KCOTF
Kent County
Opioid Task Force

Kent County Opioid Task Force Meeting
Thursday, May 9, 2024
12:00 – 1:30 PM

Attendance: Jessica Barnes Najor, Rick Barnett (MSU); Jayne Courts (Trinity Health); Lyndsie Cole (Kent County Sheriff's Office); Jason Storm, Mike Rocklin, Eric VanDePol (Cherry Health); Susan DeVuyst-Miller (Ferris State University); Karley Deering (Private practice); Kari Kempema (Network180); Heather Bunting (Catherine's Health Center); Dolly Kellogg, Sarah Flinsky (Kent ISD); Jean Talsma (West Michigan Comprehensive Treatment Center); Vicki Makley (Priority Health); Hillary Boersma, Cathy Worthem (Arbor Circle); Calvin Nguyen (GRAAHI); Catherine Kelly, Steve Alsum, Julia Lopez, Bobby Crampton, Gabe Bieszka, Clare Livezey (Grand Rapids Red Project); Rachel Walter (University of Michigan Health-West); Jenny James (Kent County); Julie Bylsma, Nick Nichols (Reentry Reimagined); Kahana Harrison (Family Outreach); Michelle MacDonald (Alternative Directions); Chris Eakin, Joann Hoganson, Sharon Schmidt (Kent County Health Department); Kayla Belasco (Pine Rest)

Agenda

Welcome to KCOTF and Introductions

Announcements

- Opioid settlement spend plan is available. Folks should have received that email.
  - Jenny James and Rachel Jantz have been working on developing the spend plan with feedback from the task force.
  - Scheduled to be presented at the May 21 Board of Commissioners Finance and Physical Resources Committee. Update – the plan will no longer be presented at the May 21 meeting. When we have a rescheduled date, we will share that with the task force.
  - This will be a public meeting with time for public comment (3 minutes per person).
- Please see the upcoming subcommittee meetings at the bottom of the notes.

Community Needs Assessment - Dr. Jessica Barnes Najor and Rick Barnett, MSU

Jenny James – We want to make sure that we're doing ongoing specific outreach to the community to know what the needs of the community are around substance use so that when we make plans for future years, that we know the needs of the community. The state of Michigan is contracted with MSU to provide technical assistance to counties with their opioid settlement plans.

The MSU Technical Assistance team has been doing community assessment work across the state with various counties. With some counties, that work is heavily quantitative and involves gathering survey data. In other counties, like Kent, that work is focused on qualitative data from specific populations to make sure we hear that voice to guide the work. The Technical Assistance Collaborative includes Michigan State University, University of Michigan, and Wayne State University.

This is a community-lead assessment, so the goal is to hear from the community. This will inform long-term planning for sustainable and comprehensive services. The purpose is to supplement ongoing quantitative data collection with qualitative data to give us a greater understanding. Primarily through interviews and focus groups.

Timeline (Can alter timeline if need to):

- May – review questions
- June – get focus groups together
- July – do the focus groups
- August/September – analyze data
- December – provide report

Resource mapping – where resources are in the county and what partnerships exist in the county. If we know that communities in certain areas of the county are experiencing certain needs, then we can bring resources to that part of the county. These are guiding questions, not necessarily the questions that will be asked in interviews.

1. How does substance use impact residents of the county. How does that impact differ across identified groups?
    a. Comment – how to include a comment about opioid use and the contaminated supply?
    b. Response – the state is encouraging counties to think about substance use broadly. Many people may not see themselves in opioids, even though the substances they are using may be contaminated with opioids.
2. What assets exist to respond to substance use in our county and what resources do individuals feel most supported by and why?
    a. Audience comment: It's critical that we are targeting people who are actively using drugs. With this question, there will be very different responses between people who are actively using and people who are in long-term recovery.
        i. Response: The networks and people that you work with will be critical for MSU to sit down and have those conversations. MSU is willing to show up in any space that people feel comfortable in to have these conversations.
    b. Audience comment: It's really important to think geographically about the county as well.
        i. Response: If it's really easy, we're probably not doing a great job of reaching out to people. The timeline can adjust; in some counties, it can take a couple of months just to get a good representation.

    c. Audience comment: With the incarceration and post-incarceration communities, they don't see the services that aren't offered to them. There could be slanted results because people just don't know that those services should be available to them.
3. What gaps in substance use services are in our county?
    a. Resources, support systems
4. What do those impacted by substance use need from the community?
5. What are some of the barriers preventing individuals from seeking help?
6. How does stigma influence individuals' recovery?
7. How could Kent County create a more comprehensive stigma-free environment for individuals with substance use disorder?
    a. Audience comment: Just make sure that we look at stigma with mental health and the co-occurring aspect.
8. How can community organizations and local governments work together to create a comprehensive and sustainable plan to combat substance use?
    a. Audience comment: When we say combat, what do we mean? Is it chaotic substance use? There are people who are using substances and are fine with it and aren't looking to stop.
        i. Response: It's important that we're using language that is following the spirit of what we're trying to do.
    b. Audience comment: There is unique stigma for pregnant people who are using substances. Can we include a question about meeting the needs of people who are pregnant?
        i. Response: Yes
    c. Audience comment: I worry about this type of assessment getting to some interventions that are available in other parts of the world but not available here. Example – safer consumption sites/overdose consumption sites are illegal in the United States. How does a community assessment like this get us closer to the things that we need to actually make an impact?
        i. Response: Speaking to providers like you and your colleagues and your networks can help and be incorporated into our responses.
9. What supports are needed to ensure that the individuals receive treatment and transition across the different services?
10. How does someone's interaction with the criminal justice system impact their recovery?

Communities of focus: Black, Latino, Native, LGBTQIA+, court program participants, those formerly or currently incarcerated

- Audience question: how will we identify groups for the focus groups?
    - We will rely on the Kent County Opioid Task Force and our networks to be able to connect with those groups.

Focus groups are nice when you are talking about a specific program because you can talk to many people at once, but with certain kinds of topics (e.g., lived experience, etc.), an interview can be so much easier because the stories are rich and cover a lot of time.

Panel: Methadone Treatment - Bobby Crampton; Gabe Bieszka; Dr. Jean Talsma, West Michigan Comprehensive Treatment Center; Dr. Eric VanDePol, Emergency Care Specialists

The transcription below is from the panel recording and done to the best of my ability. Please know that errors may exist, and some parts of the recording were too quiet or not picked up sufficiently by the recording device and could not be transcribed.

Please introduce yourselves and talk about why you're here on a panel about methadone.

Bobby Crampton: harm reduction educator and recovery coach, OD prevention and HIV linkage to care at the Grand Rapids Red Project. I'm hoping to get a fair perspective on the positive and negative aspects of methadone treatment.

Gabe Bieszka: harm reduction educator and program manager for NEXT Distro. I'm hoping to describe the pros and cons of experience at the methadone clinic.

Jean Talsma: medical director at WMCTC. I work in Grand Rapids area with methadone and MOUD. Also work with a couple entities across the state in various areas of recovery.

Eric VanDePol: medical director for Cherry Health MOUD clinics, Southside in Grand Rapids and MRC (Muskegon Recovery Center) in Muskegon.

What was behind your decision to choose or prescribe methadone?

Bobby: I chose methadone out of necessity. I was fully reliant on the tainted supply as a daily source of opioids. That comes with a lot of struggles. Methadone provides a safe supply of a measured dose of a safe substance.

Gabe: I suffer from chronic cluster headaches. My doctor had prescribed Dilaudid for several years and the doctor let me know that he didn't need to fill the script anymore. He left me high and dry saying that I need to find a doctor willing to prescribe opioids. No one on the street had pills but I resorted to heroin for several years. Methadone was the way away from all of that, so I didn't have to rely on illegal drugs. It gave me a safe option out.

Jean: I fell into prescribing methadone by accident. I was doing primary care and found my way into treating SUD and had the opportunity to work at a methadone clinic.

Eric: I'm emergency medicine trained. The ER is actually not the front lines. I feel like we're closer to that at the methadone clinic than I was at the ER for a lot of patients. I've been touched personally and professionally by a lot of patients. I was introduced by a mentor that introduced me to the practice and it's been a second chance at a different career. Primarily practice addiction medicine.

What are some of the biggest benefits of methadone?

Gabe: Personally, it's allowed me to be a functioning member of society. I'm able to be a reliable employee and make it to work every day. I don't have to search the streets trying

to find something to just feel normal. A big thing was opioid withdrawal. I was desperately afraid of withdrawal and even had a plan to commit suicide because once you've been through withdrawal once you don't want to go through it again. It was freedom from that fear.

Jean: One of the biggest benefits of methadone is the ability to maintain someone who is dependent on opioids on a safer version of what they were going to get on the street. We can achieve that with other medications for OUD as well, but methadone has a broader range of dosing than buprenorphine. We have a little more wiggle room in how much medication we can use to get someone to the point where they feel like they can function as a normal human being and not need to go out and chase something illicit to fill that gap in their life.

Eric: Methadone is a full agonist. It is a more natural replacement on the opioid receptor than buprenorphine. It is a medicine that we can use for OUD and some patients do better on it. It's hard to know who, and some people go back and forth between the two medications. Some people just do better on methadone.

Bobby: It's a pretty safe supply for people who are relying on a tainted source of illicit drugs. It provides a lot of reliability in a world where there isn't any. It gives people their life back. It allows you to focus on real life things to progress yourself as opposed to always chasing something.

What are some of the biggest barriers to people accessing methadone and what would help improve access?

Jean: Transportation is a huge barrier. The fact that you have to go to the office every day to receive the medication is often a barrier for folks. The limited hours that most methadone clinics are open can be a barrier. In Grandville, we dose from 5:30-11am, but if someone can't get there until the afternoon, they're out of luck. There are a lot of things that could be done to reduce barriers, many of them systemic infrastructure-type things. Improving public transportation, improving access to low-cost transportation for folks who don't live on a bus line. There are too many answers to the question.

Eric: Stigma is the first barrier. The second is, the state of Michigan has 15 OTP clinics. Nothing north of Gaylord, nothing in Traverse City. It depends on what county you're in and how close you are trying to access care. We are fortunate to have three in Kent County, two in Muskegon, Kalamazoo. If you're in a metropolitan area you have access. If you're in a rural area, transportation is an issue. Transportation is really the number one thing – getting to the clinic. The fact that it's a specialty medication and a specialty clinic and it's not available in every place in Michigan.

Bobby: There are a lot of barriers, even inside the clinics themselves. People having to attend every day. Transportation is impossible for a lot of people. Having to drop clean even though that's not necessarily relevant to methadone being effective. You're 60-80% less likely to overdose if you're on methadone. That forces a lot of people out the door because they can't progress. You have to drop clean otherwise you can't get take-homes.

Gabe: Transportation is a huge issue. Not only trying to get there if you have a car. I've gone through the issue where I had a vehicle that wasn't safe to drive anymore, so I purchased another vehicle that I didn't even make it home before the engine blew because it had a bad head gasket. So, in the meantime, I was trying to take the bus. It was a four-hour ride for me to get from home to the clinic and back. They're only open for certain hours of the day. That was a huge issue for me. There are all these hoops that you have to jump through when you are in the clinic. You have to make all these counseling appointments and you have to drop every day. So don't even thinking about peeing in the morning before you go out, because if you're not able to drop, you're not able to dose. There are everyday life barriers, but transportation is the biggest one I want to bring attention to.

How is methadone viewed by people in your community?

Eric: Traditionally we've been a black box in the community. Secret society. We're trying to reshape that. It's a place where people come and get treatment. It's a place where people get safe treatment. It's not the last stop on the continuum of opioid use disorder or a bad outcome. I think there's still a lot of stigma and bias. I think it's lessened since I started practicing. I see more understanding, more collaboration, and work with the community. But there's still a lot of communities out there that don't want a methadone clinic in their town.

Bobby: It's the most highly stigmatized form of MOUD available while remaining the most effective. It's unfortunate that it carries over to the recovery community itself. People don't consider people in recovery if they're using MOUD, methadone, suboxone.

Gabe: You nailed it, that's exactly what I wanted to say. There are communities that don't want a methadone clinic in their community because there's a stigma that if you're on methadone, you must be a junkie. And if you're on methadone, you must be committing crimes because you are a junkie. It's just getting through that barrier. It's giving people a chance. People need a chance to live their lives in a normal way. It's sad, it really is.

Jean: I think everyone in here, if you close your eyes and picture a methadone clinic, there's a pretty common picture that will pop into your head. It's a doctor's office. There are exam rooms, and we have nurses that take your blood pressure. And yes, we have a bathroom that has a camera in it, but a lot of places do. And you know, it's not a dangerous place to be. It's not a place where people are getting shot in the parking lot. It's a doctor's office and people don't see it that way.

There's currently legislation known as MOTAA (Modernizing Opioid Treatment Access Act) that would allow providers to prescribe methadone outside of the methadone clinic. How would this impact our community?

Bobby: It would eliminate a lot of the barriers for people as far as transportation goes. I think people have a lot more trusting relationships with some of their providers outside of clinics and that eliminates a lot of the need for over-supervised treatment. It would make a big difference.

Gabe: It would make life easier from beginning to end. It allows people to be a functioning member of society, it allows you to be a human being again. Just again, give people a chance to be normal and to be like everybody else.

Jean: I would hope that if this legislation passes, that it would allow treatment for opioid use disorder to be more uniform. We already have medications that can be prescribed by outpatient physicians that can be filled by a pharmacy that you can take at home without direct supervision. This would just add methadone to that list. Sure, there is abuse potential and there is diversion potential, but there are a lot of medications that are still prescribed on an outpatient basis and filled by pharmacists. It would reduce a whole lot of stigma and make it easier for a whole lot of people to get treatment.

Eric: I agree. The way that methadone is purposed now, most people know you can have methadone prescribed by a pain clinic doctor or a medicine doctor and oncologist for pain. But once it's prescribed for opioid use disorder, it's essentially [*inaudible*]. You always have to keep in mind the difference in properties between something like buprenorphine, methadone as far as the properties. But since this has been proposed, I can think of several patients that I've seen that I thought this would be a person that I would consider doing this for. That's a sea change for methadone and OTP clinics across the country.

There have been several changes made at the federal level to improve access to methadone. The state of Michigan has not yet made these changes. Some things like the number of days that someone has to come in person in order to get take-home days. What are your thoughts on this, and what are barriers to implementing these changes at the state level?

Gabe: I think it's sad. It's good that the changes have been made, but it's got people like me who are doing this every day jumping through hoops every day. It's well past time that we should have something like this approved to make our lives easier on the day to day. It's such a pain in the butt having to wake up every morning, not being able to use the restroom, trying to get there, there's just too many hoops that we have to jump through. It would be great if we could cut down on the number of days that are required for us to get the take-homes because some people try so hard to get there. But there's so much time that you gotta put into until you're able to get there. In the meantime, you're trying to pay for transportation or maybe get a kid to school and make it there in time before they close because of the hours they're open. I think it's sad nothing has been done yet, but I think we're headed in the right direction.

Jean: We actually just had a meeting about this the other day. We're in sort of a grey area in Michigan right now where the state has said, ok, we're going to follow these changes, but we're not sure when or how or who is going to enforce it or what it's going to look like. We are looking as a treatment community at trying to balance the latitude that some of the new recommendations allow in terms of things like take-home days and keeping people medically safe. I think there is a line to walk there between handing someone two weeks of take-home medication and having that level of trust of whether they're going to take it appropriately or sell it. And I don't want to think that way about my patients, but I

have patients that I know will sell it, because they've told me they will. We have to walk that line as a treatment community of figuring out how we give our patients the treatment they need, the treatment they deserve, the trust they deserve, but also keep them and the rest of the community safe. I'm excited that the state of Michigan is moving toward liberalizing these recommendations. I think it's going to be a positive thing in the end, but I do think there's a lot of work and juggling and logistics to be figured out about how to make it work in a way that is effective and safe for everybody.

Eric: I think we have a precedent. During the pandemic, methadone clinics were given basically exceptions that would give more take-homes because of the public health emergency. Some research came out that it was appreciated by patients. It was a scary time for methadone clinics. We couldn't close our doors, we had to make sure everyone got their dose. It was a challenging time for us. In the end, when we pushed that button and we gave all these take-homes, it actually worked pretty well. That's where I think the precedent is, that we did this fairly recently. It's a lot of changes. You read through the final rule, it's a lot of changes for methadone clinics. We're working on these things. We're starting to anticipate that the state will adopt at least some of them. I think more will be revealed and methadone will be in the spotlight to some extent over the next 6 to 12 months.

Bobby: I think it's unfortunate that we haven't done it quickly. There are people that need it, and people are dying.

What is the biggest takeaway that you would like people to know about methadone?

Jean: It's not scary and bad. It's an effective medication and it helps people get their lives back. That's it.

Eric: I think you used the term like we have real doctors and real nurses, therapists, MAs, recovery coaches. People are there to help. It's an effective medication. There are other options too. I think the injectable buprenorphine is giving patients other options too. We're trying to break down barriers for what our reception is in the community. We do dosing at the jail and deliver dosing to recovery centers. We deliver doses to nursing homes. We don't have a methadone bus that's our charge nurse driving around town. But a lot of changes have already happened since I've been the medical director with jail dosing. Just the way we have changed our policies over time.

Bobby: I think methadone saves and changes people's lives in a lot of different ways. It allows people to transition from relying on a tainted illicit supply to a safer supply of a known and reliable substance. It can help people from overdosing. It saved my life. I wouldn't probably be here in the position that I am today without methadone, but only because I had the support system to help me overcome the barriers to follow the rigorous guidelines of clinics.

Gabe: I want people to know that it saves lives. It allows people to do really important things for them. For example, it allows parents to be parents rather than spending all their waking time trying to find a way not to be going through withdrawal. They're able to work and do daily activities.

How can the Kent County Opioid Task Force support the community around this issue?

Eric: There are a lot of different walks of life here today. First of all, give a message to the community, be ambassadors for one of the MOUD drugs in your community. There are other wishes I have, like case management, transportation, but the first thing is to equip the community with the knowledge.

Bobby: Encourage continued breaking down barriers and fighting against the stigma. People are losing their lives and that's unacceptable. I think we should move as quickly as possible to address these things. We wouldn't be here today without methadone, either in this position or alive. I think it's important to keep fighting and breaking down barriers and stigma.

Gabe: By having meetings like this and passing on the knowledge you've learned from meetings like this. Breaking down the wall to change the stigmatism that everyone seems to have around methadone.

Jean: The stigma has to go. Once we can get rid of that stigma, I think that will go so far toward opening up the other things that would be helpful, like transportation.

Jayne: Thanks to the panel for taking the time to come to be here, to address the stigma. We so appreciate that you are here.

Open Q&A

Audience question: At our clinic we do buprenorphine. A) I can't do methadone, it's not even an option. But just because bupe and Sublocade is so much easier for patients in terms of all the barriers you talked about. I always think methadone is for people who fail bupe, you know like we tried [*inaudible*]. Clinically, is that correct, or are there patients that I should be recommending they go to the methadone clinic?

Jean: From my perspective, I don't think of methadone as the medication for patients who failed bupe. I don't think that's accurate. I think of methadone as the medication for people who can't get sober long enough to start bupe, because there's that period of abstinence that's required to start buprenorphine without putting someone into precipitated withdrawal. So, if someone is unable to stop using for 72 hours to one week or two with the amount of fentanyl that's out there, if they can't stop using that long to get on bupe, I can put them on methadone today. If they used five minutes ago, I can put them on methadone right now and get them on that path toward getting off illicit drugs and then we can talk about switching them over to bupe once they're more controlled and once they're in a safer place mentally, emotionally, physically.

Gabe: I couldn't have said it better myself. That time that you have to go where you know you're gonna go through withdrawal, I have had my doctor tell me you're not gonna die but you're gonna wish you did. It's just that bad. I literally had a suicide plan because I was so deathly afraid of going through that. If you don't have that time frame that you think you can be sober, it's an option to keep you alive.

Audience comment: We've been doing [*inaudible*]. It's not that they don't have to go through withdrawal, you slowly increase the bupe and that's much better tolerated.

Eric: I agree, like a pregnant patient, we can start them on day one with methadone. There's really no barriers to starting in with the new 42 CFR final rule, there's a lot of these conditions that are required, so as long as we have someone with at least moderate use disorder, start methadone. You can get transitioned to bupe if that works better, but some people just do better on methadone, that's really the message that I want to say. It's not the last stop on the MOUD bus, it is an option. Some people are more stable in recovery. Transitioning back and forth, we're still in the infancy of that. In CIM and other clinics, a lot of people probably know that if someone is on buprenorphine, you can basically start methadone the next day. It's sort of a phone a friend kind of process. It's getting better over time. Moving between the three medications that are approved, we're making progress. Thank you for doing Sublocade and Suboxone.

Audience question: There's a rumor through the clients that I work with that methadone is more appropriate for people that opioid use is often co-occurring with chronic pain. There's a lot of people that I talk to who reject bupe out of hand because they say they need to treat their pain as well, so they need methadone. Is that a myth or is there truth to that?

Jean: Buprenorphine is an indirect agonist and methadone is a direct agonist. Methadone lights up those opioid receptors and turns them on all the way. Buprenorphine, that effect stops at a certain point, it doesn't turn it on all the way. So, if we're trying to manage pain, methadone can be more effective for pain because it's a broader range of dosing and the direct agonist effect. Buprenorphine is still effective for pain to a certain extent and manages some people's chronic pain just fine.

Eric: Methadone is not a great pain medicine. Its analgesic effects really are most potent in the first four hours, which is great for withdrawal, but after that its analgesic effects kind of decay. [*inaudible*] It's a complex interaction because a lot of patients ended up exposed to opioids with pain. We are not a pain clinic, but we also understand that patients there have pain. So, we try to mitigate through non-opioid options for chronic pain, but we also understand that methadone [*inaudible*].

Audience question: I was blown away with the statistic you shared, Bobby, that methadone makes people 60-80% less likely to die of an overdose, because that's really what we're dealing with right now. We have this medication that can make people 60-80% more likely to stay alive? That seems pretty successful to me. Why would we not be doing everything we can to get more people on methadone as a strategy to reduce fatality in our community? I heard your point about worrying about diversion. From my perspective, the people who are using opioids you would be giving methadone, they're using an unregulated poisoned supply right now. People aren't just gonna all of a sudden pick up methadone, they're substituting an unregulated dangerous supply with a safe, regulated substance. So why are we not as a community, doing everything we can to make this available?

Jean: It's a great question. Part of it is I have a medical license to maintain, or I can't do this at all. If I go too far outside the bounds of what's legally and medically acceptable by the licensing board, then I can't help anybody. I think in terms of legislative advocacy and trying to reduce some of those artificial barriers that have been placed on our ability to do some of this work, that's a great avenue to pursue.

Audience comment: I think one of the difficult parts with that is that we haven't studied methadone on its own. When you go to the methadone clinic, you get counseling, you get a lot of other services. And so, we don't know is it just the medication that's saving lives, or is it the combination?

Audience comment: This is widely studied.

Audience comment: All the data is combining it with other services, and we're not using that in real life necessarily. I'm not saying it shouldn't be more widely available, but it's hard to say is it medication or is it the combination of medication and all of the other services that are provided.

Gabe: That's why they need to speak with people like me and Bobby who have been on methadone and have had the counseling visits. Is it both that's working, or just the methadone? For some people, the counseling is great but for some people I think it's unnecessary. I think it's a great thing when you first start out to get you adapted to the clinic and whatnot, but I think if the doctor is able to prescribe methadone out of their office and I could take the prescription home, it would be greatly effective for the majority of people who are going to the clinic now.

Audience comment: And who is to say that the same person who is in charge of prescribing the methadone should be in charge of someone's therapy also? Those are two separate services. I hear what you're saying with people who might take the methadone and sell it but also that's a part of the broad barrier in society. If a person is taking a four-hour trip to get their methadone in the morning, they can't work first shift. On average in our city, rent is a little under $2,000, and that limits where they work and how they're paying their bills. I can't guarantee that I wouldn't make those same choices. If we had more access to things like housing and therapy and things like that instead of leaving it all to one provider, then I think that would help with getting to where we want to be.

Audience comment: We're hearing access and transportation and stigma, but it's really the legal aspect of this that's a huge barrier. I think, Dr. Talsma, when you said we need legislative change, we do. If we could eliminate some of these barriers, which are imposed by the war on drugs, which is really a war on people. Talking about what Steve said, we know that in the early 1900s when we were able to prescribe heroin, we didn't have overdose. The rules and regulations have been codified to contain people and to criminalize people. We need to address that legal aspect of that.

Audience comment: I don't know if you know this or not, but there is a stigma about MOUD in general and there has been for a long time. I was guilty of that at one time, and I think that is because of a lack of education. So, the fact that I'm here today

probably means something. And that there are people like me who are willing to consider it. For every five people I have talking to me about, "you should really consider this," I have 100 people over here saying, "are you kidding me, this is a ridiculous, you can't get people high to get off drugs." This is what the lack of education is over here. The good news is that we're starting to talk about it and some people have been talking about it for a long time, but we didn't listen to them. The fact that I'm hearing all of this today, I've learned so much. I'm sure that if I could get other people involved that do I do in these conversations, then they would learn a ton as well. Because I think a lot of that stigma that we're talking about today, let's be honest, comes from what I do. It comes from a criminal justice system. It comes from the probation officers and the parole officers and corrections officers. I could go on. A lot of these folks are old school. I just want to say thank you for the opportunity to be here so I can learn and hopefully open the doors for other people. I think it's a good idea to keep offering this information.

Audience comment: Before we wrap this up, I just want to validate the transparency and vulnerability that the panelists, especially you two with lived experience, to share your lived experience. Being a part of a methadone program has so much stigma. There is far more trauma than anyone realizes because that stigma keeps us from speaking to the advancement we need to see. And I've seen a lot of advancement in the last ten years, but we have a long way to go. To be willing to sit there and share that experience, I know you impacted everyone who was sitting here, myself in particular. I want to create more avenues for that voice to be heard, because we need that voice to be heard. For those old white men making decisions. So, thank you.

Audience comment: I just picked up what you said about criminal justice and the criminal justice system perpetuating stigma. I speak as a member of the healthcare community, and there's a lot of stigma in the healthcare community as well. I just read a journal article that talked about a retrospective look at medical notes for individuals who were on methadone and the stigma came flying through in the very documentation. But we're not giving up, we're going to keep working. My particular contribution with that is with nursing students. People won't graduate from nursing school until they have heard about stigma and how they have perpetuated it and how they can change it.

Audience comment: I spend 90% of my time with parole officers and probation officers and I will say that while there is a huge amount of stigma everywhere, there is a ton of changing hearts happening. I've been in my role for two years and there's such a difference from two years to now. Just Tuesday, I was having lunch with a bunch of parole agents, and someone started talking about, "why don't we have clean needles here?" That conversation would have never happened two years ago, five years ago, ten years ago. I think that criminal justice has done a lot of harm to this community and continues to perpetuate that harm, but a lot of people in that community are trying to be part of the solution too.

Adjourn

Addendum: Subcommittee Updates

Prevention

We are offering another LifeSkills parent workshop, this one will be virtual. A flier is attached for folks to share. We are also working on establishing a list of summer events for us to attend to provide educational resources. If you know of any events that KCOTF should table at, contact Sarah at SarahFlinsky@kentisd.org.

Intervention

Current priorities of the subcommittee are increased syringe access, naloxone distribution, drug checking services, Never Use Alone, advocacy for low barrier access to treatment, and additional advocacy opportunities. The subcommittee has been identifying priority areas for naloxone distribution once the settlement spend plan is approved.

Treatment & Recovery

MOUD in the jail – similar update as before. All forms of medications for opioid use disorders are now available within the jail for continuation of current prescriptions of induction onto medications for individuals who are not currently in treatment for OUDs. The jail and collaborating agencies are working toward best practice of MOUD within the jail and more timely assessment and beginning of medications. To accomplish this, jail staffing will need to increase and have a dedicated prescriber. The opioid settlement dollars are intended to go for these program improvements.

Black population and increasing education and access to MOUD – The task force has met with the Grand Rapids African American Health Institute (GRAAHI) three times and is scheduling a fourth meeting. These collaborative meetings are working to create a plan on how best to engage the Black community and determine what their needs are when it comes to opiate use disorders and access to harm reduction and treatment. We are very close to participating in focus groups with Pilgrim Rest Missionary Baptist Church and from there we will analyze the information we gather and create a plan as to how best to engage. The genesis of these efforts is the disturbing statistic that the rate of overdose death among our Black community is 300% greater than our White community in Kent County.

Same Day Access to Care for MOUD – The group is beginning to work on this issue and work with providers who show some willingness to implement this or at least explore it. Currently, the Addiction Clinics at Corewell Health is the only provider that has same-day access.

Methadone Dosing Federal Requirements – SAMHSA has relaxed dosing requirements with 42 CFR Part 8 for methadone but not all states have adopted this, including Michigan. The group is looking into who at LARA we need to contact to discuss.

Upcoming Meetings

Quarterly Full Task Force	Thursday, August 8, 12:00-1:30pm
Prevention	Thursday, June 20, 11am-12pm
Intervention	Thursday, June 20, 12-1pm
Treatment & Recovery	Friday, June 21, 12-1pm