CONNECTING CARE PODCAST // EPIDSODE #13 // TRANSCRIPT

Caring for People Who Have Been Incarcerated: Substance Use Care in the Transition from Jail or Prison

Alex Walley:

In the United States, opioid use disorder is criminalized and therefore people with opioid use disorder are commonly incarcerated, especially people of color. For those entering and exiting the system, regulations related to providing addiction treatment as well as probation and parole rules can prevent people from accessing the proper care they need and paradoxically increase the likelihood of incarceration. Innovation and reform are needed to reduce the barriers and ease the transition out of jail or prison.

Ricardo Cruz:

It's just a way to push to get to system, trying to advocate and counsel and prevent my patients from being involved. Then if they're involved, unfortunately, and they come out, like let's make this transition period seamless. Let's work on this together and little by little try to eliminate these barriers that this history of criminal justice involvement has on leading a normal life.

Alex Walley:

You're listening to Connecting Care. I'm Alex Wally, an HIV primary care doctor and addiction medicine specialist in Boston, Massachusetts. During this episode, we'll build on last month's conversation about providing HIV and substance use care for people who are incarcerated.

Alex Walley:

This month, my colleagues Dr. Jessica Taylor, Dr. Sim Kimmel and I talk with Dr. Ricky Cruz, a primary care physician and addiction specialist who frequently provides care for people transitioning out of incarceration. During our conversation, Dr. Cruz describes how race shapes the systems and policies around opioid use disorder, shares the challenges of providing care for people recently released from jail or prison, offers advice on how physicians can talk to their patients about a history of incarceration and highlights experiences that inspire him in his work.

Jessica Taylor:

You're listening to Connecting Care, the intersection of HIV and opioid use disorder. I'm Jessica Taylor, an HIV and primary care doctor and addiction medicine specialist in Boston, Massachusetts and I'm joined again by my colleagues Alex Walley and Sim Kimmel.

Jessica Taylor:

During our last podcast, special guest Dr. Alysse Wurcel gave us an inside view into correctional facilities. We heard about what's happening inside, especially as it relates to addiction treatment and HIV treatment in House of Corrections. We learned about how things are changing, some of the challenges and some of the opportunities, but we didn't get to talk as much about who gets incarcerated in the first place and what happens after someone is released from a house of corrections.

Jessica Taylor:

Today we're thrilled to be able to continue that conversation and have another special guest, our friend and colleague Dr. Ricardo Cruz, an assistant professor of medicine at Boston University School of Medicine who focuses his clinical and teaching on post-incarceration care.

Jessica Taylor:

Ricky, thank you so much for being here. Welcome.

Ricardo Cruz:

Thank you, Jess, for the invitation and having me here. I'm very excited to have this conversation.

Sim Kimmel:

All right. So we're going to get right into this. Ricky, can you tell us a bit about what you do, how you interface with correctional facilities and people who have been incarcerated?

Ricardo Cruz:

So I'm a primary care physician and addiction specialist. I do the majority of my clinical work at a safety-net hospital, Boston Medical Center. The way I interface with correctional facilities is I have a strong interest in working with individuals, patients, and reintegrating them back into their care after spending time in a correctional institution. So I take care of patients that are transitioning out of incarceration and addressing a lot of their chronic medical conditions.

Alex Walley:

Ricky, could you talk a little bit about your relationships with the people who run corrections facilities, your discussions with them about how to improve the care of people who are incarcerated both while they're incarcerated and when they're released? As you talk about that, I'm particularly interested in your thoughts about the issue of working inside the system versus working outside the system.

Ricardo Cruz:

So I do work with a number of folks that work for corrections institutions. I have a working relationship with our colleagues at Suffolk House of Corrections. This is more sort of a relationship to ensure that patients or individuals as they transition out have a solid sort of discharge plan so that they could come to Boston Medical Center and my clinic to reintegrate back into, or to continue their primary care.

Ricardo Cruz:

In addition to that, we have a strong collaboration with ensuring that our future doctors are trained and taking care of individuals who have criminal justice involvement. This is one topic that really isn't taught in medical school and/or during residency training is how you take care of this vulnerable population. Obviously, we'll get to sort of the complexities and the disparities in healthcare impact this group of individuals. So having a strong relationship with the House of Corrections has been very fruitful in providing an educational experience for our medical students and residents at Boston Medical Center in Boston University School of Medicine.

Ricardo Cruz:

I don't provide care within the system. There used to be a clinic at Boston Medical Center called the pre-release assessment and reintegration in the clinic. I would go in along with one of our addiction nurses and we would meet with individuals at House of Corrections who are in the pre-release state. So this is within like three months of being released and these are individuals with addiction and interested in getting care at Boston Medical Center. We would meet these individuals and do addiction intake and we would sort of figure out what their thoughts are in getting care at Boston Medical Center and what they wanted for their addiction treatment. Once they were released, they could come right over to our clinic that was embedded in our office based addiction treatment clinic. We would have a discussion and NDA treatment with medications to treat their substance use disorder, so this could be for opioid use disorder or alcohol use disorder. Mainly, we would initiate buprenorphine for opioids and/or continue naltrexone if this was given prior to release.

Ricardo Cruz:

So having strong collaboration with the House of Corrections sort of fostered this, sort of program this pre-release case management and assessment piece to our clinic. Then just working very closely with the superintendent there, she's been really sort of adamant about ensuring that future physicians sort of understand the complexities of providing care for this patient population and allowing us to use their site as the experiential experience.

Jessica Taylor:

Ricky, was there ever any tension around being in collaboration with the system when you're seeing patients and how do you navigate that space as a doctor?

Ricardo Cruz:

Yeah, that's a great question, Jess. I think this is something that I struggle with every day, because I feel like this system should not exist. This is a system that for a variety of reasons has disproportionately impacted a lot of people, specifically people of color. This is a system that has harmed black and brown people for a number of years now and continues to harm these individuals.

Ricardo Cruz:

Then when it comes to sort of the addiction perspective, this is a system that has deemed addiction or substance use as a moral failing and as criminalized, a chronic medical illness that I have dedicated my short career thus far to addressing. But nonetheless, the system does exist. There's a huge number of individuals that are tied to this criminal justice system, 2.3 million individuals that are incarcerated in a given time point in this country, an additional four million tied to the system via probation and parole mechanisms. So seven million people are tied to this system.

Ricardo Cruz:

I guess the good news is that the majority of them are going to ultimately be released from this system or from these correctional institutions. A lot of these individuals are at that age where there is a lot of chronic disease, so high blood pressure, diabetes, asthma, COPD, and they're going to need a primary care doctor. So rather than sort of dismissing the system and saying, "I'm never going to work with the system," I feel like we have to collaborate to ensure that these individuals get the best care possible when they're making that transition, because it's so crucial for them to remain in care.

Alex Walley:

It's particularly important and also particularly disappointing with the intersection of race and substance use and how that drives this incarceration system. I mean, that's what sticks out or I think about when I think about my own patients and you kind of talking about your experience and your view on it. It's like not only is addiction stigmatized and criminalized, but it's disproportionately targets people of color, black, Latinx, native people. They're incarcerated at a higher rate, like essentially there's like they don't get a treatment system. They get incarcerated whereas our addiction treatment systems disproportionately are accessible to white people. At least that's been my experience. That's what we see here at BMC. So if we want to try to do something about it, it sounds like what you're saying is we have to engage with this system.

Ricardo Cruz:

Yeah. We definitely have to engage with the system specifically in Massachusetts. I think things are, are improving. We're still putting folks in jail with addiction or, and for addiction. However, they're now being offered treatment in certain institutions. These are individuals that tend not to engage in care for brighter reasons, obviously, a lot of its stigma and maybe some cultural understanding to treatment.

Ricardo Cruz:

But in order to sort ensure that the outcomes are good for my patients specifically, my patients of color is I do have to work collaboratively with the institution. I mean, right now in Massachusetts, things are moving in the right direction with regards to having access to treatment for opioid use disorder. There's these pilot programs, but there's a lot of stipulations to these pilot programs. You have to have been engaged in treatment already in the community to get access to treatment if you're going to be incarcerated.

Ricardo Cruz:

So one thing we can do as addiction specialist is, "Hey, you know what? You might be facing some time in a correctional institution. You're sort of in that pretrial sort of state. Like what have you thought about your addiction? What do you think about how you're going to be treated in this correctional institution? Is there something we can do right now in order to ensure that you get access to treatment in this institution? Because you may not get access if you're not on treatment already and you may have to undergo force withdrawals. So why don't we talk about initiating treatment." So that kind of sort of bypasses some of these stipulations and helps our patients.

Ricardo Cruz:

Then again, too, like we have to like collaborate or sort of partner with the folks in the criminal justice side. As individuals come out, obviously, they're going to be tied to a probation or parole officer or whatever mechanism they're going to sort of be in for a few months post incarceration. Fortunately, the system still impacts how various medical conditions are treated. They somewhat try to dictate it and have a say in how a patient should be treated specifically when it comes to addiction.

Ricardo Cruz:

So there's programs before where they would only limit individuals to naltrexone for their addiction treatment. This has happened to me before where I have a patient come see me, recently released from incarceration has opioid use disorder and was stipulated to naltrexone or Vivitrol treatment. The person was not doing well, was having cravings, not really tolerating the medication, having side effects and wanted to get off. From my clinical opinion and expertise, we had discussion and I thought that the best thing for him would be putting him on buprenorphine and started him on that treatment. Unfortunately,

given the sort of stipulations of probation/parole requiring urine drug testing, his urine drug testing came back positive for buprenorphine and he was ultimately, he violated his parole or probation requirements and ultimately went back to jail.

Ricardo Cruz:

This case sort of shows a frustrating part of the criminal justice system and how they can at times sort of step in our lane as clinicians and try to dictate what patients or what individuals should be doing, what kind of treatment they should be doing. But after this particular incident, if I feel like something's not going to go well, if I feel like my patient is after making this treatment decision or switch in treatment, I tend to sort of advocate for the patient. I'll call the probation officer. I'll call the parole officer and be like, "Hey, this is my medical opinion and the patient is willing to make this change. I don't think he should be punished for this and he needs to remand in the community so that we can work on his addiction."

Ricardo Cruz:

So it's very important to the system is one that is frustrating, but it's one that we need to work with in order to continue to work with our patients and ensure that there's positive outcomes when it comes to addiction.

Jessica Taylor:

Would it be okay if I just rephrase exactly what you said about the case? Because I know some of our listeners may be less familiar with probation, parole and sort of the medical aspects. So Ricky just described a case where the legal system told the patient that they were required to stay on a specific medicine for opioid use disorder, which is not as effective as our two other medicines for opioid use disorder at preventing overdose death. When the patient saw an addiction specialist who recommended a change, he was reincarcerated. So that if you haven't heard about things like this happening before, they unfortunately do happen across the country and we should all be shocked by that. There is no judge, parole officer, court system that should be making medical decisions like that. In this case, it had a really unfortunate consequence for the patient.

Jessica Taylor:

So I just wanted to highlight that because that is so shocking. There is no other disease where a judge gets to say for your diabetes you're required to do this medicine, for your blood pressure you have to pick lisinopril not amlodipine. We just don't see this or hear of this for other conditions. It's of course rooted in stigma and bias against people with substance use disorders, which in the criminal justice system has a larger impact and inequitable impact on people of color.

Ricardo Cruz:

Just to add to that too, Jess, another case of a similar situation is a patient coming to see me and is on naltrexone or Vivitrol and having really severe side of effects, but understands that the stipulation that he needs to remain on this medication and not wanting to come off of it and not wanting to switch and sort of adamant about continuing the medication. This was like a really difficult case because it put me in a sort of an ethical dilemma whether I should continue to give this medication.

Ricardo Cruz:

The oath that I took in becoming a doctor do no harm and I felt like continuing to do this, even though I was going to prevent other harm by him going back to jail, it just put me in this strange predicament. Ultimately, I had to give this medication and I felt horrible about it because he was not tolerating it.

Jessica Taylor:

The most extreme case I ever had in my panel was a patient who came to our Bridge Clinic, who did not have a substance use disorder, but had been provided early release in exchange for receiving injectable naltrexone through a program that no longer exists in Massachusetts and came to our addiction clinic and said, "I need my next shot of injectable naltrexone otherwise I have to go back to be incarcerated," but did not have a substance use disorder. So you can pretty quickly see how programs that are coercive around medications lead to people, either getting best-case scenario medicine that is not optimal for them, which is still a very serious bad situation, but worst-case scenario can end up with people being coerced into a treatment that may not even be necessary in the first place.

Sim Kimmel:

These stories are pretty powerful and just striking how like the tentacles of the correctional system, how it reaches beyond. When you first started talking about these cases, you were talking about someone who wouldn't have access to addiction treatment when they're incarcerated, unless they were on treatment. So you have to counsel some patients that you should try to get on medications, other patients that they, their stipulations that they can't and it just must be so confusing for the patients, confusing for you as the doctor. Just really, really challenging.

Ricardo Cruz:

Yes, Sam, it is a challenging situation. Fortunately, I work in a clinic with a lot of support, the nurses, social workers that are able to support my patients in this transition and are able to make the call. As much as I can, I'll try to reach out to the probation or parole officer to ensure that they understand what the treatment plan is. But I think having a multi-disciplinary team to help take care of these complex individuals makes it a little bit easier, ensuring that you're doing what's best for the patient. You don't feel alone and just sort of taking on the burden in doing that, but it is a frustrating situation.

Ricardo Cruz:

Unfortunately, the confusion that patients or the individuals perceive or experience is it's frustrating that I think it contributes to poor health outcomes. I mean, as you can imagine someone who is arrested and charged and sentenced and spends time in a correctional facility and they have an addiction and no longer have access to that substance and then they undergo significant withdrawals, it's a horrible experience just speaking to my patients about withdrawals. Just because they may be sort of in remission while they're incarcerated doesn't mean that they're not going to have that risk of relapse when they come out, which we know the data that shows that the transition period is a huge risk for relapse and overdose.

Ricardo Cruz:

But this sort of, this experience that these individuals face, I mean, there's a lot of data showing that they may not want to be on treatment once they are finally released from incarceration from a correctional institution. Because they're afraid that I've been incarcerated once already. So my risk of being incarcerated a second time is just as high, is higher. If I'm going to have that risk, I don't want to undergo those withdrawals again, so why beyond treatment. We all know, as addiction specialist, when

someone has a really active substance use and is struggling with their addiction, it puts some increased risk for overdose and ultimately death. So we want these individuals be on treatment.

Alex Walley:

Ricky, is there a particular patient or case that got you interested in the topic of incarceration and racism that got you started on this path and to have this interest?

Ricardo Cruz:

Yeah, Alex. 2015, I was about a year of being full-time faculty at our primary care clinic. Obviously, new primary care doc has a lot of open spaces and a lot of, as we're building our patient panel. So I was, I kind of see a trend in sort of my patients. One patient that I saw this specific day in January was a 37-year-old male who was coming into established care. I just assumed there would be sort of a meet and greet your primary care doc and do a journal physical exam, but ended up being one of the toughest patient cases that day under that clinic session.

Ricardo Cruz:

So he was a 37-year-old black male and as I started trying to build rapport with him and trying to get his story, he basically told me his story that he was actually two weeks out post-incarceration. He spent 17 years of his life. So he's 37, 17 years of his life in a state prison and the past two weeks were not going well. He reported that these were the most horrible two weeks he's ever lived.

Ricardo Cruz:

This is sort of interesting that he's said that because he's in a correctional institution for 17 years. He was trying to adjust to this new world that he was facing. When he left, TVs were those huge tube TVs or no cell phones and so technology had changed. He was complaining about sort of the traffic and people sort of being mean to each other and just honking. He was trying to transition back to a community where he felt he didn't belong. He was homeless. He was staying with his father. He was sleeping on the couch. Well, he had concerns that he would impact his father's housing because he was a felon, to serious health to be a felon that would potentially impact given what he did would impact his father's housing. So he was only staying there for a short time. He was basically reporting depression, anxiety. He was feeling frustrated about this transition period.

Ricardo Cruz:

The one thing that sort of shocked me and that took me aback was at this one point in the interview, he felt like he basically told me he wishes that he could just commit another crime so he could go back to jail where life was so much easier. I was thinking like, "Who in the right mind would want to go back to jail?" It just sort of shows that the struggles that individual with criminal justice involvement has to get back on their feet to transition back to community after this prolonged period of incarceration.

Ricardo Cruz:

He was struggling to get the basic needs, struggling to get housing, struggling to get food, looking for a job. He was not having any luck. This stigma of being a criminal was impacting his future and it just seemed very, he thought that his future was, it was not going to be a bright one. He would rather just go back to a place where he had housing, he had food. Unfortunately, this is sort of like the strange things about criminal justice setting is that social term itself may be addressed for a brief period of time, but this all gets worse upon release, so.

Alex Walley:

So that's the case that inspired you.

Ricardo Cruz:

Yeah. I know it's a sad case. But after writing my documentation on this case and just sort of thinking back, I was like, "Could I have done anything different to help support this guy?" So that just sort of led me to reading, okay, this guy's coming out of jail. What does he have access to? What resources are out there for him? What community organizations are assisting this group of individuals? What should I be looking out for when it comes to depression, anxiety, trauma, PTSD. It was just a lot of things that I didn't know about that I had to read up on and learn more about.

Ricardo Cruz:

Ultimately, what I found was that this is something that's been going on for a lot of years now in this country. Unfortunately, this is some continues to create this structural vulnerability in these individuals, the homelessness, poverty, desperate, poor health conditions and just becomes this vicious cycle.

Ricardo Cruz:

Just to sort of finish up, I think I saw this patient maybe once or twice after this and then within like the first two months of meeting him and I haven't seen him since. I have this very sick feeling that he ended up back where he was trying to get to where life was so much easier. I assumed that he was reincarcerated.

Alex Walley:

It's hard, that's a hard story, but I can see how it drives you. We said before, Jess said that we should be shocked at these stories, but actually they resonate. I mean, this is something that I've heard in my patients as well. So thanks for taking it on.

Jessica Taylor:

So Ricky, the patient you just described came to your office and shared something really profound, which was that they had just left a 17-year incarceration. Sometimes that happens in a clinic visit, but oftentimes people don't just spontaneously share a history of incarceration or other criminal justice involvement because of the stigma that surrounds it, right, and because of the way that the medical community has stigmatized criminal justice involvement and sort of other issues like addiction that we've talked about on this podcast.

Jessica Taylor:

So I'm wondering for those of us that are clinicians or in public health roles or other type of support roles, what's the right way for us to ask about incarceration? I think a lot of us feel, feel that it's an important driver of health for all the reasons that you mentioned and really want to be able to be a resource the way that you just described being a resource for your patient, and also worry about saying the wrong thing or potentially creating an experience of stigma. So I'm curious how you approach this in your practice if you ask everyone, if you don't? What words you use? What language do you think is the right fit?

Ricardo Cruz:

That's a great question, Jess, and you mentioned one of my interests is educating medical students and residents about how to take care of this vulnerable population. I think one thing that I do highlight is we have to screen for this. Because we screen for a lot of sensitive topics every day with our patients, we talk, we discuss with our patients and screen them about risky sexual behavior, risky substance use or substance use, so why not ask for an inquirer about the history of criminal justice involvement.

Ricardo Cruz:

I sort of pose this question to the medical students and residents that I work with and they're like, "Well, I think we shouldn't ask that because we're going to stigmatize a patient and the patient may not like that and then we'll sort of disrupt the relationship and whatever rapport we built. We'll be out, sort of be thrown out the window." I sort of play devil's advocates that we screen for all these sort of sensitive topics that may stigmatized patients all the time, but we do it in a way where we're not stigmatizing.

Ricardo Cruz:

So the way I ask my patients or how I screen regarding criminal justice involvement is I just sort of have a simple conversation. I open it up, "Have you or your family or any of your family members have had any criminal justice or legal issues, yes or no?" Keep it open-ended, tell me about that and then let the patient sort of tell you their story. Then I get to a point where, "Have you had any legal issues and if so, have you spent any time in a correctional institution?" Then I'd say, "Tell me about that experience. How was that? Can I ask how many years of your life have you had to be in the system and just sort of, how has this impacted you?" So I just sort of keep it open-ended.

Ricardo Cruz:

Obviously, I'm not asking have you been in jail, what you did. I think these are things that we shouldn't ask. I definitely recommend not asking about reason for being incarcerated. Then the patient questions, "Why are you asking me these questions?" I just sort to have a conversation and I say like, "Look, a lot of people have unfortunately been affected by this system and this system has negative impacts on health in a variety of ways. It's hard for you to get housing, hard for you to get a job and then if you have medical issues, it's hard for you to pay for your prescription. So, and there's organizations and there's resources out in the community that we can do something about this.

Ricardo Cruz:

It's just about having a conversation. I don't have like a specific phrase I start with, have you or your family, any of your family have any legal problems. I just keep it open-ended and let the conversation sort of play out.

Alex Walley:

Ricky, I've been involved in caring for people with HIV and opioid use disorder for a long time and there has been a lot of loss. But there's also a sense of optimism with HIV and opioid use disorder, because there are effective treatments. Our conversation today, given how grim and equitable and stigmatizing incarceration from the war on drug has been, especially for black, Latinx and indigenous people, why do you focus your work on it?

Ricardo Cruz:

Thanks for asking that question, Alex. Incarceration obviously has disproportionately impacted people of color. You probably have seen the sort of staggering and very shocking sort of statistics like a black male

born in 2001 has a one in three chance of being incarcerated in his life, Latinx male one in six, and then the same sort of disparities exist among women of color.

Ricardo Cruz:

As a Latinx male, Latinx physician, I've sort of have seen these statistics play out in my own family and personal experience. So I have a pretty big family and I grew up with five cousins sort of similar age and it played out. I think I'm the only person that has not been involved in the system. I have personal experience with the system. Uncles and other cousins that the system has impacted and it's a shame. It's shameful. It's frustrating how the system just sort of targets people of color. We see it play it out every day still in the news. We see the horrible cases of unfair policing and individuals being incarcerated for petty stuff. But yet we have folks doing higher crimes and just sort of get to walk out on the street every day and don't get any sort of repercussions from it.

Ricardo Cruz:

So I think that's one thing that sort of drives me to know more about the system and try to help my patients, obviously, prevent them from being involved with the system specifically with those that have addiction. Because, unfortunately, addiction is criminalized, I know we've spoken about this before. So how can I prevent them from being incarcerated and this is sort of like I think it's a component of harm reduction. Like, "Yeah, we don't want them to overdose and die, but again we don't want them to be in jail as well.

Ricardo Cruz:

So I think someone in a conversation that, "Look, you're a black male. You're a Latinx female." Like, "You have a substance use disorder that's out of control." Let's have this conversation. These are your risk. You could potentially do something and be put in jail. I guess it's just a way to try to push to get to system is trying to advocate and counsel and prevent my patients from being involved. Then if they are involved, unfortunately, and they come out, like let's make this transition period seamless. Let's work on this together and little by little try to eliminate these barriers that this history of criminal justice involvement has on leading a normal life.

Sim Kimmel:

Thanks for sharing all of that. It's really powerful to hear and motivating for all of us to do better and to make an impact. If you were to be talking to policymakers or health departments, what do you want them to know? What do you want them to do about this? How can we change this for the better?

Ricardo Cruz:

I think we need to stop putting people in jail for a medical condition. I mean, I think ultimately we need to stop putting people in jail, but it really is frustrating when the best we can do for someone with a chronic medical condition like addiction is to put them in jail. It makes no sense to me. I think these patients need healthcare. These patients need housing. They need jobs. They don't need to be in the jail setting or a prison setting. So that's what I would say to policymakers is we need to stop criminalizing addiction. We need to address this in with humanity, compassion and let's just stop playing political games with people's lives. It doesn't improve people's situations when you put them in jail.

Ricardo Cruz:

Just like with the recent Massachusetts Avenue and Melnea Cass situation here in Boston, it really became frustrating where one of the ways that potentially was going to be addressed was by putting people in jail. I think that was the worst thing to do.

Sim Kimmel:

Thanks for sharing all of that and your thoughts. I've learned a lot from hearing you reflect on taking care of patients and your experiences, and I hope our listeners also feel the same way.

Jessica Taylor:

When you were talking about talking to patients for people of color about the risks of substance use such as incarceration, I have a handful of patients who are black where I've been able to have that conversation. It's a small number. It's patients that I know well where I feel like we've been able to talk about challenging sort of charged, high-stigma topics in a way that has felt comfortable for both of us, at least for that I think. But I will say that as a white physician I feel like I need to be really thoughtful about ensuring that I don't come across as making an assumption. I think about being really direct when I want to talk about racism in the system, having to really name that to make sure that I don't give someone an impression that I'm assuming that they would be incarcerated because they're a person of color, compound trauma and bias and stigma that people have clearly experienced in the system in the past.

Jessica Taylor:

So I don't know. There's no single right answer to that, but I don't know if you have any thoughts on how clinicians and physicians who are white can sort of have these conversations in a way that's sensitive and appropriate and does not increase stigma and bias. We're just recognizing the fact that our workforce is not diverse enough and there are huge power gradients that often exist between physicians and patients coming into care.

Ricardo Cruz:

Yeah, Jessica, I think you bring up a good point and I think is it better to you sort of bring... I think by you doing that obviously, you're sort of demonstrating like sort of allyship and obviously, you're this person's position. You care about this position regardless of whether this is accordance among gender and race and ethnicity. I mean, I assume that you're having this conversation after maybe some establishing some rapport already. So I think it's sort of difficult to come out and first visit and be like, "Hey, you're a black male, so you have a one-in-three-chance of being in jail. You have addiction so you should think about that, like, "Yeah." I mean, I think it's sort of if you build rapport, I don't think you should not have a conversation because I think you're doing a disservice to the patient.

Ricardo Cruz:

I assume that you're going demonstrate that you are caring for this patient. You really care what happens and what their outcomes are. So again, I think just sort of using, addressing it in a not stigmatizing person first sort of patient-centered way is a way to do it. Like I said, like, yeah, there's not enough physicians of color. There's not enough physicians of color who do addiction work to be able to have these conversations with all the people of color who struggle with addiction. So I don't think you should feel that you need to not have the conversation and feel that you're going to stigmatize somebody.

Jessica Taylor:

It's definitely something that I think we should think about this with the profound histories of stigma that people come into medical care with and power radiance and just the inherent structural racism. In a medical center type environment, that's very institutional and ways that sometimes parallels the way that correctional settings function as advance big institutions.

Ricardo Cruz:

Yeah. I guess one thing I didn't sort of mention in this topic is just sort of like the healthcare utilization is really, I guess I don't know for lack of a better term, inappropriate or unnecessary. So a lot of these folks that are transitioning out of incarceration tend to use the ED more often. Because of the stigmatization, the perceived stigmatization of establishing care, they may feel like, "Oh my, that doctor's just going to think I'm a criminal and I'm not going to get the medications I need." So they just go back to the ER, in ER and ER. Obviously, we know that ER is great for emergencies and trauma, but not for primary care, not for building a longitudinal relationship with the provider, so.

Jessica Taylor:

Thank you so much for doing this.

Ricardo Cruz:

Thanks, Jess, pleasure being here. Thanks for the opportunity.

Alex Walley:

You're listening to Connecting Care. Our program was produced today by JSI and Boston Medical Center. Connecting Care is supported by the HRSA-funded project, strengthening systems of care for people with HIV and opioid use disorder. The project aims to enhance system level coordination and networks of care among Ryan White, HIV/AIDS, program recipients and other federal state and local entities. You can learn more about the project and find resources at www.ssc.jsi.com.