Insights in Providing Medication-assisted Treatment in Rural Jails: A Jail Medical Staff Administrator'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.

Jen Christie: Hello, and welcome to our podcast, Insights in Providing Medication-assisted Treatment in Rural Jails: A Jail Medical Staff Administrator's Perspective. This is one of a series supported by the Bureau of Justice Assistance and 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. I'm Jen Christie, a senior program associate at Advocates for Human Potential, one of six training and technical assistance providers for the COSSAP initiative.

I assist COSSAP grantees with implementing and sustaining the programs that are COSSAP grant-funded. This podcast is one of five that will provide insights on providing medication-assisted treatment in rural jails from the perspective of the different partners involved, including jail administrators, jail medical providers, among others.

Today we're speaking with a health service administrator about creating and implementing MAT in a rural jail. Hi, Jill.

Jill Harrington: Hi Jen. How are you?

Jen: Good. Jill Harrington is the health service administrator for CFG Health Services, LLC, at Albany County Correctional and Rehabilitative Services Center. She has over 27 years' nursing experience with almost 22 of those years in correctional nursing. She is a certified correctional health professional registered nurse through National Commission on Correctional Health Care (NCCHC) and has assisted in achieving accreditation for the medical unit at Albany County with NCCHC and the New York State's Sheriffs' Association. Thanks so much for joining us, Jill. Let's jump right in.

Jill: Thank you.

Jen: So, Jill, one of the overarching issues associated with medication-assisted treatment, what we have often refer to as MAT, is this stigma associated with substance use disorders and medication-assisted treatment. As a nurse overseeing a jail MAT program, what are some ways to address stigma as a barrier to implementing a MAT program in jail settings?

Jill: In general, there is a general lack of understanding about opiate use disorder and seeing it and understanding it as a chronic care condition or chronic disease just like we would in jail or an outpatient setting. We've received our diabetics, our endocrinology patients, cardiac patients. Opiate use disorder needs to be seen as chronic disease, and sometimes it's not. So we're trying to change that perception. In rural communities, it can be very challenging since there's a few opportunities to learn about MAT and the jail medical providers really need to bring that into the facility as a contracted vendor for a correctional facility as we are here. All of our providers that we hire here, whether it be a physician, nurse practitioner, physician's assistant, all have to be X-waiver providers. So they have some of that background already coming into the facility, which is very helpful.

Working here as a jail nurse and health service administrator, we have to constantly combat stigma related to opiate use disorder or any other, some issues in the facility. Could be medical staff, custodial staff, other jail staff, and most of that is done with education with the employees, just letting them know, emphasizing how we can approach opiate use the same way we would approach other diseases, whether it be mental health disorders, heart disease, diabetes. It's also important for us to provide medical services to the patients here, recognizing that, and that would be very helpful in this facility and in all the correctional facilities, is that everybody could step back and look at that patient as an overdose disorder and then see that as a chronic care disorder.

And we have the responsibility to serve people with a substance abuse disorder and ensure that they're on a path for recovery just like we would for any other disease.

Jen: That makes a lot of sense. I appreciate that. What are the types of collaboration among essential partners that need to happen for a successful rural jail-based MAT program?

Jill: So for us, collaboration is the key to any successful program. And here at the jail we started collaborating back in the end of 2018 with the sheriff and some other outside entities, the superintendent, some

advocacy groups that had come in and approached the sheriff. That was the starting point for it all. And we expanded from there, started collaborating with not only just the correctional staff but the mental health staff, our CASACs here at the facility, and then the community support partners that we've created partnerships with. It's essential for success for a program to have those collaborations in place. And in rural areas, sometimes it's very difficult. We're really lucky here in Albany; we have three local methadone clinics, we have several community entities that are willing to help us with this program. And some of those rural communities, that could be a challenge for them.

And it's really important to get the community agencies involved, the courts involved, especially the drug courts if they have them to assist in, especially the discharge planning process. Speaking with the courts, it's important for the communication, for the collaboration, including those in the discussion and making sure that several people aren't doing the same plans for patients too. So you don't have drug courts making plans and the CASACs making plans. And we use Project Safe Point through Catholic Charities also. So everybody really needs to collaborate and come together to make plans for the patients to avoid an overlap for that. As far as the community providers, like I mentioned, we are very, very lucky. We do have several facilities that we know locally here with the MAT that do MAT, that do methadone, and they have been very helpful to us creating the agreements that we've had with them.

The larger jails, depending where they're located, it's going to be easier for them to do. And now with the new MAT law coming into place in New York State, several facilities are struggling with that. Not surprising, the rural facilities is a challenge for them. So having those community-based relationships is very important. Having partnerships also with the state departments of health or local departments of health, people really don't realize when you work in the facility how helpful that can be. They can help with creation of policies, they can help with supporting you for education, creating tracking programs, statistical gathering, analyzing information about the program and many cases to the programs for the schools, whether it be nurse practitioner for schools; we do have students that could be involved in that as well.

Some of the local jails, if they don't have MAT in place, one of the things that we did to support them and to support the patients and the continuation of MAT is to have a substitute jail order assigned with the Commission of Corrections, who oversees all the jails to keep a patient here. So say if they were here and they needed to transfer to another facility, it doesn't have MAT, we would keep them here at the facility to continue treatment. And then there's been times also that the facilities

don't do MAT and they want to send somebody here that comes in on high doses. So they would come into our facility, and we would order them here for that.

Jen: That's really great. Sounds like you have a ton of collaboration that reaches very broadly across your community. That's very helpful, I have no doubt. So, I want to switch a little to the actual program participants. So, can you tell me how do you go about identifying potential MAT program participants?

Jill: The identification really starts right at the booking process, when they first come into the jail. The patient comes in, and they're seen by the booking officers. They do a suicide screen sheet. Part of that screening does include also drug and alcohol history. They can put them on an observation for medical or mental health. Every single patient that comes into the jail comes to medical for medical evaluation. And when they're seen by us, we do that initial intake within two hours of them being booked in. We review the suicide screening sheet that booking did; we review really the same questions with the patient because sometimes they're a little bit more honest and upfront with the medical staff than the correctional staff. So we go through the questions and a little bit more in-depth into their drug and alcohol history, how much have they used, their current history, their past history, history of overdoses, history of hospitalizations or inpatient detoxification.

So all of those questions we do try to get right at the get-go when the patient comes in. Using that information, we also do a drug screen with their consent, and using that information, if they come in as Suboxone or any other MAT, whether it be methadone or something else, we would continue that for the patient. We would call the provider, have them sign all the appropriate consents, and get that medication started for them as soon as possible. We also do a referral right at intake to the CASACs so they can see them, Project Safe Points, they can get into the jail to see them. And then our correctional staff is a big part of that too because we have a commander that will go through and they'll check their court dates when they're getting out, if they're sentenced, if they have any holes or warrants in other areas.

So that way, we have an idea of how long the patient is going to be with us so we can plan for discharge right away and make sure that they have a script when they get released, make sure they have the Narcan kits put in their property right away. All these things we want to make sure are in place before the patient and let you know if they get unexpectedly released that they have some sort of a plan in process that we've started right on intake.

Jen: Thanks so much, Jill. So that's really helpful, Jill. And that makes a lot of sense with identifying people right from the beginning and planning already for their discharge. So tell me more about how you ensure continuity of care for your patients who are being released from jail, because it sounds like you're planning for that right from the very beginning.

Jill: We do plan for continuity of care. We want to make sure that there's a warm handoff when the patient gets released, whether they get released within an hour, they get released in a day or two days or six months or a year. We want to make sure that they're appropriately sent into the community with the services that they need, whether it be Project Safe Point providing connection with Medicaid, picking them up from the jail when they get released, providing that script for them when they get released or the medication for them when they get released, helping them with their housing, HIV and hepatitis, CD care and treatment. All of these things we try to have in place. And Project Safe Point has been really important for us as one of our community providers. And of course, the CASACs in-house too, helping with the transitional process into whether it be inpatient, outpatient, or connecting them with some other service or one of the drug courts.

Jen: Thanks. And I seem to remember you saying that Project Safe Point has done in-reach in your facility. Have they still been able to do that during COVID?

Jill: They have, to some extent. At one point, the jail wasn't allowing anybody coming in, but they were doing some phone interviewing. Everybody, as of this point, they're allowed to come in, they're allowed to have meetings face-to-face with the patient, which is much more helpful. Previous to that, there's been certain times when the COVID cases were really high in the jail, and really that was just early last year in 2021 and then early again this year that there was a small period of time that everything was shut down with few people coming in, and groups have resumed, individual and group therapy has resumed also.

Jen: That's great to hear. Thanks so much. So I want to move on to some of the concerns that folks have when they're starting MAT programs. And I know that diversion of medication is often a primary concern. So what can be done to address these concerns of diversion?

Jill: So diversion is always the number one concern of most facilities. Not so much the medical staff. Sometimes it is, but the correctional staff. They see it as we're bringing more control substances into the jail. Why are we doing that? And that's something that we want to try to dispel. And basically showing that providing MAT in the facilities, if it's done

properly, will reduce incidents of violence in the facility, incidents of more contraband being brought in, and creating policies and procedures and following those policy procedures is very important. With diversion, we've had to change our process through the years. Switching from tablets to films was one of the ways, doing a max daily dosing, providing the way it's set up in the . . . Right now, we're doing dosing in a gymnasium, so we're just doing the MAT people at once rather than trying to do it on a medication pass when you have all these other patients up at the cart looking for medications.

So it's easier to track. We check their hands and their mouths before and after dosing to make sure that there's no diversion. Diversion, it does happen. It's going to happen, especially in the correctional facilities. With bail reform, parole reform, we're not typically seeing a lot of the same patients that were here for 30-, 60-, 90-day sentences anymore. That would be really good candidates for programs. Sometimes the people that are here are people that aren't eligible for the bail reform. So some of them have more serious histories and charges. And then sometimes there are people that try to get on for the wrong reason. And using that diversion program and catching someone diverting is really showing that the program is working because we don't want people on the program for the wrong reason and trying to sell them the facility and using it as a business opportunity.

We want people to have the opportunity to come in here, to have the opportunity to be on the MAT program and get all the benefits, not just from the medication but from the treatment that's provided here with the counseling and the CASACs and Project Safe Point and everything that goes along with the program.

One of the other things we're looking at right now, and that was halted with COVID, but we are exploring now, we had a meeting last week about it, is creating an MAT unit and having all the patients housed together, which would make it easier for the facility for dosing. But the one benefit is that the patients would actually have the opportunity to be with other patients that have some of the same issues. And there would be more counseling programs and we would try to bring back. . . . A few years back before things changed with COVID, we had another outside agency coming in here to do other drug treatment programs. And we're trying to bring that back and give some incentives to be on that unit to make it more of a home feeling that they can feel comfortable and open up, not only with the staff that work here but with the other patients that are on the program and support each other. And we think that'll be really helpful.

Jen: Yeah, sounds like it. I would love to talk with you again after you've opened that and opened that unit and had a chance to see how it works. I know our listeners would love to hear that as well. So, Jill, thank you so much for sharing your experience and insights on this complex issue. I'm sure it's given our listeners a lot to think about and hopefully inspired them to implement some of these strategies 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 there for everyone interested in bringing MAT to rural jails.

For more information on similar topics, check out our resource pages at www.cossapresources.org and be sure to sign up for the COSSAP Listserv. Again, thank you, Jill, for your time.

Jill: 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.