



National Judicial Opioid Task Force

Promising Strategies in Providing Opioid Use Disorder Treatment to Rural, Frontier, and other Underserved Communities

The Challenges Facing Opioid Use Disorder in Rural, Frontier, and other Underserved Communities

Over 42 million people live in non-metropolitan communities in the United States. The individuals who live in these areas and misuse or abuse opioids tend to be young, unmarried, lack health insurance, and have lower incomes compared to their urban counterparts.¹ Substance use disorders (SUDs), especially opioid use disorders (OUDs), can affect individuals who live in rural, frontier, or other underserved communities more severely than those in urban settings. While gaps in our nation's capacity to treat OUD exist, these gaps are most pronounced in rural areas because of their limited health and social service infrastructures. With fatal overdoses in rural areas on the rise and a drug-related death rate almost twice as high as in cities, the need for naloxone in rural areas is 22 percent higher than in metropolitan areas.² Therefore, expanding access to treatment is critically important.

Barriers to Treatment in Rural Areas

There are a number of unique socioeconomic vulnerabilities and healthcare challenges in rural communities which create barriers to treatment not often experienced by those in urban settings. These difficulties include: (1) accessibility; (2) availability; (3) stigma; (4) funding; and (5) bias against medication assisted treatment (MAT).

Accessibility

Those who live in rural areas are typically geographically dispersed, often requiring them to travel long distances to services that may be available. Moreover, these individuals often do not have a driver's license, a reliable vehicle, or public transportation options. Some people who live in frontier areas (*i.e.*, particularly remote or isolated areas) may even have to travel by boat or air to obtain treatment. People cannot complete treatment if they cannot get to treatment.

Availability

Rural communities often have a lack of specialized services, as it can be difficult to recruit and retain trained treatment professionals in less populated areas.

Stigma

Even though more Americans view SUDs as a medical condition rather than a moral failing, the shame of being an "addict" still exists for many. Since treatment in rural areas is not plentiful, someone seeking treatment

may encounter a lack of anonymity, making them unlikely to find help.

Inadequate Funding

When a treatment program exists in a rural area, lack of funding often prevents it from being able to meet even the most basic needs of someone with SUD. Moreover, if a program cannot offer professionals a competitive salary, it will not be able to recruit and retain competent personnel.

Institutional Bias Against MAT

While acceptance for MAT for OUD is growing, and despite research indicating that it supports long-term recovery, some in the treatment field and throughout society believe that MAT is trading one drug for another. They believe that abstinence from any substance is the only way to overcome an addiction and enter long-term recovery.

These and other barriers can be, and have been, overcome in various ways, allowing those in rural areas to access resources that previously have been unavailable. While there are countless ways that rural courts have integrated treatment for OUD into their operations, there are three types of programs that have been pioneers in innovation and have been, and can be, replicated in almost any community. They are: (1) Office-based Opioid Therapy (OBOT); (2) the Hub-and-Spoke Model for Opioid Addiction Treatment; and (3) Project ECHO (Extension for Community Healthcare Outcomes).

Medication Assisted Treatment

As the opioid epidemic continues to affect more people each year, the SUD community has increasingly turned to MAT to help individuals suffering from OUD. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines MAT as “the use of medications, in combination with counseling and behavioral therapies, to provide a ‘whole patient’ approach to the treatment of SUDs.”³ The three medications approved by the Food and Drug Administration that are primarily used to treat OUDs are: (1) methadone; (2) naltrexone; and (3) buprenorphine.

Methadone alleviates the pain associated with opioid withdrawal and blocks the effects of opioids. Offered in pill, liquid, and wafer forms, it can only be dispensed through a certified, SAMHSA opioid treatment program or clinic.⁴ **Naltrexone** blocks the euphoria and sedation caused by opioids and reduces opioid cravings. Offered in pill form or via injection, it can be prescribed and dispensed by service professionals who are licensed to prescribe or dispense medications.⁵ **Buprenorphine** produces similar effects as opioids, but the dose is titrated until the person with OUD is at a safe maintenance level. The only medication that may be prescribed and dispensed in various settings, including in an office or correctional facility, it is offered as a film to be placed under one’s tongue, as a skin patch, by injection, or as an implant. MAT with buprenorphine is often referred to as OBOT.

Office Based Opioid Therapy (OBOT)

According to the American Society of Addiction Medicine, OBOT refers to all types of opioid agonists (*i.e.*, drugs that *activate* receptors in the brain, as opposed to antagonists, which are drugs that *block* the effects of an opioid in the brain) “that seek to integrate the treatment of opioid addiction into the medical and psychiatric care” of a person, treating OUD as a “chronic medication condition,” not unlike diabetes or heart disease.⁶ The key to OBOT is that it allows healthcare professionals to provide treatment in clinical settings, thus “expanding the availability of care.”⁷

The healthcare professional administering the buprenorphine must obtain a waiver in accordance with the Drug Addiction Treatment Act of 2000 (DATA 2000).⁸ For physicians to qualify for a waiver, they must complete eight hours of required training then submit an

online waiver notification application and forward it to the Drug Enforcement Administration (DEA) which assigns a “special identification number” to the doctor. This number must be included on all buprenorphine prescriptions in addition to his or her regular DEA registration number.⁹ A DATA 2000-waived physician may treat 30 patients initially and up to 100 patients if the doctor files a notification to increase.¹⁰ Those in rural jurisdictions are often met with the reality that there are not enough primary care physicians (PCPs) who know about, and can prescribe and dispense, buprenorphine. However, in July of 2016, the Comprehensive Addiction and Recovery Act¹¹ expanded buprenorphine prescribing to nurse practitioners and physician assistants, making buprenorphine available to many more individuals with OUD.

Combined with behavioral therapy, MAT is effective in enabling someone suffering from OUD to achieve full recovery. However, according to SAMHSA, MAT is greatly underused, particularly in rural areas. This is evidenced in one study that found that 90 percent of physicians with waivers were in urban areas, with only 1.3 percent in remote communities.¹² With nurse practitioners and physician assistants able to prescribe and dispense buprenorphine, this infinitesimal number can increase. In rural areas where there are fewer PCPs and even fewer specialists, nurse practitioners and physician assistants should be encouraged to obtain waivers. Nurse practitioners and physician assistants can also provide mental health counseling and medical advice and are an integral part of a treatment team. Their utility is critical in rural areas.

In some communities, law enforcement officials and others have opposed having nurse practitioners and physician assistants in this role, expressing concern about the proliferation of unethical prescribers and increased diversion. However, there are ways to address this concern,¹³ such as state-mandated OBOT Rules and Buprenorphine Prescriber Guidelines with appropriate accountability measures.

Some healthcare professionals have noted that even though they are able to prescribe and dispense buprenorphine, they do not feel comfortable doing so as they do not possess enough knowledge about SUD and OUD to effectively treat patients in primary care

settings. Some innovative programs address this challenge and have been successful in providing treatment in rural areas.

The Hub-and-Spoke Model for Opioid Addiction Treatment

A majority of those who reside in the State of Vermont live in rural areas, which is why in 2012 the first Hub-and-Spoke Model for Opioid Addiction Treatment was created in the state. Vermont's system called the Care Alliance for Opioid Addiction, "weaves together existing infrastructure already dispensing SUD medication, including federally-qualified health centers, methadone clinics, OBOT, and more,"¹⁴ and creates regional treatment centers.

The "hubs," or specialized addiction treatment clinics with board-certified addiction specialists, are located throughout the state and use MAT. At the hubs, specialists also perform physical and mental health evaluations.¹⁵ Individuals are referred to the hubs in a number of ways that include from hospitals, physicians' offices, treatment programs, and the court system; and through self-referrals.¹⁶

The "spokes," or special care teams, are located in various places throughout the state, including in therapists' offices and drug courts. They provide ancillary services for those with OUD, from general health care to housing or GED assistance, thus providing a continuum of recovery support care.¹⁷

This model expands MAT and integrates addiction treatment into general health care. A recent study of the Vermont system, conducted by the University of Vermont, found, among other things, a 96 percent decrease in opioid use; a 92 percent decrease in injection drug use; and a 89 percent decrease in emergency department visits.¹⁸

Vermont's Hub-and-Spoke Model can be and has been replicated in other states such as Washington.¹⁹ While not in all of the counties in the state, Washington already has seen some progress in helping those suffering with OUD. To learn more about the Hub-and-Spoke Model and Vermont's Care Alliance for Opioid Addiction, go to: <http://www.healthvermont.gov/alcohol-drugs/services>.

Telehealth

The Center for Connected Health Policy defines telehealth as "a collection of means or methods for enhancing health care, public health, and health education delivery and support using telecommunications

technologies."²⁰ Telehealth uses various technological advances from a remote site to deliver "virtual" services to patients. While "telehealth" and "telemedicine" are often used interchangeably, telehealth encompasses a broader array of applications in a greater number of healthcare disciplines, including SUD.

There are four main types of applications used in telehealth: (1) Live video/synchronous: Live, two-way, video interaction between a person and a provider using audiovisual telecommunications technology in real-time; (2) Store-and-forward/asynchronous: Transmission of information (e.g., videos or x-rays) through a secure electronic system to someone who accesses and evaluates the information outside a live interaction and provides an opinion or service; (3) Remote patient monitoring: Data is collected from an individual in one location through an electronic communication system and is transmitted to a provider in a different location for use in the care of the individual, usually once the patient is released home or to a care facility; and (4) Mobile health (mHealth): Health care and education supported by mobile communication devices (e.g., cell phones or tablets) that range from targeted text messages to wide-scale alerts.²¹

The use of telehealth has expanded greatly in the last several years, often providing rural communities with access to, and resources for, OUD treatment. However, none has been more widely hailed and replicated as Project ECHO.

Project ECHO

Begun in 2003, Project ECHO combines primary and specialty care, linking "expert specialty teams" from an academic hub with PCPs in local, often rural, communities. The healthcare providers "meet" via video conferencing or teleECHO™ programs, where doctors in rural settings confer with specialists in academic settings about patient care. Case-based learning at its best, this allows PCPs to treat patients with complex needs within their communities, as specialists share their expertise and provide guided practice assistance and mentorship to the PCPs.²² While a formal teleconference between the specialist team and the PCP occurs on a weekly basis, all of the specialists are required to commit to helping the PCPs outside of the formal meetings (e.g., through emails and random phone calls).²³

Project ECHO addresses over 65 complex conditions, including OUD. Miriam Komaromy, MD, Associate

Professor of Medicine and Associate Director of Project ECHO and the founder of the Integrated Addictions and Psychiatry (IAP) TeleECHO Clinic at the University of New Mexico, delivers a weekly, two-hour teaching module to mentor PCPs about addiction. Topics in the curriculum include: (1) Introduction to OUD; (2) Risk reduction and safe use of opioids; (3) Adverse childhood events and addiction; (4) Introduction to motivational interviewing; (5) Evidence-based screening and Screening and brief intervention techniques; (6) MAT for OUD; (7) Nurse care model and social determinants of health; (8) Office management of OUD (two parts); (9) Co-occurring physical and mental health disorders with OUD; (10) Management of pain in patients who have OUD; and (11) Pregnancy and care of adolescents who have OUD.²⁴

The goals of the program are to use case-based learning to teach PCPs throughout New Mexico how to treat those with SUD and expand patient access to doctors who can prescribe buprenorphine because they have obtained DATA 2000 waivers (see the section on OBOT for details about these waivers).²⁵ Supporting MAT through the use of buprenorphine, the teleECHO clinic recruits doctors for its certified, eight-hour, DATA 200 waiver training. Physicians also earn continuing medical education credits for their teleconferences and trainings.²⁶ One study found “marked increases in the number of waived physicians who practice in traditionally underserved areas in New Mexico” and learned that the state has the “highest per capita number of waived physicians in the United States.”²⁷ A number of other studies have shown similar results. Dr. Komaromy calls Project ECHO a “force multiplier” in helping to address the opioid crisis.²⁸

Other jurisdictions inside and outside the United States have replicated Project ECHO, including for OUD. For example, in an attempt to defeat the statewide shortage of substance abuse clinicians in Montana, in 2016, the Billings Clinic launched its first Montana-based Project ECHO hub in collaboration with the University of Montana. The Billings Clinic has three specialty clinics, one of which is called the Opioid Addiction Treatment Clinic which hosts semi-monthly, two-hour teleECHO meetings. The Opioid Addiction Treatment ECHO clinical team comprised of a board-certified addictions psychiatrist, a board-certified psychiatrist, and an expert addictions counselor provides free “training” in opioid addiction treatment. At any of these teleECHO sessions, PCPs can present actual patient cases, in a de-identified

format, to receive advice and support from the clinical team; learn how to manage a patient who is on a combination of buprenorphine and naloxone (*e.g.*, Suboxone) or injectable naltrexone (*e.g.*, Vivitrol); access treatment guidelines, tools, and patient resources; receive a certificate of training completion from ECHO and American Society of Addiction Medicine; and obtain continuing medical education credits. For more information, go to <https://echo.unm.edu/about-echo/>.

Other Technological Solutions

Many jurisdictions have created their own technological solutions for treatment services in rural communities. The following are three examples, but many more exist.

The Addiction Comprehensive Health Enhancement Support System (A-CHESS) Platform Offered by CHESS Health at the University of Wisconsin-Madison

The Addiction Comprehensive Health Enhancement Support System (A-CHESS) platform is a relapse-prevention technology administered through a smartphone application and is designed to improve continuing care for adults in recovery from alcohol and drug use disorders by providing ongoing support.

A-CHESS can detect impending relapse rather than reacting to a relapse that has already taken place. It is a smartphone application that consists of a patient-facing mobile “connections” application, clinician or peer companion application, and a web-based clinician dashboard. Continuously updated to best serve the needs of the client, A-CHESS is adaptable to existing technological and information systems but requires technical support to do so.

Two features of the A-CHESS application are: (1) the beacon button for when someone is in crisis and can speak immediately to a clinician through the push of a button; and (2) the geofencing feature which the patient hears an alarm when he or she comes within 300 feet of a place that is a relapse trigger.

A-CHESS can identify signs and symptoms prior to a relapse. Patients have found that the mobile recovery support assists their continuing sobriety efforts. For more information, log on to: <https://center.chess.wisc.edu>.

The Veterans Treatment Court of Billings and Great Falls, Montana

Montana has a population density of approximately seven people per square mile. Consequently, most of

Montana's counties are classified as either rural or frontier. Access to health care, in general, and addiction treatment, specifically, is limited. Most individuals with SUDs and involved in the criminal justice system do not have access to treatment. In order to help bridge the geographic and service gaps, Montana has developed several specialty treatment courts. Two of the most successful are the Veterans Treatment Courts in Billings and Great Falls which operate independently with different presiding judges but use identical technologies that help justice-involved veterans and others suffering from OUD.

Approximately 12 percent of Montana's population is veterans, yet Montana has only one Veterans Administration hospital, located in Helena, serving approximately 147,164 square miles. Montana veterans have few options to assist them with their OUDs. Courts Assisting Military Offenders (CAMO), the veterans' treatment court in Billings, is one option that heavily relies on technology to bridge the distance gap and bring services to Indian Country, and rural/frontier communities. These technologies include:

1. Polycom Real Presence – the primary tool for connecting individuals to the court, delivering treatment, and connecting service providers with the court and clients. Using this free, secure application, participants can “call-in” and participate in court and group treatment activities, such as counseling sessions and trauma-informed yoga. Facilitated by a licensed addiction counselor, the court's Post-Acute Withdrawal Support group meets virtually and is accessible throughout the state. There are many uses for this system, including linking doctors administering and overseeing MAT.
2. Drug Court Case Management System – a readily available case management system where court staff is able to add treatment notes and other relevant information to the system. This information is then used as part of the data collection process and as a way for staff members to coordinate with each other remotely.
3. Computer-based Training for Cognitive Behavioral Therapy – a program that allows individuals to receive remote, psychiatric consultations. These consultations allow providers to adjust medication and shorten prescription refill delays.
4. IliveInspired – a secure texting system that sends inspirational messages throughout the day to help individuals maintain sobriety. Court staff use the

program to send messages to participants, update them about their progress, and provide information about additional support services and court dates.

5. SCRAM Continuous Alcohol Monitoring – a transdermal alcohol monitoring anklet worn by participants which provides crucial information such as if an individual uses alcohol. Through the CheckBAC unit that attaches to a smart phone, participants must blow into the unit at random times throughout the day, and the results are sent to court staff. If a positive result is noted, the participant is sanctioned.
6. Wi-Fi pill boxes – medication organizers and reminder systems that send text messages reminding individuals to take their medication. Some of these pill boxes can be used to send missed dose alerts to court staff and treatment staff. Medication checks can also be completed remotely through these boxes to ensure that participants are in compliance with their treatment plans.

In addition to technology, individuals meet several times each week with mentors who help them adjust to civilian life. Mentors also appear in court with participants. Lastly, CAMO's presiding judge also presides over a second drug treatment court working with individuals with OUD. STEER (Sobriety, Treatment, Education, Excellence, and Recovery) is a felony DUI court in which the primary drugs of choice are marijuana and opioids.

Coconino Online Probation Education (COPE) in Flagstaff, Arizona

The Coconino County Online Probation Education (COPE) Program serves a large geographic area, and its purpose is to bring probation services to clients who would otherwise not have easy access to such services, because they may have to drive hours to access such services or do not have access to transportation (*e.g.*, they have a suspended driver's license or do not have a vehicle). The program offers: (1) online probation courses on varying subjects (*e.g.*, substance abuse, life skills, finances and budgeting, and theft deterrence); (2) virtual mentoring; and (3) virtual Moral Reconciliation Therapy. One of the communities served is Tuba City, located within the Navajo Nation.

The County determined where the COPE sites would be placed, where probationers could physically go to access the services that include online courses, mentoring, and support assistance through Skype. It then obtained the space and technology in those communities which

include a tribal justice center, the court building with a conference room used to conduct virtual Moral Reconciliation Therapy, and a site at a neighborhood association. A conference room, desktops, and a smart TV are at each site.

The program received the National Association of Counties' Use of Technology to Bring Services to Clients Emerging Program Best in Category Achievement Award for the Category of Public Safety and Criminal Justice. For more information, go to:

<http://coconino.az.gov/112/Adult-Probation>.

Other Initiatives

Many rural and underserved communities have used strategies without the use of medication or technology to treat those suffering from SUDs, particularly OUDs.

A few jurisdictions use alternative or non-traditional SUD treatment such as yoga and art in their programs. Some Native American programs incorporate cultural norms such as sweat lodges in theirs. Others use whatever resources that may be available to them to help those in their communities attain recovery. While challenges continue to exist, jurisdictions have implemented various types of interventions that can help alleviate the opioid problems plaguing their communities as evidenced by the following.

Certified Recovery Congregations

In June of 2015, the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSA) launched a faith-based initiative called Certified Recovery Congregations to connect the faith-based community with the state's prevention coalitions; recovery courts; treatment, jail and prison, and recovery programs; and Tennessee Lifeline volunteer peers around the state to increase access to resources and to become a resource. Congregations that follow a "best practice model" are recognized as "Certified Recovery Congregations" which offer individuals with SUDs in the state the chance to attain recovery through their faith-based organizations. Begun with 20 certified recovery organizations, the state now boasts over 360. The TDMHSA trains and educates volunteers in faith-based organizations and churches on: (1) how to provide spiritual and pastoral support to those suffering from SUD; (2) the fact that treatment is a disease and not a moral issue; (3) how to embrace and support those

suffering from SUD; (4) providing outreach in the community; (5) how to share recovery information; and (6) housing recovery support groups.

The faith-based initiative actively engages with religious communities as a means of increasing outreach, educational activities, access, and visibility to individuals seeking substance abuse services. The initiative engages places of worship to support and strengthen families in their communities by offering recovery support programs to help individuals overcome their addictions. For more information, go to:

<https://www.tn.gov/behavioral-health/substance-abuse-services/faith-based-initiatives.html>.

CHI St. Gabriel's Health Clinic

In 2014, healthcare providers in the rural town of Little Falls, Minnesota, realized that their community was experiencing an overwhelming problem with opioid abuse and misuse. In each month of 2014, the three local pharmacies were dispensing approximately 100,000 doses of narcotics, and local law enforcement reported that opioid prescriptions written by CHI St. Gabriel's Health Clinic physicians were found at numerous drug-related crime scenes. Moreover, the number one reason why citizens went to the emergency room was to obtain opioids for pain management.

Realizing someone needed to take immediate action, CHI St. Gabriel's Health Clinic activated its long dormant Morrison County Prescription Drug Abuse Task Force, on which sit representatives of local law enforcement, the public health department, social services providers, pharmacy personnel, and school officials. The Task Force developed a plan to reduce the number of opioid prescriptions within the family practice setting, with the following three goals: (1) changing the approach to pain management at the health clinic, emphasizing alternatives to opioids for pain management (*e.g.*, physical therapy or pain-blocking injections); (2) working with police to reduce diversion and street access to prescription opioids; and (3) educating clinicians and the community about the dangers of opioids. The clinic now limits new and refilled opioid prescriptions, and patients who must take opioids on a long-term basis must agree to obtain them from one prescriber only; to take regular urine tests to prove that they are using the drugs "as directed;" and to prevent the resale of the opioids.²⁹

Multi-agency teams collaborate to arrive at solutions to the opioid problem. As a result, inmates in the county jail

may now continue their MAT (of Suboxone, only) while they are incarcerated. Additionally, pharmacists' use of the state's prescription drug monitoring program has been critical to reducing the street supply of illegal prescription drugs.

As of 2017, there has been a monthly reduction in prescriptions for pills, patches, or liquids in the county. One local pharmacy reported a monthly double-digit percent reduction in the number of opioid doses it dispensed, and the Morrison County Sheriff's Office said that there has been a significant decrease in the number of prescription opioids that are available to purchase in drug sting operations. This opioid program led by CHI St. Gabriel's Health Clinic has won awards and citations for its work.³⁰ For more information, go to:

<https://www.chistgabriels.com/family-medical-center/>.

Project Lazarus

In 2007, in response to extraordinarily high overdose rates and based on the premise that a community is responsible for the health of its citizens, Project Lazarus was established in Wilkes County, North Carolina by the county health department and other local organizations. A community-based overdose prevention program in one of the largest and most rural counties in the North Carolina, it offers: (1) coalition formation, capacity building, and sustainability; (2) pain management; (3) safe prescribing practice training and education; (4) education, awareness, and safe usage materials; (5) naloxone kits; (6) medication disposal programs; (7) peer-guided recovery support; (8) diversion control tips; and much more.³¹

Studies on Project Lazarus have found a reduction in the rate of overdose-related deaths and emergency department visits and a large decrease in unintentional overdose deaths in the county.³² Since it began in North Carolina, communities in 24 states as well as military and tribal communities have implemented a Project Lazarus program. The model has won several awards and recognitions. For more information, go to:

<https://www.projectlazarus.org/>.

White Bison, Inc.

White Bison, Inc., an American Indian-owned, not-for-profit organization located in Colorado Springs, CO, provides culturally-based healing to native people. Begun in 1988, its original mission was to offer healing resources to alcoholic Indian youth, but its mission quickly expanded to include raising awareness about and

treating substance use disorders, dysfunctional family relationships, and mental health issues. It developed the grassroots, "Wellbriety Movement," which incorporates community involvement into its sobriety teachings and teaches that in addition to being sober, it is important to thrive in one's community and lead an emotionally, mentally, physically, and spiritually balanced life, committing to "wellness and healing" on a daily basis. Wellbriety circles and meetings take place on various dates and times throughout the United States and Canada. These sobriety circles use evidence-based best practices and are highly successful for many Native Americans. For more information, go to:

<http://whitebison.org>.

Yurok Tribal Court

The Yurok Tribe in Northern California has not escaped the opioid epidemic, so Judge Abby Abinanti of the Yurok Tribal Court uses what little resources there are in the region (*e.g.*, some of the residents do not have electricity) to address the issue. The judge incorporates traditional tribal principles into contemporary jurisprudence for those with SUD who appear before her. Her philosophy is that she will support, but not enable, an individual in his or her journey to sobriety. When someone first comes in front of her, the first thing she asks is, "who is your mom?" because they live in a village society where most people know one another or at least know their families, and "the people who help you resolve your problems are the people you know."³³

She conducts a comprehensive interview of each person to determine what she believes will work best. She may order the person into treatment, but treatment may mean different things for different people. For one, it may mean weekly drug testing and holding a steady job. For another, it may mean regularly attending a 12-step program and volunteering in the community. If she assigns homework (*e.g.*, an essay about what the person's SUD has done to his or her family), she must be mindful of whether the person struggles with literacy. If so, she arranges for a court employee to work with the person in order to complete the homework. However, she almost always asks a defendant to come up with his or her own path to atonement rather than fine or incarcerate the person. Judge Abinanti believes that her "purpose is to help you make it right if you made a mistake. For me, jail is banishment. It's the last resort."³⁴

Conclusion

While a number of barriers to treatment exist in rural communities, there are several innovative programs that can help these communities overcome these challenges. Whether a jurisdiction uses MAT through OBOT or the Hub-and-Spoke Model; telehealth through Project ECHO or a host of other technology-based programs; or other inventive treatment services like Certified Recovery Congregations, there are ways to help those suffering from SUDs wherever they live. With numerous resources upon which to rely, individuals in rural, frontier, or underserved areas can obtain the help that they need to live happy, productive, and sober lives.

The judge requires all of the court staff to put in extra volunteer hours to work with defendants. This may mean driving the person to his or her treatment appointments. Through federal grants, she ensures that all of her court staff is educated on alcohol and other drugs and their concomitant behavior, and requires them to attend substance abuse trainings and view webinars. She also asks individuals who are in recovery and who have been in her court to volunteer their time to help others in the court.³⁵

Recognized by local, state, and federal organizations for her work, Judge Abinanti has seen many successes. She said, “[w]e have to keep going – from case management, to inpatient/outpatient treatment, to follow-up – and make sure these people right themselves.”³⁶ For more information, go to: <http://www.yuroktribe.org/tribalcourt/>.

Resources

American Society of Addiction Medicine <http://www.asam.org>

Center for Connected Health Policy <http://www.cchpca.org>

Centers for Medicare and Medicaid <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html>

Federal Communications Commission: Connect America Fund (CAF) <https://www.fcc.gov/general/connect-america-fund-caf>

Federal Communications Commission: Rural Health Care Program <https://www.fcc.gov/general/rural-health-care-program>

Federal Office of Rural Health Policy <https://www.hrsa.gov/rural-health/index.html>

Healthcare Information and Management Systems Society <http://www.himss.org>

National American Indian and Alaska Native Addiction Technology Transfer Center Network <https://attcnetwork.org/centers/global-attc/taking-action-address-opioid-misuse>

National Conference of State Legislatures <http://www.ncsl.org>

Opioid Misuse Community Assessment Tool <https://opioidmisusetool.norc.org>

Rural Health Information Hub <http://www.ruralhealthinfo.org>

Substance Abuse and Mental Health Services Administration <http://www.SAMHSA.org>

Telebehavioral Health Center of Excellence <https://www.ihs.gov/telebehavioral>

Telehealth Resource Centers <http://www.telehealthresourcecenter.org>

U.S. Department of Agriculture: Opioid Misuse in Rural America <https://www.usda.gov/topics/opioids>

U.S. Department of Agriculture: Rural Development <https://www.rd.usda.gov/programs-services>

U.S. Department of Agriculture: Federal Resources for Rural Communities to Help Address Substance Use Disorder and Opioid Misuse <https://www.rd.usda.gov/files/RuralResourceGuide.pdf>

ReConnect Program <https://reconnect.usda.gov/s/> and https://www.rd.usda.gov/files/RD_ReConnectWebinarFlyer122018.pdf

Endnotes

- ¹ Gale, John A., et. al., "Rural Opioid Prevention and Treatment Strategies: The Experience in Four States," *Rural Health Research Policy Centers*, April 2017, accessed at <http://muskie.usm.maine.edu/Publications/rural/PB63-Rural-Opioid-Prevention-Treatment-Strategies.pdf>.
- ² "Rx Painkiller Overdoses in the United States," *CDC Vital Signs*, Centers for Disease Control and Prevention (CDC), Nov. 2011, accessed at <https://www.cdc.gov/vitalsigns/painkilleroverdoses/>.
- ³ "Medication-Assisted Treatment (MAT)," SAMHSA, U.S. Department of Health and Human Services (USHHS), accessed at <https://www.samhsa.gov/medication-assisted-treatment>. (See also, "MAT," Health Resources and Services Administration (HRSA), SAMHSA, USHHS, accessed at <https://www.integration.samhsa.gov/clinical-practice/mat/mat-overview>.)
- ⁴ MAT, SAMHSA, accessed at <https://www.samhsa.gov/medication-assisted-treatment>.
- ⁵ *Id.*
- ⁶ American Society of Addiction Medicine, Public Policy Statement on Office-based Opioid Treatment, accessed at <https://www.asam.org/docs/default-source/public-policy-statements/1obot-treatment-7-04.pdf?sfvrsn=0>. (See, "Treatment Improvement Protocol 63," *Medications for Opioid Use Disorder, Part 3*, SAMHSA, USHHS, February 2018, accessed at http://www.williamwhitepapers.com/pr/dlm_uploads/SAMHSA-Medications-for-Opioid-Use-Disorders-2018.pdf.)
- ⁷ *Id.*
- ⁸ Drug Addiction Treatment Act of 2000, Title XXXV, § 3502 of the Children's Health Act of 2000 (42 U.S.C. § 201).
- ⁹ "Buprenorphine Waiver Management," SAMHSA, HHS, accessed at <https://www.samhsa.gov/programs-campaigns/medication-assisted-treatment/training-materials-resources/buprenorphine-waiver>.
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