Massachusetts*
*Office of the Sheriff*

*Franklin County*

# DIRECTIVE

## Dispensing Protocol for Medically Assisted Treatment (MAT) of Opioid Use Disorder

**DATE:** **February 18, 2020**

**ISSUED BY:** **Captain Chris Pelletier:** _____

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**Daily Medication call for Medically Assisted Treatment for Opioid Use Disorder**

1. Medication Distribution will commence at 6:00am and will take place in the medium security library. A maximum of 15 inmates will be moved to the programs area in OMS and will be counted in the library during this time. Three security staff will be assigned at all times to monitor the medication distribution unless the group of inmates is six or less, at which time, the number of security staff can be reduced to two. If there is only one inmate receiving medication, only one officer will be required. Security staff will follow the direction of medical personnel.

   Medication distribution grouping will be organized by the overnight shift supervisor in accordance with the information below. If numbers dictate, all groups will be filled to capacity.

   a. Group 1 (Library)
      Court
      Community Service/Off site jobs

Offsite morning appointments
Security Quarantine
All other inmates from Pod A, C, and D

b. Group 2 (Library)

Female inmates (Female inmates scheduled for court will be medicated by the 5:30am – 5:30pm nurse between 5:30am-6:00am in the Medical department.)

c. Group 3 (Library)

Any remaining general population, segregation and disciplinary inmates. (All of these inmates can be grouped together unless enemy status dictates. Segregation/disciplinary inmates shall have the handcuffs removed upon arrival to MAT distribution and shall follow all distribution procedures. Segregation/disciplinary inmates shall be handcuffed prior to return to their housing unit).

d. Any remaining inmates on the list will be incorporated into additional sessions in the library until the conclusion of the distribution process (up to 15 per session) is completed. In the event the medication distribution lasts until 8:45am, and at the direction of shift commander, inmates will be escorted to the intake/booking area (current restraint chair area) and have their medication distributed there. If the restraint chair area is in use, the medication pass will take place in the booking iso-pass area. **Distribution on Sunday can remain in library for the duration of the distribution.**

e. Medical staff may request to have an inmate receive their dosing separately from any group based on past behavior issues, etc. Medical staff will discuss the situation with the Shift Commander and indicate this on the Daily MAT/OTP List.

f. An officer shall be assigned to escort inmates to the intake/booking area with a nurse and remain with the nurse until distribution is completed. Once in the intake area inmates shall be seated in chairs and will adhere to the same procedures required in the library.

2. Security Staff shall call the Housing Units and request the necessary inmates to be seen.

3. The Housing Unit Officer shall log the inmate/s out to medical documenting the name and time of departure on the Unit Log.

4. In both locations, Officer will instruct inmates to sit on their hands and remain in this position for the duration of medication distribution.

5. **(Methadone)** The inmate will be called to the medication cart. The Nurse on duty will administer the crushed Methadone slurry (medication and water) per the provider order. The inmate will then have a small rinse of water added to their cup by the nurse, which the inmate will then drink. The nurse will visually check with a flashlight to ensure that the crushed medication has been swallowed. The inmate will then eat one Saltine cracker, followed by a final mouth rinse which will be swallowed. The nurse will then complete a final mouth check.

   After all inmates have received their medication, the group will remain in the waiting area (both locations) with the Officer and Nurse for approximately 15-18 minutes. After this time has passed, the nurse will instruct all Methadone patients to move his/her chair to the opposite side of the medication distribution line and be seated.

6. **(Buprenorphine or Buprenorphine/Naloxone)** The Nurse on duty will administer the crushed Buprenorphine or Buprenorphine/Naloxone sublingual (under the tongue) per the provider order. There will be no talking, manipulating of medication with tongue or mouth movements for the remainder of the distribution time. The nurse will visually check with a flashlight to ensure that the crushed sublingual medication remains under the tongue.

   After all inmates have received their medication, the group will remain in the waiting area (both locations) with the Officer and Nurse for approximately 15-18 minutes. After this time has passed, the nurse will complete a final mouth check with a flashlight to determine if the crushed sublingual medication has fully dissolved. Inmates who receive their medication in both locations (library and intake/booking area) shall be individually, with their hands behind their backs, escorted to the bathroom by the Officer. Prior to

being escorted to the bathroom, the inmate shall move his/her chair to the opposite side of the medication distribution line. Medical staff will instruct the inmate to begin a mouth rinse and spit the residue out, and then have the inmate eat one package of saltine crackers, and repeat rinse and spit. The inmate shall then be instructed to use their fingers to open and expose their upper and lower lip, under their tongue and do a complete finger sweep of their mouth. At this time the inmates are to wash their hands. Prior to returning to the unit, the Officer shall conduct another mouth and hand check. If the inmate salivates onto any part of their jumpsuit, that piece of clothing will be removed and replaced.

7. If an inmate on MAT has dentures, the following shall apply. If the inmate is able to chew crackers without dentures, the dentures will be left in his/her cell for MAT distribution. If the patient is not able to chew crackers without dentures, the dentures may be kept on person (pocket) during MAT. After the inmate has completed the first mouth rinse/check, the dentures may be worn to proceed with the cracker consumption.

8. Once all inmates from Minimum Security/Kimball House have completed their final mouth rinse/check, they will immediately be escorted back to the minimum security building in preparation for work details. All remaining medium security inmates will wait until the rest of the group has undergone the mouth rinse/check before being transported back to the housing unit.

9. Inmates that are in Protective Custody Status will be escorted to the medication distribution area (individually or in a group of up to 15) and adhere to the procedures above.

10. If an inmate is suspected of tampering with or attempting to divert the medication, the Officer present shall follow the FCSO disciplinary procedure.

**UNITED STATES DISTRICT COURT**
**FOR THE WESTERN DISTRICT OF MICHIGAN**
**SOUTHERN DIVISION**

CYRUS PATSON,

Plaintiff,

Case No.:
Hon.:

v.

GRAND TRAVERSE COUNTY, MICHIGAN; THOMAS J. BENSLEY, in his official capacity as Sheriff of Grand Traverse County; MICHAEL SHEA, in his official capacity as Undersheriff of Grand Traverse County; and CHRIS BARSHEFF, in his official capacity as Administrator of Grand Traverse County Correctional Facility,

Defendants.
_____/

**DECLARATION OF RICHARD N. ROSENTHAL, MD**

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

## I. PROFESSIONAL BACKGROUND AND QUALIFICATIONS

1. I received my undergraduate degree from Oberlin College in 1973. I then received a Master's degree from the Department of Physiology and Pharmacology at Duke University. During that time, I also received a Neurosciences Training Grant Award from the National Institute of Health. I attended medical school at State University of New York Downstate Medical Center, where I received my medical degree in 1980.

2. From 1980 to 1984, I worked in psychiatry at Mount Sinai Hospital in New York City, beginning as an intern, then resident, and ultimately chief resident of the department. I became a Diplomate of the National Board of Medical Examiners in 1981 and I received my license to practice medicine from the New York State Department of Education Office of the

Professions in 1982. In 1985, I was certified by the American Board of Psychiatry and Neurology and in 1993, I received a subspecialty certification in addiction psychiatry.

3. Since becoming a licensed physician, I have worked and taught on substance use disorders ("SUDs") and addiction at various medical schools, including Beth Israel Medical Center, Albert Einstein College of Medicine, Columbia University College of Physicians and Surgeons, Icahn School of Medicine at Mount Sinai, and Stony Brook University School of Medicine, where I currently work as Professor of Psychiatry and was Inaugural Director of Addiction Psychiatry at Stony Brook University Medical Center.

4. I have received several grants for research on alcohol and drug addiction, including research on the effectiveness of buprenorphine to treat opioid use disorder ("OUD"). I have also written numerous peer-reviewed articles, editorials, and book chapters on the treatment of opioid dependence and the opioid addiction crisis generally.

5. I am a distinguished life fellow of the American Psychiatric Association ("APA"), having been a member since 1981, and served on its Council on Addiction Psychiatry for a number of years. I have also been a member of the New York Society for Clinical Psychiatry since 1985, where I served on the Committee on Alcoholism and Drug Abuse for five years, whereupon it became the NY State Psychiatric Association Committee on Addiction Psychiatry that I continue to serve on. I served as a delegate to the Governor's combined Psychiatric and Addiction/Abuse Task Force from 1987 to 1989. In 1986, I was a founding member of the American Academy of Addiction Psychiatry and served as that organization's president from 2001 to 2003. I have since served as the head of its Public Policy Section and Public Policy Committee—a position I have held since 2004. I have also been a member of the American Society of Addiction Medicine ("ASAM") since 1990, and have served as an editor on several editions of ASAM's textbook, the

*ASAM Principles of Addiction Medicine*.

6. I have also been honored to receive a number of awards for my work in the area of substance abuse and addiction psychiatry. In 2005, I received the ASAM Medical-Scientific Program Committee Award. In 2008, I received the American Academy of Addiction Psychiatry Founders' Award. And in 2010, I was named The American Journal on Addictions' Distinguished Clinical Research Scholar on the Addictions.

7. A copy of my *curriculum vitae* further detailing my expertise, qualifications, and list of publications is attached to this report as Appendix A.

## II. OPIOIDS AND ADDICTION

8. Opioids are a class of drugs that inhibit pain and have euphoric side effects.[1] Some opioids, such as OxyContin® and Vicodin®, are prescribed for pain management purposes; others, such as heroin, are illicit. All opioids are highly addictive.

9. Although many opioids have legitimate medical uses, all opioids can halt breathing at high enough doses, risking death or irreversible brain damage from oxygen deprivation.[2] Chronic opioid use leads to physical dependence: withdrawal symptoms include severe dysphoria, craving for opiates, irritability, sweating, nausea, tremor, vomiting, and muscle pain.[3]

10. Roughly 21 to 29 percent of patients who are prescribed opioids for chronic pain

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[1] Ex. 1, *How Opioid Addiction Occurs*, MAYO CLINIC (Feb. 16, 2018), https://www.mayoclinic.org/diseases-conditions/prescription-drug-abuse/in-depth/how-opioid-addiction-occurs/art-20360372

[2] *See* Ex. 2, *Prescription Opioids Addiction and Overdose*, CTRS. FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/drugoverdose/opioids/prescribed.html (last updated Aug. 29, 2017).

[3] Ex. 3, AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 547-48 (5th ed. 2013) ("DSM5"); Ex. 4, Schuckit, MA, *Treatment of Opioid-Use- Disorder*, 375 NEW ENGL. J. MED. 357, 358-59 (2016) ("Schuckit").

use them other than as prescribed, and between 8 and 12 percent become addicted.[4] Opioid use disorder is seen in people from all educational and socioeconomic backgrounds.[5]

**A. The Science of Opioid Addiction**

11. Opioid use disorder ("OUD") is a chronic brain disease that some people can get from frequently taking opioids and is sometimes referred to as opioid dependence or opioid addiction. This type of disease leads to craving opioids, not being able to stop using opioids, and can cause major life problems.[6] Signs of OUD can include craving, increasing tolerance to opioids, withdrawal symptoms, and a loss of control over the frequency of use or the amounts taken.

12. Like other chronic diseases, OUD often involves cycles of relapse and remission.[7] Without treatment or other recovery, patients with opioid use disorder are frequently unable to control their use of opioids. OUD is progressive and can result in disability or premature death.

13. According to the ASAM, addiction (including OUD) "is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors."[8]

14. The brain reward element of opioid use disorder involves the brain's dopamine neurotransmitter system that is the primary neurotransmitter involved in reward. All drugs of

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[4] *See* Ex. 5, Vowles KE, *et al.*, *Rates of opioid misuse, abuse, and addiction in chronic pain: a systematic review and data synthesis*. PAIN. 2015;156(4):569-576.

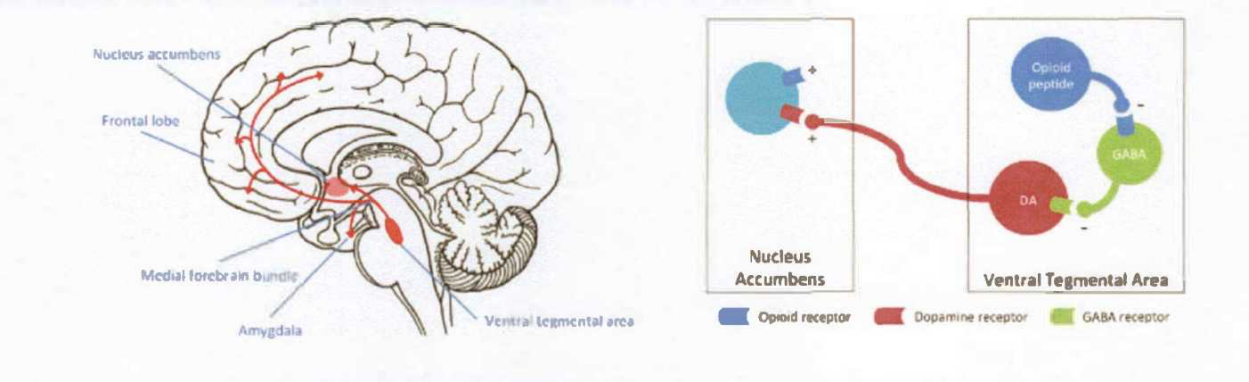
[5] Ex. 4, Schuckit at 357.

[6] Ex. 6, *Opioid Overdose Commonly Used Terms*, CTRS. FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/drugoverdose/opioids/terms.html (last updated Jan. 26, 2021).

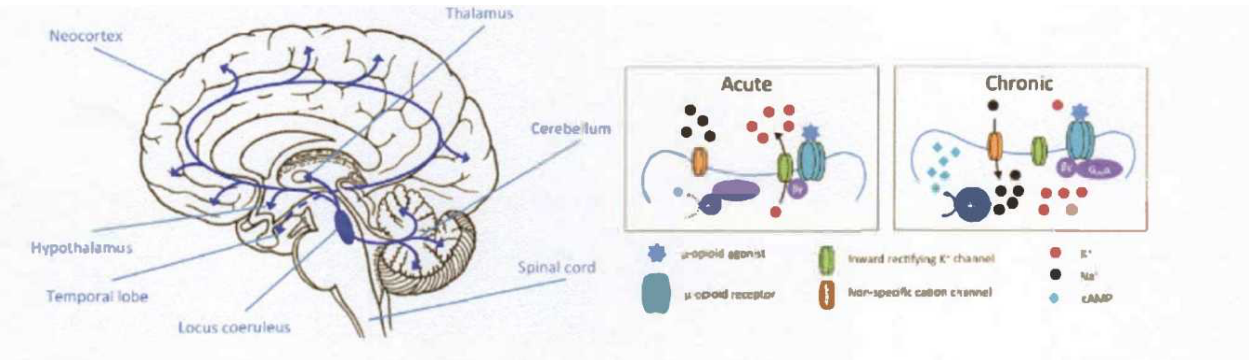
[7] Ex. 3, DSM5.

[8] Ex. 7, *Definition of Addiction*, AM. SOC'Y OF ADDICTION MEDICINE, https://www.asam.org/quality-practice/definition-of-addiction (last visited Oct. 28, 2021).

abuse, including opioids, directly or indirectly enhance dopamine release within the nucleus accumbens.[9]




15. Opioid use disorder also changes the circuitry in the brain for regulating arousing and psychological stress. Specifically, the cycle of addiction, including withdrawal, leads to hyperactivity of the locus coeruleus noradrenergic system that regulates arousal and psychological stress.[10] This leads to people with OUD having more difficulty managing life stressors without turning to drug use.




16. Genetic factors account for between 40 and 60 percent of a person's vulnerability

[9] Ex. 8, Fellers, Management of Addiction Issues in Complex Pain at 9 (Oct. 2, 2016), available at https://www.acponline.org/system/files/documents/about_acp/chapters/me/management_of_addiction_issues_in_complex_pain_j_fellers.pdf (citing Olds, J., & Milner, P.(1954). Positive reinforcement produced by electrical stimulation of septal area and other regions of rat brain. Ex 9, J Comp Physiol Psychol 47(6), 419-27; Ex 10, Nestler, E.J. (2005). Is there a common molecular pathway for addiction? Nat Neurosci: 8(11), 1445-9).

[10] *Id.*; Ex. 11, Nestler, E.J., Alreja, M., & Aghajanian, G.K. (1999). Molecular control of locus coeruleus neurotransmission. Biol Psychiatry; 46(9), 1131-9; Ex. 12, Koob, G.F., Buck, C.L., Cohen, A., Edwards, S., Park, P.E., Schlosburg, J.E., et al. (2014). Addiction as a stress surfeit disorder. Neuropharmacology; 76 (Part B), 370-82.

to addiction. Those who are genetically predisposed to addiction experience an altered response to the drug and changes in drug metabolism. This is in part why vulnerability to developing substance use disorder runs in families.

17. Additionally, adverse childhood experience creates a two- to four-fold increase in the likelihood of early initiation into illicit drug use.[11] Additional predictors of addiction include peer influence, family history, and drug availability.

## III. THE OPIOID CRISIS NATIONALLY AND IN MICHIGAN

18. Opioid dependence and its related public health consequences have reached epidemic proportions in this country. The United States is now in the midst of an opioid crisis that has claimed an increasing number of lives from overdose over the past 30 years. Nationally, opioid overdoses are the leading cause of death for Americans under 50 years old.[12] The crisis results from a dramatic increase in overdose deaths from prescription opioids and a concomitant increase in overdose deaths from a secondary epidemic of illicit opioids such as heroin and fentanyl.[13]

19. The harm of illicit opioid use is particularly high given the recent increased presence of illicit synthetic fentanyl: since around 2013, there has been a sharp increase in overdoses attributed to the illicit use of, or accidental exposure to, this drug, an extremely potent synthetic opioid. *See* ¶ 21, *infra*. Accidental exposure to fentanyl can occur because fentanyl is

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[11] Ex. 13, Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. Am J Prev Med. 1998 May;14(4):245-58.

[12] Ex. 14, Maya Salam, *The Opioid Epidemic: A Crisis Years in the Making*, N. Y. TIMES, Oct. 26, 2017, https://www.nytimes.com/2017/10/26/us/opioid-crisis-public-health-emergency.html

[13] Ex. 15, Nat'l Academics of Sciences, Engineering, Medicine, Pain Management and the Opioid Epidemic: Balancing Societal and Individual Benefits and Risks of Prescription Opioid Use (Bonnie, EJ et al., eds.) (2017), at 2, available at https://www.ncbi.nlm.nih.gov/books/NBK458660/pdf/Bookshelf_NBK458660.pdf ("NASEM Report").

frequently mixed with heroin and other drugs without the user's knowledge. The following figure compares a lethal dose of heroin (left) with a lethal dose of fentanyl (right):[14]


20. Over 2.5 million Americans are addicted to opioids.[15] And the harms associated with that addiction "affect not only patients with pain themselves but also their families, their communities, and society at large."[16]

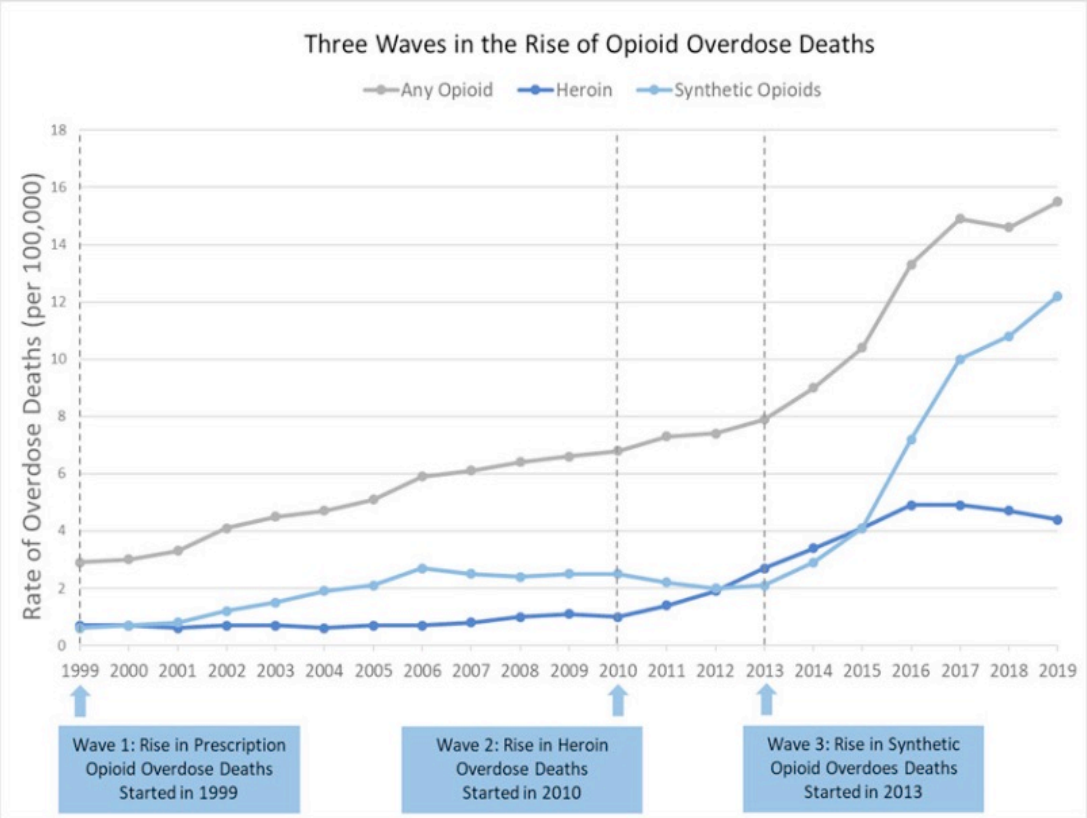
21. As illustrated in the below graph published by the Center for Disease Control, the death toll from opioid abuse has risen dramatically in recent years. More than half a million people

[14] Ex. 16, Allison Bond, *Why fentanyl is deadlier than heroin, in a single photo*, STAT NEWS, Sep. 29, 2016, https://www.statnews.com/2016/09/29/why-fentanyl-is-deadlier-than-heroin/.

[15] Ex. 17, *Effective Treatments for Opioid Addiction*, NAT'L INST. ON DRUG ABUSE, https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction/effective-treatments-opioid-addiction (last updated Nov. 2016) ("NIDA, Effective Treatments").

[16] Ex. 15, NASEM Report at 3.

have died from opioid overdose in the first two decades of the 2000s, and the death toll from opioid overdose has risen exponentially since 2013.[17] In 2016, a reported 64,070 people died from drug overdoses—a larger loss of American life than in the worst year of the AIDS crisis or in the entirety of the Vietnam War.[18]



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[17] *See* Ex. 18, *Opioid Overdose: Understanding the Epidemic*, CTRS. FOR DISEASE CONTROL https://www.cdc.gov/drugoverdose/epidemic/index.html (last updated Mar. 17, 2021) ("CDC, Opioid Overdose").

[18] Ex. 19, Ashley Welch, *Drug overdoses killed more Americans last year than the Vietnam War*, CBS NEWS, Oct. 17, 2017, https://www.cbsnews.com/news/opioids-drug-overdose-killed-more-americans-last-year-than-the-vietnam-war/.

[19] Ex. 20, Centers for Disease Control and Prevention, Nat'l Ctr. for Health Stats., Data Brief 394 (Dec. 2020), https://www.cdc.gov/nchs/data/databriefs/db394-tables-508.pdf#page=3; Centers for Disease Control and Prevention, Understanding the Epidemic, https://www.cdc.gov/drugoverdose

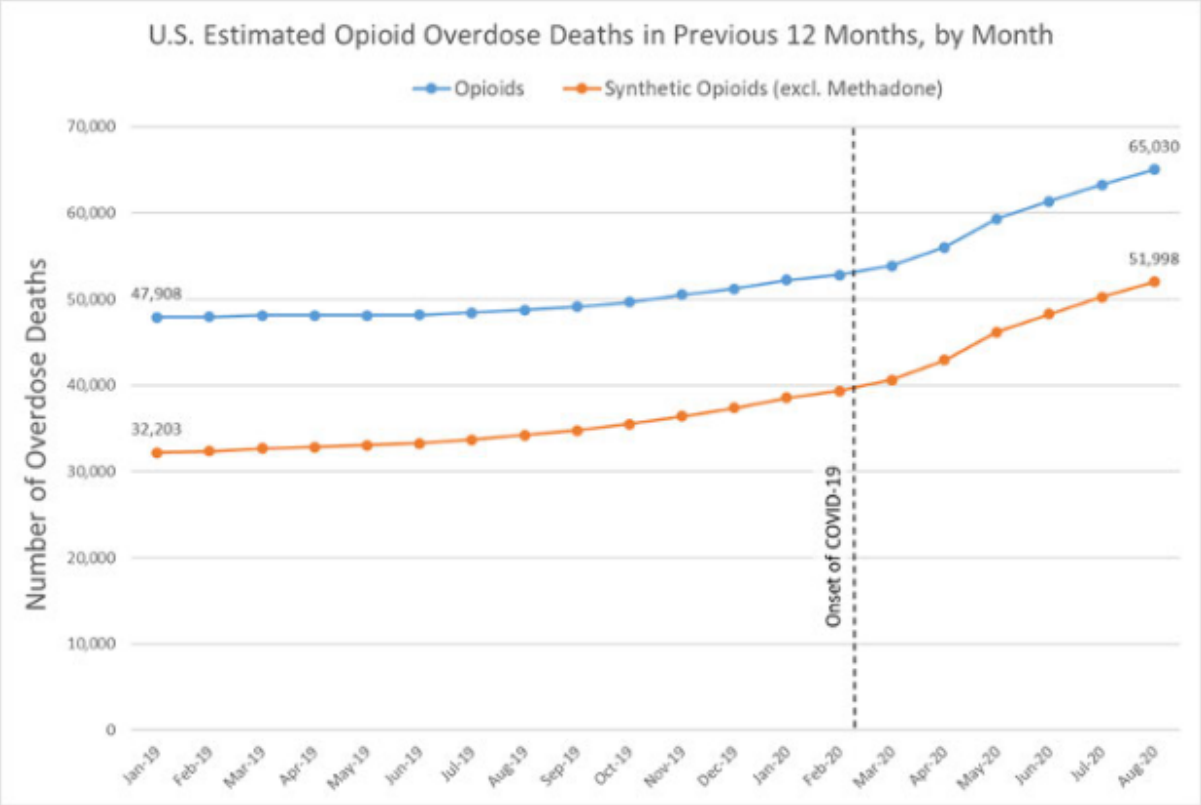
22. This trend has accelerated even further during the Covid-19 pandemic. The CDC reported a record 65,030 estimated *opioid*-related overdose deaths in the United States during the twelve months preceding August 2020.[20] In the one-year period ending December 2020, 69,710 people died from opioid-involved overdoses, as compared to 50,963 in 2019.[21] That means on average 178 people die in America each day from an opioid-related overdose—equivalent to one person every 8.5 minutes. The CDC estimates that synthetic opioid deaths rose more than 52% during this same period.[22]

/epidemic/index.html#three-waves.

[20] Ex. 21, *Provisional Drug Overdose Death Counts,* CTRS. FOR DISEASE CONTROL AND PREVENTION (Feb. 7, 2021), https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm#dashboa ("CDC Provisional Drug Overdose Death Counts").

[21] Ex. 22, Julie Steenhuysen and Daniel Trotta, *U.S. Drug Overdose Deaths Rise 30% to Record During Pandemic*, REUTERS, July 14, 2021, https://www.reuters.com/world/us/us-drug-overdose-deaths-rise-30-record-during-pandemic-2021-07-14/.

[22] Ex. 21, CDC Provisional Drug Overdose Death Counts.




[23]

23. In Michigan in particular, "opioid deaths have grown ten-fold" since 2000.[24] In 1999, 118 people in Michigan died from overdoses; by 2018, that number had grown to 2,036.[25] According to the National Institute on Drug Abuse, there were about 2,011 opioid-related overdose deaths in Michigan in 2018, *i.e.*, 78% of all drug overdoses in the state that year involved at least one opioid.[26] A 2019 study found opioid deaths in Grand Traverse County to have "dramatically

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[23] *Id.*

[24] Ex. 23, *Opioid Resources: Opioid Epidemic by the Numbers*, MICHIGAN.GOV, https://www.michigan.gov/opioids/0,9238,7-377-88139---,00.html (last visited Oct. 15, 2021).

[25] *Id.*

[26] Ex. 24, *Michigan: Opioid-Involved Deaths and Related Harms*, NAT'L INST. ON DRUG ABUSE, https://www.drugabuse.gov/drug-topics/opioids/opioid-summaries-by-state/michigan-opioid-involved-deaths-related-harms (last revised Apr. 2020).

increased in the past 5 years . . . . Since 2009, the number of opioid overdose deaths has quintupled."[27] In 2018, the Michigan Department of Corrections indicated that more than 20% of its incarcerated residents have OUD.[28]

24. The opioid crisis has broader effects in economic consequences as well. According to a CDC estimate, in 2017, the total economic burden of the opioid crisis had risen to $1,021 billion.[29] Approximately one-fourth of that cost is borne by the public sector—for example, in health care, substance abuse treatment, and criminal justice costs.[30] The total cost of the crisis is much higher. Indeed, the White House Council of Economic Advisors has estimated that in 2015 alone, the opioid epidemic cost $504 billion.[31]

25. In 2016, the Surgeon General released a report that summarized the impact of the substance abuse crisis in America as follows: "The accumulated costs to the individual, the family, and the community are staggering and arise as a consequence of many direct and indirect effects, including compromised physical and mental health, increased spread of infectious disease, loss of productivity, reduced quality of life, increased crime and violence, increased motor vehicle

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[27] Ex. 25, Wendy Hirschenberger, et al., *Grand Traverse County Substance Use Assessment*, 46 (May 1, 2019), GRAND TRAVERSE CTY. HEALTH DEP'T, https://www.gtcountymi.gov/DocumentCenter/View/11468/GTCO-Substance-Use-Assessment-2019-Final.

[28] Ex. 26, Corrections Connection, *Ending Addiction, Michigan Department of Corrections Launches Medication-Assisted Treatment at Correctional Facilities*, 3 – 6 (Feb. 25, 2020), https://www.michigan.gov/documents/corrections/CC_FebruaryNewsletter2020_682036_7.pdf.

[29] *See* Ex. 27, Florence CS et al., *The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the United States, 2013.* MED CARE. 2016;54(10):901-906; Ex. 28, Feijun Luo, et al., *State-Level Economic Costs of Opioid Use Disorder and Fatal Opioid Overdose – United States, 2017*, CDC.GOV MMWR https://www.cdc.gov/mmwr/volumes/70/wr/mm7015a1.htm

[30] *Id.*

[31] Ex. 29, German Lopez, *White House: One Year of the Opioid Epidemic Cost the US Economy More than $500 Billion*, VOX, Nov. 20, 2017, https://www.vox.com/science-and-health/2017/11/20/16679688/white-house-opioid-epidemic-cost.

crashes, abuse and neglect of children, and health care cost."[32]

## IV. STANDARD OF CARE FOR OPIOID USE DISORDER

26. Medication to treat opioid use disorder has proven successful in treating OUD. The standard of care for the treatment of opioid dependence is agonist or partial-agonist therapy in combination with behavioral counseling and support. Agonists work by activating opioid receptors in the brain to relieve withdrawal symptoms and control cravings. Partial agonists work by partially activating opioid receptors. Full agonists fully activate opioid receptors, resulting in a stronger effect. The combination of medication with behavioral counseling and support is now commonly referred to as "medication-assisted treatment" and more recently and more accurately referred to as medication for opioid use disorder ("MOUD") or medication for addiction treatment ("MAT").[33] MOUD "is a comprehensive approach that combines FDA-approved medications … with counseling and other behavioral therapies to treat patients with opioid use disorder (OUD)."[34] Although MOUD is typically a comprehensive approach, the medication piece is critical and generally the most impactful, and should be provided even when counseling and other behavioral therapies are not available.[35] Without medication, there is no MOUD. As the FDA recently reported, "[a]ccording to the Substance Abuse and Mental Health Services Administration,

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[32] Ex. 30, U.S. DEP'T OF HEALTH & HUMAN SERVS., OFF. OF THE SURGEON GEN., FACING ADDICTION IN AMERICA: THE SURGEON GENERAL'S REPORT ON ALCOHOL, DRUGS, AND HEALTH, 1-1(Nov. 2016), *available at* https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf.

[33] Ex. 31, Rosenthal RN. Medication for Addiction Treatment (MAT). American Journal of Drug and Alcohol Abuse, 2018;44(2):273-274.

[34] Ex. 32, FDA News Release, FDA Approves First Generic Versions of Suboxone® Sublingual Film, Which May Increase Access to Treatment for Opioid Dependence (June 14, 2018), https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm610807.htm ("FDA News Release").

[35] Ex. 33, Amato L, et al., *Psychosocial combined with agonist maintenance treatments versus agonist maintenance treatments alone for treatment of opioid dependence*, Cochrane Database Syst Rev. 2011; (10), at 13; *see* Ex. 32, FDA News Release.

patients receiving MOUD for treatment of their OUD cut their risk of death from all causes *in half*."[36]

27. MOUD has been shown to decrease opioid use, opioid-related overdose deaths, criminal activity, and infectious disease transmission.[37] MOUD has also been shown to increase patients' social functioning and retention in treatment.[38] As the FDA has explained, MOUD is a focus of efforts to combat the opioid addiction crisis: "Improving access to prevention, treatment and recovery services, including the full range of MAT, is a focus of the FDA's ongoing work to reduce the scope of the opioid crisis and one part of the U.S. Department of Health and Human Services' Five-Point Strategy to Combat the Opioid Crisis."[39]

28. In my experience, the primary driver of treatment efficacy in MOUD regimens is medication, and recovery without MOUD after detoxification from opioids is perilous by comparison.[40] Attempts at other addiction-treatment regimens, such as abstinence- or twelve-step-type treatment programs that have been successful in other contexts (such as alcohol addiction) have not been successful in treating opioid addiction.[41] Studies have shown that maintenance

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[36] Ex. 33, Amato L, et al.

[37] Ex. 34, Volkow, ND et al., *Medication-Assisted Therapies — Tackling the Opioid Overdose Epidemic.*, 370 New Eng. J. Med. 2063, 2064, *available at* https://www.nejm.org/doi/pdf/10.1056/NEJMp1402780 ("Volkow"); Ex. 17, NIDA, Effective Treatments.

[38] *Id.*

[39] Ex. 32, FDA News Release; *see* Ex. 35, FDA News Release, FDA Takes New Steps to Encourage the Development of Novel Medicines for the Treatment of Opioid Use Disorder (Aug. 06, 2018), https://www.fda.gov/news-events/press-announcements/fda-takes-new-steps-encourage-development-novel-medicines-treatment-opioid-use-disorder

[40] Ex. 36, Bailey GL, Herman DS, Stein MD. Perceived relapse risk and desire for medication assisted treatment among persons seeking inpatient opiate detoxification. J Subst Abuse Treat. 2013;45(3):302-305.

[41] *See* Ex. 4, Schuckit.

medication treatments of opioid use disorder reduce all-cause and overdose mortality,[42] and have a more robust effect on treatment efficacy than behavioral components of MOUD.[43]

29. The only FDA-approved medications for treating OUD are buprenorphine, methadone, and naltrexone.[44]

30. Buprenorphine and methadone activate the brain's opioid receptors, relieving withdrawal symptoms and physiological cravings that cause chemical imbalances in the body.[45] Both methadone and buprenorphine present a substantially lower risk of overdose than heroin, especially when properly administered in a clinical setting.

31. Because of this important ability to act on opioid receptors without presenting the same risk of overdose, buprenorphine and methadone have both been deemed "essential medicines" according to the World Health Organization.[46] "Numerous clinical trials and meta-analyses have shown that methadone treatment is associated with significantly higher rates of treatment retention and lower rates of illicit opioid use," as well as reduced mortality, criminal conduct, and contraction of HIV.[47] Likewise, "[r]egular adherence to MAT with buprenorphine reduces opioid withdrawal symptoms and the desire to use opioids, without causing the cycle of

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[42] Ex. 37, Sordo L, Barrio G, Bravo MJ, Indave BI, Degenhardt L, Wiessing L, Ferri M, Pastor-Barriuso R. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. BMJ. 2017 Apr 26;357:j1550.

[43] Ex. 33, Amato L, et al. at 13.

[44] *See* Ex. 38, *Medication and Counseling Treatment*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN. (SAMHSA), https://www.samhsa.gov/medication-assisted-treatment/treatment#medications-used-in-mat (last updated Sept. 15, 2021).

[45] *See id.*

[46] *Id.*

[47] Ex. 39, SAMHSA, *Treatment Improvement Protocol 63: Medications for Opioid Use Disorder* 3-15, *available at* https://www.ncbi.nlm.nih.gov/books/NBK535268/pdf/Bookshelf_NBK535268.pdf.

highs and lows associated with opioid misuse or abuse. At proper doses, buprenorphine also decreases the pleasurable effects of other opioids, making continued opioid abuse less attractive."[48]

32. Naltrexone works by a different mechanism: It blocks opioid receptors without activating them, preventing opioids from producing their euphoric effects and thus reducing a desire for opioids over time. Patients in criminal justice settings should not be forced to transition from agonist to antagonist (naltrexone) treatment.[49] To be effective, it requires patients to have completely withdrawn from opiates before they can begin treatment—a high hurdle in some cases.[50] Administering naltrexone to a patient who has not completely withdrawn from opioids can trigger acute and severe withdrawal, and for that reason is contraindicated. No physician, acting in accordance with reasonable judgment and professional standards, would administer naltrexone to a patient not completely withdrawn from opioids.

33. Studies have shown that naltrexone treatment has poorer outcomes in terms of treatment retention than either methadone or buprenorphine. My clinical experience treating patients with OUD is consistent with those results. Treatment retention is crucial for MOUD because the length of treatment is positively correlated with outcomes: on average, the longer a patient stays in treatment the better the treatment outcome. Because methadone and buprenorphine are better able than naltrexone to keep patients in treatment for longer periods, I conclude that methadone and buprenorphine are the standard of care for OUD, particularly among patients with severe OUD. Furthermore, a patient who immediately stops using naltrexone has a lower opioid tolerance—that is, the ability for the body to handle a given amount of opioids without

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[48] Ex. 32, FDA News Release.

[49] Ex. 40, The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update: J Addict Med. 2020 May/Jun;14(3):267. doi: 10.1097/ADM.0000000000000683. PMID: 32487948.

[50] *See* Ex. 17, NIDA, Effective Treatments.

experiencing an adverse reaction—than their baseline while receiving no medication. This brain response, known as "reverse tolerance" means that a patient who discontinues naltrexone and takes opioids is at a higher risk of overdose than if they had taken no medication beforehand and were at their "baseline" tolerance.

34. Patients' responses to medications for OUD vary significantly based on their individual profile. While one patient may do well on any of these medications, another patient may find that only one provides effective treatment without significant adverse side effects. The severity of a patient's OUD is one factor that may affect the relative effectiveness of these different medications. For example, a patient with severe OUD may require a medication that produces a stronger opioid effect (like a full agonist) to fully suppress opioid cravings than a patient with only mild OUD. A patient with more severe OUD may also require a higher dosage of a given medication than a patient with less severe OUD.

35. Another factor that may influence a patient's response and the effectiveness of medications for OUD are any co-occurring other mental disorders the patient may have. A patient's positive response to one medication does not guarantee all medications for OUD will not exacerbate the patient's co-occurring mental health disorders and/or have detrimental effects on the patient's mental health. Accordingly, switching a patient from one form of MOUD medication that is working to another, when the patient is not experiencing problematic side effects, is medically contraindicated and contrary to the acceptable standard of care.

36. As a result, public agencies and physician groups alike have recognized the urgent need for more accessible treatment options. In April of this year, then-acting assistant secretary for the federal Substance Abuse and Mental Health Services Administration (SAMHSA) stated that "[t]he need for more accessible medication-based services has never been more urgent than it

is today."[51] A growing coalition of state and federal government agencies and physician groups has advocated for increased access to MOUD to combat the growing crisis of opioid addiction. For example, SAMHSA has dedicated billions of dollars to grant programs directed at increasing access to treatment of OUD. In 2019, SAMHSA awarded $932 million to continue its State Opioid Response grant funding which supports states' efforts to combat the national opioid crisis.[52] The following year, SAMSHA released $1.5 billion through the grant program enabling states and tribes to "provide community-level resources for people in need of prevention, treatment and recovery support services."[53] In fiscal year 2021, the agency awarded $123 million in funding to support communities combatting the overdose epidemic, $71.3 million of which was aimed directly at expanding communities' access to MOUD.[54] SAMHSA has also established a national training and clinical mentoring program to encourage and facilitate physicians to provide MOUD to patients with opioid use disorder in various care settings. Under that program, SAMHSA has announced a $24 million grant to ensure the provision of evidence-based prevention, treatment, and recovery programs, and a $10.8 million grant for students in the medical, physician assistant and nurse practitioner fields to ensure they are trained to prescribe buprenorphine products in

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[51] Ex. 41, Amy Goldstein, *Biden Administration Eases Restrictions on Prescribing Treatment for Opioid Addiction*, WASH. POST (April 27, 2021), https://www.washingtonpost.com/health/biden-administration-eases-restrictions-on-prescribing-treatment-for-opioid-addiction/2021/04/27/9a1c8fa4-a776-11eb-8d25-7b30e74923ea_story.html.

[52] Ex. 42, Press Announcement, SAMHSA, SAMHSA Directing $932 Million to Nation's Communities Through the Continuation of its State Opioid Response Grant Funding (Sept. 4, 2019), https://www.samhsa.gov/newsroom/press-announcements/201909041245.

[53] Ex. 43, Press Announcement, SAMHSA, HHS Releases $1.5 Billion to States, Tribes to Combat Opioid Crisis (Aug. 27, 2020), https://www.samhsa.gov/newsroom/press-announcements/202008270530.

[54] Ex. 44, Press Announcement, SAMHSA, SAMHSA Awards $123 Million in Grants for Multifront Approach to Combat the Nation's Overdose Epidemic (Sept. 13, 2021), https://www.samhsa.gov/newsroom/press-announcements/202109130300.

office-based settings, among others.[55]

## V. FORCED WITHDRAWAL FROM MOUD

37. No physician, acting consistent with prudent professional standards and in a manner reasonably commensurate with modern medical science, would discontinue the administration of buprenorphine to a patient in treatment for opioid use disorder, where the treatment is resulting in lasting recovery and there are no significant adverse side effects or other contraindications. Discontinuing buprenorphine treatment in an abrupt and arbitrary manner would result in even more serious harm.

38. Jail policies that prohibit treatment with buprenorphine can force patients into acute withdrawal. Acute withdrawal causes symptoms including bone and joint aches, vomiting, diarrhea, excessive sweating, hypothermia, hypertension, tachycardia (elevated heart rate), and psychological symptoms like depression, anxiety, and desperation. Some cases of opioid withdrawal have resulted in death, in particular due to dehydration and heart failure resulting from diarrhea and vomiting.[56] Withdrawal symptoms occur within 24 to 48 hours of non-use, and can last for several days, weeks, or even months.

39. Withdrawal without medical support, which would typically be in the form of a slow tapering of the dosage amounts, is especially dangerous for patients with co-occurring disorders, such as depression, anxiety, psychosis or other mental disorders. For such patients,

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[55] Ex. 45, Press Announcement, SAMHSA, FY 2018 Opioid State Targeted Response Technical Assistance (Nov. 8, 2017), *available at* https://www.samhsa.gov/grants/grant-announcements/ti-18-004; Ex. 46, Press Announcement, SAMHSA, SAMHSA is announcing the availability of up to $10.8 million for the Providers Clinical Support System – Universities program (June 4, 2018), https://www.samhsa.gov/newsroom/press-announcements/201806040200.

[56] Ex. 47, Shane Darke et al., *Yes, People Can Die from Opiate Withdrawa*l, 112 Addiction 199 (2017).

forced withdrawal may cause severe depression, suicidal ideation, and decompensation.[57] In the psychological sense, decompensation refers to a patient's inability to maintain defense mechanisms in response to stress, which can result in uncontrollable anger, mania, and other dangerous symptoms.

40. Forced withdrawal and even medical detoxification is not medically appropriate for incarcerated patients who were already being successfully treated with MOUD prior to their incarceration. It disrupts their treatment plan, leading to a seven-fold decrease in continuing MOUD after release.[58] Discontinuation of MOUD increases the risk of relapse into active addiction. Over 82% of patients who leave methadone treatment relapse to intravenous drug use within a year.[59]

41. Patients are more likely to suffer from overdose and potential death as a consequence of forced withdrawal. Detoxification or forced withdrawal reduces the tolerance to high-dose opioids seen in persons with opioid use disorders, rendering them more highly susceptible to overdose with new use.

42. Death is three times as likely for people out of treatment versus when receiving MOUD.[60] The risk of opioid overdose for people being released from jails and prisons is even more staggering. One study in Washington State between 1999 and 2003 found that during the

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[57] Ex. 48, Rich JD, McKenzie M, Larney S. Wong JB. Tran L, Clarke J. (2015) Methadone continuation versus forced withdrawal on incarceration in a combined US prison and jail: a randomized, open-label trial. Lancet: 386: 350–59.

[58] *Id.*

[59] Ex. 49, *Methadone Research Web Guide, Part B: 20 Questions and Answers Regarding Methadone Maintenance Treatment Research*, B-10, NAT'L INST. ON DRUG ABUSE https://www.drugabuse.gov/sites/default/files/pdf/partb.pdf. (last visited Oct. 26, 2021)

[60] Ex. 50, Evans E, Li L, Min J, Huang D, Urada D, Liu L, Hser YI, Nosyk B. (2015). Mortality among individuals accessing pharmacological treatment for opioid dependence in California, 2006-10. *Addiction*; 110(6): 996- 1005.

first two weeks following release from prison incarcerated people were 129 times as likely as a member of the general public to die of a drug overdose.[61] A 2016 national study in England regarding the use of MOUD in jails and prisons found that MOUD "was associated with a 75% reduction in all-cause mortality and an 85% reduction in fatal drug-related poisoning in the first month after release."[62]

43. Because illicit drugs are commonly available in jail and prison, the risk of overdose and death that results from forced withdrawal or medical detoxification is present both during incarceration and upon release. My understanding is that Grand Traverse County Correctional Facility has a policy providing for the administration of Narcan[63] to people in its custody, which recognizes the danger of opioid overdose during incarceration. Given the availability of drugs in jails and prison, post-release care alone would do nothing to address the risk of relapse and overdose while a person is incarcerated.

44. It is my understanding that the Grand Traverse Country Correctional Facility prohibits the use of methadone and buprenorphine maintenance treatment for all incarcerated people except those incarcerated for very short periods of time.

45. The cessation of an appropriately prescribed medication for a chronic disease is unethical as it discriminates against patients with OUD as compared to persons with other chronic medical problems. Even more important than the short-term impact of detoxification from MOUD on an immediate or accelerated basis is the added profound risk of releasing a person with a chronic

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[61] Ex. 51, Binswanger, et al., Release from Prison A High Risk of Death for Former Inmates, New Eng. J. of Med. 336:2 157-165 (2007).

[62] Ex. 52, Marsden, et al., Does Exposure to Opioid Substitution Treatment in Prison Reduce the Risk of Death After Release? A National Prospective Observational Study in England, Addiction 112, 1408–1418 (2017).

[63] Narcan is the brand name of naloxone injection and naloxone nasal spray, which is used to block the effects of opioids in persons who may be experiencing an opioid overdose.

OUD after incarceration without the medical benefit and protection of MOUD.

46. Given the high rate of relapse to opioid use after detoxification and discharge from an institutional setting, and the high risk of fatal overdose among those who relapse and who also have no tolerance for opioids as a result of having had their maintenance medications stopped, preventing access to maintenance medication is arbitrarily withholding a life-saving medicine.

## VI. MR. PATSON'S TREATMENT

47. I have reviewed medical records of Cyrus Patson's OUD treatment, including records from MHC Munson Family Practice Center Traverse City and communications from Kelly J. Clark, MD, and the Grand Traverse County Correctional Facility, including Wellpath records.

48. It is my opinion based on those records that maintenance of Mr. Patson's buprenorphine treatment is not only appropriate, but medically necessary. The records show that buprenorphine has been the only effective course of treatment for Mr. Patson's opioid use disorder demonstrated in the medical record and has helped him remain in recovery, demonstrating no use of illicit opioids when he was treated adequately. The records also show he has tolerated the medication well, and that there are no contraindications. In contrast, the records demonstrate that detoxification off of buprenorphine while incarcerated has been insufficient to suppress Mr. Patson's severe cravings and mental anguish as compared to continued buprenorphine treatment. He also had increased use of illicit opioids in the community when not treated with or on receiving insufficient doses of buprenorphine.

49. The records also show clear exacerbation of Mr. Patson's mood and anxiety disorders when forced to undergo buprenorphine withdrawal while in jail. Dr. Clark's communications to the Grand Traverse County Correctional Facility clearly document her medical

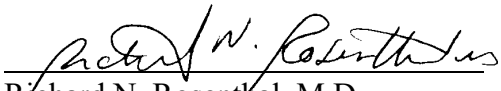
opinion about a patient she has treated over time and knows well, that, in addition to considerable and unnecessarily painful and medically concerning physical withdrawal symptoms, forced withdrawal of indicated medical treatment (buprenorphine) was causing a significant "decline in his mental health." Taking a patient who is stable with reduced or no symptoms and with few side effects on maintenance medication, off of that medicine for a chronic, potentially life-threatening illness, is not appropriate medical practice.

50. Unfortunately, it is a common practice, which I have observed in my medical practice, that people receiving medication for opioid use disorder will opt to receive a less-than-therapeutic dose when they anticipate being forcibly withdrawn from their medication in the near future. Receiving a less-than-therapeutic dose, which does not effectively suppress a patient's withdrawal symptoms and opioid cravings, causes onset of physical and psychological pain. It is also dangerous because it puts the patient at increased risk of relapse and overdose, and threatens their long-term continuity of treatment.

* * *

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

Executed on Oct. 27, 2021



Richard N. Rosenthal, M.D

# APPENDIX A

**10/23/21**

# CURRICULUM VITAE

RICHARD NELSON ROSENTHAL, M.D.

**OFFICE ADDRESS:** Renaissance School of Medicine, Stony Brook University
Department of Psychiatry and Behavioral Science
Putnam Hall, South Campus
Stony Brook, NY 11794-8790

**TELEPHONE:** **Business** 631-638-1535 **Fax:** 631-632-5870

**EDUCATION:**

| Date | Degree | Institution |
|---|---|---|
| 1969 - 1970 | | Lafayette College |
| 1970 - 1973 | B.A., 1973 | Oberlin College |
| 1974 - 1976 | M.A., 1977 | NIH Neurosciences Training Grant Award<br>Duke University, Dept Physiology & Pharmacology<br>(passed separate physiology and pharmacology comprehensive exams) |
| 1976 - 1980 | M.D., 1980 | SUNY, Downstate Medical Center |

**TRAINING:**

| Date | Type | Institution |
|---|---|---|
| 1980 - 1981 | Rotating Internship | Mount Sinai Hospital, N.Y. |
| 1981 - 1983 | Resident in Psychiatry | Mount Sinai Hospital, N.Y. |
| 1983 - 1984 | Chief Resident, Psychiatry<br>outpatient, emergency room, inpatient; Elective: Human Sexuality Program | Mount Sinai Hospital, N.Y. |
| 11/15-23/97 | Understanding the New World of Health Care: Harvard Medical School, Harvard School of Public Health, JFK School of Government | |
| 6/11-14/19 | Visiting Mentor Development Program, NYU School of Medicine. Substance Abuse Research Education and Training program (SARET) | |

**CURRENT POSITION:**

| Date of appointment | Title | Institution |
|---|---|---|
| 2017 - | Professor of Psychiatry (S) | Stony Brook University School of Medicine |

**PREVIOUS POSITIONS:**

| Date of appointment | Title (S, V, T) | Institution |
|---|---|---|
| 1984 – 1987 | Instructor in Psychiatry (S) | Mount Sinai School of Medicine |
| 1987 - 1990 | Assistant Professor of Clin. Psych. (S) | Mount Sinai School of Medicine |
| 1990 - 1994 | Assistant Professor of Psychiatry (S) | Mount Sinai School of Medicine |
| 1994 - 1995 | Assistant Professor of Psychiatry (S) | Albert Einstein College of Medicine |
| 1995 - 2002 | Associate Professor of Psychiatry (S) | Albert Einstein College of Medicine |
| 2002 - 2013 | Professor of Clinical Psychiatry (S) | Columbia Univ. College of Physicians and Surgeons |
| 2010 - 2013 | Arthur J Antenucci Professor of Clinical Psychiatry (S) | Columbia Univ. College of Physicians and Surgeons |
| 2014 - 2017 | Professor of Psychiatry (S) | Icahn School of Medicine at Mount Sinai<br>(Adjunct Professor [V] as of 11/1/17 to 2020) |

**ADMINISTRATIVE APPOINTMENTS:**

| Date | Title | Institution |
|---|---|---|
| 1984 - 1992 | Physician-in-Charge, Addiction Psychiatry Inpatient Service | Beth Israel Medical Center, NY |
| 1989 - 2001 | Chief, Division of Substance Abuse | Beth Israel Medical Center, NY |
| 1992 - 1994 | Associate Director, Psychiatry | Beth Israel Medical Center, NY |
| 1994 - 2002 | Program Director, Fellowship in Addiction Psychiatry | Albert Einstein College of Medicine at Beth Israel Medical Center, NY |
| 1994 - 2001 | Associate Chairman for Clinical Services, Department of Psychiatry | Beth Israel Medical Center, NY |
| 1996 - 1999 | Medical Director, Chair, Credentialing Committee | Continuum Health Partners Managed Behavioral Health Care |
| 1996 - 2001 | Director, Division of Substance Abuse | Albert Einstein College of Medicine |
| 2001 - 2014 | Chairman, Department of Psychiatry | St. Luke's-Roosevelt Hospital Center, NY |
| 2009 - 2013 | Senior Associate Dean for the St. Luke's Roosevelt Affiliation | Columbia University College of Physicians and Surgeons |
| 2012 - 2013 | Physician-in-Chief, Behavioral Health Service Line | Continuum Health Partners, NY |
| 2012 - 2014 | Director, and Chair, Advisory Council | Continuum Health Home Network |
| 2014 - 2016 | Medical Director, Addiction Psychiatry | Mount Sinai Behavioral Health System |
| 2014 - 2015 | Co-Chair, Advisory Council | Mount Sinai Health Home |
| 2014 - 2015 | Site Director, Mount Sinai Hospital Addiction Psychiatry Fellowship Prog. | Mount Sinai St. Luke's Roosevelt Hospital Center |
| 2015 - 2017 | Program Director, Addiction Psychiatry Fellowship Program | Icahn School of Medicine at Mount Sinai/Mount Sinai St. Luke's/Roosevelt |
| 2017 - 2021 | Director of Addiction Psychiatry | Stony Brook University Health Sciences Center<br>Stony Brook Eastern Long Island Hospital<br>Quannacut Outpatient Services<br>Stony Brook Psychiatric Associates, UFPC<br>at 169 Putnam Hall, Stony Brook South Campus<br>at Advanced Specialty Care, Commack |

**BOARD CERTIFICATION:**

| | |
|---|---|
| 11/85 | Certified by the American Board of Psychiatry and Neurology, #27536. |
| 3/93, 4/02, 4/12 | Subspecialty Certification in Addiction Psychiatry, #366. |

**LICENSURE:** New York: Practice of Medicine and Surgery #152861
Drug Enforcement Agency # AR2011207 #XR2011207

**HOSPITAL APPOINTMENTS:**

| | |
|---|---|
| 1984 - 1987 | Assistant, Department of Psychiatry, Beth Israel Hospital, NY |
| 1987 - 1990 | Assistant Attending, Department of Psychiatry, Beth Israel Hospital |
| 1990 - 1994 | Associate Attending, Department of Psychiatry, Beth Israel Hospital |
| 1994 - 2017 | Attending, Department of Psychiatry, Beth Israel Hospital |
| 2001 - 2019 | Senior Attending, Department of Psychiatry, Mount Sinai St. Luke's-West, NY |
| 2014 - 2017 | Attending, Mount Sinai Hospital, NY |

**ACADEMIC AND PROFESSIONAL AWARDS AND HONORS:**

| | |
|---|---|
| 1974 | NIH Neurosciences Training Grant Award |

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|---|---|
| 1984 | Richard L. Scharf, M.D. Memorial Award for Excellence in Teaching |
| 1989 | Fellow, New York Academy of Medicine |
| 1994 | Max Needleman, M.D. Award for Excellence in Teaching |
| 1996 | The Best Doctors in New York, New York Magazine (through 2008, 2021) |
| 1996 | Fellow, American Psychiatric Association |
| 1996 - | Who's Who in America |
| 1997 | Community Mental Health Award, Crotona Park CMHC Governing Board |
| 1997 - | Top Doctors: New York Metro Area (through 2021) |
| 1999 - | The Best Doctors® in America (through 2021) |
| 2001 - 2003 | President, American Academy of Addiction Psychiatry |
| 2003 | Distinguished Fellow, American Psychiatric Association |
| 2004 | Distinguished Visiting Professor, UC Davis/Napa State Hospital: Forensic Visiting Scholars Program |
| 2005 | Medical-Scientific Program Committee Award, Am. Soc. of Addiction Medicine |
| 2006 | Who's Who in Science and Engineering, 9th Edition, 10th Edition |
| 2007 | 4th Annual Francisco Silva Distinguished Lecturer, Our Lady of the Lake Regional Medical Center/Louisiana State University, Baton Rouge, Louisiana |
| 2008 | Founders' Award, American Academy of Addiction Psychiatry https://www.aaap.org/annual-meeting/annual-meeting-overview/aaap-founders-award-recipients/ |
| 2008 | America's Top Doctors® (through 2021) |
| 2009 | Distinguished Fellow, American Academy of Addiction Psychiatry |
| 2009 | Super Doctors, NY Times Sunday Magazine (through 2021) |
| 2009 - 2012 | President, American Association for Technology in Psychiatry |
| 2010 | Distinguished Clinical Research Scholar on the Addictions, The American Journal on Addictions |
| 2015 | Distinguished Life Fellow, American Psychiatric Association |

**PROFESSIONAL AND SCIENTIFIC SOCIETY MEMBERSHIPS:**

1981 - **American Psychiatric Association**

| | |
|---|---|
| 1996 - 2003 | Fellow |
| 2002 - 09, 2011-13 | Council on Addiction Psychiatry |
| | Chair, Position Statement on Marijuana as Medicine, 2013 |
| 2003 - | Distinguished Fellow, APA |
| 2015 - | Distinguished Life Fellow, APA |

1985 - New York Society for Clinical Psychiatry (NYSCP), the New York County District Branch of the APA

| | |
|---|---|
| 1985 - 94 | Committee on Public Relations. |
| 1985 - 90 | Committee on Alcoholism and Drug Abuse. |
| 1987 - 89 | Delegate to Governor's Combined Psychiatric and Addiction/Abuse Task Force; OMH MICAA Program Development Work Group. |
| 1989 - 2000 | Executive Council |
| 1989 - 91 | Ad Hoc Task Force on Psychiatric Services to the Women's Detention Center at Ward's Island. |
| 1989 - 1997 | Contrib. Editor NY District Branch Newsletter |
| 1992, 1994 | Elected Treasurer, appointed 1999-2000 |
| 1992 - 2000 | Finance Committee; Chair, 1992 - 96; 1999- 00 |
| 1995 - 1996 | President - Elect, NYSCP |
| 1996- 1997 | President, NYSCP |
| 1996 - 1998 | Computer Technology Task Force |

| | | |
|---|---|---|
| | 1997 - 1998 | Immediate Past President |
| | 1998 - 1999 | Past President |
| | 2001 - 2011 | Resident Research Award Review Committee<br>Chair, 2003 - 2011 |
| 1990 - | NY State Psychiatric Association (Area II): Committee on Addiction Psychiatry | |

| | | |
|---|---|---|
| 1986 - | **American Academy of Addiction Psychiatry** - Founding Member | |
| | 1988 - 1996 | Resident's Award Committee |
| | 1989 - 1994 | Director, Area II |
| | 1991 - 2000 | Addiction Psychiatry Board Review Course Committee<br>Chair, 1993 - 2000 |
| | 1992 - 2000 | Fellows Award Committee |
| | 1992 - 2001 | PGY-V Education Committee |
| | 1993 - 2010 | Program Committee |
| | 1994 - 1997 | Treasurer |
| | 1994 - | Board of Directors |
| | 1996 - 2003 | Finance Committee; Chair, 1997 - 1999. |
| | 1998 - 2000 | Chair, Publications/Products Committee |
| | 1999 - | Ad Hoc Committee on Office-based Opioid Treatments |
| | 1997 - 1999 | Vice President |
| | 1999 - 2001 | President - Elect |
| | 2001 - 2003 | President |
| | 2004 - | Head, Public Policy Section; Chair, Public Policy Committee |
| | 2005 - 2007 | Chair, Past Presidents' Council |
| | 2009 - | Distinguished Fellow, AAAP |

| | |
|---|---|
| 1989 - | **Fellow, New York Academy of Medicine** |

| | | |
|---|---|---|
| 1990 - | **American Society of Addiction Medicine (ASAM)** | |
| | 1997 – | Coalition for National Clinical Criteria:<br>1997 – 1999 Associate Chairman, - Co-Occurring Mental/Substance Use Disorders Workgroup; Chair - Severe Disorders Subgroup (ASAM - PPC-2 revisions)<br>2008 – 2009 Member, Steering Committee |
| | 2003 – 2004 | State of the Art Course Planning Committee |
| | 2006 – 2008 | Parity Action Group |
| | 2007 – | Medical Scientific Conference Program Planning Committee |
| | 2007 – 2009 | Section Editor, Behavioral Interventions: ASAM Principles of Addiction Medicine, 4th ed., 2009. |
| | 2012 – 2013 | Section Editor, Behavioral Interventions: ASAM Principles of Addiction Medicine, 5th ed., 2013. |
| | 2015 – 2019 | Co-Editor, ASAM Principles of Addiction Medicine, 6th ed. |
| | 2016 – | ASAM Publications Council |
| | 2021 – 2024 | Co-Editor, ASAM Principles of Addiction Medicine, 7th ed. |

| | | |
|---|---|---|
| 1996 - | **American Association for Technology in Psychiatry** (techpsych.org) | |
| | 1997 – 2006 | Steering Committee |
| | 1999 – 2006 | Chair, Membership Committee |
| | 2000 – 2001 | Member, ISMHO/PSI Suggested Principles for the Online Provision of Mental Health Services Workgroup |
| | 2007 – 2009 | Secretary |
| | 2009 – 2012 | President |

| | |
|---|---|
| 2002 - 2013 | **Association for Academic Psychiatry** |

2009 - **Healthcare Information and Management Systems Society**
2012 - HIMSS NYS Physician Committee

2011 - **World Psychiatric Association**
Section on Addiction Psychiatry, Board Member 2014-
Section on Informatics and Telecommunications in Psychiatry

**RESEARCH GRANT SUPPORT:**

1988 - 1990 Rosenthal RN, Rosenthal, J, Nuclear Magnetic Resonance Effects upon the Blood-Brain Barrier **- PI**. Dept. Psychiatry Research Fund, Beth Israel Medical Center.

1989 - 1993 Rosenthal RN, Hellerstein DJ. Integrated Services for Mentally Ill Chemical Abusers **– PI** (NIMH grant MH 46327) $856K R-01 grant to study longitudinal effects of combined psychiatric and substance-abuse treatment with schizophrenia patients.

1992 - 1994 Galynker I, Feinberg T, Rosenthal RN. Imaging of Brain Dopaminergic Activity in Neurological and Psychiatric Disorders with PET and SPECT. **Co-I** $27K grant - Nell and Herbert Singer Research Award

1993 - 1995 Galynker I, Feinberg T, Rosenthal RN, Miner CR. Remote metabolic effects and neuropsychiatric consequences of discrete striatal infarction: A positron emission tomographic study. **Co-I** $25K grant - Nell and Herbert Singer Research Award

1993 - 1995 Rosenthal RN, Levine S, Galynker I, Miner CR. A multisite phase II, four week, double-blind, placebo-controlled study evaluating the efficacy and safety of two doses of oral CP-88,059-1(Ziprasidone) in the acute exacerbation of schizophrenia; **Site PI** (Pfizer Laboratories) $80 K grant.

1993 - 1995 Rosenthal RN, Hellerstein DJ, Levine S, Galynker I, Miner CR. A 52 week, double-blind, placebo-controlled extension study evaluating safety and outcome of four doses of oral CP-88,059-1(Ziprasidone) in maintenance treatment of patients successfully completing Protocol 128-106; **Site PI** (Pfizer Laboratories)

1994 - 1995 Galynker I, Rosenthal RN, Phillips E. Stimulant treatment of negative symptom complex in stroke patients: A SPECT study. **Co-I** $41K grant - Nell and Herbert Singer Research Award

1994 - 1995 Mechanic D (PI), Kellerman SL, Boyer CA, Rosenthal RN (**Site PI**). Rutgers Hospital and Community Survey. $43 K subcontract to NIMH Center for Research on the Organization and Financing of Care for the Severely Mentally Ill at Rutgers University for multisite study of impact of inpatient treatment upon outpatients with schizophrenia.

1994 - 1999 Rosenthal RN, Hellerstein DJ, Miner CR, Muran JC. Assertive outreach for substance dependent mentally ill. **PI** NIDA grant DA 09431) $2.2M R01 grant: longitudinal effects of targeted assertive outreach plus psychiatric and substance-abuse treatment in schizophrenia

| | |
|---|---|
| 1995 - 1997 | Rosenthal RN, Galynker I, Miner CR. Correlates of Negative Symptoms with Tc-99m-HMPAO Brain SPECT in patients with psychoactive substance abuse and schizophrenia. $37.7 K grant - Nell and Herbert Singer Research Award, **PI**. |
| 1995 - 1998 | Feinberg TE, Miner CR, Roane D, Rosenthal RN. Gabapentin in the treatment of agitation in Alzheimer's Disease. **Co-PI** $50 K grant |
| 1996 -1998 | Galynker I, Rosenthal RN, London E, Des Jarlais D, Miner CR. The effects of methadone maintenance on regional cerebral glucose metabolism of opiate abusers. **Co-PI** $134,074 supplement to NIDA DA 09431 |
| 1997 -2000 | Galynker I, Rosenthal RN, Poznansky O, Cullen K, London E. PET studies of deviant sexual behavior. (**Co-I)** $38.9 K grant - Nell and Herbert Singer Research Award. |
| 1996 -2001 | Tross S, Ackerman S, Nunes E, Rosenthal RN, Richman B. Imipramine+Relapse prevention in depressed methadone patients. (**Co-PI,** $683,956 sub-contract to NIDA grant DA 09583) |
| 1998 -2003 | Galynker I, Rosenthal RN, London E, Des Jarlais D, Miner CR (**Co-I**) The effects of methadone maintenance on regional cerebral glucose metabolism of opiate abusers. $1,131,809 NIDA RO1 grant DA 12273 |
| 2001 - 2005 | Lachman H, Rosenthal RN, Knowles J, Miner C, Nunes EV, et al. Genome-wide analysis for addiction susceptibility genes. (**Co-PI; Site PI**, $543,045 sub-contract to NIDA grant $2,462,445 R01 DA12853-01A1) |
| 2006 -2008 | Rosenthal RN, Haller D, Posner D, Nunes EV. The use of acamprosate in alcohol dependent individuals with comorbid anxiety and depressive disorders. Forest Laboratories, Inc. (**PI**. $150,000) |
| 2007 - 2008 | Rosenthal RN, McGahee W, Posner D, Cummings A, Haller D. PRO-805: A randomized, double-blind, placebo-controlled, multi-center study of Probuphine® in patients with opioid dependence. Titan Pharmaceuticals, Inc. **(Site PI)**. $160,000) |
| 2008 - 2012 | Nasser J, Geliebter A, Pi-Sunyer X, Rosenthal RN. Methylphenidate and binge eating disorder in obese women. R21 DK076748-01A2 NIDDK, **Co-I** |
| 2009 - 2011 | Beebe K, et al. Titan Pharmaceuticals, Inc via Research and Research Infrastructure Grand Opportunities program (GO Grant, NIDA 5RC2 DA028910 02) PRO-806:A Six-Month, Randomized Clinical Trial of Probuphine® Safety and Efficacy in Opioid Addiction. **(Site PI)** |
| 2011 - 2012 | Beebe K, et al. Titan Pharmaceuticals, Inc PRO-811: PRO-811, A Phase 3, Six-Month, Open-Label Re-Treatment Study of Probuphine® in Opioid Addiction. **(Site PI)** |
| 2007 - 2012 | DeLisi LE, Caton C, Rosenthal, RN. Biological predictors of psychosis susceptibility among adolescent cannabis users. 1R01DA021576-01A2 NIDA; **(Site PI)** |

| | |
|---|---|
| 2014 - 2016 | Rosenthal RN, Vocci F. Braeburn Pharmaceuticals, Inc. PRO-814: A Randomized, Double-Blind, Double-Dummy, Active-Controlled Multicenter Study of Adult Outpatients with Opioid Dependence Transitioned from a Daily Maintenance Dose of 8 mg or Less of Sublingual Buprenorphine or Buprenorphine/Naloxone to Four Probuphine® Subdermal Implants. (**National PI**) |
| 2015 - 2017 | Litten RZ, et al. NIAAA NCIG-006 Randomized, Double Blind, Placebo-Controlled Trial of the Safety and Efficacy of HORIZANT® (Gabapentin Enacarbil) Extended-Release Tablets for the Treatment of Alcohol Use Disorder (**Site PI**) |
| 2019 – 2020 | Litten RZ, et al. NIAAA NCIG-7 Randomized, Double-Blind, Placebo-Controlled Trial of The Efficacy of Intranasal Oxytocin for The Treatment of Alcohol Use Disorder (**Site PI- FDA Clinical Hold, 5/19**) |
| 2016 - 2019 | D'Onofrio G, Fiellin D, et al. NIDA CTN-0069 "Implementation of ED-initiated Buprenorphine for Opioid Use Disorder." (**Community PI; consultant 11/17-19**) |
| 2015 - 2020 | McNeely J, Rosenthal RN, Kannry J, et al. NIDA CTN-0062Ot - A Phased-Implementation Feasibility and Proof-of-Concept Study to Assess Incorporating the NIDA CTN Common Data Elements (CDEs) into the Electronic Health Record (EHR) in Large Primary Care Settings. (**2015-18: National Co-PI, Mount Sinai Administrative PI; 2018-20 Study Executive Committee, Mount Sinai Co-PI**) |

ACTIVE:

| | |
|---|---|
| 2019 – 2021 | Wang F, Rosenthal RN, Hou W, Schonfeld E. SBU Office of the Vice President for Research OVPR Seed Funding Award. AI Based Opioid Overdose Prevention (**Co-PI**) |
| 2020 – 2024 | Schwartz A, R01 AA028032 Large-scale Data Scientific Assessment of Unhealthy Alcohol Consumption Among Front-Line Restaurant Workers **(Co-I)** |
| 2020 – 2025 | Moeller S, R01 DA51420 Neurocircuitry of clinical insight predicting relapse outcomes in opioid addiction. **(Co-I)** |
| 2021 – 2026 | Moeller S, R01 DA49733 Neural, endocrine, and behavioral markers of psychosocial stress predicting drug use outcomes in human opioid addiction (**Co-I**) |
| 2020 – 2023 | Bisaga A, Nunes EV. (Multi PI) UG1 DA13035 CTN-0097: Surmounting Withdrawal to Initiate Fast Treatment with Naltrexone (SWIFT): Improving the Real-World Effectiveness of Injection Naltrexone for Opioid Use Disorder (NIH HEAL Initiative) **(Site PI)** |

PENDING:

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|---|---|
| 2021 – 2026 | Swain J (PI) R61/R33 Postpartum Intervention for Mothers with Opioid Use Disorders - Brain-Behavior Mechanisms<br>(**Co-I**) |
| 2022 – 2027 | Rosenthal RN, Wang F (Multi PI) R01 Interpretable Temporal and Graph Based Deep Learning for Early Opioid Risk Prediction Using Electronic Health Records<br>(**PI**) |

**MEDICAL SCHOOL COMMITTEE MEMBERSHIPS:**

**Albert Einstein College of Medicine**

| | |
|---|---|
| 1995 - 2001 | Academic Council, Department of Psychiatry |
| 1997 - 2001 | College of Medicine Faculty Senate |

**Columbia University College of Physicians and Surgeons**

| | |
|---|---|
| 2001 - 2013 | Executive Committee, Department of Psychiatry |
| 2009 - 2013 | Co-Chair, Joint Committee on the University–Hospital Affiliation |
| 2010 - 2011 | Academic Tracks Committee |
| 2012 - 2013 | Academic Tracks Implementation Taskforce; Educational Scholarship and Leadership Sub-Committee |
| 2013 - 2014 | Permanent Voting Member, Faculty of Medicine Faculty Council |

**Icahn School of Medicine at Mount Sinai**

| | |
|---|---|
| 2014 - 2016 | Mount Sinai Performing Provider System (PPS) Clinical Committee<br>- DSRIP Behavioral Health Subcommittee; 3ai workgroup |
| 2014 - 2015 | Mount Sinai PPS IT Committee |
| 2017 - 2018 | Scientific Review Group (SRG) for Mount Sinai Mentored Career Development Program Leadership (KL2) award applications |

**Mount Sinai Department of Psychiatry/Mount Sinai Behavioral Health System**

| | |
|---|---|
| 2013 – 2016 | Mount Sinai Behavioral Health System Integration Steering Committee |
| 2014 – 2016 | Chair, Core Clinical Performance Committee (Clinical Targets and Outcomes) |
| 2014 – 2016 | Chair, Work Standardization Committee (Addiction Policy and Care Quality Group) |
| 2014 – 2016 | Mount Sinai Beth Israel Opioid Treatment Prog. Financial Operations Group |
| 2015 – 2016 | Mount Sinai Center for Addictive Disorders Leadership Group |
| 2015 – 2016 | Mount Sinai Center for Addictive Disorders Internal Advisory Committee |
| 2015 – 2016 | Acute Care BH Revenue Cycle Committee |
| 2015 – 2016 | Mount Sinai Beth Israel Opioid Treatment Program Leadership Meeting |

**Renaissance School of Medicine Stony Brook**

**School of Medicine Standing Committees**

| | |
|---|---|
| 2020 - | Faculty Senate Executive Committee |

**CONTINUUM HEALTH PARTNERS COMMITTEE MEMBERSHIPS**

| | |
|---|---|
| 2002- 2003 | Clinical and Executive Leadership Forum<br>2002- Chair, Recruitment and Retention Subcommittee |
| 2002 - 2009 | Chairman, Addictions Service Line Development Committee |

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|---|---|
| 2003 - 2006 | Board of Trustees, SLRHC Physician Delegate |
| 2004 - 2006 | Strategic Design Team |
| 2006 - 2008 | Clinical Strategy Group |
| 2010 - 2013 | Behavioral Health Task Force |
| 2010 - 2012 | Branding Committee |
| 2010 - 2012 | Continuum Psychiatry Quality/Performance Improvement Committee |
| 2013 - 2014 | Chair, Behavioral Health Performance Improvement Team |

**BETH ISRAEL HOSPITAL/BETH ISRAEL MEDICAL CENTER COMMITTEE MEMBERSHIPS:**

| | |
|---|---|
| 1986 - 1989 | Beth Israel Medical Center AIDS Task Force |
| | 1987- Co-Chair, Bernstein Pavilion AIDS Task Force |
| 1987 - 1992 | Committee on Scientific Activities (IRB) |
| | 1991, 92, 93 - Acting Chairman |
| 1991 - 1993 | Committee on Continuing Medical Education |
| 1991 - 2001 | Research Newsletter - Editorial Board |
| 1992 - 2001 | Committee on Quality Improvement |
| 1993 - 2002 | Singer/Hillman Research Award Committee |
| 1993 - 2001 | Ethics Committee: |
| | 1994 - 99 Research/Publications Subcommittee |
| | 1999 - 01 Policy Subcommittee |
| 1994 - 2002 | BIMC Alumni Association Housestaff Essay Contest Award Committee |
| 1995 - 1996 | Information Technology Re-engineering Sub-Team |
| 1995 - 1996 | Administrative Services Task Force |
| 1996 - 1997 | Information Technology Clinical Governance Group |
| 2000 - 2001 | Chair, Psychosurgery Advisory Committee |
| 2000 - 2001 | Chair, Leadership Development Workgroup |

**Beth Israel Medical Center Department of Psychiatry**

| | |
|---|---|
| 1984 - 2001 | Department of Psychiatry Quality Assurance Committee |
| | 1992 – 2001 Chair |
| | 1992 – 1998 Inpatient Special Review Committee |
| | 1992 – 1998 Continuing Day Treatment Committee |
| 1984 - 1992 | Inpatient Attendings' Committee |
| 1984 - 2001 | Division Chiefs Committee |
| 1988 - 1990 | Chair, Pharmacotherapy Task Force, Department of Psychiatry, BIMC |
| 1988 - 1994 | Grand Rounds Committee |
| 1989 - 1992 | AIDS Executive Coordinating Council |
| 1989 - 2001 | Research Committee |
| | 1993 - 1996 Chair |
| 1992 - 2001 | Residency Education Committee |
| 1992 - 2001 | Executive Committee, Department of Psychiatry |
| 1994 - 2002 | Chair, Addiction Psychiatry Residency Education Subcommittee |

**ST. LUKE'S - ROOSEVELT HOSPITAL CENTER COMMITTEE MEMBERSHIPS:**

| | |
|---|---|
| 2001 - 2014 | Executive Committee, Medical Board |
| 2001 - 2014 | Medical Board (*ex officio*) |
| 2001 - 2014 | Chair's Committee |
| 2001 - 2003 | Reconfiguration Initiative Team |
| 2001 - 2004 | Team Leader - Psychiatry/Substance Abuse Operational Growth Team |
| 2002 - 2009 | Columbia University Academic Affiliation Committee |

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|---|---|
| 2002 - 2013 | Pastoral Care and Education Advisory Committee |
| 2004 - 2005 | Graduate Medical Education Strategic Planning Committee |
| 2004 - 2006 | Strategic Planning Team |
| 2007 - 2009 | Chair, Department of Neurology Chair Search Committee |
| 2008 - 2013 | Strategic Planning Steering Committee |
| 2010 - 2012 | Chair, Eating and Metabolic Disorders Initiative Planning Group |
| 2010 - 2014 | Academic Affairs Committee |
| 2011 - 2013 | SLR Pilot Grant Steering Committee and Scientific Review Panel |

**St. Luke's - Roosevelt Hospital Center Department of Psychiatry**

| | |
|---|---|
| 2001 - 2014 | Chair, Department Executive Committee |
| 2001 - 2014 | Research Committee |
| 2001 - 2014 | Department of Psychiatry Quality Improvement Committee |
| 2001 - 2014 | Residency Education Committee |
| 2005 - 2014 | Faculty Practice Committee (*ex officio*) |
| 2011 - 2014 | Chair, Department of Psychiatry Transformation initiative Workgroup 1 |
| 2014 - 2016 | SLR BH Finance Workgroup |

**STONY BROOK MEDICINE**

**Department of Psychiatry and Behavioral Health**

| | |
|---|---|
| 2019 - | Residency Training Committee |
| 2020 - | Residency Training Program Evaluation Committee |

**TEACHING EXPERIENCE AND RESPONSIBILITIES:**

**Beth Israel Medical Center**

| | |
|---|---|
| 1984 - 2001 | Clinical supervisor for St. Sinai Medical Students, AECOM Medical Students; Psychiatry Residents and Addiction Psychiatry Fellows at Beth Israel Medical Center. |
| 1985 - 1992 | Director of Biological Psychiatry Course, two-year core track in the Beth Israel Psychiatry Residency Training Program: All PGY I's and II's, Coordinator and Faculty, lecture tracks on addiction neurobiology, addiction genetics |
| 1985 - 2001 | Supportive Psychotherapy Project, Beth Israel Medical Center, Co-Investigator, Clinical and research Supervisor of residents and staff (weekly) |
| 1986 - 1996 | Short Term Dynamic Psychotherapy Study – Therapist/ Supervisor |
| 1990 - 1998 | Brief Psychotherapy Continuous Case Seminar, PGY IV's, weekly, Faculty (10 residents) |
| 1992 - 2001 | Department of Psychiatry Morbidity and Mortality Conference –monthly case conference Organizer, Leader, and Faculty (35-40 residents) |
| 1993 - 1996 | Research Design/Statistical Methods course, PGY II, Coordinator and Faculty (5 weeks) |
| 1990 - 2001 | Division of Consultation/Liaison Psychiatry – yearly lectures on:<br>Substance Abuse in the inpatient medical setting<br>Neurobiology of Addiction |
| 1990 - 2001 | COPAD (Combined Psychiatric and Addictive Disorder) Group Psychotherapy Conference, PGY III's and IV's, Fellows - weekly |
| 1993 - 2001 | Addiction Psychiatry Journal Club, Residents and Fellows, biweekly x 32 weeks, Faculty |
| 1993 - 2001 | Substance Abuse Basic Course for PGY II's 10 weeks, coordinator and faculty |
| 2001 - 2007 | Addiction Psychiatry Fellowship: Lecturer |

**New York State Psychiatric Institute**

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|---|---|
| 1993 - 2012 | Seminar: Treatment of Schizophrenia and Substance Abuse, Public Psychiatry Fellowship, Faculty (~ 10 fellows) |

**Hunter College, New York, NY**

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|---|---|
| 1988 - 1993 | Lecture series on mental illness and addiction, CAC training program (4hr) |

**Molloy College, Rockville Centre, NY**

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|---|---|
| 1990 - 1991 | Lecture series on mental illness and addiction, CAC training program (4hr) |

**American Academy of Addiction Psychiatry**

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|---|---|
| 1993 - 2001 | Annual Review Course on Addiction Psychiatry, Course Director (13 hr.), Faculty (≈300 enrollees) |

**Mount Sinai St. Luke's - Roosevelt Hospital Center Department of Psychiatry**

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|---|---|
| 2001 - 2002 | Emergency Psychiatry and Substance Abuse Lecture - PGY 2 (2 Hr.) |
| 2001 - 2003 | Substance Abuse Basic Course - PGY 3's 6 weeks, coordinator/faculty (9 Hr.) |
| 2001 - 2012 | Clinical Case Conference - PGY 1 & 2 monthly (18 Hr.) |
| 2002 - 2007 | Major Syndromes Course - PGY 2 Substance Use Disorders (3 Hr.) |
| 2004 - 2017 | Supportive Psychotherapy Course Director/faculty - PGY 2 10 weeks (15 Hr.) |
| 2005 - 2009 | Journal Club - PGY 2 and 3 (6 Hr.) |
| 2005 - 2013 | Substance Abuse Basic Course - SLR PGY 2 faculty (3 Hr.) |
| 2007 - 2013 | Clinical Psychopharmacology Course (2 Hr.) |
| 2007 - 2013 | Research Methods Course (2 Hr.) |
| 2011 - 2013 | Tutorial in Community Psychiatry (2 Hr.) |
| 2013 - 2017 | Psychodynamic psychotherapy supervisor (80 Hr.) |

**Mount Sinai School of Medicine Department of Psychiatry and Behavioral Science**

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|---|---|
| 2014 - 2017 | Substance Abuse Basic Course – MSSM PGY 2, 6 Wks, Dir./faculty (9Hr) |
| 2015 - 2017 | Topics in Clinical Neuroscience – doctoral students (BSR 6705) (1.5Hr) |
| 2015 - 2017 | Lectures on Substance use disorders PGY 3 (2 Hr.) |
| 2017 - Present | Addiction Psychiatry Fellowship Lectures (3Hr.) |

**STONY BROOK UNIVERSITY**
**Stony Brook University Undergraduate**

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|---|---|
| 2018 - | BIO 335 Neurobiology lab course. Neuroethics lecture (Annual, 1Hr) |
| 2019 - | PSY 349-02 Psychology of Addiction. (1.5 Hr) |

**Stony Brook University Graduate Schools**

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|---|---|
| 2020 - | Pharmacotherapy of SUD, SBU Consortium Didactics Lecture Series; Clinical Psychology Interns, (1.5 Hr) |

**Renaissance School of Medicine at Stony Brook University**

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|---|---|
| 2018 - | Mind-Brain-Behavior Block, Phase 1– The Opioid Crisis + Sm. groups (3 Hr) |
| 2019 - | MED 468 Addiction & Pain – Selective 4 wks, semiannual, Dir/faculty (64 Hr); 30 students/Selective as of 4/20 |

**Stony Brook University Department of Psychiatry and Behavioral Health**

| | |
|---|---|
| 2018 - present | Substance Use Disorders, PGY-1 Bootcamp (3 Hr) |
| 2018 - present | Substance Use Disorders, PGY-2 (3 Hr) |
| 2018 - present | Substance Use Disorders, PGY-3 (3 Hr) |
| 2019 - present | Psychodynamic psychotherapy supervisor (40 Hr.) |
| 2020 - present | Substance Use Disorders, Child Fellows (Dir., 2 Hr) |
| 2020 - present | Advanced Addiction Psychiatry, PGY-4 (2 Hr) |
| 2020 - present | Supportive Psychotherapy Course Director/faculty - PGY 2 9 weeks (9 Hr.) |
| 2020 - present | Supportive Psychotherapy Supervisory guidance. - Faculty Supervisors |

**NYU School of Medicine**

| | |
|---|---|
| 2020 - | Visiting Mentor Development Program, Substance Abuse Research Education and Training program (SARET) – Neurobiology of Substance Use Disorders (1 Hr.) |
| 2020 - | Addiction Psychiatry Fellowship Didactic Course, Alcohol Use Disorders (3 Hr.) |

| **PhD Thesis Examiner** | **Candidate** | **Institution** | **Date** |
|---|---|---|---|
| | Laura Ospina Pinillos, MD | University of Sydney, AU | October, 2019 |
| | Kathryn Hill, MD/PhD Student | Stony Brook University | December, 2021 |

**EXTERNAL PROMOTION/TENURE REVIEWER**

| | |
|---|---|
| 2003 | Mount Sinai School of Medicine |
| 2004 | New York University School of Medicine |
| 2006 | Columbia University College of Physicians & Surgeons |
| 2006 | The David Geffen School of Medicine at UCLA |
| 2008 | Feinberg School of Medicine, Northwestern University |
| 2010 | Wayne State University School of Medicine |
| 2012 | UC Irvine School of Medicine |
| 2014 | Duke University Medical Center |
| 2019 | Boston University School of Medicine |
| 2020 | University of British Columbia |
| 2021 | University of Utah School of Medicine |

**DATA SAFETY MONITORING BOARD MEMBERSHIPS**

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|---|---|
| 2017 - 2021 | Single Site, Randomized, Double Blind, Placebo-Controlled Study to Assess the Long-Term Safety of Tafenoquine [DynPort Vaccine Company] |

**SPONSORSHIP OF POST-DOCTORAL FELLOWS:**

**Addiction Psychiatry PGY-V Residents/Fellows, Mount Sinai Beth Israel**

| | **Name** | **Current Appointment** |
|---|---|---|
| 1995 - 96 | Gabriela Centurion, M.D. | Private Practice, New York, NY |

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|---|---|---|
| 1996 - 97 | Prameet Singh, M.D. | Chair of Psychiatry, Mount Sinai St. Luke's-West; Associate Dean for GME, Associate Professor of Psychiatry, Icahn School of Medicine at Mount Sinai |
| 1998 - 99 | Charles A. Perkel, M.B., B.Ch | Private Practice; formerly Chief, Division of Addiction Psychiatry, Mount Sinai Beth Israel; Assistant Professor of Psychiatry, Icahn School of Medicine at Mount Sinai |
| 1999 - 2000 | Ilana Zylberman, M.D. | Assistant Professor of Psychiatry, Columbia University Medical Center |
| 1999 - 2000 | Mary Lawlor, M.D. | Private Practice, Greenwich, CT |
| 1999 - 2001 | Anavel Carin, M.D. | Attending Psychiatrist, Northport VA Medical Center, NY |
| 2000 - 2001 | Joshua Deane, M.D. | Atascadero State Hospital, Atascadero, CA |
| 2000 - 2001 | Aslam Naz, M.D. | Private Practice, New Haven, CT |

**Addiction Psychiatry PGY-V Residents/Fellows, Mount Sinai West**

| | **Name** | **Current Appointment** |
|---|---|---|
| 2014 – 2015 | Evelyn A Dennison, M.D. | Private Practice, Kirkland, Washington |
| 2014 – 2015 | Gibson George, M.D. | Penn Foundation Behavioral Health, Sellersville, PA |
| 2015 – 2016 | Arnab Datta, M.D. | Medical Director, Addiction Services, St. Joseph Hospital, Yonkers, NY |
| 2015 – 2016 | Viral Goradia, M.D. | Clinical Assistant Professor Psychiatry, SUNY Upstate Medical University, Syracuse, NY |
| 2015 – 2016 | Jyothsna Karlapalem, M.D. | Dir. Wakefield Recovery, Montefiore Med Ctr, Bronx, NY |

**Research Mentor of BIMC Psychiatric Residents:**

| | **Name** | **Current Appointment** |
|---|---|---|
| 1991-93 | Michael H. Goldstein, M.D. | Assistant Professor of Psychiatry, Icahn School of Medicine at Mount Sinai; Director, Neuroscience Program, Division of Neurobehavior & Alzheimer's Disease, Mount Sinai Beth Israel |
| 1993-96 | Laurence Westreich, M.D. | Clinical Associate Professor of Psychiatry, NYU Medical Center; Past President, American Academy of Addiction Psychiatry |
| 1997-99 | Zinoviy Gutkovich, M.D. | Assistant Professor, Icahn School of Medicine at Mount Sinai |
| 1994-96 | Teodor T. Postolache, M.D. | Professor of Psychiatry, University of Maryland; Director, Mood and Anxiety Program (MAP) |
| 2001-03 | John J. Mariani, M.D. | Associate Professor of Clinical Psychiatry; Director, Substance Treatment and Research Service, Columbia University College of Physicians & Surgeons |

**Research Mentor of SLR Psychiatric Residents:**

| | **Name** | **Current Appointment** |
|---|---|---|
| 2005-07 | Bachar Arnaout, M.D. | Assistant Clinical Professor of Psychiatry, Yale University School of Medicine, CT |
| 2008-09 | Agnieszka Wisniewska, MD | Assistant Professor of Psychiatry, Icahn School of Medicine at Mount Sinai |
| 2009-11 | Sabish Balan, M.D. | Attending Psychiatrist, The Floating Hospital, NY |
| 2010-12 | Geetha Nampiaparampil, MD | Attending, Miami Cancer Institute of Baptist Health South |

| | | |
|---|---|---|
| Florida | | |
| 2010-12 | Navjot Khinda, M.D. | Attending, Department of Psychiatry, Mount Sinai Morningside-West Hospitals, New York, NY |
| 2011-13 | Philip Krick, M.D. | Private Practice, La Jolla, CA [deceased] |
| 2011-13 | Angeliki Pesiridou, M.D. | Attending, Callen-Lorde Community Health Center, NY |
| 2012-13 | Irina Kolos, M.D. | Attending, Lebanon VA Medical Center, Pennsylvania |
| 2012-13 | Evelyn Stephens, MD | Assistant Clinical Professor, Icahn School of Medicine at Mount Sinai, New York, NY |
| 2014-16 | Hart N Kopple-Perry, MD | Assistant Professor, Icahn School of Medicine at Mount Sinai New York, NY |
| 2015-16 | Marcel Green, MD | Clinical Instructor, Icahn School of Medicine at Mount Sinai New York, NY |
| 2015-16 | Ludwing Florez Salamanca, MD | Instructor in Psychiatry, Columbia University Medical Center, NY |
| 2016 -17 | Dmitry Ostrovsky, MD | Assistant Clinical Professor, Icahn School of Medicine at Mount Sinai, New York, NY |
| 2016 - 17 | Lara Katz, MD | Fellow, Child and Adolescent Psychiatry, Mount Sinai Morningside - Mount Sinai West, New York, NY |

**Administrative Mentor of Columbia University Faculty at SLR:**

| | | |
|---|---|---|
| 2002 - 10 | Ramon Solhkhah, MD | Chair, Department of Psychiatry and Behavioral Health, Hackensack Meridian School of Medicine at Seton Hall University |
| 2002 - 13 | Petros Levounis, MD, MA | Professor and Chair, Department of Psychiatry, Rutgers New Jersey Medical School |

**OTHER PROFESSIONAL ACTIVITIES**:

**EDITORIAL:**

| | |
|---|---|
| 1989-1997 | Contributing Editor APA NY District Branch Newsletter |
| 1999 - | Editorial Board, American Journal on Addictions |
| 2004 - 2007 | Contributing Editor, Psychiatric Services: Coeditor, Clinical Computing Column |

*Ad Hoc Journal Reviewer*:

Addiction (Britain)
Addictive Behaviors
Alcoholism: Clinical and Experimental Research
American Journal on Addictions
American Journal of Public Health
American Journal of Psychiatry
Annals of the New York Academy of Sciences
British Medical Journal (BMJ Cases)
Drug and Alcohol Dependence
Experimental and Clinical Psychopharmacology
Expert Systems With Applications
International Journal of Social Psychiatry
Journal of Addiction Medicine
Journal of the American Medical Informatics Association
Journal of Clinical Psychiatry
Journal of Medical Internet Research Public Health and Surveillance
Journal of Substance Abuse Treatment

The Lancet
The Medical Letter
New England Journal of Medicine
Therapeutic Advances in Psychopharmacology
Psychiatric Services
Psychiatry Research
Social Psychiatry and Psychiatric Epidemiology
Substance Abuse

**CONSULTATION:**

*Federal/National:*

| | |
|---|---|
| 1992 | NIMH/NIAAA Co-Occurring Disorders Services Research Workgroup, Bethesda, Md. |
| 1993 - 2001 | Consortium for Medical Fellowships in Alcoholism and Drug Abuse |
| 1994 - 1997 | SAMHSA National Advisory Council, Subcommittee on Services Integration for Individuals with Co-occurring Mental and Addictive Disorders: Consultant, National Conference on Co-Occurring Mental Health and Substance Abuse Disorders Focus Workgroup |
| 1994 - 1995 | NIDA Office of Extramural Program Review: Small Business Innovation Research Concept Reviewer; Contract Review Group |
| 1995 | NIDA Health Services Research Planning Group, (A. Leshner, Ph.D., Chair) |
| 1995 - 1997 | NIDA Office of Extramural Program Review: Behavioral Therapies Development Programs: Initial Review Groups SRCD-G (51, 52) Ad Hoc Reviewer |
| 1995 - 1998 | ACGME Specialist Site Visitor in Addiction Psychiatry, Residency Review Committee for Psychiatry |
| 1996 - 1997 | NIDA Office of Extramural Program Review: Pharmacological Therapies Development Programs: Initial Review Groups SRCD-G 54 Ad Hoc Reviewer |
| 1996 - 1997 | CMHS (Center for Mental Health Services), Managed Care Initiative, Clinical Standards and Workforce Competencies Project, Co-Occurring Mental/Substance Disorders Panel. |
| 1999 | NIDA Office of Extramural Program Review: Medication Development Centers Special Emphasis Panel SEP - ZDAI |
| 2001 | NIDA Office of Extramural Program Review: NIDA-K , March 6-7, Oct. 23-24 |
| 2001 | NIDA Clinical Trials Network, Blending Conference Planning Committee; New York/ Long Island Regional Nodes |
| 2001 - 2003 | Physician Leadership on National Drug Policy, Outreach Partner Representative (AAAP) |

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|---|---|
| 2002 - 2004 | American Board of Psychiatry and Neurology: Committee on Certification in Addiction Psychiatry |
| 2002 | Social Sciences and Humanities Research Council of Canada, Grant Review Committee |
| 2002 - 2003 | Residency Review Committee for Psychiatry: Program Requirements Workgroup for Addiction Psychiatry Revisions. |
| 2003 | Buprenorphine National Consensus Panel: AAAP, Treatment Research Institute, CSAT/Robert Wood Johnson Foundation |
| 2003 | Faculty Advisory Committee: Hanley Family Foundation/PLNDP project "Empowering Health Professional Students to Advocate for More Training in Substance Abuse" |
| 2004 - 2009 | Co-Chairman, National Steering Council, SAMHSA Co-Occurring Cross-Training Center for Excellence (COCE.SAMHSA.GOV) |
| 2004 - 2009 | Senior Fellow, SAMHSA Co-Occurring Disorders Center for Excellence |
| 2004 | NIDA Office of Extramural Program Review: Special Emphasis Panel ZDA1 MXG-S (03) (R) Jul. 7-8, 2004 |
| 2004 | CSAT/SAMHSA Expert Panel on Co-Occurring Disorders and Emerging Issues in Opioid Treatment, Div. Of Pharmacologic Therapies, CSAT |
| 2004 - 2005 | US Office of Narcotic and Drug Control Policy, Leadership Conference on Medical Education in Substance Abuse, Member, Expert Panel, Graduate Medical Education Working Group |
| 2005 - | Friends of NIDA, Executive Committee |
| 2006 | US Office of Narcotic and Drug Control Policy, Leadership Conference on Medical Education in Substance Abuse, Member, Planning Committee |
| 2006 - 2007 | Expert Advisory Board, CSAT Treatment Improvement Protocol (TIP 49), Incorporating Alcohol Pharmacotherapies Into Medical Practice |
| 2006 - 2008 | Chair, Expert Advisory Board, CSAT Treatment Improvement Protocol (TIP 48), Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery |
| 2007 - | Canada Foundation for Innovation (CFI) Research Hospital Fund Large-Scale Institutional Endeavours Competition (RHF-LSIE), Reviewer |
| 2007 - 2009 | Expert Panel on Strategic Planning, Co-Occurring and Homeless Activities Branch (CHAB) of the Center for Substance Abuse Treatment (CSAT). |
| 2007 - 2008 | American Medical Association, American Psychiatric Association/ Physician Consortium for Performance Improvement/ National Committee for Quality Assurance; Substance Use Disorders Workgroup |

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|---|---|
| 2008 | US Office of Narcotic and Drug Control Policy, Third Leadership Conference on Medical Education in Substance Abuse, Member, Expert Panel/Planning Committee |
| 2010 - 2011 | CSAT Knowledge Application Program (KAP) Treatment Improvement Protocol (TIP) User Liaison Group (ULG), Rockville, MD. |
| 2010 - 2011 | NIDA Clinical Trials Network Electronic Health Record Workshop and SIG: NIDA Common Data Elements |
| 2010 - 2013 | SAMHSA Expert Consensus Panel + workgroup: Using Technology-Based Therapeutic Tools in Behavioral Health Services |
| 2011 | SAMHSA Expert Consensus Panel: Medical Guidelines for Treating Individuals with Post-Traumatic Stress Disorder and Co-Occurring Opioid Use Disorders |
| 2011 | SAMHSA Expert Consensus Panel: General Principles for the Use of Pharmacological Agents to Treat Persons with Co-Occurring Mental Health and Substance Use Disorders |
| 2013 | AMA-APA Coalition on Mental Health and Violence Issues (Dilip Jeste, MD, Chair) |
| 2014 - 2019 | NIAAA Clinical Investigation Group (NCIG) |

*State:*

| | |
|---|---|
| 1986 - 1988 | Governor's (NY) Task Force on Combined Psychiatric and Addictive Disorders; Program Development workgroup |
| 1987 - 1990 | New York State Office of Mental Health, Senior Supervisory Panel, Mentally Ill Chemical Abuser (MICA) Programs. |
| 1989 - 1991 | Training Consultant to "States Helping States" ADAMHA Block Grant to NY State OMH - Conducted, evaluated staff training on the acute evaluation/ treatment of MICA patients at Comprehensive Psychiatric ER sites; Developed and promoted Larkin's 4-quadrant co-occurring disorders model. |
| 1990 - 1991 | Medical Malpractice Mediation Panels, 12th Judicial District, Supreme Court, State of New York |
| 1993 - 1994 | Consultant to Mental Health Association of New York - developed software expert system diagnostic tool "PERDS" for emergency assessment of comorbid psychiatric and addictive disorders |
| 1994 - | New York State Office of Alcoholism and Substance Abuse Services Committee on Medical Education in Addiction |
| 1994 - 1995 | Consultant to New York State Office of Mental Health: refining program of 'PERDS' expert system diagnostic tool for distribution of beta version to emergency room sites. |

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|---|---|
| 1999 - | New York State Office of Mental Health, Addictions Training Program Advisory Committee |
| 2000 - 2001 | SUNY Upstate Medical University Institute for Applied Psychiatry/NY State Office of Mental Health - Workforce competencies initiative for persons in dual recovery: Curriculum Development Forum. |
| 2003 | State of Texas, Texas Medication Algorithm Project (TMAP): Co-occurring Mental Illness and Substance Use Disorder Medication Algorithm Consensus Conference |
| 2004 - 2010 | New York State Department of Health, State Hospital Review and Planning Council (SHRPC) Appointed by Governor George Pataki - Member<br>Member, Executive Committee: 2008 - 2010<br>Vice Chair, Code and Regulations Committee: 2008 - 2010<br>Chair, Information Systems Review Committee: 2009 - 2010<br>I worked successfully with SHRPC staff and DOH leadership to re-initiate the dormant IS Review Committee given the growing deployment of public and private resources and need for public planning in health IT. |
| 2004 - 2011 | New York State Office of Mental Health, Mental Health Services Council Appointed by Governor George Pataki- Member<br>2008 - 2011 Chair, Regulations Subcommittee<br>Council considered issues regarding the improvement of NYS mental health services and advised the Commissioner of the Office of Mental Health (OMH) therein. The Council assisted in formulation and establishment of statewide goals and objectives for mental health services. The Regulations Subcommittee reviewed all proposed OMH rules and regulations and made recommendations to the Council. |
| 2004 - 2005 | New York State Department of Health, Empire Clinical Research Investigator Program (ECRIP) Project Reviewer |
| 2007 - 2008 | New York State Office of Alcoholism and Substance Abuse Services/Department of Health Joint Task Force on the Continuum of Care for Alcoholism and Substance Abuse Services (Detoxification Reform) |
| 2007 | New York State Office of Mental Health /New York State Office of Alcoholism and Substance Abuse Services Co-Occurring Disorders Task Force, Expert Consultant. |
| 2008 - 2013 | New York State Health Foundation, Center for Excellence in Integrated Care (CEIC), Implementation Steering Committee, Partner/Senior Advisor. |

*Local Government/Community Service:*

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|---|---|
| 1985 - 1995 | Manhattan Mental Health Council<br>1985 – 1987 Chair, Dual Diagnosis Workgroup |
| 1988 - 1989 | Greater New York Hospital Association, Mental Health Committee: Dual Diagnosis Sub-Committee |

| | |
|---|---|
| 1995 - 1998 | Action Committee, Alliance for the Mentally Ill/ Greater New York Hospital Association |
| 1997 - 2007 | Board of Advisors, National Alliance for the Mentally Ill/NYC Metro, New York. |
| 1998 | City of New York Symposium '98 (Drug Abuse), Dept. Mental Health, Mental Retardation and Alcoholism Services |
| 1998 - 2001 | Action Committee to Improve Mental Health Policy |
| 2005 - | Greater New York Hospital Association, Substance Abuse Services Planning Workgroup |
| 2018 - | Suffolk County MAT Workgroup |
| 2018 - | Suffolk County Heroin and Opioid Advisory Panel |
| 2018 - | Greater New York Hospital Association, Opioid Advisory Group |
| 2019 - | Suffolk County Emergency Department Opiate Response Working Group |

*Private/clinical*

| | |
|---|---|
| 1984 - 1986 | Consultation and staff education, Stuyvesant Square Chemical Dependence Rehabilitation Program, Beth Israel Medical Center. |
| 1988 - 2000 | Clinical and Administrative Consultant, Dual Diagnosis Program Development:<br>Creedmoor Psychiatric Center, Queens, NY<br>Kingsboro Psychiatric Center, Brooklyn, NY<br>Elmira Psychiatric Center, Elmira, NY<br>St. Joseph's Hospital, Lexington, KY<br>Allen Pavilion, NY Presbyterian Medical Center, NY |
| 1993 - 2020 | Region IV Consulting Psychiatrist, National Football League/National Football League Players Association, Policy and Program for Substances of Abuse. |

*Research-related*

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| 2020 - | NIH HEALing Communities Study, NY State Community Advisory Board (CAB), NIH HEAL initiative |

*Legal Consultation*

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| 2018 | Pesce v. Coppinger, Essex County Sheriff and the Superintendent of the Essex County House of Corrections – Middleton. United States District Court for The District of Massachusetts. Rosenthal RN, Expert Declaration for Plaintiff, American Civil Liberties Union of Massachusetts.<br>*On November 26, 2018, a federal judge required Essex County correctional authorities to provide a Massachusetts man with continued access to his methadone while he was in their custody. |
| 2019 | DiPierro v. Hurwitz, Acting Director of the Federal Bureau of Prisons, and Assistant Director of the Health Services Division of the Federal Bureau of |

Prisons. United States District Court for The District of Massachusetts. Rosenthal RN, Expert Declaration for Plaintiff, American Civil Liberties Union of Massachusetts.
*On June 7, 2019, the Federal Bureau of Prisons agreed to provide DiPierro with medication for her addiction treatment during her incarceration. The final settlement marks a first-of-its-kind victory.

2021 P.G., Plaintiff, v. Jefferson County, New York, et al., United States District Court Northern District Of New York. Rosenthal RN, Expert Declaration for Plaintiff, New York Civil Liberties Union, American Civil Liberties Union Foundation.
*On September7, 2021, a federal judge required Jefferson County correctional authorities to provide a New York man with continued access to his methadone while he was in their custody.

**BOARD MEMBERSHIPS:**

1995 - 2014 Board of Directors, Senior Vice-President, General Informatics Corporation, Del.

1996 - 1998 Action Committee, Alliance for the Mentally Ill/ Greater New York Hospital Association

1997 - 2006 Board of Advisors, National Alliance for the Mentally Ill, NAMI-NYC Metro

1997 - 1999 Medical Director, Behavioral Health, Greater Metropolitan MSO, Inc.
1997 - 1999 Chair - Credentialing Committee

1997 - 2000 Board of Directors, Continuum Behavioral Health IPA, Inc.
1999- 2000 Advisory Committee

1997 - 1998 Board of Directors, New York Physicians Practice Corporation (IPA)
Utilization Management/Quality Improvement Committee

1998 - 2001 Board of Managers, Benchmark Physician Organization, LLC. (PO)
1997 – 2000 Medical Management Committee
1999 – 2000 Contract/Negotiation/Finance Committee
1999 – 2000 Secretary (elected)
Nominating Committee

1999 - 2001 Medical Advisory Board, Helios Health, Atlanta, Georgia.

2000 - 2004 Medical Advisory Board, Healthology, Inc. New York, NY

2002 - 2006 Acamprosate Executive Advisory Board, Forest Laboratories, Inc., NY

2003 - 2006 Advisory Board, Alkermes, Cambridge, Massachusetts

**ORIGINAL PEER-REVIEWED PUBLICATIONS:**
http://orcid.org/0000-0002-6011-809X

1. Rosenthal RN, Slotkin TA. Development of nicotinic responses in the rat adrenal medulla and long-term effects of neonatal nicotine administration. Brit J Pharm. 60: 59-64, 1977.

2. Pinsker H, Rosenthal RN. Beth Israel Medical Center Supportive Psychotherapy Manual. Social and Behavioral Sciences Documents 18. Washington, D.C, American Psychological Association, 1988, #2886.

3. Rosenthal RN, Hellerstein DJ, Miner CR. A model of integrated services for outpatient treatment of patients with comorbid schizophrenia and addictive disorders. American Journal on Addictions, 1: 339-348, 1992. DOI:10.3109/10550499208993154

4. Rosenthal RN, Hellerstein DJ, Miner CR. Integrated services for treatment of schizophrenic substance abusers: Demographics, symptoms and substance abuse patterns. Psychiatric Quarterly 63: 3-26, 1992.

5. Taylor N, Rosenthal RN, Chabus B, Levine S, Hoffman A. Feasibility of smoking bans on psychiatry units. General Hospital Psychiatry 15: 36-40, 1993.

6. Rosenthal RN, Hellerstein DJ, Miner CR. Positive and negative syndrome typology in schizophrenic patients with psychoactive substance use disorders. Comprehensive Psychiatry 35:91-98, 1994.

7. Galynker I, Kampf R, Rosenthal RN. Dose-related visual hallucinations in patients with macular degeneration receiving phenelzine. American Journal of Psychiatry 151:450, 1994.

8. Hellerstein DJ, Pinsker H, Rosenthal RN, Klee S. Supportive therapy as the treatment model of choice. J Psychotherapy Practice and Research 3: 100-106, 1994.

9. Westreich L, Rosenthal RN. Physical examination of substance abusers. Postgraduate Medicine, 97:111-123, 1995.

10. Hellerstein DJ, Rosenthal RN, Miner CR. A prospective study of integrated outpatient treatment for substance-abusing schizophrenic patients. American Journal on Addictions 4:33-42, 1995. DOI:10.3109/10550499508997421

11. Levinson I, Galynker I, Rosenthal RN. Methadone withdrawal psychosis, J Clinical Psychiatry 56: 73-76, 1995.

12. Galynker I, Levinson I, Miner CR, Rosenthal RN. Negative symptoms in basal ganglia strokes. Neuropsychiatry, Neuropsychology and Behavioral Neurology, 8(2): 113-117, 1995.

13. Westreich LM, Rosenthal RN, Muran JC. A preliminary study of therapeutic alliance and dually diagnosed inpatients. American Journal on Addictions 5: 81-86, 1996. **DOI**:10.3109/10550499608995661

14. Galynker I, Ieronimo C , Miner C, Rosenblum J, Vilkas N, Rosenthal R. Methylphenidate treatment of negative symptoms in patients with dementia. J Neuropsych Clin Neurosci. 9:231-239, 1997.

15. Galynker I, Prikhojan A, Phillips E, Focseneanu M, Ieronimo C, Rosenthal R. Negative symptoms in stroke patients and length of hospital stay. J Nerv Ment Dis 185: 616-621, 1997.

16. Miner CR, Rosenthal RN, Hellerstein DJ. Prediction of non-compliance with outpatient treatment referral in substance-abusing schizophrenics. Arch Gen Psych 54: 706-699, 1997.

17. Rosenthal RN, Miner CR. Differential diagnosis of substance-induced psychosis and schizophrenia in patients with psychoactive substance use disorders. Schizophrenia Bull 23:187-193, 1997.

18. Rosenthal RN, Perkel C, Singh P, Anand O, Miner C. A pilot open randomized trial of valproate and phenobarbital in the treatment of acute alcohol withdrawal. American Journal on Addiction 7: 189-197, 1998.

19. Hellerstein DJ, Rosenthal RN, Pinsker H, Wallner-Samstag L, Muran JC, Winston A. A randomized prospective study comparing supportive and dynamic therapies: outcome and alliance. J Psychother Prac Res 7:261-271, 1998.

20. Rosenthal RN, Muran JC, Hellerstein DJ, Pinsker H, Winston A. Interpersonal change in supportive psychotherapy. J Psychother Prac Res, 8:55-63, 1999.

21. Gutkovich Z, Rosenthal RN, Galynker I, Muran C, Batchelder S, Itskhoki E. Depression and demoralization among Russian-Jewish immigrants in primary care. Psychosomatics, 40: 117-125, 1999.

22. Postolache TT, Rosenthal RN, Hellerstein DJ, Aromin R, Kelton GM, Muran JC, Londono JH. Early augmentation of sertraline with methylphenidate. Journal of Clinical Psychiatry. 60(2):123-4, 1999 Feb.

23. Galynker II, Dutta E, Vilkas N, Ongseng F, Finestone H, Gallagher R, Serseni D, Rosenthal RN. Hypofrontality and negative symptoms in patients with dementia of Alzheimer type. Neuropsychiatry Neuropsychol Behav Neurol. 13(1):53-9, 2000.

24. Roane DM, Feinberg TE, Meckler L, Miner CR, Scicutella A, Rosenthal RN. The treatment of dementia-associated agitation with gabapentin. Journal of Neuropsychiatry and Clinical Neurosciences, 12(1):40-43, 2000.

25. Galynker I, Cohen L, Salvit C, Miner C, Phillips E, Focseneanu M, Rosenthal R: Psychiatric symptom severity and length of stay on an intensive rehabilitation unit. Psychosomatics, 41(2):114-20, 2000.

26. Galynker II, Watras-Ganz S, Miner C, Rosenthal RN, Des Jarlais DC, Richman BL, London E. Cerebral metabolism in opiate-dependent subjects: Effects of methadone maintenance. Mount Sinai J Med 67: 381-387, 2000.

27. Hellerstein DJ, Little SAS, Samstag LW, Batchelder S, Muran JC, Fedak M, Kreditor D, Rosenthal RN, Winston A. Adding group psychotherapy to medication treatment in dysthymia: A randomized prospective pilot study. Journal of Psychotherapy Practice and Research, 10: 93-103, 2001

28. Bergasa NV, Link MJ , Keogh M, Yaroslavsky G, Rosenthal RN, McGee M.Pilot study of bright-light therapy directed towards the eyes for the pruritus of cholestasis. American Journal of Gastroenterology 96:1563-1570, 2001.

29. Hellerstein DJ, Rosenthal RN, Miner CR. Integrating services for schizophrenia and substance abuse. Psychiatric Quarterly 72: 291-306, 2001.

30. Kranzler HR, Rosenthal RN. Dual diagnosis: Alcoholism and co-morbid psychiatric disorders. Am J Addict 12[suppl 1]:S26-40, 2003.

31. Minkoff K, Zweben J, Rosenthal RN, Ries R. Development of service intensity criteria and program categories for individuals with co-occurring disorders. J Addictive Diseases, 22, [Suppl 1], 113-129, 2003.

*32. Ziedonis DM, Smelson D, Rosenthal RN, Batki SL, Green AI, Henry RJ, Montoya I, Parks J, Weiss RD. Improving the care of individuals with schizophrenia and substance use disorders: consensus recommendations. Journal of Psychiatric Practice 11:315–339, 2005.

33. Mariani JJ, Rosenthal RN, Tross S, Singh P, Anand OP. A randomized open-label controlled trial of gabapentin and phenobarbital in the treatment of alcohol withdrawal. Am J Addict. 2006 Jan-Feb;15(1):76-84.

34. Rosenthal RN. Current and future drug therapies for alcohol dependence. Journal of Clinical Psychopharmacology 26[suppl 1]: S20-S29, 2006

35. CME Institute of Physicians Postgraduate Press; O'Brien CP, Koob GF, Mee-Lee D, Rosenthal RN. New developments in addiction treatment. J Clin Psychiatry. 67(11):1801-12, 2006. PMID: 17196062

36. Lachman HM, Fann CSJ, Bartzis M, Evgrafov OV, Rosenthal RN, Nunes EV, Miner C, Santana M, Gaffney J, Riddick A, Hsu C-L, Knowles J. Genomewide suggestive linkage of opioid dependence to chromosomes 5p and 14q.Human Molecular Genetics, 2007 Jun 1;16(11):1327-34. Epub 2007 Apr 4.

37. Galynker II, Eisenberg D, Matochik JA, Gertmenian-King E, Cohen L, Kimes AS, Contoreggi C, Kurian V, Ernst M, Rosenthal RN, Prosser J, London ED. Cerebral metabolism and mood in remitted opiate dependence. Drug Alcohol Depend. 2007 Oct 8;90(2-3):166-74. Epub 2007 May 22.

38. Rosenthal RN, Gage A, Perhach JL, Goodman AM. Acamprosate: safety and tolerability in the treatment of alcohol dependence. Journal of Addiction Medicine 2:40-50, 2008

39. Arnaout B, Batchelder S, Rosenthal RN, Hyler S, Hellerstein DJ. Does a history of alcohol use disorder affect response to antidepressant medication in patients with dysthymic disorder? Journal of Dual Diagnosis 4:377-393, 2008

*40. Ling W, Casadonte P, Bigelow G, Kampman KM, Patkar A, Bailey GL, Rosenthal RN, Beebe KL. Buprenorphine Implants for Treatment of Opioid Dependence: A Randomized Controlled Trial. JAMA 304(14):1576-1583, 2010

41. Rosenthal RN, Nunes EV, LeFauve C. Implications of epidemiological data for identifying persons with substance use and other mental disorders. American Journal on Addictions 21:97-103, 2012.

42. Camera AA, Tomaselli V, Fleming J, Jabbar GA, Trachtenberg M, Galvez-Buccolini, Proal AC, Rosenthal RN, DeLisi LE. Correlates to the variable effects of cannabis in young adults: a preliminary study. Harm Reduction Journal, 15:9, 2012 doi:10.1186/1477-7517-9-15

43. Rosenthal RN, Ling W, Casadonte P, Vocci F, Bailey GL, Kampman KM, Patkar A, Chavoustie S, Blasey C, Sigmon S, Beebe KL. Buprenorphine implants for treatment of opioid dependence: randomized comparison to placebo and sublingual buprenorphine/naloxone. Addiction. 2013 Dec;108(12):2141-9. doi: 10.1111/add.12315. Epub 2013 Sep 18. PMID: 23919595

*44. Rosenthal RN, Lofwall MR, Kim S, Chen M, Beebe KL, Vocci FJ; PRO-814 Study Group. Effect of buprenorphine implants on illicit opioid use among abstinent adults with opioid dependence treated with sublingual buprenorphine: a randomized clinical trial. JAMA. 2016 Jul 19;316(3):282-90. doi: 10.1001/jama.2016.9382. PMID: 27434441 Altmetrics: 1010

45. Mathai AJ, Kanwar J, Okusaga O, Fuchs D, Lowry CA, Giegling I, Hartmann AM, Konte B, Friedl M, Gragnoli C, Reeves G, Groer M, Rosenthal RN, Rujescu D, Postolache TT. Blood levels of monoamine precursors and smoking in patients with schizophrenia. Frontiers in Public Health. 2016 Aug 30;4:182. doi: 10.3389/fpubh.2016.00182. eCollection 2016.

46. Dammerman R, Bailey GL, Beebe KL, Chen M, Rosenthal RN, Sigmon S, Ling W. Long-Term Buprenorphine Implants for Treatment of Opioid Dependence: Safety Outcomes from Two Open-Label Extension Trials. J Addict Behav Ther Rehabil 2017;6:1. doi: 10.4172/2324-9005.1000162

47. Rosenthal RN, Goradia VV. Advances in the delivery of buprenorphine for opioid dependence. Drug Design, Development and Therapy. 11:2493-2505, 2017 http://dx.doi.org/10.2147/DDDT.S72543

48. McNeely J, Kumar PC, Rieckman T, Sedlander E, Farkas S, Chollak C, Kannry JL, Vega A, Waite EA, Peccoralo L, Rosenthal RN, McCarty D, Rotrosen J. Barriers and facilitators affecting the implementation of substance use screening in primary care clinics: a qualitative study of patients, providers, and staff. Addiction Science & Clinical Practice, 2018 Apr 9;13(1):8. doi: 10.1186/s13722-018-0110-8. PMID: 29628018

49. Falk DE, Ryan ML, Fertig JB, Devine EG, Cruz R, Brown E, Burns H, Salloum IM, Newport J, Mendelson J, Galloway G, Kampman K, Brooks C, Green AI, Brunette MF, Rosenthal RN, Dunn KE, Strain EC, Ray L, Shoptaw S, Ait-Daoud Tiouririne N, Gunderson EW, Ransom J, Scott C, Leggio L, Caras S, Mason BJ, Litten RZ, for the National Institute on Alcohol Abuse and Alcoholism Clinical Investigations Group (NCIG) Study Group. Gabapentin Enacarbil Extended-Release for Alcohol Use Disorder: A Randomized, Double-Blind, Placebo-Controlled, Multisite Trial assessing Efficacy and Safety. Alcohol Clin Exp Res. 2019 Jan;43(1):158-169. PMID: 30403402

50. Rosenthal RN. Update: Novel Formulations of Buprenorphine for Treatment of Opioid Use Disorder. FOCUS: The Journal of Lifelong Learning in Psychiatry 2019;17(2):103-109. DOI: 10.1176/appi.focus.20180043

51. Dong X, Rashidian S, Wang Y, Hajagos J, Zhao X, Rosenthal RN, Kong J, Saltz M, Joel Saltz J, Wang F. Machine Learning Based Opioid Overdose Prediction Using Electronic Health Records. AMIA Annu Symp Proc 2020 Mar 4;2019:389-398. PMID: 32308832

52. Rosenthal RN, Welsh JW, Connery HS, Barnett BS, DeVido J, Hill K, Levin FR, Williams AR, Greenfield SF. Advocacy and Public Policy Efforts of the American Academy of Addiction Psychiatry. American Journal on Addictions, 2020;29:401-406 PMID: 32902042 doi: 10.1111/ajad.13085

53. Yao H, Rashidian S, Dong X, Duanmu H, Rosenthal RN, Wang F. Detection of Suicidality Among Opioid Users on Reddit: Machine Learning–Based Approach J Med Internet Res 2020;22(11):e15293 doi: 10.2196/15293 PMID: 33245287 PMCID: 7732714 URL: https://www.jmir.org/2020/11/e15293

54. Dong X, Deng J, Hou W, Rashidian S, Abell-Hart K, Rosenthal RN, Saltz M, Saltz JH, Wang F. Predicting Opioid Overdose Risk of Patients with Opioid Prescriptions Using Electronic Health Records Based on Temporal Deep Learning. Journal of Biomedical Informatics, Volume 116, April 2021, 103725. doi: 10.1016/j.jbi.2021.103725. Online ahead of print. PMID: 33711546

55. Chen X, Hou W, Rashidian S, Wang Y, Zhao X, Leibowitz GS, Rosenthal RN, Saltz M, Saltz JH, Schoenfeld ER, Wang F. A large-scale retrospective study of opioid poisoning in New York State with implications for targeted interventions. Sci Rep. 2021 Mar 4;11(1):5152. doi: 10.1038/s41598-021-84148-2. PMID: 33664282

56. McNeely J, Adam A, Rotrosen J, Wakeman SE, Wilens TE, Kannry JL, Rosenthal RN, Wahle A, Pitts S, Farkas S, Rosa C, Peccoralo L, Waite EA, Vega A, Kent J, Craven C, Kaminsky TA, Firmin E, Isenberg B, Harris M, Kushniruk A, Hamilton L. Comparison of methods for alcohol and drug screening in primary care. JAMA Network Open, 2021;4(5):e2110721. doi:10.1001/jamanetworkopen.2021.10721

57. Xiang A, Hou W, Rashidian S, Rosenthal RN, Abell-Hart K, Zhao X, Wang F. Association of Opioid Use Disorder With 2016 Presidential Voting Patterns: A Cross-Sectional Study in New York State at Census Tract Level. JMIR Public Health and Surveillance, 2021 Apr 21;7(4):e23426. doi: 10.2196/23426 PMID: 33881409 PMCID: PMC8100884

58. Dong X, Deng J, Rashidian S, Abell-Hart K, Hou W, Rosenthal RN, Saltz M, Saltz JH, Wang F. Identifying Risk of Opioid Use Disorder for Patients Taking Opioid Medications with Deep Learning. Journal of the American Medical Informatics Association, 2021 Apr 30;ocab043. doi: 10.1093/jamia/ocab043 PMID: 33930132

In Review:

59. Westenberg JN, Krausz RM, Tsang V, Suen J, Ignaszewski MJ, Mathew N, Azar P, Cabanis M, Elsner J, Vogel M, Spijkerman R, Orsolini L, Vo D, Moore E, Moe J, Strasser H, Koeck P, Marian C, Duersteler K Backmund M, Roehrig J, Post M, Haltmeyer H Wladika W, Mulle C, Trabi T, Rechberge G, Teesson M, Farrell M, Christie G, Merry S, Mamdouh M, Alinksy R, Levy S, Fishman M, Atkinson D, DiNicola VF, Rosenthal RN, Jang K, Choi F. Prevention, Treatment, and Management of Youth with a High-Risk Substance Use and Increased Risk of Opioid Overdose – Consensus in an international Delphi study. Journal of Adolescent Health, Submitted

60. Katz M, Nyman JC, Leora R. Heckelman LR, Sergi J, Rosenthal RN. A Framework for the Implementation of Supportive-Expressive Psychotherapy Techniques in the Supervisory Relationship. Psychotherapy, Submitted

**REVIEWS, EDITORIALS, COMMENTARIES, AND LETTERS:**

1. Rosenthal RN. Crack and the Psychiatric Emergency Room, New York County District Branch APA Newsletter, vol. XIII, No.1, 1989.

2. Rosenthal RN. Smoking is an Addiction, NY County DB APA Newsletter, vol. XIV, No.4, 1990.

3. Rosenthal RN. Comorbidity of psychiatric and substance use disorders. Primary Psychiatry 2(7): 42-45, 1995.

4. Rosenthal RN. Is schizophrenia prone to addiction? Current Opinion in Psychiatry 11(1):45-48, 1998.

5. Rosenthal RN. Treatment of co-occurring schizophrenia and substance use disorders. Psychiatric Times 22(14): 84-87, 2005

6. Rosenthal RN. Out of the Pipeline. Intramuscular naltrexone. Targeting adherence in alcohol dependency treatment. Current Psychiatry 5(3): 106-113, 2006.

7. Rosenthal RN. Alcohol-related illness in the mental health patient: Conundrums in the diagnosis and pharmacologic management. Consultant 46(7):S5-S15, 2006

8. CME Institute of Physicians Postgraduate Press; Rosenthal RN, Brady KT, Levounis P, Willenbring ML. Advances in the treatment of alcohol dependence. J Clin Psychiatry 68(7):1117-28, 2007.

9. Rosenthal RN. Reply to Dr Caputo and colleagues regarding "GABAergic medications for treating alcohol dependence". J Clin Psychopharmacol. 2007 Oct;27(5):540-2.

10. Ling W, Rosenthal RN, Beebe KL. Buprenorphine Implants and Opioid Dependence—Reply. JAMA. 2011;305(3):254

11. Rosenthal, RN. Free Will and Substance Use Disorders: A Thought Experiment. American Academy of Addiction Psychiatry Newsletter. Fall/Winter, 2012.

12. Rosenthal RN. Medication for Addiction Treatment (MAT). American Journal of Drug and Alcohol Abuse, 2018;44(2):273-274. doi: 10.1080/00952990.2018.1427757. Epub 2018 Feb 2. PMID:29394112

13. Rosenthal RN. Managing the Opioid Use Disorder Crisis. Current Psychiatry 2018 Apr; 17(4):S9-S18

14. Moeller SJ, Fox HC, Hsu DT, Rosenthal RN. Dispositional neural signatures: When group main effects on fMRI tasks can still be interesting. Psychiatry: Cognitive Neuroscience and Neuroimaging 2018;3(11):905–906 PMID: 30409388

15. Saitz R, Miller SC, Feillin DA, Rosenthal RN. Recommended Use of Terminology in Addiction Medicine. Journal of Addiction Medicine, 2020 May 29. doi: 10.1097/ADM.0000000000000673. PMID: 32482955

16. Williams AR, Hill K, Rosenthal RN, Connery HS, Welsh JW. Proposed Model State Cannabis Laws to Reduce Harms. The American Journal on Addictions 2020;29:426-427. DOI:10.1111/ajad.13088 PMID: 32902047

**CASE REPORTS**

1. Yanowitch P, Rosenthal RN. A suicide attempt by blowing air into a heparin lock. Hospital & Community Psychiatry 45: 382-383, 1994.

2. Galynker I, Perkel C, Rosenthal RN. Doxepin withdrawal mania. J Clinical Psychiatry, 56:122-123, 1995.

3. Gutkovich Z, Rosenthal RN, Bogdanoff L. Transient psychosis with psychogenic polydipsia in schizotypal patient taking fluoxetine. Psychosomatics 29: 295-296, 1998.

**BOOKS:**

1. Rosenthal RN. (Editor) Important Issues in Dual Diagnosis Treatment. American Journal on Addictions Compendium Series, Brunner-Routledge, New York, 2003.

2. Winston A, Rosenthal RN, Pinsker H. Introduction to Supportive Psychotherapy. American Psychiatric Publishing, Inc, Washington, DC, 2004.

Chinese translation, 支持性心理治療入門, 心靈工坊 (Mind Workshop) Taiwan, 2005
周立修, 蔡东杰等译. Zhi chi xing xin li zhi liao ru men, Taipei
Slovak translation, Úvod do podpornej psychoterapie, Vydavateľstvo F, 2006
Japanese translation, 支持的精神療法入門 /Shijiteki seishin ryōhō nyūmon, 星和書店, Tōkyō : Seiwa Shoten, 2009.
Chinese translation, 支持性心理治疗导论 People's Health Publishing House, 2010.
Turkish translation, Destekleyici Psikoterapiye Giriş, 2011

3. Winston A, Rosenthal RN, Pinsker H. Learning Supportive Psychotherapy: An Illustrated Guide. American Psychiatric Publishing, Inc., Washington, DC, 2011.

Japanese Translation 動画で学ぶ支持的精神療法入門 /Doga de manabu shijiteki seishin ryoho nyumon, 医学書院, Tōkyō Igakushoin, 2015

4. Miller SC, Fiellin D, Rosenthal RN, and Saitz R., Eds. The ASAM Principles of Addiction Medicine, 6th Edition, Lippincott, Williams & Wilkins, 2019

5. Winston A, Rosenthal RN, Roberts LR. Learning Supportive Psychotherapy, 2nd Edition. American Psychiatric Publishing, Inc., Washington, DC, 2020.

Hungarian Edition 2021

**BOOK CHAPTERS:**

1. Pinsker H, Rosenthal RN, McCullough L. Supportive Dynamic Psychotherapy, in, Handbook of Short-Term Dynamic Therapy, Crits-Christoph P, ed. Basic Books, 1991, 220-247.

2. Rosenthal RN, Mental Illness/Chemical Addiction: A Guide to Emergency Services Assessment and Treatment, NY State Office of Mental Health, Division of Clinical Support Systems, Albany, 1992.

3. Rosenthal RN. Psychopharmacologic agents in the clinical treatment of patients with cocaine use disorder. In: Proceedings from the Symposia on Cocaine Addiction: Trends, Laboratory Research, Clinical Issues and Treatment, Monograph 1: 16-18, Chemical Dependency Research Working Group, NY State Office of Substance Abuse Services, Albany, 1994.

4. Rosenthal RN. Guidelines for comorbidity: Substance abuse in the mentally ill. Center for Substance Abuse Prevention/ Aetna US Healthcare. Proceedings, Prevention Training in Managed Behavioral Healthcare, Center for Substance Abuse Prevention, 1997.

5. Rosenthal RN. The socioeconomic impact of substance abuse/dependence disorders, anxiety disorders, and comorbidity, In, Treatment Challenges in the Psychiatric Setting: Comorbidity of Substance Abuse/ Dependence Disorders and Anxiety Disorders, ed. Kosten, TR; Bristol-Myers Squibb Monograph, 1998.

6. Rosenthal RN, Westreich L. Treatment of persons with dual diagnoses of substance use disorder and other psychological problems. In: Addictions: A Comprehensive Guidebook, eds. McCrady, B.S., Epstein, E.E. Oxford University Press, New York, 1999.

7. Winston A, Rosenthal RN, Muran JC. Supportive psychotherapy of personality disorder, in Handbook of Personality Disorder, ed. Livesley WJ, Guilford Press, 2001.

8. Rosenthal RN. Group treatments for schizophrenic substance abusers, In: The Group Psychotherapy of Substance Abuse, eds. Brook, D.W., Spitz, H.I. The Haworth Press, Inc., New York, 2002.

9. Rosenthal RN. An Inpatient Based Service Model. In Substance Use In Psychosis: A Handbook Of Approaches To Treatment And Service Delivery. Eds. Graham H, Birchwood M, Copello A, Mueser K. John Wiley & Sons, Ltd., 2002.

10. Minkoff K, Zweben J, Rosenthal RN, Ries R. Development of Service Intensity Criteria and Program Categories for Individuals with Co-Occurring Disorders. In, Ed. Gastfriend DR. Addiction Treatment Matching: Research Foundations of the American Society of Addiction Medicine (ASAM) Criteria, Haworth Medical Press, Inc, New York, 2003, pp. 113-129.

11. Rosenthal RN. Concepts of Evidence Based Practice. In Eds. Roberts AR and Yeager KR. Evidence-Based Practice Manual: Research and Outcome Measures in Health and Human Services, Oxford University Press, 2004, pp. 20-29.

12. Rosenthal RN, Solhkhah R. Psychopharmacology of Club Drugs. In, Ed. Kranzler HR and Ciraulo DA Clinical Manual of Addiction Psychopharmacology. American Psychiatric Publishing, Inc, Washington, DC, 2005, pp. 243-267.

13. Rosenthal RN, Levounis P. Polydrug Abuse. In Eds. Frances RJ, Miller SI and Mack AH. Clinical Textbook of Addictive Disorders, 3rd Edition. Guilford Press, 2005, pp. 245-270.

14. Postolache TT, Hung TM, Rosenthal RN, Soriano JJ, Montes F, Stiller JW. Sports chronobiology consultation: From the lab to the arena. Clin Sports Med 24:415– 456, 2005.

15. Rosenthal RN. Overview of Evidence Based Practice. In Eds. Roberts AR and Yeager KR. Foundations of Evidence-Based Social Work Practice. Oxford University Press, 2006, pp. 67-80.

16. Rosenthal RN. Alcoholism. In Eds. Rakel RE. And Bope ET. Conn's Current Therapy, 60th Edition (2008) WB Saunders Co., 2008

17. Rosenthal RN. Techniques of Individual Supportive Psychotherapy, in: The American Psychiatric Publishing Textbook of Psychotherapeutic Treatments in Psychiatry, G.O. Gabbard, (ED.), American Psychiatric Publishing, Inc, Washington, DC, 2008, pp. 417-445.

18. Taintor Z, Rosenthal RN. Microprocessor Abuse and Internet Addiction. In Eds.Ries R, Fiellin D, Miller S, and Saitz R. Principles of Addiction Medicine, 4th Edition, Lippincott, Williams & Wilkins, 2009, pp. 875-882.

19. Rosenthal RN, Ries RK. Medical Management Techniques: Integrating Pharmacological and Behavioral Treatments. In Eds.Ries R, Fiellin D, Miller S, and Saitz R. Principles of Addiction Medicine, 4th Edition, Lippincott, Williams & Wilkins, 2009, pp. 899-908.

20. Rosenthal RN. Alcoholism. In, Eds. Rakel RE and Bope ET, Conn's Current Therapy, 61st Edition. WB Saunders Co., 2009, pp. 1097-1104.

21. Rosenthal RN, Westreich LM. Cosmetic Psychopharmacology: Drugs that Enhance Well-Being, Performance, and Creativity. In Eds. Brizer D, Castaneda R. Clinical Addiction Psychiatry, Cambridge University Press, 2010, pp. 72-87.

22. Rosenthal RN. Alcoholism. In, Eds. Rakel RE and Bope ET, Conn's Current Therapy, 62nd Edition. WB Saunders Co., 2010, pp. 1103-1109.

23. Rosenthal RN. Alcohol Abstinence Management. In Eds: Ruiz P, Strain E. Lowinson & Ruiz's Substance Abuse: A Comprehensive Textbook, 5th Edition. Lippincott Williams & Wilkins, Baltimore MD, 2011, pp 477-493.

24. Rosenthal RN. Alcoholism. In, Eds.Rakel RE, Bope ET, and Kellerman RD, Conn's Current Therapy, 63rd Edition. WB Saunders Co., 2011, pp. 1111-1117.

25. Rosenthal RN, Ries RK, Young J. Integrating Pharmacological and Behavioral Treatments. In Ed. Cavacuiti CA. Principles of Addiction Medicine: The Essentials, Lippincott, Williams & Wilkins, 2011, pp 345-348.

26. Taintor Z, Rosenthal RN, Young J. Microprocessor Abuse and Internet Addiction. In Ed. Cavacuiti CA. Principles of Addiction Medicine: The Essentials, Lippincott, Williams & Wilkins, 2011, pp 337-339.

27. Rosenthal RN. Basic treatment techniques for persons with mental disorders and co-occurring substance use disorders. In Eds: McQuistion, HL, Sowers, W, Ranz, JM, Feldman, JM. American Association of Community Psychiatrists Handbook of Community Psychiatry. Springer, Inc. New York, 2012, pp 257-273.

28. Rosenthal RN. Alcoholism. In, Eds. Bope ET, and Kellerman RD, Conn's Current Therapy, 64th Edition. WB Saunders Co., 2012, pp. 931-937.

29. Rosenthal RN. Treatment of persons with dual diagnoses of substance use disorder and other psychological problems. In: Addictions: A Comprehensive Guidebook, eds. McCrady, B.S., Epstein, E.E. Oxford University Press, New York, 2013, pp. 659-707.

30. Rosenthal RN, Solhkhah R. Club Drugs and Synthetic Cannabinoid Agonists. In, Eds. Kranzler HR Ciraulo DA and Zindel LR. Clinical Manual of Addiction Psychopharmacology. American Psychiatric Publishing, Inc, Washington, DC, 2013, pp. 351-386.

31. Rosenthal RN. Alcoholism. In, Eds. Bope ET, and Kellerman RD, Conn's Current Therapy, 2013. WB Saunders Co., 2013, pp. 921-926

32. Rosenthal RN, Taintor Z. Microprocessor Abuse and Internet Addiction. In Eds. Ries R, Fiellin D, Miller S, and Saitz R. Principles of Addiction Medicine, 5th Edition, Lippincott, Williams & Wilkins, 2014, pp. 980-990.

33. Rosenthal RN, Zweben JE, Ries RK. Medical Management Techniques and Collaborative Care: Integrating Behavioral with Pharmacological Interventions in Addiction Treatment. Principles of Addiction Medicine, 5th Edition, Lippincott, Williams & Wilkins, 2014, pp. 1008-1023.

34. Rosenthal RN. Alcoholism. In, Eds. Bope ET, and Kellerman RD, Conn's Current Therapy, 2014. WB Saunders Co., 2014, pp. 931-937.

35. Rosenthal RN, Microprocessor Abuse and Internet Addiction. In Eds. Herron A, Brennan TK. The ASAM Essentials of Addiction Medicine, 2nd Edition, Wolters Kluwer, Philadelphia, 2015, pp. 372-377.

36. Rosenthal RN, Medical Management Techniques and Collaborative Care: Integrating Behavioral with Pharmacological Interventions in Addiction Treatment. In Eds. Herron A, Brennan TK. The ASAM Essentials of Addiction Medicine, 2nd Edition, Lippincott, Wolters Kluwer, Philadelphia, 2015, pp. 382-387.

37. Rosenthal RN, Clinical Communication Technologies for Addiction Treatment. In Eds. Dewan NA, Luo JS, Lorenzi NM. Mental Health Practice in a Digital World. Springer Inc., New York, 2015, pp. 123-140.

38. Rosenthal RN. Alcoholism. In, Eds. Bope ET, and Kellerman RD, Conn's Current Therapy, 2015. WB Saunders Co., 2015, pp. 963-969.

39. Rosenthal RN, Levounis P, Herron AJ. Polysubstance Use, Abuse and Dependence. In Eds. Mack AH Brady K, Miller SI, and Frances RJ, Clinical Textbook of Addictive Disorders, 4th Edition. Guilford Press, 2016, pp 267-291.

40. Lynch MJ, Arnaout B, Rosenthal RN. Integrating MI with other Psychotherapies. In Eds. Levounis P, Arnaout B, and Marienfeld C. Handbook of Motivation and Change: A Practical Guide for Clinicians, Second Edition. American Psychiatric Publishing, Inc., Washington, DC, 2016.

41. Rosenthal RN. Alcoholism. In, Eds. Bope ET, and Kellerman RD, Conn's Current Therapy, 70th Edition, 2018. Saunders, 2018, pp. 731-736.

42. Saitz R, Miller SC, Feillin DA, Rosenthal RN. Recommended Use of Terminology in Addiction Medicine. The ASAM Principles of Addiction Medicine, 6th Edition, pp 24-28, Lippincott, Williams & Wilkins, 2019.

43. Rosenthal RN. Alcohol Use Disorders. In, Eds. Kellerman RD and Rakel DP, Conn's Current Therapy, 71st Edition, 2019. WB Saunders Co., 2019, pp.747-753

44. Rosenthal RN, Taintor ZC, Grant JE. Microprocessor-based Disorders. In Eds. Miller SC, Fiellin D, Rosenthal RN, and Saitz R. The ASAM Principles of Addiction Medicine, 6th Edition, pp 648-663, Lippincott, Williams & Wilkins, 2019

45. Rosenthal RN, Zweben JE, Ries RK. Medical Management Techniques and Collaborative Care: Integrating Behavioral with Pharmacological Interventions in Addiction Treatment. In Eds. Miller SC, Fiellin D, Rosenthal RN, and Saitz R. The ASAM Principles of Addiction Medicine, 6th Edition, pp 1057-1072, Lippincott, Williams & Wilkins, 2019

46. Rosenthal RN. Alcohol Use Disorders. In, Eds. Kellerman RD and Rakel DP, Conn's Current Therapy, 2020. WB Saunders Co., 2019, pp.761-766.

47. Rosenthal RN, Microprocessor-based Disorders. In Eds. Herron A, Brennan TK. The ASAM Essentials of Addiction Medicine, 3rd Edition, pp 267-271, Wolters Kluwer, Philadelphia, 2020.

48. Rosenthal RN, Medical Management Techniques and Collaborative Care: Integrating Behavioral with Pharmacological Interventions in Addiction Treatment. In Eds. Herron A, Brennan TK. The ASAM Essentials of Addiction Medicine, 3rd Edition, pp 412-418, Wolters Kluwer, Philadelphia, 2020

49. Rosenthal RN, Urmanche AA, Muran JC. Techniques of Individual Supportive Psychotherapy, in: The American Psychiatric Publishing Textbook of Psychotherapeutic Treatments in Psychiatry, 2nd Edition. G.O. Gabbard, (ED.), American Psychiatric Publishing, Inc, Washington, DC, In Press

50. Rosenthal RN. Basic treatment techniques for persons with substance use disorders and co-occurring mental disorders. In Eds: Sowers W, McQuistion HL, Feldman JM, Ranz JM, Runnels P. American Association of Community Psychiatrists Handbook of Community Psychiatry. Springer Nature Switzerland AG, In Press.

**ABSTRACTS AND CONFERENCE PROCEEDINGS:**

1. Pinsker H, Barron CT, Rosenthal RN, Davidowitz J. Inpatient Treatment of Disturbed Substance Abusers. American Psychiatric Association 139th Annual Meeting Program, May 10-16, 1986, Washington, D.C.

2. Pinsker H, Rosenthal RN, Hellerstein DJ, Winston A. Supervision of Supportive Psychotherapy. APA 141st Annual Meeting, Montreal, Quebec, Can., May 7-12, 1988.

3. Rosenthal RN, Identification of Dual Diagnoses in Drug Abusers. NIDA National Conference on Drug Abuse Research & Practice Conference Highlights. p.63-64, Wash., D.C., Jan.12-15, 1991.

4. Taylor N, Rosenthal RN, Chabus B, et al. Effects of a smoking ban on two inpatient psychiatry units. New Research Program & Abstracts, American Psychiatric Association 144th Annual Meeting, New Orleans, La., May 1991.

5. Rosenthal RN. Identification and proper referral. Recognition and Treatment of Alcohol and Other Substance Abusers: The Physicians Role, NY Acad. Med. Conference Proceedings: New York County Medical Society Medical Review, Oct. 1991.

6. Rosenthal RN, Hellerstein DJ, Miner CR. A model of sufficient services for outpatient treatment of patients with comorbid schizophrenia and addictive disorders. 4th Annual NY State OMH Research Conference Proceedings, p. 16, Albany, NY, December 4-6, 1991.

7. Rosenthal RN, Hellerstein DJ, Miner CR Typology of schizophrenia in patients with comorbid substance abuse. New Research Program & Abstracts, American Psychiatric Association 145th Annual Meeting, Washington, D.C., May 2-7, 1992.

8. Hellerstein DJ, Rosenthal RN, Pinsker H. Supportive therapy as a treatment of choice. Scientific Proceedings, p.155, American Psychiatric Association 145th Annual Meeting, Wash., D.C., May 2-7, 1992.

9. Hellerstein DJ, Rosenthal RN, Miner CR. Schizophrenic substance abusers-A treatment study. New Research Program & Abstracts, p.199, American Psychiatric Association 146th Annual Meeting, San Francisco, CA., May 2-7, 1993.

10. Westreich LM, Rosenthal RN, Muran JC. Therapeutic alliance and dual diagnosis patients. New Research Program & Abstracts, p.110, American Psychiatric Association 146th Annual Meeting, San Francisco, CA., May 2-7, 1993.

11. Levinson I, Galynker I, Rosenthal R. Methadone Withdrawal Psychosis. Biological Psychiatry 35: 692, 1994.

12. Rosenthal RN, Hellerstein DJ, Miner CR. Syndrome typology effects upon engagement and outcome in schizophrenic substance abusers. New Research Program & Abstracts, American Psychiatric Association 147th Annual Meeting, Philadelphia, PA., May 21-26, 1994.

13. Rosenthal RN, Hellerstein DJ, Miner CR. Tipologia del sindromepositivo y negativo en pacientes esquizofrénicos con trastornospor use de sustanciaspsicoactivas. Focus on Psychiatry 3(1):11-12, 1995.

14. Rosenthal RN, Miner CR. Differential diagnosis of organic psychosis and schizophrenia in patients with psychoactive substance use disorders. New Research Program & Abstracts, American Psychiatric Association 148th Annual Meeting, Miami, FL., May 20-25, 1995.

15. Postolache T, Lowrimore P, Gutkovich Z, Rosenthal RN. No relationship found between mood and occupational stress in the staff of an inpatient psychiatric unit. New Research Program & Abstracts, American Psychiatric Association 148th Annual Meeting, Miami, FL., May 20-25, 1995.

16. Postolache T, Miner C, Rosenthal RN. Atmospheric pressure and agitation on a psychiatric inpatient unit. New Research Program & Abstracts, American Psychiatric Association 148th Annual Meeting, Miami, FL., May 20-25, 1995.

17. Galynker I, Rosenblum J, Ieronimo C, Phillips E, Focseneanu M, Miner C, Rosenthal R: Clinical significance of negative symptoms in stroke patients. Biol. Psychiatry 1995; 37:672

18. Galynker I, Ieronimo C, Rosenblum J, Miner C, Rosenthal R: Methylphenidate treatment of negative symptoms in dementias. Biol Psychiatry 1995; 37:651.

19. Galynker I, Ieronimo C, Finestone H, Ongseng F, Gallagher R, Phillips E, Focseneanu M, Miner C, Rosenthal R: 99-m Tc HMPAO brain SPECT in stroke patients with negative symptoms. Biol. Psychiatry 1995; 37:673

20. Rosenthal RN, Hellerstein DJ, Pinsker H. Testing effectiveness of supportive therapy: model and scope. Society for Psychotherapy Research Annual Meeting Programme Abstracts, Vancouver, B.C. Canada. June 22-25, 1995.

21. Pinsker H, Rosenthal RN, Hellerstein DJ. Supportive therapy and supportive elements in treatment. Society for Psychotherapy Research Annual Meeting Programme Abstracts, Vancouver, B.C. Canada. June 22-25, 1995.

22. Hellerstein DJ, Wallner-Samstag L, Rosenthal RN, Pinsker H, Hall W, Rachman E, Muran JC, Winston A. A randomized prospective study comparing supportive and dynamic therapies: alliance and outcome.

Society for Psychotherapy Research Annual Meeting Programme Abstracts, Vancouver, B.C. Canada. June 22-25, 1995.

23. Rosenthal RN, Hellerstein DJ, Miner CR. Positive and negative syndrome typology in schizophrenic patients with psychoactive substance use disorders, in: Year Book of Psychiatry and Applied Mental Health, Mosby-Year Book, Chicago, 1995.

24. Rosenthal RN. Addiction treatment in the United States, in Symposium: Clinical Research in Substance Abuse, M. Galanter, Chair, Syllabus & Proceedings, American Psychiatric Association 149th Annual Meeting, New York, NY, May 4-9, 1996.

25. Rosenthal RN, Muran JC, Hellerstein DJ, Pinsker H, Winston A. "Interpersonal change in supportive psychotherapy" in Symposium: Supportive psychotherapy: an effective modality, D. Hellerstein, Chair, Syllabus & Proceedings, American Psychiatric Association 149th Annual Meeting, New York, NY, May 4-9, 1996.

26. Hellerstein DJ, Wallner-Samstag L, Rosenthal RN, Pinsker H, Muran JC, Winston A. "Supportive versus dynamic therapy: An outcome study" in Symposium: Supportive psychotherapy: an effective modality, D. Hellerstein, Chair, Syllabus & Proceedings, American Psychiatric Association 149th Annual Meeting, New York, NY, May 4-9, 1996.

27. Galynker I, Burcescu SM, Teusink JP, Ongseng F, Finestone H, Serseni D, Dutta E, Vilkas N, Rosenthal R: SPECT correlates of depressive symptoms in patients with dementia of Alzheimer's Disease. New Research Program & Abstracts, American Psychiatric Association 149th Annual Meeting, New York, NY, May 4-9, 1996.

28. Salvit C, Miner C, Focseneanu M, Rosenthal R,Galynker I: Standardized assessment of psychiatric symptom severity enhances the prediction of length of stay on an intensive rehabilitation unit. New Research Program & Abstracts, American Psychiatric Association 149th Annual Meeting, New York, NY, May 4-9, 1996.

29. Galynker I, Vilkas N, Serseni D, Dutta E ,Focseneanu M, Rosenthal R,Ongseng F, Finestone H. Negative Symptoms associated with hypofrontality in stroke patients. New Research Program & Abstracts, American Psychiatric Association 149th Annual Meeting, New York, NY, May 4-9, 1996.

30. Harrigan E, Morrissey M, Ziprasidone Working Group (includes Rosenthal RN,) The efficacy and safety of 28-day treatment with ziprasidone in schizophrenia/schizoaffective disorder. New Research Program & Abstracts, American Psychiatric Association 149th Annual Meeting, New York, NY, May 4-9, 1996.

31. Galynker I, Cai J, Salvit C, Miner C, Rosenthal R: Overlap of negative and depressive symptoms in non-schizophrenic subjects. Biol. Psychiatry 1996; 39:543.

32. Galynker I, Vilkas N, Dutta E, Serseni D, Finestone H, Gallagher R, Rosenthal R: Regional cerebral blood flow in patients with dementia of Alzheimer's type: relationship to psychiatric symptoms. Biol. Psychiatry 1996; 39:659.

33. Galynker I, Salvit C, Phillips E, Focseneanu M, Miner C, Rosenthal R: Negative symptoms in medical and surgical patients undergoing intensive rehabilitation. Biol. Psychiatry 1996; 39:663.

34. Postolache T, Rosenthal RN, Hellerstein DJ, Aromin R, Londono J, Kelton G, Yanowitch P, Muran JC. Methylphenidate and sertraline for major depression. X World Congress of Psychiatry Abstracts. Madrid, August 23-28, 1996.

35. Rosenthal RN. New developments in dual diagnosis treatment. Syllabus and Proceedings, 48th Institute on Psychiatric Services, Chicago, IL, October 18-22, 1996.

36. Galynker I, Vilkas N, Dutta E, Serseni D, Cai J, Finestone H, Gallagher R, Rosenthal R. Negative syndrome and abnormal perfusion in the dorsolateral prefrontal cortex. ACNP Annual Meeting, San Juan, Puerto Rico, December 8-13, 1996.

37. Galynker I, Vilkas N, Dutta E, Serseni D, Cai J, Finestone H, Gallagher R, Rosenthal RN. Secondary negative syndrome and rCBF in prefrontal cortex. Biological Psychiatry 41:65, 1997.

38. Rosenthal RN. Substance abuse and schizophrenia: New treatment models. in Symposium, Research on psychosocial treatment for addiction, M. Galanter, MD, Chair. Syllabus and Proceedings Summary, American Psychiatric Association 150th Annual Meeting, San Diego, CA May 17-22, 1997.

39. Rosenthal RN, Miner CR, Hellerstein DJ. Effects of targeted assertive outreach in patients with schizophrenia and substance use disorders. New Research Program & Abstracts, American Psychiatric Association 150th Annual Meeting, San Diego, May 17-22, 1997.

40. Hellerstein DJ, Little SAS, Batchelder S, Samstag LW, Rosenthal RN, Winston A. Dysthymia: An outcome study of combined group therapy and medication treatment versus medication treatment alone. New Research Program & Abstracts, American Psychiatric Association 150th Annual Meeting, San Diego, May 17-22, 1997.

41. Hellerstein DJ, Little SAS, Samstag LW, Winston A, Rosenthal RN. Combined medication and group therapy for dysthymia. Syllabus and Proceedings Summary, American Psychiatric Association 150th Annual Meeting, San Diego, May 17-22, 1997.

42. Rosenthal RN, Muran JC, Hellerstein DJ, Winston A. Interpersonal change in supportive psychotherapy. In Symposium, "Pretreatment personality factors, interpersonal process, and interpersonal outcome in Brief Supportive Psychotherapy (BSP)", A. Winston, MD, Chair. Society for Psychotherapy Research 28th Annual Meeting Programme Abstracts, Geilo, Norway. June 25-29, 1997.

43. Hellerstein DJ, Muran JC, Wallner-Samstag L, Rosenthal RN, Winston A. Personality predictors of treatment success in brief supportive psychotherapy. in Symposium, "Pretreatment personality factors, interpersonal process, and interpersonal outcome in Brief Supportive Psychotherapy (BSP)", A. Winston, MD, Chair. Society for Psychotherapy Research 28th Annual Meeting Programme Abstracts, Geilo, Norway.June 25-29, 1997.

44. Winston A, Muran JC, Wallner-Samstag L, Hellerstein DJ, Rosenthal RN. Interpersonal process in brief supportive psychotherapy.in Symposium, "Pretreatment personality factors, interpersonal process, and interpersonal outcome in Brief Supportive Psychotherapy (BSP)", A. Winston, MD, Chair. Society for Psychotherapy Research 28th Annual Meeting Programme Abstracts, Geilo, Norway. June 25-29, 1997.

45. Rosenthal RN. New developments in dual diagnosis treatment. Syllabus and Proceedings, 49th Institute on Psychiatric Services, Washington, DC, October 24-28, 1997.

46. Gutkovich Z, Rosenthal RN, Muran JC, Galynker II, Batchelder S, Itskhoki E. Depression and demoralization among Russian-Jewish émigrés in primary care. Syllabus and Proceedings, 49th Institute on Psychiatric Services, Washington, DC, October 24-28, 1997.

47. Postolache TT, Rosenthal RN, Elsmore TF. Descending 1100 meters from the base camp of Everest improved sleep before Summit attempt. Sleep Research 26: 268, 1997.

48. Gutkovich Z, Rosenthal RN, Muran JC, Galynker II, Batchelder S, Itskhoki E. Depression and demoralization among Russian-Jewish émigrés in primary care. Proceedings Academy of Psychosomatic Medicine Annual Meeting, San Diego, CA, November 21, 1997.

49. Galynker II, Rosenthal RN, Des Jarlais D, Watras-Gans S, Friedman E, London E. PET studies of brain function in patients in methadone treatment. Effective Medical Treatment of Heroin Addiction NIH Consensus Development Conference. Abstracts. Bethesda, MD, November 17-19, 1997.

50. Rosenthal RN. Psychiatric comorbidity in stimulant abusers. Syllabus and Proceedings Summary, American Psychiatric Association 151st Annual Meeting, Toronto, Ontario May 30-June 4, 1998.

51. Bergasa NV, Link MJ, Keogh M, Yarolovsky G, Rosenthal RN, McGee M. Effect of Bright-light phototherapy (BLPT) directed towards the eyes for the pruritus of cholestasis: Results of a pilot study. American Association for the Study of Liver Disease, November 11, 1998.

52. Rosenthal RN, Mee-Lee D. Comorbidity in the Paradigm Shift: The ASAM PPC-2R. Proceedings, American Academy of Addiction Psychiatry, Ninth Annual Meeting and Symposium, Amelia Island, FL., December 3-6, 1998.

53. Rosenthal RN. Psychiatric comorbidity in stimulant abusers. Syllabus and Proceedings Summary, American Psychiatric Association 152nd Annual Meeting, Washington, D.C., May 15-20, 1999.

54. Galynker I, Dutta E, Cai J, Ongseng F, Finestone H, Prikhojan A, Rosenthal RN.Characterization and treatment of negative symptoms in nonschizophrenia patients. Syllabus and Proceedings Summary, American Psychiatric Association 152nd Annual Meeting, Washington, D.C., May 15-20, 1999.

55. Prikhojan A, Galynker I, Vilkas N, Rosenthal RN.Negative symptoms: Principal component analyses of psychometric scales in nonschizophrenia patients. Syllabus and Proceedings Summary, American Psychiatric Association 152nd Annual Meeting, Washington, D.C., May 15-20, 1999.

56. Miner CR, Rosenthal RN, Hellerstein DJ. Effects of assertive outreach in the dually diagnosed. New Research Program & Abstracts, American Psychiatric Association 152nd Annual Meeting, Washington, D.C., May 15-20, 1999.

57. Rosenthal RN, Miner CR, Hellerstein DJ, Muran JC. Alliance and treatment engagement in substance abusing patients with schizophrenia. New Research Program & Abstracts, American Psychiatric Association 152nd Annual Meeting, Washington, D.C., May 15-20, 1999.

58. Hellerstein DJ, Rosenthal RN, Miner CR. Dual diagnosis patients need integrated treatment. New Research Program & Abstracts, American Psychiatric Association 152nd Annual Meeting, Washington, D.C., May 15-20, 1999.

59. Rosenthal RN, Miner CR, Sena P, Hellerstein DJ, Muran JC. The therapeutic alliance in group treatments for substance abusers with schizophrenia , in Symposium, “The therapeutic alliance and interpersonal process in different treatments, outcomes and populations”, A. Winston, MD, Chair. Society for Psychotherapy Research 30th Annual Meeting Programme Abstracts, Braga, Portugal June 16-20, 1999.

60. Rosenthal RN. Conceptual overview, in Symposium, "Who gets treated where? Establishing procedures for level of care." R. Rosenthal, MD, Chair. Proceedings of the American Academy of Addiction Psychiatry Tenth Annual Meeting and Symposium, December 2-5, 1999.

61. Rosenthal RN. Identification and Treatment of Stimulant Abuse, in Symposium, “Psychiatric comorbidity in stimulant abusers”, D. Gorelick, MD, Chair. Syllabus and Proceedings Summary, American Psychiatric Association 153rd Annual Meeting, Chicago, IL, May 13-18, 2000.

62. Hellerstein DJ, Rosenthal RN,Miner CR. "Integrated services for schizophrenia and substance abuse, in Symposium, "Evolution of care: Schizophrenia and substance abuse", R. N. Rosenthal, MD, Chair. Syllabus and Proceedings Summary, American Psychiatric Association 153rd Annual Meeting, Chicago, IL, May 14-19, 2000.

63. Miner CR, Rosenthal RN, Hellerstein DJ. Effects of assertive outreach in the dually diagnosed, in Symposium, "Evolution of care: Schizophrenia and substance abuse", R. N. Rosenthal, MD, Chair. Syllabus and Proceedings Summary, American Psychiatric Association 153rd Annual Meeting, Chicago, IL, May 14-19, 2000.

64. Rosenthal RN, Miner CR, Sena P, Hellerstein DJ, Muran JC. The therapeutic alliance in group treatments for substance abusers with schizophrenia , in Symposium, "Evolution of care: Schizophrenia and substance abuse", R. N. Rosenthal, MD, Chair. Syllabus and Proceedings Summary, American Psychiatric Association 153rd Annual Meeting, Chicago, IL, May 14-19, 2000.

65. Rosenthal RN, Miner CR, Hellerstein DJ. Stable patients tolerate step-down of Targeted Assertive Outreach (TAO) services. New Research Abstracts, American Psychiatric Association 153rd Annual Meeting, Chicago, IL, May 14-19, 2000.

66. Rosenthal RN. Therapeutic climate in group treatments for dually diagnosed patients, in Symposium, "Therapeutic relationship and psychotherapy efficacy", A. Winston, MD, Chair. Syllabus and Proceedings Summary, American Psychiatric Association 153rd Annual Meeting, Chicago, IL, May 14-19, 2000.

67. Galynker II, Rosenthal RN, Ernst M, London E. "Regional cerebral glucose metabolism in patients removed from opiate replacement therapy" The American College of Neuropsychopharmacology, 39th Annual Meeting, Puerto Rico, December 10 - 14, 2000.

68. Rosenthal RN, Miner CR "Differential diagnosis of psychosis in drug abusers" in Symposium, "Substance use and psychosis: Tackling the chicken-and-egg problem", M. First, MD, Chair.Syllabus Proceedings and Summary, American Psychiatric Association 154thAnnual Meeting, New Orleans, LA, May 5-10, 2001.

69. Rosenthal RN, "Psychiatric comorbidity in stimulant abusers" in Symposium, "Update on Treatment of Stimulant Abuse", D. Gorelick, MD, Chair. Syllabus Proceedings and Summary, American Psychiatric Association 154thAnnual Meeting, New Orleans, LA, May 5-10, 2001.

70. Rosenthal RN, "The dually diagnosed patient" in Symposium, "When a substance abuser presents in your office: What do you do?", M. Galanter, MD, Chair. Syllabus and Proceedings Summary, American Psychiatric Association 154thAnnual Meeting, New Orleans, LA, May 5-10, 2001.

71. Galynker II, Cohen LJ, Nikiforov K, Acker S, Moesse T, Rosenthal RN, Cullen K. "Cerebral glucose metabolism and deviant sexual arousal in male pedophiles." Syllabus and Proceedings Summary, American Psychiatric Association 154thAnnual Meeting, New Orleans, LA, May 5-10, 2001.

72. Rosenthal RN, "Psychiatric comorbidity in stimulant abusers" in Symposium, "Update on Treatment of Stimulant Abuse", D. Gorelick, MD, Chair. Syllabus and Proceedings Summary, American Psychiatric Association 155thAnnual Meeting, Philadelphia, PA, May 19-23, 2002.

73. Rosenthal RN, "Outcome criteria and guidelines from an international point of view." in Symposium, "Opiate-Substitution Treatment: International Trends and Perspectives", R. Rosenthal, MD, Chair. Syllabus and Proceedings Summary, American Psychiatric Association 155thAnnual Meeting, Philadelphia, PA, May 19-23, 2002.

74. Galynker II, Miner CR, Des Jarlais DC, Matochik A, Contereggi C, Kimes AS, Ernst M, Rosenthal RN, London E, Weaver C, Gertmenian-King EC, Kurian V. "Differences in cerebral glucose metabolism in patients on and off opiate replacement therapy." In Symposium, "Circuitry of Failed Cognitive Strategies in Addiction." Syllabus and Proceedings Summary, American Psychiatric Association 155th Annual Meeting, Philadelphia, PA, May 19-23, 2002.

74. Rosenthal RN, Reimer J. Die Rolle von Standards in der Suchtbehandlung in den Vereinigten Staaten von Amerika. Suchttherapie 3: S117-119, 2002.

75. Rosenthal RN, "Psychiatric comorbidity in stimulant abusers" in Symposium, "Update on Treatment of Stimulant Abuse", D. Gorelick, MD, Chair. Syllabus and Proceedings Summary, American Psychiatric Association 156th Annual Meeting, San Francisco, CA, May 17-22, 2003.

76. Rosenthal RN, "Addictions and the internet" in Symposium, "Internet: Technical, Clinical and Societal", Z. Taintor, MD, Chair. Syllabus and Proceedings Summary, American Psychiatric Association 156th Annual Meeting, San Francisco, CA, May 17-22, 2003.

77. Rosenthal RN, " Gamma Hydroxybutyrate (GHB), Gamma-butyrolactone (GBL) and 1,4 Butanediol" in Symposium, "E, K, and GHB: The new ABC's of Drug Abuse", R. Rosenthal, MD, Chair. Syllabus and Proceedings Summary, American Psychiatric Association 157th Annual Meeting, New York, NY, May 1-6, 2004.

78. Rosenthal RN, "Psychiatric comorbidity in stimulant abusers" in Symposium, "Update on Treatment of Stimulant Abuse", D. Gorelick, MD, Chair. Syllabus and Proceedings Summary, American Psychiatric Association 157th Annual Meeting, New York, NY, May 1-6, 2004.

79. Serby M, Kelly R, Rosenthal RN, Graziano M. Poster, "Seclusion and Restraints Use Related to Psychiatric Admission." 56th Institute on Psychiatric Services October 6-10, 2004, Atlanta, GA

80. Rosenthal RN, Petry, N, Pettinati HM, Kranzler HR. Advances In the Treatment of Addictions: How Do We Measure Success? RN Rosenthal, MD, Symposium Chair; American Academy of Addiction Psychiatry 15th Annual Meeting and Symposium Program & Abstracts, December 9-12, 2004, San Juan, Puerto Rico

81. Gastfriend DR, Rosenthal RN, Sanchez-Samper X.The Role of Comorbid Disorders in the ASAM Patient Placement Criteria, workshop. American Academy of Addiction Psychiatry 15th Annual Meeting and Symposium Program & Abstracts, December 9-12, 2004, San Juan, Puerto Rico

82. Singh P, Rosenthal RN, Kron M. Workshop, To Treat or Not to Treat: Conundrums in The Pharmacological Treatment of Addicted Patients.American Academy of Addiction Psychiatry 15th Annual Meeting and Symposium Program & Abstracts, December 9-12, 2004, San Juan, Puerto Rico

83. Galynker I, Matochik JA, Cohen LJ, Kimes AS, Varughese K, Contoreggi C, Ernst M, Rosenthal RN, London ED. Regional Brain Metabolism and Negative Affect in Opiate Abusers Receiving or Removed from Long-Term Methadone Maintenance.ACNP 43rd Annual Meeting December 12-16, 2004 San Juan, Puerto Rico

84. Rosenthal RN, Gage A, Perhach J, Goodman A. Medical-Scientific Program Committee Award Paper: Acamprosate is safe and well-tolerated for the treatment of alcohol dependence. ASAM 2005 Annual Meeting, April 14-17, 2005, Dallas, Texas

85. Rosenthal RN, "Substance use disorders in the workplace." in APA Committee on APA/Business Relationships Workshop, "Why Business Needs Quality Care for Depression, Anxiety, and Substance-Use

Disorders.", N. Clemens, MD, Chair. Syllabus and Proceedings Summary, American Psychiatric Association 158th Annual Meeting, Atlanta, GA, May 22-26, 2005.

86. Rosenthal RN, "NHI Initiative: Psychiatry in a General Medical System and in Addiction Treatment."in Symposium, "National Health Information: General Hospital and Addiction Psychiatry", Z. Taintor, MD, Chair. Syllabus and Proceedings Summary, American Psychiatric Association 158th Annual Meeting, Atlanta, GA, May 22-26, 2005.

87. Rosenthal RN, Gage A, Perhach J, Goodman A. Acamprosate is safe and well-tolerated for the treatment of alcohol dependence. College on Problems of Drug Dependence2005 Meeting Program & Abstracts, June 18-23, 2005, Orlando, Florida

88. Rosenthal RN, Gage A, Perhach JL, Goodman AM. Acamprosate is safe and well-tolerated in the long-term treatment of alcohol dependence. Journal of Addictive Diseases 24(2):112, 2005.

89. Rosenthal RN. Evaluating efficacy in treatment of alcohol dependence. In: Emerging concepts and recent updates in the pharmacotherapy of alcohol dependence. RN Rosenthal, MD, Symposium Chair; American Academy of Addiction Psychiatry 16th Annual Meeting and Symposium Program & Abstracts, December 8-11, 2005, Scottsdale, AZ.

90. Johnson B., Rosenthal RN, Strong P. Workshop, The Basis of Psychotherapy for Addiction; Psychoanalytic Therapy, Cognitive Behavioral Therapy or Motivational Enhancement Therapy? American Academy of Addiction Psychiatry 16th Annual Meeting and Symposium Program & Abstracts, December 8-11, 2005, Scottsdale, AZ

91. Rosenthal RN, Wilkins J, Brady K. Different paths to success in alcohol dependence: An interactive review of case studies. American Academy of Addiction Psychiatry 16th Annual Meeting and Symposium Program & Abstracts, December 8-11, 2005, Scottsdale, AZ

92. Rosenthal RN, Myrick H. "Unmasking alcoholism in the mental health patient," US Psychiatric Congress Regional Extensions, Chicago, IL,March 11, 2006.

93. Rosenthal RN,"The US healthcare delivery system for the treatment of alcoholism." The European Society for Biomedical Research on Alcoholism (ESBRA), Paris, France, April 12-13, 2006

94. Rosenthal RN, Myrick H. "An overview of alcohol-related illness in the mental health patient: conundrums in diagnosis and management,"US Psychiatric Congress Regional Extensions, New York, NY, April 22, 2006.

95. Rosenthal RN,"Current and emerging treatment options in alcoholism," in Symposium, "Diagnosing and Treating Alcohol Dependence in the Office," Kathleen Brady, MD, PhD, Chair, Syllabus and Proceedings Summary, American Psychiatric Association 159th Annual Meeting, Toronto, Canada, May 21-25, 2006

96. Rosenthal RN, Brady K, Weiss R. Models of treatment success in alcohol dependence: An interactive review of case studies. American Academy of Addiction Psychiatry 17th Annual Meeting and Symposium Program & Abstracts, December 7-10, 2006, St. Petersburg, FL

97. Gottdiener WH, Brubacher M, Rosenthal RN, Schaffer M, Uy P, Winarick D, Bornstein RF, Katz S, Maile J. Defense mechanisms in substance abuse patients. Presented at the Annual meeting of Division 50 (Addictions) at the August, 2008 Annual Meeting of the American Psychological Association, Boston, MA.

98. Sonne SC, Potter JS, Rosenthal RN, Tyson C. The use of acamprosate vs placebo in alcoholics with comorbid anxiety or depression.71st Annual Scientific Meeting of the College on Problems of Drug Dependence, June, 2009, Reno/Sparks, NV.

99. Rosenthal RN, Marsch LA, Rosenbloom DL. David Wanser D, Wetterau N. Improving Addiction Treatment Through Technology. Richard N. Rosenthal, MD; Norman Wetterau, MD, Symposium Chairs, American Society of Addiction Medicine 41st Annual Medical Scientific Conference, San Francisco, CA, April 15-18, 2010.

100. Levounis P, Miller MM, Rosenthal RN, Brady KT. Training in Addiction Medicine. American Academy of Addiction Psychiatry 21st Annual Meeting and Symposium Program & Abstracts Boca Raton, Florida, December 2-5, 2010

101. Miller SI, McCance-Katz EF, Rosenthal RN, Albanese M. Who? Or Whom? What Really Matters in a Scholarly Review. American Academy of Addiction Psychiatry 21st Annual Meeting and Symposium Program & Abstracts Boca Raton, Florida, December 2-5, 2010

102. Winarick DJ, Gottdiener WH, Bornstein RF, Rosenthal RN. Personality, Affect, and Post-traumatic Stress in Substance Use Disorders. 2010 American Psychological Association Annual Convention (Divison 50 - Addictions), San Diego, CA. 2010

103. Winarick DJ, Gottdiener WH, Bornstein RF, Rosenthal RN. Ego functioning in substance abusers with PTSD. American Psychoanalytic Association Annual Conference, New York, NY, 2010

104. Taylor T, Rosenthal RN, McLellan AT, Volkow ND, Lindblad R, Gore-Langton R. Full day workshop: The Interface of Electronic Health Records and Addiction Medicine: What You Should Know and How It Will Affect Your Practice. American Society of Addiction Medicine 42nd Annual Medical Scientific Conference, Washington, DC, April 14-17, 2011.

105. Beebe KL, Ling W, Rosenthal RN, Bailey GL, Patkar A, Vocci F. Comparing the Efficacy and Safety of Probuphine™ to Placebo Implants and Suboxone® for Opioid Addiction; A Six-Month, Randomized, Controlled, Phase 3 Trial. 13th Annual Meeting of the International Society of Addiction Medicine, Oslo, Norway, September 6-10, 2011

106. Rosenthal RN. Compulsive internet use: is it really an addiction? In Section Symposium, "Informatics and telecommunications in psychiatry,"15th World Congress of Psychiatry, Buenos Aires, Argentina, September 18-22, 2011.

107. Beebe KL, Rosenthal RN, Ling W, Casadonte P, Vocci F, Bailey GL, Kampman K, Patkar A, Chavoustie S. Results of a Six-Month, Randomized, Controlled, Phase 3 Trial Comparing the Efficacy and Safety of Buprenorphine Implants To Placebo Implants, and Sublingual Buprenorphine/Naloxone for Opioid Addiction. American Society of Addiction Medicine 43rd Annual Medical Scientific Conference, Atlanta, GA, April 19-22, 2012.

108. Nasser JA, Wolper C, Geliebter A, Rosenthal RN, Kolak P, Hashim SA. Effect of Dopamine Agonist on Food Reinforcement and Selection in Obese Women With and Without Binge Eating Disorder (BED). Diabetes 2012;61:A505-A505

109. Rosenthal RN. Addiction Psychiatry/Addiction Medicine: The North American Approach. In Section Symposium, "The psychiatric response to substance use – international perspectives on a key challenge?" M. Krausz, L. Kuey, Chairs, World Psychiatric Association International Congress, Prague. October 17-21, 2012.

109. Sirikantraporn S, Gottdiener W, Rosenthal RN. The role of defense mechanisms in the relationship between PTSD and alcohol use problems among young adults. Poster, American Psychoanalytic Association Annual Conference, New York, NY, January 15-20, 2013

110. Rosenthal RN, Sacks S, Chaple M. Improving Care for Co-Occurring Disorders across NY State- a Systemic Approach, In Symposium, "Addiction and mental illness among the most vulnerable" M. Krausz, A. Heinz, Chairs, World Psychiatric Association International Congress, Vienna. October 26-30, 2013.

111. Rosenthal RN. The impact of politics on addiction psychiatry—yes we can? In Section Symposium, "Systems in motion–major challenges for Addiction Psychiatry." M. Krausz, A. Heinz, Chairs, World Psychiatric Association International Congress, Vienna. October 26-30, 2013.

112. Rosenthal RN. The Psychopharmacology of Cocaine and Club Drugs. In Symposium, "Advances In Addiction Psychopharmacology," Kranzler HR, Ciraulo, DA, Chairs. Syllabus and Proceedings Summary, American Psychiatric Association 167th Annual Meeting, New York, NY, May 3-7, 2014.

113. Rosenthal RN. Childhood Trauma and Substance Use Among Vulnerable Populations In Symposium, "The Impact of Trauma on Substance Abuse and the Consequences for Care." M. Clerici, M. Krausz, Chairs. World Psychiatric Association International Congress, Madrid. September 14-18, 2014.

114. Rosenthal RN. Access to Care for Patients with Substance Use Disorders: Dual Diagnosis. In Workshop , "Access To Care For Patients With Substance Use Disorders: Dual Diagnosis, Inpatient Treatment, and MAT. American Academy of Addiction Psychiatry," APA Institute on Psychiatric Services, New York. October 8-11, 2015.

115. Rosenthal RN, Lofwall MR, Kim S, Beebe KL and Vocci FJ. A Randomized Trial of Probuphine® Implants in Adults Stablized on Sublingual Buprenorphine. Program, American Society of Addiction Medicine 47th Annual Conference: Innovations in Addiction Medicine and Science, Baltimore, MD, April 14-17, 2016

116. Rosenthal RN. Choice vs. Compulsion in Addiction Psychiatry in Symposium, "Critical Issues in Addiction Psychiatry," American Psychiatric Association, APA 169th Annual Meeting, Atlanta, Georgia, May 14-18, 2016.

117. Rosenthal RN, Lofwall MR, Kim S, Chen C, Beebe KL and Vocci FJ for the PRO-814 Study Group Predictors of Response of a Comparative Trial of 6 Month Buprenorphine Implants and Sublingual Buprenorphine in Stable Opioid Dependent Patients. APA 169th Annual Meeting, Atlanta, Georgia, May 14-18, 2016.

118. Rosenthal RN, Lofwall MR, Kim S, Chen C, Beebe KL and Vocci FJ for the PRO-814 Study Group. Sensitivity Analyses of a Comparative Trial of 6 Month Buprenorphine Implants (Probuphine) and Sublingual Buprenorphine in Stable Opioid Dependent Patients. Drug and Alcohol Dependence 2017; 100 (171), e179

119. McNeely J, Kumar P, Rieckmann T, Sedlander E, Sleiter L, Farkas S, Kannry JL, Vega A, Waite EA, Peccoralo L, Rosenthal RN, McCarty D, Rotrosen J. Barriers and facilitators affecting the implementation of substance use screening in primary care clinics: a qualitative study of patients, providers, and staff . Association for Medical Education and Research in Substance Abuse (AMERSA) 40th Annual National Conference, November 3-5, 2016, Washington, DC.

120. McNeely J, Kumar P, Rieckmann T, Sedlander E, Sleiter L, Farkas S, Kannry JL, Vega A, Waite EA, Peccoralo L, Rosenthal RN, McCarty D, Rotrosen J. Barriers and facilitators affecting the implementation of substance use screening in primary care clinics: a qualitative study of patients, providers, and staff. 2017 Society for General Internal Medicine Annual Meeting, April 19-22, 2017 in Washington, DC.

121. McNeely J, Kumar P, Rieckmann T, Sedlander E, Farkas S, Kannry JL, Vega A, Waite EA, Peccoralo L, Rosenthal RN, McCarty D, Rotrosen J. A qualitative study of barriers and facilitators affecting

implementation of electronic health record-integrated screening for substance use in primary care. College on Problems of Drug Dependence 79th Annual Scientific Meeting Abstracts, Montreal, CA, June 17-22, 2017.

122. Rosenthal RN. Reasons for the overdose crisis in the United States. In Symposium, "The North American overdose crisis from an international perspective." M Krausz, RN Rosenthal, Chairs. World Psychiatric Association XVII World Congress of Psychiatry Scientific Programme, Berlin, October 8-12, 2017

123. Rosenthal RN. Novel Delivery Systems in the Treatment of Opioid Addiction. In Symposium, "New interventions in the treatment of addiction," RN Rosenthal, M Krausz, Chairs. World Psychiatric Association XVII World Congress of Psychiatry Scientific Programme, Berlin, October 8-12, 2017

124. McNeely J, Kumar P, Rieckmann T, Sedlander E, Farkas S, Kannry JL, Vega A, Waite EA, Peccoralo L, Rosenthal RN, McCarty D, Rotrosen J. Oral Presentation: Usability testing to guide development of a clinical decision support system for substance use screening and interventions in primary care. American Medical Informatics Association 2017 Annual Symposium, Washington, DC, November 4-8, 2017

125. Rosenthal RN. The opioid epidemic and the need for new interventions. Proceedings of the 13th European Congress on Heroin Addiction and Related Problems, Krakow, Poland, May 25-27, 2018. Heroin Addiction and Related Clinical Problems 20(s1):20-21, 2018

126. Rosenthal RN. "Why Telepsychiatry?" In, Biomedical Informatics Bootcamp IV: Telehealth and Data Analytics of the Future, Stony Brook University Department of Biomedical Informatics, Wang Center, Stony Brook, NY, October 12, 2018.

127. Rosenthal RN. Invited State of the Art Symposium Lecture: "The biggest public health crisis since the HIV epidemic – a serious reflection!" in: Treatment as prevention responding to the North American overdose crisis, RN Rosenthal, M Krausz, Chairs; World Psychiatric Association, 19th World Congress of Psychiatry, Lisbon, Portugal, August 21, 2019.

128. Rosenthal RN. Symposium lecture: "USA: Ongoing Changes in the Cannabis Regulations" in Scientific Session: Changes in the legality of cannabis: International experiences with old and new regulations, RN Rosenthal, Chair. World Psychiatric Association, 19th World Congress of Psychiatry, Lisbon, Portugal, August 21, 2019

129. McNeely J, Kannry JL, Rosenthal RN, Wakeman SE, Wilens TE, Farkas S, Adam A, Rosa CL, Wahle A, Pitts S, Rotrosen J. It's not just what you do, it's how you do it: Variation in substance use screening outcomes with commonly used screening approaches in primary care clinics. In Symposium: Best Practice: Increasing Knowledge and Improving Training for Health Care Providers (S09) Proceedings of the 16th annual conference of INEBRIA International Network on Brief Interventions for Alcohol and Other Drugs). Lübeck, Hamburg, Germany, September 26-27, 2019 *Addiction Science & Clinical Practice* 2019; 14(Suppl 1):A25

130. Dong X, Rashidian S, Wang Y, Hajagos J, Zhao X, Rosenthal RN, Saltz M, Joel Saltz J, Wang F. Machine Learning Based Opioid Overdose Prediction Using Electronic Health Records. Proceedings of the American Medical Informatics Association, 2019 Annual Meeting, Washington, DC, 11/16-20/19, S60: Oral Presentations, November 19, 2019. AMIA Annu Symp Proc 2020;2019:389-398. eCollection 2019 PMID: 32308832

131. McNeely J, Kannry JL, Rosenthal RN, Wakeman SE, Wilens TE, Farkas S, Adam A, Rosa CL, Wahle A, Pitts S, Rotrosen J. Self-directed Screening (PROMS/EPIC) is Effective in Screening for Unhealthy Alcohol Use in Primary Care Clinics. American Academy of Addiction Psychiatry 30th Annual Meeting and

Scientific Symposium Poster Abstracts, San Diego, CA, December 4-8, 2019. American Journal on Addictions 2020; 29(3):109

132. Wilens TE, McNeely J, Kannry JL, Rosenthal RN, Wakeman SE, Farkas S, Adam A, Rosa CL, Wahle A, Pitts S, Rotrosen J. It's Not Just What You Do, It's How You Do It: Variation in Substance Use Screening Outcomes With Commonly Used Screening Approaches in Primary Care Clinics. American Academy of Addiction Psychiatry 30th Annual Meeting and Scientific Symposium Poster Abstracts, San Diego, CA, December 4-8, 2019. American Journal on Addictions 2020; 29(3):210

133. Tsui P, Zacharoff KL, Rosenthal RN, Cahaney C, Friedmann T. Medical Student Education in Pain and Addiction: Curriculum Development and Preliminary Outcomes. American Academy of Pain Medicine 36th Annual Meeting Poster Abstracts, #205, National Harbor, MD, February 26-March 1, 2020

134. Hamilton L, Wakeman S, Wilens T, Kannry J, Rosenthal RN, Goldfeld K, Adam A, Appleton N, Farkas S, Rosa C, Rotrosen J, McNeely J. Patient attitudes toward substance use screening and discussion in primary care encounters. Journal of General Internal Medicine 2020; 35(Suppl 1):S218.

135. Hamilton L, Appleton N, Wakeman SE, Wilens TE, Kannry JL, Rosenthal RN, Goldfeld K, Adam A, Farkas S, Rosa C, Rotrosen J, McNeely J. Primary care medical staff attitudes toward substance use: Results of the Substance Abuse Attitudes Survey (SAAS). Association for Multidisciplinary Education and Research in Substance use and Addiction (AMERSA) 44th Annual Conference, November 5-7, 2020 (canceled). Substance Abuse Journal 2020; 41: In Press.

136. McNeely J, Adam A, Hamilton L, Kannry JL, Rosenthal RN, Wakeman SE, Wilens TE, Farkas S, Wahle A, Pitts S, Rosa C, Rotrosen J. Variation in substance use screening outcomes with commonly used screening strategies in primary care: Findings from a multi-site implementation study of electronic health record-integrated screening for alcohol and drug use. Addiction Health Services Research Conference 2020, Virtual Meeting, October 14th-16th, 2020

137. Rosenthal RN. Keynote presentation, "US opioid crisis and lessons learned," "Deutscher Suchtkongress 2021" (German Addiction Congress), Berlin, Germany, Virtual Meeting, September 13th-16th, 2021

**AUTHORED EDUCATIONAL/CLINICAL/PUBLIC DOMAIN MATERIALS**

1) MICA – Dual Diagnosis. (video) New York State Office of Mental Health, Division of Staff Education, Training and Support, Albany, 1986

2) Beth Israel Medical Center Supportive Psychotherapy Manual. Pinsker H, Rosenthal RN. Social and Behavioral Sciences Documents 18: #2, 1988.

3) Mental Illness/Chemical Addiction: A Guide to Emergency Services Assessment and Treatment, RN Rosenthal, MD, author. NYS Office of Mental Health, Div. of Clin. Support Systems, Albany, 1992. (First in print version of Larkin's 4-quadrant COD model, basis of SAMHSA 4-quadrant COD model)

4) Psychiatric Emergency Room Diagnostic System, Software expert system diagnostic tool on EXSYS platform, RN Rosenthal, MD, author. Mental Health Association of New York, New York, 1994.

5) Supportive Group Psychotherapy and Counseling Manual for Patients with Substance Abuse and Schizophrenia: The COPAD Program; Beth Israel Medical Center Psychotherapy Research Program. Rosenthal RN, Pinsker H, Winston A. 1993, Rev. 1996.

6) Course Syllabus, American Academy of Addiction Psychiatry, Review Course on Addiction Psychiatry, R. Rosenthal, MD, Course Chairman, Syllabus Contributor/Editor, Washington, D.C., September 10-11, 1994.

7) Course Syllabus, American Academy of Addiction Psychiatry, Review Course on Addiction Psychiatry, R. Rosenthal, MD, Course Chairman, Syllabus Contributor/Editor, Amelia Island, FL, December 1-3, 1995.

8) Biomap Psychiatric Screening Software, IVR/Web-enabled behavioral health screening and tracking software. RN Rosenthal, MD, author. General Informatics Corporation, Studio City, CA. 1996.

9) Course Syllabus, American Academy of Addiction Psychiatry, Review Course on Addiction Psychiatry, R. Rosenthal, MD, Course Chairman, Syllabus Contributor/Editor, San Francisco, CA, December 6, 1996.

10) Targeted Assertive Outreach (TAO) Manual for Patients with Substance Abuse and Schizophrenia: Addictive Disorder Enhanced Psychiatric Treatment (ADEPT) Research Program. Rosenthal RN, Hellerstein DJ, Miner CR, Primeau C, Jefferson Z, O'Brien T., 1998.

11) Course Syllabus, American Academy of Addiction Psychiatry, Review Course on Addiction Psychiatry, RN Rosenthal, MD, Course Chairman, Syllabus Contributor/Editor, Kansas City, MO, February 7-8, 1998.

12) Course Syllabus, American Academy of Addiction Psychiatry, Review Course on Addiction Psychiatry, RN Rosenthal, MD, Course Chairman, Syllabus Contributor/Editor, Albuquerque, NM, January 23-24, 2000.

13) Psychiatric UPDATE, "New and Promising Medications for Treating Addiction," Vol. 20, Issue 12, 2001, Kleber HD, Rosenthal RN, Westreich L; GL Usdin, MD, Editor.

14) Center for Substance Abuse Treatment. *Services Integration*. COCE Overview Paper 6. DHHS Publication No. (SMA) 07-4294. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2007. Rosenthal RN, Lead author.

15) Center for Substance Abuse Treatment. *Overarching Principles to Address the Needs of Persons with Co-Occurring Disorders*. COCE Overview Paper 3. DHHS Publication No. (SMA) 07-4165 Rockville, MD: Substance Abuse and Mental Health Services Administration, 2007, Rosenthal RN, major writing contributions.

16) Center for Substance Abuse Treatment. *Systems Integration.* COCE Overview Paper 7. DHHS Publication No. (SMA) 07-4295. Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services, 2007, Rosenthal RN, major writing contributions.

17) Substance Abuse and Mental Health Services Administration, TIP 48: Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery, 2009. Inventory # SMA08-4353. Rosenthal RN, Chair, Expert Advisory Group (lead author).

18) Substance Abuse and Mental Health Services Administration, TIP 49: Incorporating Alcohol Pharmacotherapies into Medical Practice, 2009. Inventory # SMA09-4380. Rosenthal RN, Expert Advisory Board (co-author).

19) Substance Abuse and Mental Health Services Administration, TIP 60: Using Technology-Based Therapeutic Tools in Behavioral Health Services, 2015. Inventory # SMA15-4924. Rosenthal RN, Expert Consensus Panel (co-author).

http://www.ncbi.nlm.nih.gov/sites/myncbi/richard.rosenthal.1/bibliography/40341070/public/?sort=date&direction=ascending.

https://www.ncbi.nlm.nih.gov/myncbi/1DcE-F8BOp-chd/bibliography/public/

Richard N Rosenthal, MD October 23, 2021

**UNITED STATES DISTRICT COURT**
**FOR THE WESTERN DISTRICT OF MICHIGAN**
**SOUTHERN DIVISION**

CYRUS PATSON,

Plaintiff,

Case No.:
Hon.:

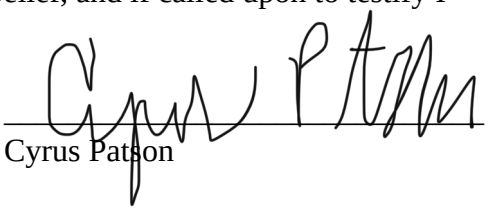
v.

GRAND TRAVERSE COUNTY, MICHIGAN; THOMAS J. BENSLEY, in his official capacity as Sheriff of Grand Traverse County; MICHAEL SHEA, in his official capacity as Undersheriff of Grand Traverse County; and CHRIS BARSHEFF, in his official capacity as Administrator of Grand Traverse County Correctional Facility,

Defendants.
_____/

**PLAINTIFF'S VERIFICATION OF COMPLAINT AND MOTION FOR TRO/PRELIMINARY INJUNCTION**

Under 28 U.S.C. § 1746, I state under penalty of perjury that the factual statements in my complaint and in my motion for a temporary restraining order and preliminary injunction are true and correct to the best of my knowledge, information, and belief, and if called upon to testify I would testify consistently with those statements.



Cyrus Patson

Dated: October 27, 2021