COSSUP
Comprehensive Opioid, Stimulant, and Substance Use Program

PODCAST SERIES TRANSCRIPT

Insights on Providing Medication-assisted Treatment in Rural Jails: A Community-based MAT Provider's Perspective

Announcer: Welcome, and thank you for listening to this recording, part of the Comprehensive Opioid, Stimulant, and Substance Use Program, or COSSUP, podcast series.

Dr. Melissa Stein: Hello, and welcome to our podcast, Insights on Providing Medication-assisted Treatment in Rural Jails: A Community-based MAT Provider's Perspective. I'm Dr. Melissa Stein, a senior research associate with Policy Research Associates. We are a partner of Advocates for Human Potential, which is one of six training and technical assistance providers for the Comprehensive Opioid, Stimulant, and Substance Abuse Program, also known as COSSAP. The cornerstone of BJA's COSSAP initiative is its emphasis on partnership and collaboration across the public health, behavioral health, and public safety sectors. Effective community responses leverage the combined expertise of each of these disciplines and rely upon unified and coordinated strategies. This podcast is one of five that will provide insights on providing medication-assisted treatment in rural jails from the perspectives of the different partners involved, including jail administrators, jail medical providers, among others. Today, we're speaking with a community-based MAT provider about supporting MAT in a rural jail. Rachel Katz is the director of addiction services at Community Health Center of Franklin County, Massachusetts. Ms. Katz is a board-certified family nurse practitioner with over 14 years of experience in primary care, and most of her practice has been in rural settings.

She is a graduate of Smith College and Columbia University and a member of the American Association of Nurse Practitioners. Ms. Katz has been practicing addiction medicine for the last eight years and is a strong advocate for incorporating treatment for substance use disorders in the scope of routine primary care. She currently sees patients at the Community Health Center of Franklin County in Greenfield, Massachusetts, where she directs the office-based addiction treatment program, and is actively engaged in teaching students and residents. She is also a community faculty advisor for the NIH-funded HEALing Communities Study. Ms. Katz, thank you so much for being with us today and speaking with us about such an important topic, and I'm excited to jump right into this conversation with you, starting with

our first question. One of the overarching issues associated with MAT, or medication-assisted treatment, is the stigma associated with substance use disorders and medication-assisted treatment. As a community-based MAT provider, how have you encountered stigma as a barrier to implementing MAT in your community?

Rachel Katz: Hi, Melissa. It's so nice to be able to speak with you today, and I'm really glad that we're getting started with this particular question. I think that stigma is just wrapped around anything involving addiction, and it's certainly the biggest, or one of the biggest, barriers to providing safe and effective treatment for a substance use disorder, specifically opiate use disorder. Unfortunately, throughout time, our society has been subjected to a pretty racist and discriminatory war on drugs, which means that the narrative around drug use has been considered either a moral failing or criminal activity rather than the symptom of a medical condition or disease. Most of the patients that I treat are no longer using drugs to get high; they're simply using drugs to get well or to continue their baseline functioning throughout the day.

Shame and stigma keep people from accessing treatment due to this harmful narrative that has been put forth by the war on drugs. And in addition to external stigma, I see so much internal stigma and shame with my patients. They've been exposed to that external stigma and that false narrative that goes along with drug use that it's been really hard for them to not just take that in and make it part of their identity that's then associated with their ongoing drug use. So, a lot of my work with my patients actually involves undoing their own sense of shame and guilt and stigma and helping them really relearn that they are human beings worthy of dignity and respect and getting the appropriate treatment for their disease. And in that case, that appropriate treatment is medication.

It's still routinely called MAT, or medication-assisted treatment, but more and more in the medical community, especially on the community side, we're really referring to it as just medication for opioid use disorder. The medication isn't really assisting the treatment, the medication is often the first line for treatment. I think there's that aspect of shame and stigma, and even just continuing the language of MAT in and of itself can be harmful. And there continues to be a lot of shame and stigma around some particular medications for opioid use disorder, and most specifically where I'm seeing it right now is with methadone. Methadone has been around for ages, it is still considered often the gold standard or the treatment of choice for moderate to severe opioid use disorder, and it's really becoming increasingly successful, especially in the age of fentanyl. The more fentanyl that's

in the drug supply, often the harder it is to get folks onto buprenorphine/naloxone, or Suboxone.

And really, methadone is becoming the most effective agent to get people to stop using dangerous, contaminated, illicit drugs and help them achieve some stability. Locally in my community, I think that buprenorphine/naloxone is really viewed quite positively—it's been around for a long time, a lot of people prescribe it—but methadone is still often considered sort of substituting one drug for another, and so there's a lot of that stigma associated with methadone, both from outside providers but also within patients themselves. Folks don't want to go on methadone; they consider it liquid handcuffs, it's still just as much of a drug to them. Again, it's really having those conversations with folks, both external but then also with my own patients, about just relearning what it means to get appropriate treatment, what treatment itself means, what that could enable them to do—all of those things.

Melissa: Thank you for that. And building on this issue, particularly in rural communities, many people are seeing firsthand the impact that substance abuse is having on their families, on their children. How do you work to increase buy-in among community members of medication for opioid use disorder?

Rachel: Absolutely. Again, that's a great question, and certainly here in Franklin County, the most rural county in Massachusetts, I don't think there's a single person really in our community who has not been affected by a substance use disorder. And certainly over the last year, year and a half, we've seen a record increase in overdoses, both fatal and nonfatal, so it's definitely a huge piece of it. I view humans a couple ways. I view us as herd animals that we all have to stick together, but I also believe that we are narrative creatures, and so really to understand our history and to understand where we're coming from, it's really all about telling stories and giving people a story for the things that they've gone through. One of the most important things to increase community engagement in our community has been the opioid task force, which was founded just about 10 years ago, and it was originally comprised of members of law enforcement, health care, harm reduction agencies.

And they have worked really tirelessly on telling those stories, on educating the community specifically about the role of trauma in drug use and addiction; they have been instrumental in advocating for increased treatment options here in Franklin County, including inpatient treatment, multiple detox beds and long-term treatment beds, and then really working on community providers to increase the prescriptions of things like buprenorphine/naloxone. And they've also really empowered people with lived experience to tell their stories. I think that we're

actually really lucky in Franklin County that we have a large amount of community buy-in. Folks have been working on this for a really, really long time. Obviously, there's always more work to be done.

Melissa: Well, that is such a powerful example of community collaboration, partnership, and multidisciplinary approach to this work in the community. And so, moving from the community into the jail setting, because providing MAT inside jails not only needs community buy-in but also requires the commitment and involvement of a number of different medical, criminal justice, and social support services, what are some of the benefits you've seen from taking a multidisciplinary approach to implementing MAT in the jails?

Rachel: I think a multidisciplinary approach is key to just about everything in medicine, but also specifically for treating addiction and opioid use disorder. I think that having that multidisciplinary approach just creates this really nice wraparound for clients and for patients. And just an example of the nitty-gritty of how that works is that the Community Health Center of Franklin County, which is where I work, and then the Franklin County Sheriff's Office actually co-fund a position. The position is for a community health worker who is employed by the Community Health Center but is actually embedded into our local jail. And so he is able to meet with folks while they're incarcerated; he's involved in their discharge planning or their release planning; and because he also is employed by the Community Health Center, he's able to outreach me or my team directly, a variety of other medical providers, ensure that someone is going to be able to transition their medications for opioid use disorder from the inside of the jail to back in the community as seamlessly as possible.

He is then also able to meet with folks, again either pre-release or after release, to help them organize things like getting their insurance reestablished, getting their license back, being able to locate a social security card—all of these things that are so important and can so often lead to more chaos in someone's life. I think that is just a really amazing example of this cross-coverage, this multidisciplinary approach. People on the inside are able to say, "I have Lewis and I have Rachel, I have my inside partner and my outside partner, and we're going to know that those two people are constantly in connection, that I'm not going to fall through the cracks. And so, when I get released from jail, I know that I have my safety net."

Melissa: Delving another layer deeper into this work, as you are working with your colleagues across these different disciplines, the reality is many colleagues or local leaders might be concerned about some of the folks that are on MAT who are nodding off, or concerned about dosing issues,

or as you mentioned earlier, continuing to think of MAT as simply replacing one drug with another. What do you say to those colleagues?

Rachel: Yeah, again, another really great question, and I think this comes down to just a basic misunderstanding of MOUD, or medications for opioid use disorder. I still get really frequent phone calls from police officers, parole officers, other law enforcement officials who are worried about folks either nodding off or appearing sedated. And often what happens is I will just call those patients or even walk over to the courthouse and speak with the patients themselves. And often they're tired because they were up all night with a cranky baby or a fussy toddler or they work overnight and they got called in for a drug screen first thing in the morning [and] they haven't had a chance to go to bed yet. When it's working the way that it's supposed to, MOUD doesn't make people sedated or doesn't make them nod off; it really is just meeting their body's basic needs for the correct substance or medication so that they can feel well, so they can function, so they have a baseline where they can parent that fussy baby who's been up all night or work that night job that is helping to pay the rent and buy food.

Buprenorphine/naloxone inherently you cannot overdose on. Buprenorphine/naloxone you should never nod off on or feel sedated on. And that's because of just the way that it works. It is what's considered a partial agonist, so it meets some of the body's mu receptors or opioid receptors, but it's never going to cover all of them nor is it supposed to. It also has built-in naloxone, which is the overdose reversal agent, so you can never take too much buprenorphine/naloxone, or Suboxone; it just inherently will stop working. And so again, I think that just comes down to a basic misunderstanding of the medication and how it works in the body. Methadone certainly can make people appear drowsy or sedated, and often that can happen when there has been a dose adjustment, but again it is not intended to do that. No one should be walking through their day or trying to function feeling like they're underwater or like they're going to nod off.

I really encourage our law enforcement officials, or partners, or anyone else in the community that if there is a concern about a dose or concern about patients' behavior to please just contact either their addictions nurse or their addictions provider, their community-based provider directly. We certainly never want to be overdosing a patient; that is never anyone's goal. And at least for myself, I don't want them to be getting in trouble with our law enforcement collaborators; I want to be able to be on the same page to make sure that someone is moving towards their goals. And I will also say, just based on the relationship that people who use drugs often have with law enforcement officials, I

will often have more information than the parole officer has because a patient just maybe isn't going to disclose as much to them as they are to me. So I can be able to put some context into that story to advocate for the patient to let the parole officer or the other law enforcement official know that there's more to this picture than just what they're seeing in the moment.

Melissa: True public health approach to their medical needs. Good.

Rachel: Yes, absolutely.

Melissa: The unfortunate reality is that even among treatment providers, we still see a preference for abstinence-only approaches. What do you think drives this kind of thinking?

Rachel: We see approaches to abstinence very greatly, not just in jail settings; we see it across medical settings as well, so in ERs, community-based settings. Folks are really only going to view recovery through one lens, and that's going to be complete abstinence, when in fact we know that medications do help people achieve ongoing sobriety, achieve stability in their life, prevent overdose and death. I think that it is really all about continuing to educate providers as well as our law enforcement officials about the use of medications, how effective they are. I'm a medical provider; we practice evidence-based medicine, and so you can point to any of the wide variety of studies that show that medication really does help save lives. And an example that I really like to use and that is common across the addiction world is the example of diabetes.

And so, if I had someone that's sitting in front of me who was a diabetic who was still eating sugar and having ice cream every night, there's no way that I would say, "Oh, you don't get your insulin today. You're breaking the rules. We set forward this contract and therefore you have to get complete abstinence from sugar before I will provide you your medication or before I will refer you to a support group or to our diabetes educator." There's no way that would happen; there's no way that would fly. It would be malpractice for that to happen. And I think the same really goes for treatment of addiction, that in a lot of ways it can be considered malpractice. It's certainly very dangerous to tell someone, "No, I'm not going to give you your medication because you continue to use heroin once a week or because you continue to use cocaine once a week." It's just not a realistic view of the world, and I think that we're really putting people in danger when we do that.

Melissa: You touched on the importance of educating and training providers. What are your thoughts on how we are educating and training the provider workforce to deliver medication-assisted treatment?

Rachel: We really desperately need more training and education for all providers, both folks who are in school as well as folks who are out of school, on addiction and medication for addiction, medication for substance use disorders. And we also need a pathway for all providers, including nurse practitioners and physicians' assistants, to be able to prescribe all of the FDA medications used to treat opioid use disorder, including methadone. The regulations around methadone are draconian at best and discriminatory at worst. As we touched on earlier, methadone is still often considered the gold standard for treatment, it is being increasingly used, and yet there are a million rules and regulations surrounding methadone, which make it incredibly difficult to access and make it really hard for folks such as myself to be able to prescribe methadone for the treatment of opioid use disorder. The other piece I would like to add would be teaching students.

One of my favorite parts of practice is to host students, medical students, NP students, PA students, is to bring them into my practice, and maybe they have some preconceived ideas about addiction and addiction treatment, and I love to expose them to actually how it can really be done in the real world in this low-barrier, functional way. And people's minds are totally blown because they have been taught that addiction is either so dysfunctional and chaotic or so scary that it can't be treated in a general practice setting, that it has to be referred out, they go to the addiction provider, they go to the methadone clinic. And treating opioid use disorder can absolutely be done in a primary care setting, in a general practice setting, really low-barrier, and research supports that folks do incredibly well when accessing treatment in this way. I also think that there continue to be some discriminatory practices in place for addiction providers. An example of this is that NPs, so nurse practitioners, and physicians' assistants must complete 32 hours of training in order to prescribe buprenorphine/naloxone and medical physicians only have to complete 8 hours.

And so, when we're looking at the medical system and the medical structure as a whole, specifically when it comes to addiction, I think we need to shift our paradigm a little bit. These types of requirements are unnecessary; they place an undue strain on the medical system that is really already at its bursting point. Mid-level practitioners, nurse practitioners, physicians' assistants are also really the bedrock of treatment in a lot of places, and specifically when we're talking about rural areas, and so to require them to have to continue to do this extraneous training just really continues to put barriers in people's way. Barriers to folks wanting to become addiction providers or being able to achieve the license to become addiction providers and for patients. If you're saying that a nurse practitioner has to complete 32 hours of addiction training, he or she may not be able to do that in a reasonable

time frame, and therefore you're having folks go without treatment. I think that we definitely need more education, but we really also continue to need advocacy, both at the state and federal level.

Melissa: Absolutely. Another challenge that has been currently affecting every system is the ongoing COVID-19 pandemic. How has the pandemic affected provision of treatment, both negatively and positively?

Rachel: I think, as we all know, COVID-19 was catastrophic in a lot of ways, and it certainly did not miss the addiction community. For those of you who've seen the data, in 2020 we saw the highest number of overdose deaths that we have ever seen since we started recording that kind of data in the United States. Across the South, we saw an increase in overdose deaths that range from 30 to 46 percent. Locally, in my area, we saw a jump, I believe, of approximately 20 percent. We know too that a lot of the work around addiction is connection. The opposite of addiction is not sobriety; the opposite of addiction is connection. And so, when COVID-19 happened and everything shut down, we essentially deprived everyone of any reasonable connection. And that hit everyone really hard, but I think it specifically hit folks who were already struggling even harder. However, I would also like to say that there were some silver linings to COVID, specifically in the addiction world. One of the biggest silver linings was the taking away of something called the Ryan Haight Act.

The Ryan Haight Act was a federal regulation that stated in order to start anyone on medication for opioid use disorder, including buprenorphine/naloxone, they had to be seen in person. When COVID hit, they took away the Ryan Haight Act because they wanted people to not come to medical offices, but what that means is that we can now start medication for opioid use disorder, including buprenorphine/naloxone, using telehealth. I can actually have someone who maybe is unstably housed, they're on the street, an outreach worker finds them, says, "Look, are you interested potentially in starting a medication to help you feel better to prevent overdose?", they say yes. The outreach worker can then call my clinic directly. I can have a 20-, 30-minute—sometimes not even that—conversation with someone, with the person who's using drugs, and half an hour later, they can pick up a prescription at their pharmacy.

This has really enabled us to have much more reach, to be able to get to more people, and to really be able to meet people where they're at and when they are ready to have whatever kind of treatment or medication that they're ready for. The other silver lining was when it comes to methadone. Again, we spoke about methadone having some really draconian regulations, and pre-COVID people basically had to show up

every day at the methadone clinic and get their dose. And so, if you're asking someone—especially in the rural community where there's often methadone deserts, there's no access to methadone—you're asking people to drive sometimes up to an hour and a half to their most local methadone site, well, they're not going to be able to have a job. You're driving 90 minutes there, 90 minutes back—how on earth are you going to be able to actually work? And so with COVID, they were allowing more take-home doses. Folks didn't have to show up every single day. If they were stable, if they were doing well, well then they got to take home some of their medication.

And again, we can use the example of diabetes. There's no way that I would make someone come into my office every day to get their insulin. It's unfathomable for that to happen. And so, we're hopefully going to be able to maintain some of these looser restrictions around methadone, although unfortunately, we are already starting to see them be drawn back across a variety of states, but I think it really eased the burden on a lot of people for methadone. And there are certainly now multiple methadone providers or directors of methadone clinics that really are advocating for continuing easing of the regulations and the rules around methadone. And I think now, they really have a foot to stand on. They can look at two years of data from COVID and be able to say, "Look, overdoses didn't increase. More people are working, more people have been able to get custody of their kids back. This is really a viable thing, we can do this, and it's safe to do this."

Melissa: Absolutely. Well, thank you, Ms. Katz, for sharing your experience and your insights in this incredibly complex issue. And I think you've given our listeners a lot to think about and hopefully inspired them to implement some of the strategies you've discussed in their own communities. And thank you to all of you who tuned in today. If you missed the other podcasts in this series, be sure to listen to them on this channel; there's a lot of great information for everyone interested in bringing MAT to rural jails. And for more information on similar topics, check out our resource page and be sure to sign up for the COSSAP Listserv. Again, thank you so much, Ms. Katz, for your time and sharing your experiences with us.

Rachel: Absolutely, it was my pleasure. Thank you.

Announcer: This podcast is funded through a grant from the Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice. Points of view or opinions expressed in this podcast are not necessarily the official position or policies of the U.S. Department of Justice.