

Dr. Stephen Holt: Hello all, and welcome; thanks for tuning in to this episode of ASAM Practice Pearls, a podcast series from the American Society of Addiction Medicine. I'm your host today, Dr. Stephen Holt, and I am joined by my colleague and co-host, Dr. Shawn Cohen. And both of us today are joined by Dr. Catherine Trimbur, an expert who really brings a wealth of knowledge to today's discussion, and I will let Dr. Trimbur introduce herself for us today. Please go ahead.

Dr. Catherine Trimbur: Thanks so much. I'm very happy to be with you guys today, and talking about this. So, as you said, my name is Catherine Trimbur. I am a provider here at Brown University, I practice in internal medicine, palliative care, and addiction medicine. And my primary practice is as the medical director of our transitions clinic, which is a specialized interdisciplinary clinic set up to take care of people with a history of exposure to incarceration.

So, we take care of people coming out of prison and jail, who are in community supervision, or who have been involved in the criminal legal system in any form. And so practice both primary care and addiction medicine for those folks and importantly get to work on a team with community health workers and peer recovery specialists who will be the source of all of the knowledge that anything helpful I share today, most of it comes from the community health workers lived experience.

So really happy to be able to share that important expertise that they bring to the work.

Dr. Stephen Holt: Thanks, Dr. Trimbur. So, to that end, today's episode is going to tackle an issue that many of us as clinicians face somewhat frequently and find it often very difficult to navigate. That topic is balancing patient confidentiality and legal obligations. You know, requests from parole officers, child welfare agencies, other external entities that we've received can really create ethical challenges for us as clinicians.

And so, the question that we're really going to be asking today is how do we protect our patient's privacy while also fulfilling our legal obligations, our legal responsibilities? To set the stage, I'm going to have Dr. Cohen step in here and provide us with a potential scenario that I suspect all of us can identify with.

Please go ahead, Shawn.

Dr. Shawn Cohen: Yeah, so we are all seeing today a 35-year-old patient with a history and current opioid use disorder that's currently being treated with buprenorphine in your clinic. Recently, they were released from incarceration, they're on parole and mentioned to you that their parole officer wants to be very involved in their substance use treatment and get updates, including urine drug screen results, how they're doing on their medications.

And they also mentioned that adding an additional complicated layer to this is that child welfare is involved in their life, too, and wants updates as well. And so, the patient's really worried about the implications of sharing this information, worried it might jeopardize the progress that they've made, both in their substance use treatment and in their life in general. And so, it's kind of looking to you for advice on how to best approach the situation. And I will say for me, this case really highlights a lot of how interwoven, particularly given the fact that our society criminalizes drug use, how interwoven the criminal legal system becomes when we're trying to kind of help people with substance use treatment and how it puts both the people we're treating, and I think ourselves often in this difficult balance of balancing treatment goals, requests for confidentiality. Do we collaborate? How do we collaborate? How do we advocate with the criminal legal system to kind of best meet the patient's goals, both in their lives and, I think, in their treatment. And so, we're going to kind of talk through how do you manage requests like these in a way that's best for the person that you're treating and is both kind of ethical and effective?

Dr. Stephen Holt: Awesome. So, we'll jump in with our first question, and, you know, as is often the case when we're starting to dive into a topic, it's good to make sure we're on the same page about certain definitions and concepts, and so, you know, let's try to just disentangle a little bit, some of the nomenclature here.

And I thought we might start off with, you know, giving us sort of a, a super brief, you know, parole versus probation 101, and, you know, reflecting on the particular aspects that we should know about as clinicians so, if you can give us sort of an idea of those concepts, Dr. Trimbur, please.

Dr. Catherine Trimbur: Yeah, definitely. So, you know, in the intro, I mentioned that I care for people with a history of exposure to incarceration. And so, what I mean by that, I really think about it as a risk factor, and that includes both being behind bars, but also being in community supervision. And so, when we talk about probation and parole, we're really talking about that community supervision piece.

And so, the short version of the difference between probation and parole is that probation is really instead of prison, and parole is effectively after prison. So that's sort of very simply how I think about it. Probation is generally, somebody gets sentenced to community supervision, really, as an alternative to doing time inside. In general, it's ordered by a judge, and again, it's the alternative to being behind bars.

On the other hand, parole is granted generally by the parole board, and we kind of think of it almost as early release from prison in a way. So, you've done X amount of your sentence, you've met X requirements by the parole board, and all of this is a range, which is why I'm using the word generally, and then somebody comes out and completes the rest of their sentence under community supervision for parole. So, that's sort of how they're different. They're also very

similar in some ways. So, again, we use this language of community supervision. So, they're similar in that people have to meet certain requirements. So, if you're on probation, you will have a probation officer. If you're on parole, you will have a parole officer, and there's stipulations that you have to meet that are really individual to each circumstance.

So, you may have to meet with the PO weekly, bi-weekly, monthly. You may have to be employed. You may not be able to be employed in certain circumstances. You may have to live in certain places. You may have to be in counseling. You may have to do urine drug screens. You may not be allowed to interact with certain people who are also on probation. You may not be allowed to drink alcohol. So, a lot of things, importantly, that are actually not illegal for people who are not on community supervision would be considered a violation. And then, when you violate, if you are on probation, you go to prison, and you effectively do the initial sentence that you were sentenced to. Whereas, for parole, you would go and complete your sentence.

Dr. Stephen Holt: And so, when you learn or when a patient tells you that they are, in fact, on either parole or probation, what's the next sort of series of questions that, or information you need to get from the patient to decide how to handle that?

Dr. Catherine Trimbur: Yeah, that's a great question. So, you know, in my circumstance, because I work in a transitions clinic, the vast majority of my patients are on probation or parole. And so it sort of is just part of our routine intake. I do also see primary care patients who may or may not have been referred through transitions clinic.

And I do often ask about that, for a lot of academic residencies, there's data that shows that somewhere between 40 and 50% of patients have either a personal history or an immediate family history of incarceration or have been involved in community supervision. So, you know, there's a lot of debate about how do you screen? And, in my practice, I do, and I try to do it in sort of a trustworthy way, so I generally bring it up. I think one thing to note in the case that I would really emphasize if it's coming in the opposite direction where the parole or probation officer and the patient's bringing it up, is really to express appreciation, for how courageous it is to bring it up with a primary care doctor who the patient has no idea how they're going to approach it, how they're going to receive it.

We know that there's a lot of stigma around criminal legal involvement. And so, I sort of lead with that and say, "I know that this is not easy stuff to talk about. The reason that I'm asking you about this is because I can advocate for and with you. My job is to focus on your health and to hear about what your goals are and help you meet them in any way that I can in a clinical context."

So, I try to initiate that conversation that way if I'm the one bringing it up. And then I just sort of ask them initially, how is it going? I have a good number of patients who actually have a really good relationship with their POs.

Dr. Stephen Holt: Yeah. I was going to say that. I feel like, you know, I've, I've had so many patients who will really view that person as a support person, a confidant, and it seems like they are an important part of the treatment team if you will. And of course, you know, my experience, and I'm sure yours, is that that's not always the case, and it can be more confrontational.

Dr. Catherine Trimbur: Yeah. And I think that's really where this concept of dual loyalty comes up, is how do we think about, and, you know, this comes up in medicine all the time with our views. You know, it's not just in these legal obligations, but how do we think about who is really centered and what is centered in our clinical decision-making and then, in our practice approach?

And this is easy on the surface and hard in practice. You know, the patient is at the center. Our job is to plan with them, to team up with them, and in my experience, really sharing that and saying, again, "My job is to be on your team, so how do you want me to be on your team?"

In general, I have not had cases where my patients didn't want me to talk to their PO, but I asked them and say, "Do you want me to interact with them? Here are some of the ways that I have worked with POs for other patients and in ways that they felt like was really helpful. And I'll give some examples and say, do any of these seem like they might be helpful to you? And I can give some of those examples if that would be helpful."

Dr. Shawn Cohen: Yeah, I mean, I appreciate the analogous approach of like both kind of people with criminal legal involvement and people with substance use disorders and like how you approach this very stigmatized topic in a setting, like the healthcare setting that is often not very welcoming for people like this, but I really appreciate kind of the wording you've given us so far, so I'd love to hear your perspective on this too.

Dr. Catherine Trimbur: Yeah. So, you know, when I'm interacting with POs, and this is sort of what I share with patients is, by definition, my clinical practice, I take a disease psychosocial structural framework to health and illness and wellness for my patients. And, so, as you talked about at the beginning, I'm thinking about addiction as a disease process.

I'm thinking about it as a result of social determinants and social factors. I'm thinking about it as sometimes the only effective coping mechanism that somebody has to deal with the structural factors in their life. That opens up a ton of avenues for treatment plans, for care plans, if somebody's continuing to use or trying not to use.

The criminal legal system, as we know, criminalizes addiction. And I think that there are important conversations and, important sort of advocacy trying to push the criminal legal system to really understand that penalizing substance use is not an effective treatment. But many POs are exposed to the environment that they're in, just like we are. And so, I really think about these conversations, with POs or letters that I'm writing to judges or interacting with, Child Protective Services, as an opportunity to kind of translate. We have one framework that uses a set of language. They have a different framework that uses a different set of language.

And there is power in using patient-centered, strengths-based language that describes sort of this structural determinants disease model for what's happening in the patient's life. And in my experience, you know, we listened to what the PO has to say. It is more often than not they do want the patient to do well.

Their framework just doesn't offer them very many avenues for how to help that patient do well. They can violate or not violate. It's kind of black and white. And it's punitive. And so, these conversations really are an opportunity to say, "Here's what we know about opioid use disorder. Here's what we know about alcohol use disorder. Here are the different ways in which trauma can present clinically. I know this seems like they're X, Y, and Z, but I think what's actually happening is this." And so, I worry that if they are re-incarcerated, we're going to have interruption in their medications. We have them on housing wait lists that they will get kicked off of.

They will lose their food stamps, you know, they are engaged for the first time with a trauma therapist, and that will be interrupted, and so an alternative care plan is we could intensify support, the community health worker, the peer recovery specialist will take them to more frequent meetings, we'll see them on a weekly basis. All of these things that are sort of not punitive but really offer a robust support.

In my experience, the PO is quite happy to know there are these additional layers of support the patient has access to and is usually quite happy to hear about these sort of alternative frameworks and importantly, they aren't sort of based on this punitive, well, the UTOX is positive or negative and we can kind of move beyond.

Dr. Stephen Holt: Do you, in that vein, do you ever, have you ever had, I guess, significantly divergent, opinions about how to treat patients? That is like, you know, we're addiction medicine specialists, we've got this mindset of MOUD or MAUD for folks, but there's still, you know, a lot of ethos out there about how sobriety means being off of medications, particularly methadone, buprenorphine, et cetera. So, do you find that sometimes you're at odds with what the PO is advocating for, and how do you handle those conflicts should they arise?

Dr. Catherine Trimbur: Yeah, that's a good question. So, I'm practicing in Rhode Island, and we are very lucky. We have MOUD in our prison jail, our unified prison jail system. We are also small. And so, I know when my patients are getting out, I know when they got their last Sublocade injection. If I'm giving them Brixadi, I can communicate with the OTP that goes inside the prison to make sure that they get converted to Sublocade.

So, that has trickled down to the judges, it's trickled down to the POs. And so now, compared to when I started doing this work here in Rhode Island about seven years ago, it comes up less. Honestly, it is more frequent now that the POs just want to know, like, are they doing okay? Are they on their meds?

Like is there anything that we can do differently? Anything that's come up? When we did first start practicing, we also have patients who, we have both patients from state prison and federal prison, and, you know, a while ago, there were differences in terms of what people had access to. Those differences still exist in other parts of the country.

So, a lot of our listeners today are practicing in areas where there is no MOUD in prisons or jails, and they really need to be thinking about like on-ramps and off-ramps. If somebody has criminal legal involvement, a violation for that patient is huge, right? If they go back to prison or jail on a probation or parole violation, they have interruption in their medications, that's an opportunity to call the PO and say, here's what's, you know, again, with the patient's permission, and I think when we have these conversations with patients more often than not, they're really struck by our willingness to advocate.

And our ability to move beyond, you're using bad, you're not using good, right?

We are not in that framework. We're not stuck in that framework. And so, we can share all the strengths, the patients coming to all of their appointments, they're on their medications. Yes, they're struggling a little bit. Here's a care plan that I think that we can put in place. To support them in not using. My worry is that if that go back to prison or jail, they're going to have an interruption. And we know, you know, there's all these negative health consequences that can result from it, which we can provide in documented form. But to answer the question, yes, I've definitely had cases. I had a patient who came out of federal prison many years ago, um, had severe osteoarthritis of the knee and history of opioid use disorder, hadn't been able to get knee replacement while he was incarcerated, and so we were starting the process. But he wanted to be able to work, and he needed something to help him work. Between the osteoarthritis and the opioid use disorder, he was struggling. And, so, I wanted to prescribe him suboxone. That felt like a really, really, really easy decision. And he was in a halfway house, and he was technically still under federal supervision. And the halfway house person called and was like, you can't prescribe him this. You can prescribe him Percocet, you can prescribe him oxycodone. But he can't be on

this, and, you know, obviously that was really difficult, and it took us, we put him on Butran's patch, which, you know, was okay for the time because we were treating him for strictly pain.

It was for osteoarthritis of the knee. He, by the way, got both knees replaced on the Butran's patch and did great. But it led to conversations. And so now I have POs saying, "You know, we're not allowing people to be on medical marijuana, but I see this guy is using it. I don't want to violate him for it, but I think it's actually helping him. Can you help provide some data for me to take back to the judge or to take back to the parole board so that we can educate them and we can think about this a little bit differently?" So, I do think that culture change takes time, but these conversations over time, I think, do actually both impact the framework that POs use and certainly that judges use as well.

And importantly, I think it's a really, really, really, profound site to build trust for patients, for them to see you advocating for them in this way. And for you to be able to reflect back to them the strengths, right? They're having a lot of trouble in their life, it's not easy to come out of prison or jail. It's not easy to be under supervision. And you're reflecting back to them that you think it's amazing that they're making it to their appointment, that you think it's awesome that you did all these housing applications, that you see their strengths and their resilience. And you may be like the only person who's seeing that.

The patient may not even be seeing that for themselves. And so, these conversations with POs, and we put them in the form of letters a lot. And for the patient to read that letter and have them reflected back to themselves, I think can be pretty powerful for that physician-patient relationship.

Dr. Shawn Cohen: Yeah, I mean, this is genuinely inspiring to me too, but it sounds like a lot of the interaction with POs is one advocacy and two education, which may be education is advocacy, but if you're having a phone call with the PO, this is just something that I've seen intermittently done, do you usually ask the patient if they want to be present and do it on speaker phone, or are there other ways that you kind of build trust with the patient?

It sounds like you share letters if you're writing letters.

Dr. Catherine Trimbur: Yeah. So, our usual approach when I see somebody, if somebody's coming in on probation or parole, first I ask them about their relationship how they want me to advocate. And I say, "Are you up for me talking to them? Primarily, what I will share is your strengths. If there are additional things that you want me to share, I'm happy to, but anything beyond the things that you're doing well, which I see a lot of, anything I share in addition to that will be the result of you specifically saying, will you tell them this?"

And if somebody is getting routine urine tox screens as part of their, probation or parole, I offer, and I generally offer this once I feel like I've established trust with a patient. So, this may be the first visit, it may not be until the second or third visit, but if I feel like I have their trust. I offer all my patients on probation and parole for me to order, standing UTOXs, weekly or monthly standing UTOXs, depending on how frequently they're getting called up so that when their caller gets called up, and they have to go over to the agency to leave a urine in Rhode Island, in a lot of places, the UTOXs that are done are immunoassays.

And they're not GCMS, there's not confirmatory testing. So, there's both a lot of false positives, but also people still use. And so, my patients have the option, the UTOX order is completely under their control. They don't have to call me to tell me that they're doing it. It's just ordered. They can come into any of our labs on the day that they go to do their urine to also have one with me.

And then, we can decide how to use that to advocate for them. If it's positive, and this has happened frequently, if it's, you know, positive for fentanyl on the immunoassay for their PO and there's no fentanyl in it on GCMS testing, I can share that again with the patient's permission. And generally, the POs are like, "Oof, I didn't know that this was how, you know, our urines." And now the POs learned. And then, more importantly, if they've returned to use, it's a way for them to decide whether and how they want to share it with me. So, I've had patients who say, like, "I just felt really ashamed coming in to tell you, but I felt like I could go do the urine. I knew you were going to get the results. I knew you were going to call me to figure out how to support me. I know the POs are getting it." And generally, we get the urine tox screen results before the POs get it, and so we can care plan. And then we either call, and it's rare that I call with the patient.

Usually, they say, "Nope, just call," and, you know, we play a little phone tag. But we write a lot of letters, and so we have templates that we've worked with our risk and legal team here at Brown on and we have letter templates where we document the negative health impacts of incarceration or potential violation, offer the strengths for patients.

Thanks. And then offer care plan alternatives to re-incarceration. Importantly, we're not giving legal advice, but we're sharing the additional context. And what we've heard from, we did a qualitative study with judges, but from what we've heard from both judges and POs, is that they appreciate the additional context.

Because we're not telling them what to do, we are not trying to do their job. We're not getting into the legal realm. We're simply sharing additional information about their psychosocial and medical context. And they've appreciated that additional context.

Dr. Stephen Holt: Yeah, I love how you're sort of providing a lot more nuance here because, you know, I sometimes think of the judicial system as fairly black and white, but we're really talking about lots of shades of gray, particularly with regards to success with our patients highlighting, the urine drug screens, maybe, like, I know for us, we'll be checking buprenorphine levels in the urine, or just buprenorphine presence in the urine, and I can tell a PO, this person's showing up for appointments, this person's clearly adhering to treatment, their buprenorphine levels are positive, etc., without getting into they are or they are not using cocaine, because that's a shade of gray that may not be that important for really keeping track of how this person is doing long term, so.

Dr. Catherine Trimbur: Exactly. Yep. My answer to that first question is, do you interact? Do you not? It's rarely a yes or no answer. It's really if and how. And again, this is a site for a group of patients who have historically both with physicians, but also sort of across the board with institutions, not had autonomy, not had a whole lot of control over their life.

This is particularly a site, obviously, where they don't have a lot of control. So, then for you to give that autonomy back to them and to say, "How do you want me to share about how you're doing? I see all of these strengths. Easy for me to share that. You're taking your bup. You're doing this. Do you want me to also share this additional information and offer an alternative care plan? Do you want to wait for that to come up?" Like, there's a million different ways that we can approach these interactions, the patient actually gets to control it, which I think is really different from how they've interacted, even with the kindest, best doctors on the inside often.

Dr. Shawn Cohen: Yeah. Do your interactions, moving from POs to child welfare? Are there differences in the interactions you have with workers in the child welfare system or agents in the child welfare system when you're kind of doing the same to advocate for your patients?

Dr. Catherine Trimbur: Yeah, and I think it's generally sort of that same framework of my job is to care for this patient. I am not obligated to share anything with a PO, right? I mean, they can violate them, and they can put him back in prison, and obviously, that's worst-case scenario, but I'm not required to share anything specifically about this patient.

Recovery or how they're doing or their medical stuff with the PO. Obviously, we get into slightly different situations when we're thinking about child welfare, patient harm, that kind of thing, I will sort of wave the white flag of humility when it comes to this one. I get excited, and I'm very happy to interact with POs, judges, anybody in the criminal legal system on behalf of my patients. I think a lot of us get kind of bristle at the child welfare piece and, and I think that's just to say that my goal is always to seek out a patient-centered, family-centered sort of strengths-based, nonpunitive approach.

And that's hard when it comes to this. And the reason why I sort of use the language of humility is my goal for all of my patients is to understand the ecosystem, the landscape of their lives and to be humble about that sort of small place that I play in their lives. And so, I worry a lot about this sort of false notion that we have the capacity to truly assess what's going on.

We don't get a ton of training on it. We are, I think, getting more training on trauma-informed care and sort of different presentations of PTSD and trauma and all of that, but my worry is that I think defaulting to this framework of mandated reporter really sets up this false notion that we actually have the capacity to fully assess it. And I like the framework that many have offered of mandated supporter as opposed to mandated reporter and sort of thinking about, okay, there's a family in distress. There's [a] punitive approach. I can say I have to report you. I don't even know if I have the skills to appropriately assess whatever I think I'm assessing, and that can obviously really have implications for trust as opposed to the situation with POs and judges where I think we actually are building trust in those settings.

And so, I think the short answer, the long-winded way to my short, is, I think it's really about knowing your local system, and when can you tag in additional resources so that you mandate yourself to support the patient with humility for what we can truly assess. And how do we think about sort of a legacy where I think probably we over-report and under-support?

And how can sort of tap into some DCYF offices, some Child Protective Services offices actually do have a good amount of capacity to support without it being this formal, scary, punitive report. I've had patients who've been reported by other people who ended up getting better access to mental health because of that is my humble nonanswer to the question is just sort of like, how are we supposed to even think that we have the capacity to do this? And so, what do we do instead? And I think that is support.

Dr. Shawn Cohen: I feel like so many people, at least a lot of people that I've interacted with, take it as this black or white thing of like, patient uses substances and has children, I must report this. And there's like very little contemplation about like what are the other options we can take? What are the downstream negative implications that are very likely to come from that process? And so like, how do we kind of turn that on our heads a little bit and think about instead how we can support too,

Dr. Catherine Trimbur: And I think not to absolve ourselves of the supporting part, right? I think we, like, we get stuck in this mandated reporting and, to your point, it's a yes or no. But if we can move away from that framework, then we actually, again, open up more avenues for treatment where we say, okay, like I'll figure out the reporting piece, but what I got to do is support, which means pulling in more people who have more ability to assess, who can go into the home in a way that I can't, and then you're automatically getting them more support that way.

Dr. Stephen Holt: I think, in some ways, just the verb to report. It sounds very punitive. It sounds like I'm going to report you to the principal. I'm going to report you to whatever X, Y, and Z, you know, punitive thing as opposed to what we're really talking about is enlisting the help of someone with expertise.

You know, one of my best friends works for child and family services here in Connecticut. And, you know, I know his goal is not to break up families. That's not what he's in it for. He really loves being able to better provide access for or to address those social determinants of health.

And so, you know, enlisting him to help out when these situations arise, as opposed to I'm reporting you to this strange man who's going to come to your house, I think can frame it in a more positive light and make patients realize this is about, like you said, trying to support the family, protect the family, and help them to build up their pool of resources.

Dr. Shawn Cohen: I think this whole episode, I'll say, was relatively uplifting and kind of giving us a framework and how to, again, advocate, partner with your patients, and try to, again, make their interaction with the criminal legal system less punitive.

But can you share with us a couple of really successful cases where you're able to balance kind of the legal side and the patient-centered care?

Dr. Catherine Trimbur: Yeah, absolutely. And I'm glad that this is uplifting. I do feel like this work is very soul-filling, even when it's difficult. And obviously, there are cases where people do get re-incarcerated or, you know, tough cases, but I do hope that people walk away feeling like they can do this and the letters take five minutes to write.

So, I recognize that in busy practices they can be challenging, but you can take, you know, a couple minutes to do it. I think the thing that I'm most proud of in our program, is we really identified early on that fines and fees for court involvement. It costs a lot of money to be on probation. It costs a lot of money to be on parole. If you are on home confinement, the bracelets are expensive. Every time you go to court, you get fees. These are all separate from restitution, so like if you break into a place and you break the windows, you have to pay that back. These are all separate.

These are just sort of administrative fees. We know that it's not easy to get a job, nobody wants to hire somebody with a record, so additional fines and fees are really, really quite stressful, and patients have to make tough choices, choices between paying for medications, paying for certain types of foods, all kinds of things to pay these fines and fees.

And if you don't pay the fines and fees, it's a violation of community supervision, and so you can get re-incarcerated because you couldn't afford to pay. So again, a way in which we actually criminalize poverty in this country. And so, we started writing letters to judges when patients had court fines and fees documenting the negative health impacts of these fees, saying things like they can't pay their rent. They can't buy the foods that I really want them to eat for their diabetic diet; they're not paying for their insulin, whatever it might be, or just the stress. They have hypertension, and the last thing they need is additional financial stress that they're just never going to be able to meet.

And I, in my medical opinion, if these fines and fees were waived, their health would be improved. And so we started sharing these letters to give, again, the context, and judges started waiving the fees, and it was all on just like a one-time basis where patients would be like, they just told me I don't have to pay this 1300 back, like, this is amazing, I'm going to go buy some broccoli, and then we got to a place where judges actually started waiving some of them themselves without our letters, and officers actually started waiving some of the fees in certain circumstances for home confinement bracelets after we had written a couple of letters advocating, then they just thought, well, I just put in for it because I could see that they had swelling in their leg. And so, I want them off of it, and they clearly can't work because they have this swelling from this health condition. So, I waived the fees. And so then judges asked us to put together, fee waiving conferences where anybody who had court fines and fees, we had a couple of them per year could come to this one site and just have thousands of people get evaluated and fees waived, and then that ultimately led to, people from our Center for Health Justice and Transformation advocating with judges to get legislation to pass in Rhode Island, so we no longer have court fines and fees because the judges found that Rhode Island was spending more money trying to collect the fees than they were actually getting and people are being re-incarcerated.

This came about from conversations with judges and POs, these little quick conversations saying, I think that this is really stressing them out. I think that there's negative health impacts. And it can kind of build up speed to have more, larger, like legislative implications as well.

Dr. Stephen Holt: That's a fascinating example of advocacy and really coming out so strong in favor of fairness and justice and very forward thinking as well. Just to say that these fines do not serve the community, the patient, the family, anybody, even if somebody is not collecting, you know, 50 bucks that day or something.

Dr. Catherine Trimbur: Exactly. Yep. And it all came from our community health workers saying, "Can you just write a letter for this guy, you know, talking about what he's doing well?" And it sort of, you know, built up from there.

Dr. Shawn Cohen: Yeah. Are the letter templates that you have published, or is that something you'd be willing to share? Because it sounds super useful.

Dr. Catherine Trimbur: Yeah. So, we do have the letter templates that are available on the archive of our Docs for Health website. So, it's www.dfharchive.org, and a limited number of those templates are available there as well.

Dr. Shawn Cohen: Awesome. So, let's revisit our scenario that we started with just to kind of remind everybody about we were caring for a 35-year-old person with opioid use disorder currently being treated in your clinic and is on buprenorphine as part of their treatment plan. Recently released from incarceration, they're on parole, and their parole officer kind of wants to know a little bit more about what's going on and also has, child welfare involvement as well. And so kind of based on all the things we talked about, can you just give us a couple of really quick highlights and kind of the big take-home point?

Dr. Catherine Trimbur: Absolutely. Yep. So, the big take-home point is this is an opportunity both to advocate and build trust with your patient by saying, how do you want me to interact with them? Here are the ways in which I can. I can write a letter documenting all of the strengths, all the appointments that you're coming to, that you've been taking your bup, and really saying that you're engaging in care. I can call them and communicate that verbally. If you have any concerns about urines, I can also make urine testing available for you to have under your control here in clinic. And then an opportunity to really have a conversation with parole and share, again, the strengths of the patient, but also our disease-based structural model where, we identify all the barriers that the patient is facing and all of the things that they are doing well, and to sort of translate our framework, to offer them more nuanced ways of thinking about this person's recovery and community supervision.

Dr. Shawn Cohen: So, thank you for joining us for this episode of ASAM Practice Pearls, and a special thanks to Dr. Catherine Trimbur for sharing her experiences and all these practical strategies and kind of a guide for really how to advocate for your patients, educate, manage the intersection between confidentiality, patient-centered care, and kind of some of the interactions between the criminal legal system as well.

For more insights and resources, be sure to explore ASAM's Advanced Buprenorphine Education Series, where we dive into other key challenges in addiction medicine. And we'd also love to hear from you. What other challenges have y'all faced in navigating kind of this intersection between the criminal legal system and the medical system?

What strategies have helped you? Be sure to comment and join in the conversation. And don't forget to subscribe to this podcast and share the episode with colleagues who you think might benefit from these discussions. Thanks again for listening, and we'll see you next time on ASAM Practice Pearls.

