IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MAINE

ZACHARY J. SMITH, Plaintiff, v. MAINE DEPARTMENT OF CORRECTIONS, *et al.*, Defendants.	CIVIL NO. _____

DECLARATION OF DAVID CONNER, MD

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

1. I am a family medicine physician in Caribou, Maine, and serve as the primary care physician for Plaintiff, Zachary Smith.

2. I received my medical degree from Eastern Virginia Medical School in 1995 and have had more than 23 years of experience. I completed my residency at Portsmouth Family Medicine, in Portsmouth, Virginia. A copy of my curriculum vitae is attached as Exhibit 1.

3. My practice includes treating people who have been diagnosed with substance use disorder. The standard of care for these individuals is to treat them with opioid replacement therapy, including Suboxone, buprenorphine, and methadone.

4. Over the course of my career, I have treated hundreds of patients with opioid replacement therapy and witnessed the life-changing effects it can have in people's lives.

5. When I treat individuals with substance abuse disorder, I also treat co-occurring disorders including mental health disorders such as depression and anxiety.

6. It is from the perspective of both Mr. Smith's treating physician and as a trained physician familiar with a broad range of scientific study that I offer this declaration.

7. I have been treating Mr. Smith since 2012. Over the years, Mr. Smith has

struggled with numerous diagnosed diseases, including substance use disorder. Other diagnoses include depression, anxiety, posttraumatic stress disorder ("PTSD"), attention deficit hyperactivity disorder ("ADHD"), peptic ulcer, irritable bowel syndrome, knee pain, and low back pain.

8. The coexistence of both a mental health disorder (such as anxiety or depression) along with a substance use disorder (such as opioid use disorder) is referred to as co-occurring disorders. Mr. Smith experiences the co-occurring disorders of opioid use disorder, depression, anxiety, PTSD, and other disorders.

9. 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.

10. Mr. Smith is currently taking a maintenance dosage of buprenorphine for substance use disorder, which has enabled him to keep his addiction in remission for the past five years. He is currently prescribed to take one and one half sublingual buprenorphine tablets (amounting to 12 milligrams) once daily.

11. While on buprenorphine, Mr. Smith is able to lead a relatively normal life and does not suffer from the symptoms of substance use disorder. He is able to function each day without cravings for opioids. He does not engage in the types of risky behaviors that were common during his periods of active addiction. He is not suicidal.

12. Mr. Smith's other prescribed medications include clonazepam (brand name Klonopin for anxiety), gabapentin (for pain arising from scoliosis and herniated disc), Seroquel (an anti-psychotic drug to treat mental and mood conditions), and sertraline (brand name Zoloft to treat depression).

13. Opioid use disorder is a subset of substance use disorder, and is a chronic disease. Like many diseases, opioid use disorder is, at least in part, influenced by genetic factors.

Individuals with a genetic predisposition to opioid use disorder are more likely to be diagnosed with the disease.

14. Opioid replacement therapy is a proven and cost effective treatment for opioid use disorder. The United States Food and Drug Administration ("FDA") has approved methadone and buprenorphine, both methods of opioid replacement therapy, for treatment of opioid use disorder. Both methadone and buprenorphine have undergone rigorous FDA trials and have been found to be effective in treating opioid use disorder. *See* Exhibit 2.

15. Use of buprenorphine has been supported by the American Medical Association, the American Psychiatric Association, and the American Academy of Family Physicians, among others.

16. Buprenorphine treats opioid use disorder by blocking the "high" of taking opioids, suppressing withdrawal symptoms, and curving cravings. Buprenorphine is a partial agonist, which means that it partially binds to opioid receptors. As such, buprenorphine helps to prevent cravings for opioids and simultaneously helps to prevent other opioids from binding to those receptors and creating a "high." Buprenorphine's role as a partial agonist also helps to prevent the risk of overdose during treatment.

17. The goal of buprenorphine treatment is to eliminate withdrawal symptoms and to provide the patient with a maintenance dosage for long-term stability. Mr. Smith has currently achieved remission using buprenorphine treatment and has been on a maintenance dosage for approximately five years.

18. Mr. Smith's buprenorphine treatment for drug addiction is medically necessary in order to maintain his basic ability to function.

19. If incarcerated and abruptly withdrawn from buprenorphine, Mr. Smith will experience an acute withdrawal. The immediate physical symptoms of that withdrawal will likely include severe body aches, tearing, nausea, shaking, sweating, dizziness, dehydration and

vomiting.

20. Forced withdrawal also has the potential for serious psychological effects, especially for individuals with co-occurring disorders like Mr. Smith. Withdrawal from buprenorphine could lead to Mr. Smith 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. Buprenorphine withdrawal could also create a potentially life-threatening crisis for Mr. Smith, because of his severe depression, anxiety, and PTSD. It could be months or years before Mr. Smith would be able to return to his current stable condition following such an event.

22. The long-term effects of withdrawal from buprenorphine also include the risk of overdose upon release because the patient is no longer in remission and the patient's tolerance to narcotics is gone.

23. In order to minimize the risk of serious long-term harm to Mr. Smith, he must not be abruptly taken off buprenorphine while in jail.

24. In my informed medical opinion, denying Mr. Smith his medically necessary buprenorphine during his incarceration is barbaric and inhumane. It is no different than withholding necessary medication for other chronic genetically-predisposed diseases like diabetes and coronary artery disease. Just as prisons must not withhold medically prescribed insulin for diabetic patients, they must not withhold medically necessary buprenorphine treatment—especially where, as here, the patient has relied upon that medication for years to 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 July 17, 2018

David Conner, M.D.