COSSUP
Comprehensive Opioid, Stimulant, and Substance Use Program

PODCAST SERIES TRANSCRIPT

Insights on Providing Medication-assisted Treatment in Rural Jails: An MAT Program Coordinator'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: An MAT Program Coordinator's Perspective. I am 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 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 an MAT program coordinator about creating and implementing MAT in a rural jail. Mr. Michael White has recently become the director of community programs at Hushabye Nursery, a program providing treatment and resources to families and babies experiencing neonatal abstinence syndrome. Previous to this, Mr. White was the director of community programs at a community medical services, where he was involved in the implementation of jail-based medication-assisted treatment in rural jails and prisons across the U.S. Mr. White has worked in the field of substance use disorder treatment for over nine years, with an additional three years working with children and families. Mr. White specializes in substance use disorder program development between community agencies and judicial systems and has developed, implemented, and supported the integration of medication-assisted treatment into county and state correctional facilities located in Alaska, Arizona, Montana, North Dakota, Wisconsin, and Texas.

Mr. White is a two-time graduate of Arizona State University with a bachelor of science and sociology and a master's in criminal justice with an emphasis in counseling. He has been proud to sit on the board for the Maricopa County Re-Entry Program and was a member of the Coconino County Criminal Justice Coordinating Council. Currently, Michael is associated with the Maricopa County Correctional Health Coalition, is an executive board member for Hushabye Baby, and was recently appointed as a board member to Arizona Governor Doug Ducey's substance abuse task force.

Mr. White, thank you so much for speaking with us today.

Michael White: Thank you, ma'am.

Melissa: Mr. White, one of the overarching challenges associated with implementing medication-assisted treatment, what we often refer to as MAT, is a culture that historically fosters punitive approaches versus treatment for people with substance use disorders. How can MAT program coordinators help foster a culture shift within rural jails to support the uptake of MAT and other recovery support services?

Michael: I think the most important thing I've ever implemented in the unrolling of a program in jail is actually a town hall. And so, what a town hall was, when we started a project, we brought in as many staff as we could. We'd even hit all three shifts if we could—which we would—but we would have as much staff as we could get in, so COs, admin, whoever, the entire team, but we would give a small presentation in the beginning around MAT and what this project hoped to accomplish in these other things. But there was a lot of open-ended questions on purpose too. And the reason for that is so the staff could then ask these questions.

And I think this was the most important thing we've ever done because you would get staff tell stories about their family and that family member on MAT did not have a good experience, but unfortunately it was allowing the bias of that corrections officer to look at this project in a certain set of eyes. And so, I think that's really important too, is these town halls and that preemptive education pre-rollout, because any one of these roles can have a damaging effect on the unrolling of a project, whether it's COs not getting logistically the inmate to the medical or vice versa, whatever, but anybody who doesn't buy in can kind of deter the project.

So, for me, the most important piece was to honor and validate the opinions and the beliefs of the staff that were about to do this project.

Melissa: I appreciate that so much. Just developing that trust and respect for one another through the process really is such an important component of trying to create and implement MAT, so thank you for that.

Mr. White, what are some steps for working on partnerships and collaboration in order to successfully create and support an MAT program in rural jail settings?

Michael: So in 2015, 2016, I was lucky enough to meet with a marketing firm that taught me this brilliant vocabulary word in this model that I adopted and ran with. And so, what it allowed us to do was look at Maricopa County and see that the system was broken. And so, these folks wanted us to implement medication-assisted treatment in a jail, but nobody else in the community wanted that, right? And so, what we noticed is that, okay, so when we started pre-release planning for these folks and we had an MAT, we didn't have a residential we could send them to, we didn't have IOP. And so, basically the steps, if you were to look at it to implement MAT, is you need to get synergy between the leadership.

And so, whether that's politics on the outside, whether that's the CMO of the jail or the prison who wants it or doesn't want it, but then the sheriff wants it or doesn't want it, and then the COs want it or don't want it, and so it is really important to get that synergy and to validate and honor everybody's opinion that's coming to this table.

And so, I would say that step one is just getting everybody on board and knowing. I've seen other projects get rolled out, and maybe the local politics didn't know and they put a stop to it quickly. And so, you see some of these things happen where the whole community can't sign off on it, so it's important to get all those folks to the table.

So, one of the ways that you can pull that synergy together is through the town halls, as I've described earlier, and I've seen those to be the best thing that we've ever implemented in these projects, to just get together as a collaborative team. Basically, you're going for the same outcome measures. You're trying to make your community safer, you're trying to make your classrooms safer, you're trying to lower relapse and recidivism. We have the same goals, and so we have to consistently work towards the same best practices, evidence-based practices.

And so, with that, it comes with education. Jails and prisons have enough work to do without going home and reading research papers and identifying best practices. So they need support from folks like us to come in and help when we can.

Another step of this is because we've been fighting the war on drugs for 30 years, we need to humanize the offender population. These are our neighbors, our community members. They're not . . . 75 percent of the crime happens because of a substance, and so 75 percent of the people that are sitting in prison are there because of some drug or alcohol thing. And so, we need to change the way we do things, number one, but continuing to humanize these folks and realize that they're just people struggling with different things and they had a bad day and we still need to set them up to come out and be community taxpayers. So that's the goal there. But we do need to humanize and get away off this war of drugs and bring back some of the things that have disappeared, meaning GED, college, really establishing people to get out and raise their families.

Once MAT has started, it's important to identify the benefits that staff are witnessing but maybe not identifying. And so the safety rates go up. You're not cleaning up cells with bodily fluids, you're not seeing the same inmate come over and over. Some inmates you are, some inmates aren't going to get on track the first time around, but what I can tell you is that we saw the revolving door for our opioid population go down at least 50 percent. Our numbers tell us 70 percent in Maricopa. And so we know that that's a huge impact. And there's other examples across the country of similar ones.

This is probably one of the best interventions criminal justice can implement, but you really do need to go back and let the criminal justice system know the good work that they're doing because they're trapped inside and they don't necessarily get to see the impact on the community. And so, one thing we'll do is, if they got somebody that they've seen six times in the last year and then they didn't see them for six months, we'll give them an update as long as it's okay with the client and say, "yeah man, we got started on MAT, I got out, got a job," but we'll send the COs and those folks that update to let them know that they did make an impact on this person's life. So I think those are some of the steps that we can do to improve.

Any position I'm hiring within my team, I am hoping they have some type of lived experience, whether that's they went through a child protective case, they were arrested at some point, but I am hoping that they do have some lived experience. I don't want to say I only hire peers, but for this position, my hope is that it is somebody that has had this experience. And I truly believe it's important because they can have a totally different conversation with this inmate. And I'm a peer, and so I know these things. I know that I've sat in jail cells on people's worst day, and I was able to laugh with these folks because I've been there, and so I know how important peers are and I know how important it is

for the offender to have somebody that they see as not associated with the criminal justice system. And so they get a much different relationship out of that, and we get better outcomes.

Melissa: Absolutely. It's so important also, I think, for jails, rural jails in particular, who may have challenges filling positions . . .

Michael: True, true.

Melissa: . . . they can incorporate people with lived experience at all levels. It doesn't just have to be a peer support specialist role. They can be case managers, program directors, clinical coordinators. They can take a number of different roles within the MAT program.

Michael: It's scary to hire that guy you just released or that lady you just released, but it's what you got to do.

Melissa: Well, maybe give them some time to get on their path to recovery.

Michael: Give them some time. But give them some time, but that's what it is.

Melissa: So once the jail has an MAT program up and running, I think a lot of jails struggle with "Well, how do we quickly identify people? We don't want to keep them in the booking process too long, but how do we more efficiently educate them?" For rural jails, considering MAT programming, what are some important or helpful elements they should plan on implementing?

Michael: Yeah, I think most systems are doing like a COW assessment, which is a Clinical Opioid Withdrawal scale. And so they could use technology and putting flags in their computer systems. Let's say they don't have a computer system—let's say they're so small, they don't have a computer system. You don't need a ton of technology. You need to call a good community provider that can either support you or to enter into a contract to have an OTP come in and provide these services on your behalf.

There's also another way—NaphCare has done this and a couple other third-party correctional health providers, their doctors are actually X-waivered providers now. And so, they're providing the buprenorphine while people are inside the system. And so that's a really good model, in my opinion, and something that could definitely be implemented in a rural nature more easy, even if you had a CMO or a medical officer two hours a week, which I work with some rural jails that they only have a nurse come in two hours a week because the whole population for that week may be eight.

Another useful technology in rural environments is the telehealth. And through COVID, we saw some of those specifically for opiate treatment programs, some of those regulations get relaxed to where we could definitely get people into treatment easier. It was a great tool; I think that they're going to leave it that way. And so this does provide rural jails and prisons this extra tool in their tool bag to where you can get a computer in your jail system, you can work with an outside provider through telehealth, that provider can actually induct medication-assisted treatment and then have that medication delivered to the jail and basically take care of everything on behalf of this jail through some of these telehealth things.

The other important thing is if the jail isn't ready—and we have a couple of these—if the jail is not ready for MAT, we can provide education. And so we did that for six months at one jail, and then we kind of proved our concept and they started trusting us and they said, "Okay, let's try MAT." But basically, we try to implement anything in jails that would be helpful, whether it's substance abuse classes, whether it's reentry classes, or MAT. And so telehealth is a splendid tool to be able to do those things.

Melissa: Well, I really appreciate you sharing that approach of just kind of scaling up to MAT. So starting small, starting with an education program, and then as you build that relationship, then moving into MAT. I think that that is a really helpful approach. And one of the important roles of MAT coordinators is measuring and sharing program outcomes. So, could you just touch on the importance and maybe some tips around measuring and sharing program outcomes of participants prior to and after their release?

Michael: Yeah, so we were lucky enough, in 2015, [20]16, to be awarded a SAMHSA MAT-PDOA grant, which kind of established our dedication to data, I guess, because the data that came out of that grant for us was so outstanding that we knew we were doing the right thing. And we had this really good data company, Wellington, and it was great to see the outcomes of the work that my team had done for three years. And so some of the things that we saw was like 80 percent employment. And so this was a population coming out of jail, prison, and drug court. And so 80 percent got employment; it was like 60 percent got permanent housing; 60 percent didn't have a new crime in the next year, which we flip-flopped the data or statistics on those types of things. It was really interesting to see that data.

And so what we did after that was kind of implement easy, trackable data from our stance. And so we have these Excel spreadsheets, and we use some other tools, but what we're able to do is track when the

person came out, what dose they were on, how long they were in jail, a couple different measures, but I'll give you an example of what the data was able to provide us one time.

I had this great employee, and she noticed, observationally, folks that were coming out of the jail under 30 milligrams of methadone were way less likely to show up to the clinic for their community transfer of services. But the folks that were over 30 milligrams, they were 90 percent showing up to the clinic, but then when it was below 30, it was like 40 to 50. And so this data then let us go back to Maricopa and say, "Hey, we might not be having a stable dose when these folks are getting out, and if we're able to get them to a more stable dose, they may engage in treatment upon their reentry." And so we made some adjustments, and we saw those numbers increase.

So data can give you the information to change your program and to increase your outcomes. And I think data should be looked at every three to six months to reevaluate your project and see if you're going in the right direction, because data will tell you.

Melissa: What are some of the challenges that rural communities face related to continuity of care, and what are some of your thoughts in terms of addressing those challenges?

Michael: So, I work with some jails that the staff might be four to five people, and they do not have a counselor. They do not have a case worker. They unfortunately just don't have staff that can sit down with an offender and set them up for reentry. And so I do think that it's important, and I think it's almost a duty of the community, to come help those systems. And so if there's a provider in the area, and I think it's okay for a jail to go out and ask a provider for some voluntary services and say, "Hey, can you come into my jail and provide a class twice a week for an hour?" And I think it's a mutually beneficial relationship because I think then once these people get released, if they continue to need help, they're going to go to that provider. So that provider almost gave themselves a referral just by trying to support people in these jails.

One of the things that the federal government—DEA, SAMHSA, and such—has been working on for a couple years is mobile methadone. And so, something that my old company, CMS, was working on were med units. And so, these are slimmed-down OTPs. You basically can have a nurse, your intake would happen at a real OTP, but then you would be transferred to this kind of dosing center, and that's this med unit. And so that is a good strategy for jails and prisons also. And there's

a couple jails and prisons, such like Ohio, that are attempting to put OTPs and med units, or a combination of that, in their system there. So that's how they're tackling it.

But another technology advancement that DEA and SAMHSA has been trying to do is mobile methadone. And this is something historically has been around in New York and Seattle and saw some good success in getting services to folks that normally wouldn't be able to get them. However, mobile methadone, for the purposes of criminal justice, could be outstanding. And so, what I mean by that is pretty much what you're thinking about. It's an RV that basically has a clinic inside. And so, some folks are thinking that possibly this RV could come through the sally gate or come through some fence operation through if it's a state prison, something like that. I've seen a couple prisons where it really would make sense just to pull up behind medical and then folks could walk out medical and right into the RV and dose, and then the bus turns around and goes to the next jail or prison.

And so, there are these opportunities, and I see them to be very important in places like Alaska, Montana, some of these rural nature states, but criminal justice specifically, being able to have a mobile unit pull up to your jail and provide services for people and then go to the next jail. So, this should be a state strategy. And it could also be, since all these things are turning into a liability, it should be a collective strategy. Rural communities could help each other out by supporting each other, whether it's financial or these things cost money or whatever. But yeah, I think mobile methadone, if an OTP can figure it out, it will definitely support criminal justice.

Melissa: And so, you say figure it out, what are some of the outstanding questions that need to be resolved?

Michael: That's a good question. Some of the regulations say you have to have the bus return to the home site, and so when you look at states like Montana and each place is two and a half hours away and a snowstorm can happen, some of these things might not happen as consistently as the DEA would want. So you got to be sure about that. The requirements of what's actually in the bus, so the 3,000-pound safe with a certain security alarm, those things are somewhat gray, I think. And each state has different DEA agents, and each one of those DEA agents can request a different thing.

There's a couple different advocacy groups, Georgetown Policy Advocacy Group with Regina LaBelle and those folks attempting, and I think SAMHSA's even looking at this, I mean it's a big conversation, but opening Medicaid 30 days prior to release would be a huge benefit to

rural communities. We talked about money, we talked about resources, but if we could get Medicaid open 30 days prior, then what that would allow these rural jails to do is go find these providers and actually say, "Okay, you can come into our jail and you will actually be able to bill for your interaction with these offenders." And so, nonprofits, that's the big hangup for nonprofits to kind of get them to come in and help. Nonprofits need to make money, and they need to get paid for their services or they can't do it. And so, it would be a game changer if we were able to open up Medicaid 30 days prior for rural jails and communities.

Melissa: Okay. Yes. Such an important conversation there. So, we're going to keep our pulse on that conversation, the conversation around mobile methadone units. So, thank you so much for sharing your experience and insights into this complex issue. I think you've 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 who have tuned in today. If you missed the other podcasts in this series, please be sure to check them out; there's a lot of great information for anyone interested in bringing MAT to rural jails. For information on similar topics, check out the COSSAP Resource Center at www.cossapresources.org. And there you can sign up for the COSSAP Listserv to receive more helpful information and resources on a regular basis. And again, thank you so much, Mr. White, for your time today.

Michael: You too. 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.