UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

United States of America v. **Aticha Jittaphol**	No. 21-CR-10270-MLW

DEFENDANT'S MEMORANDUM RE PROBATION PETITION

The Court should find that Probation has not established "probable cause to believe that [Ms. Jittaphol] has committed a Federal, State or local crime while on release," and has failed to establish probable cause to believe that "there is no condition or combination of conditions of release that will assure that [Ms. Jittaphol] will not flee or pose a danger to the safety of any other person or the community." *See* 18 U.S.C. § 3148; *United States v. Alfonso*, 284 F.Supp.2d 193, 202 (D.Mass 2003). The Court should find that the positive sweat patch result obtained on February 7th does not establish probable cause to believe that Ms. Jittaphol used methamphetamine. Inpatient care should not be imposed. No action should be taken on the petition submitted by Probation on February 7th.

Methamphetamine usually "can be detected in the urine … anywhere from 3 to 7 days following the last dose." American Addictions Center, "How Long Does Meth Stay in Your System," December 30, 2021, https://rehabs.com/blog/how-long-does-crytal-meth-stay-in-you-system/. Christopher C. Cruickshank & Kyle R. Dover, *A Review of the Clinical Pharmacology of Methamphetamine*, Addiction 104, 1085-1099 (2009) ("Amphetamines might be expected to be present in the urine for extended

periods in the context of abuse … methamphetamine has been detected in urine 7 days after completing a regimen of 4 daily 10-mg doses …").

Sweat patches will test positive based on drug use during any of the time that the test is worn, typically one week. The positive sweat patch was removed on January 20th. A negative urine test was conducted the following day. Thus, there was significant overlap in the dates that these tests covered.

If Probation now maintains that Ms. Jittaphol should be placed in inpatient residential care based on a single positive sweat patch test, that position is not based on the facts, but on a willingness to ignore the facts in favor of a "we told you so" mentality. This is illustrated by Probation's readiness to disregard inherent inconsistencies in its position.

Probation has asserted that inpatient care is needed because methamphetamine is extraordinarily addictive. Ms. Jittaphol requested placement in a detox because she recognized that she could not stop her daily use of methamphetamine without help. Her subsequent treatment records include candid discussion of her chronic, daily-use addiction. Methamphetamine is not a drug that users take occasionally. It provides subjective effects for no more than four hours, usually prompting addicts to take it several times a day. Daily use or multiple day binges are routine. *See* Christopher C. Cruickshank & Kyle R. Dyer, *A Review of the Clinical Pharmacology of Methamphetamine*," Addiction 104, 1085-1099 (2009) ("Acute subjective effects diminish over 4 hours … [which] may drive repeated use within intervals of 4 hours … a typical pattern of use

appears to consist of four doses daily, in binges lasting 4 days."). Withdrawal symptoms can be severe, including insomnia, depression, anxiety, cognitive impairment, agitation, and methamphetamine craving. The absence of methamphetamine withdrawal syndrome is associated with a greater likelihood of avoiding relapse and is a significant criterion in assessing the need for inpatient treatment. *See* Cruickshank & Dyer, *id.*; Report of Stuart Gitlow, M.D., previously provided. Ms. Jittaphol's treatment records do not describe any significant withdrawal symptoms.

Ms. Jittaphol has had at least six urine tests since January, about one per week. Her first sweat patch was removed on January 14th. It tested negative. It was replaced by a patch that was removed on January 20th that tested positive. She has had at least three sweat patches tested since. The results have not been produced. On February 11th, Probation produced results in its possession; the last being a urine test from February 3rd. Despite repeated requests, Probation has not produced any subsequent results. Given that the produced tests show urine results obtained within a week, and patch results within two weeks, it is likely that Probation has received results for at least two urine tests since February 3rd and results for patches removed on January 27th and February 7th or 10th[1]. Additional test results likely will be obtained prior to a hearing on this matter. Given that Probation reported the single positive test immediately, it must be presumed that all these tests were negative, since no subsequent positive test has been reported.

[1] Ms. Jittaphol's text messages with Ms. Wertz leave it unclear whether she went to court for testing on February 7th or 10th.

An updated list of the tests since January is provided:

Type of Test	Date of Sample	Date of Result	Result
Urine	1/11/22	1/18/22	Negative
Patch	1/14/22	1/27/22	Negative
Patch	1/20/22	2/7/22	Positive
Urine	1/21/22	1/27/22	Negative
Urine	1/26/22	2/1/22	Negative
Patch	1/27/22	not produced	Presumed Negative
Urine	2/3/22	2/7/22	Negative
Urine	2/7/22 or 2/10/22	not produced	Presumed Negative
Patch	2/7/22 or 2/10/22	not produced	Presumed Negative
Urine	2/17/22	not produced	Presumed Negative
Patch	2/17/22	not produced	Pending

There is an obvious inconsistency in asserting that methamphetamine is so addictive that Ms. Jittaphol needs inpatient care to avoid using but has managed to use only sporadically since her release from The Hope Center, perhaps only during the week prior to the positive sweat patch test, and perhaps only during the early days of that week, which may not have been covered by urinalysis.

Ms. Jittaphol's most recent urine test was February 17th. Once again, she asked to be observed. Given Probation's February 14th memorandum, stating a willingness to perform observed urine screens so long as a male probation officer

was available, she had reason to believe that the sampling would be observed. Instead, she again was told it was not necessary. Probation has not conducted any observed tests. To the extent that Probation asserts that the urine tests are unreliable, Probation has created and maintained this excuse by failing to conduct supervised sampling despite Ms. Jittaphol's repeated requests.

Any assertion that Ms. Jittaphol could manage to provide someone else's urine and get away with it every week this year is nonsensical. There is nothing about Ms. Jittaphol to even remotely suggest that she could succeed at such deception, or that she'd want to. Is someone looking at her before she goes into the restroom to see if there's a hidden bottle of urine? Or is Probation so inept, or Ms. Jittaphol so sleightful, that week in and week out she's able to hide the bottles without getting caught? If she was bringing someone else's urine into the courthouse again and again, why would she repeatedly ask Probation to have someone observe her urinate? If she's using methamphetamine, this extraordinarily addictive drug that routinely involves daily use, how do you explain all the negative tests, including sweat patch tests? Rather than struggle to come up with answers to these obvious questions, there is another obvious explanation – the sole positive sweat patch test was wrong.

In *Alfonso*, 284 F.Supp.2d at 193, Judge Young discussed some of the literature warning of the risk of false positives from sweat patch tests, and literature documenting reliability problems with sweat patch testing has mounted since. *See* Marilyn A Huestis, et al., *Monitoring Opiate Use in Substance Abuse*

Treatment Patients with Sweat and Urine Drug Testing, J Analytical Toxicology 24, 509-521 (2000) ("… 7.9% false-positive sweat results as compared to urine tests."); David A. Kidwell & Frederick P. Smith, *Susceptibility of PharmChek Drugs of Abuse Patch to Environmental Contamination*, Forensic Science Intl 116, 89-106 (2001) (" … normal hygiene did not remove all drugs from externally contaminated skin [of drug-free subjects] and positive sweat patches resulted."); Joseph A. Levisky, et al., *Comparison of Urine to Sweat Patch Test Results in Court Ordered Testing*, Forensic Science International 122, 65-68 (2001) (a "… high incidence of false positive sweat patch tests," referencing studies reporting false positive rates of 21.1% in cocaine detection and 7.9% in opiate detection.); Melissa Long & David A. Kidwell, *Improving the Pharmcheck Sweat Patch: Reducing False Positives from Environmental Contamination and Increasing Drug Detection*, Dept of Justice Final Report (2002) ("Urine tests on individuals have shown urine negative/patch positive results with close contact with a drug-contaminated environment. Several cases have involved individuals identified as methamphetamine positive who denied any methamphetamine use, while admittedly using other drugs. The individuals involved in these cases were all in environments where profuse sweating was common …"); D. A. Kidwell, et al., *Comparison of Daily Urine, Sweat, and Skin Swabs Among Cocaine Users*, Forensic Sci Int 133 (1-2), 63-78 (2003) ("… patch results may represent current use, prior use, contamination, or a combination … false positives occurred at a 7% rate."); Marek C. Chawarski, et al., *Utility of Sweat Patch Testing for Drug*

Use Monitoring in Outpatient Treatment for Opiate Dependence, J Subst Abuse Treat 33(4), 411-415 (2007) ("… sweat testing is less sensitive than weekly urine testing in detecting opiate use;" "… precautionary measures, including cleansing the skin before patch application are not completely reliable in preventing contamination …"); N. De Giovanni & N. Fucci, *The Current Status of Sweat Testing for Drugs of Abuse: A Review*, Current Medicinal Chemistry 20, 545-5671 (2013) ("For chronic users it is not clear whether a cocaine appearing in the patches came from current drug ingestion, previous drug ingestion, previous drug contamination, current drug contamination, or a combination of the above … The effects of vigorous or prolonged exercise on the transfer of drugs into sweat and/or the disposition of these drugs onto the patch are unknown and there is evidence that outward transdermal migration of some accumulated drugs may lead to an incorrect interpretation of new drug use."); Joy N. Hussain, et al., *Working Up a Good Sweat – The Challenges of Standardizing Sweat Collection for Metabolomics Analysis*, Clin Biochem Rev 38, 13-38 (2017) (Sweat from exercise may have a different metabolic content, and may impact test results).

Ms. Jittaphol sometimes strenuously exercises. The Fucci, Long, Huestis and Hussain articles referenced above each describe or suggest a risk of higher rates of false positive sweat patch results amongst past drug users where there is an increase in sweating caused by vigorous exercise.

In *Alfonso*, there were six positive sweat patch tests. Judge Young dismissed two as unreliable based on the way the patches were removed. He emphasized the

significance of the remaining four positive tests: "[t]he Court deems it important to note that it was the aggregate of positive results that provided probable cause to believe that Alfonso used cocaine while on supervised release." *Alfonso*, 284 F.Supp.2d at 204. In this case, not only is there only one positive test, but that test is inconsistent with all the other tests, including a negative urine test that overlapped part of the time when the positive sweat patch was worn, and involves a drug that is less likely to be used sporadically than cocaine.

Probation has never addressed the assertion that a recommendation for long-term inpatient was improper from the start and a deviation from the standard of care. Probation has never disputed that The Hope Center failed to assess whether such care was warranted. Never disputed that the clinical supervisor in charge of Ms. Jittaphol's care at The Hope Center, Hilary Moody, stated that The Hope Center did not assess whether inpatient residential care was appropriate because it understood that the treatment plan had been dictated by Probation's P45 form, which was interpreted as a "contract" requiring long-term residential care. Never disputed that Ms. Moody acknowledged that Ms. Jittaphol did not meet the criteria applied to determine whether inpatient care is warranted. Never disputed that Probation's recommendation for inpatient treatment was based on the recommendation of The Hope Center, not on any independent assessment, because Probation is not qualified to make such an assessment, and that The Hope Center's recommendation, in turn, was based on a misinterpretation of the P45 form, not on a clinical assessment. Never disputed any of the facts or opinions

stated by Dr. Stuart Gitlow in his letter concluding that the recommendation for inpatient residential care was a breach of the standard of care, lacked support in clinical findings, and was unsupported by treatment record documentation of any of the criteria deemed essential to warrant inpatient residential care.

Even if the one positive sweat patch test was legitimate, that alone would not justify inpatient care, given all the other negative tests. There has never been a clinical assessment of the need for inpatient treatment, and there should be no consideration of inpatient treatment unless a qualified care provider finds it appropriate. At that point, Ms. Jittaphol should have an opportunity to challenge such a finding. However, a single positive sweat patch test does not establish probable cause to believe that Ms. Jittaphol used methamphetamine. There is ample reason to find it likely that the positive test was false. No action should be taken on Probation's petition and Ms. Jittaphol should not be required to participate in inpatient treatment. She does not object to outpatient counselling and has worked with Probation to arrange it. The Court should accept the parties' "C Plea," and to the extent that a qualified clinician believes that outpatient counselling is warranted for Ms. Jittaphol to maintain sobriety, this would be an appropriate condition of Probation.

ATICHA JITTAPHOL
By her Attorney,

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CERTIFICATE OF SERVICE

I hereby certify that this document, filed through the ECF system, will be sent electronically to the registered participants as identified on the Notice of Electronic Filing (NEF) and paper copies will be sent to those indicated as non-registered participants on February 23, 2022.

/s/ *Keith Halpern*