Episode 24_Kawasaki_Holden
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[00:00:00] Michael Donovan: Welcome to the Evidence to Impact podcast, the podcast that brings together academics and their research partners to talk about insights and real world policy solutions in Pennsylvania and beyond. I'm Michael Donovan, the Associate Director of the Evidence to Impact Collaborative here at Penn State. In this episode, we'll be discussing the state of the opioid crisis, destigmatization and recovery.

[00:00:23] Michael Donovan: My guests today are Denise Holden, founder and CEO of the Raises Project, a recovery community organization originally started in Pennsylvania and expanded Since then, we also have Dr. Sarah Kawasaki, the Chief of Addiction Medicine, and Associate Professor of Psychiatry and Internal Medicine at Penn State Health.

[00:00:44] Michael Donovan: Just to start things off, Denise, if you just give us a little bit of an introduction on yourself.

[00:00:50] Denise Holden: Hi, I'm Denise Holden, and as you already mentioned, I'm the CEO of the Raises Project, but more importantly, I'm a woman in long-term recovery, and I've worked in the field of substance use disorder since 1984.

[00:01:08] Michael Donovan: Excellent. Thank you so much for being here, Dr. Kawasaki.

[00:01:13] Sarah Kawasaki: Hi, I am Sarah Kawasaki. I am an internist and, addiction medicine specialist, and I've been practicing since 2013. So this is my 13th year in practice treating individuals with substance use disorders, as well as primary care, medicine and, associated infections with injection drug use, HIV and hepatitis.

[00:01:41] Michael Donovan: Thank you for being here today. We'd love to talk about some of the, current dynamics that are, uh, affecting the opioid crisis in America and beyond, if the, if the conversation takes us there. If we just wanna start off, maybe Denise, if you could give us a little bit of, um, you know, your connection to the opioid crisis and recovery efforts, since your beginning, in the eighties.

[00:02:03] Denise Holden: Yeah. Okay, so I worked as a clinician, in treatment facilities for many years, and I had noticed that it got harder and harder for people to be able to stay in treatment. And there was, a term called the recovery movement that I had learned about, and a friend of mine was working in that very closely, and she pulled me into it and I found out that there were actually grassroots organizing going on of consumers and people affiliated with substance use disorder, who were joining together to advocate with anonymity, with governmental officials, the capitals, local capitals, Washington, DC to talk about the rights of people and recovery being violated by not being able to get into treatment. And that is kind of how the raise project got started, uh, was a jump off from being involved with that recovery movement.

[00:02:54] Denise Holden: Um, that was sort of triggered by SAMHSA and the recovery, uh, grants that they gave out in the late nineties, and that's how the raise project got started, as an offshoot of that. And it has just progressed from there.

[00:03:14] Michael Donovan: And, that progression, that evolution over time, uh, especially in the last decade it would be interesting to discuss what major changes have been really observed in the landscape of, of use treatment and recovery. Sarah, would you like to talk about some of the evolution.

[00:03:31] Sarah Kawasaki: Sure. So when I started practicing in 2013, I was practicing in Baltimore, Maryland, which at the time was a serious heroin epicenter and had been for several decades.

[00:03:45] Sarah Kawasaki: You couldn't practice primary care without having a special certification to prescribe buprenorphine, which is one of the medicines used to treat opioid use disorder in your primary care practice in Baltimore City. And so I worked at a safety net health clinic, and, um, treated individuals who were unhoused and who, um, suffered from mental illness and substance use and HIV and hepatitis.

[00:04:16] Sarah Kawasaki: And I learned so much from the people I was working with and the people I was treating. And around maybe 2015, something started to change in the opioid supply in Baltimore. We noticed less and less heroin on people's urine drug screens and more and more fentanyl in 2015. And then I moved up to Central Pennsylvania and joined Penn State the summer of 2016.

[00:04:49] Sarah Kawasaki: And I was going to exclusively practice in addiction medicine at this new position that I'm currently in. And there it was a very different environment. When I first arrived at Penn State, I was actually maybe one of two people, if not the only person who was able to prescribe buprenorphine at the time, given the restrictions.

[00:05:17] Sarah Kawasaki: And, um, that was a very different culture. But as soon as we started prescribing at Penn State, we quickly developed a patient base, there was an obvious need in Harrisburg. And when we opened our opioid treatment program in November of 2017, we started out with a fair number of patients with serious opioid use disorder around that time also, uh, so maybe two years after I started seeing it in Baltimore, fentanyl crept into central pa.

[00:05:57] Sarah Kawasaki: And I started noticing it because there were some people who didn't respond to Buprenorphine as well. There were, it was a lot easier, generally speaking. I mean, individuals are different all over the place, but it was a lot easier to start it, um, a few years prior to that, that it became also, I noticed that people were testing negative for opiates on our standard point of care urines, which are these fast results that we would see in the clinic as opposed to sending it out and people were in obvious opioid withdrawal.

[00:06:37] Sarah Kawasaki: So what were they taking? And it was fentanyl. And this really changed not only the rates of overdose deaths, which were beginning an unfortunate rise at that point, but uh, an apparent resistance to one of the two treatments that we had that really worked for opioid use disorder.

[00:07:03] Michael Donovan: It's great to hear from your perspective in the practitioner space. I'd love to hear Denise, how that timeline tracks with your lived experience, in the Raise project and as a professional in this space. As well as, um, and we were, we talked about the, the localities of, you know, Baltimore City and, and central Pennsylvania, Harrisburg area.

[00:07:23] Michael Donovan: As far as you can, you can speak to the timeline in Florida as well. That'd be very interesting.

[00:07:29] Denise Holden: Yeah, Florida's a lot different than Pennsylvania in so many different ways. So, you know, opioid addiction has been around forever and you know, it, it, it, there were flows over the course of the years where one drug might have been more popular than another at any time.

[00:07:47] Denise Holden: There was the cocaine and crack and methamphetamine and all those other drugs thrown in there, but opioids have always been around. Uh, I think they got more attention when it hit, uh, white suburbia and the upper class white American population. And that's when more funding started getting thrown towards it.

[00:08:10] Denise Holden: And we got a grant in 2007, a reinvestment grant to start using peers in long-term recovery to work as a team with prescribing physicians, the pharmacies, the individuals and the treatment programs they were in, to form a team approach with a peer to help these folks learn that there was more to recovery than just taking a medication.

[00:08:35] Denise Holden: And so that was, that was like earth shattering to a lot of people. No one understood what we were doing, and there was a lot of stigma associated with the use of medications or treatment. And even though methadone had been around for a long time, buprenorphine was relatively new.

[00:08:53] Denise Holden: And, um, people from the recovery community were also stigmatizing that, you know, it wasn't just in general that people thought addicts were bad, or mental health was, made them less worthy. But people that were in recovery thought, oh, you shouldn't do any kind of medication to get clean because that's just another addiction.

[00:09:15] Denise Holden: So we had to educate the recovery community as well. And then, you know, in Pennsylvania there were all kinds of funds coming towards any kind of services, human services in general, but especially towards the opioid, treatment. And when we were invited to Florida in 2017, the reason they asked us to come there was, they had put out RFIs, requests for information for people to apply for these grants to do recovery support services. And no one applied because no one knew what it was, so they asked us to come down and our services

were fairly well known. We had won some awards and things over the years, and so we brought service down here. And the same thing happened here that happened in Pennsylvania. As soon as other organizations started to see the success that we had with the Mars program, Medication Assisted Recovery Services and recovery support services in general down here and up there, everybody wanted to get into the game and it made things a little more blurry and crowded the field.

[00:10:27] Denise Holden: But that's basically what I've seen happen.

[00:10:33] Michael Donovan: Yeah, so really some interesting policy issues going on in terms of access to grants. And also I know that from past experience around working with uh, the Pennsylvania Department of Health, and PAC Mat involving, access to, uh, medication assisted treatment is, is certainly, uh, not as simple trajectory, and there's a lot of heterogeneity across the states and how they have approached that access question. It's very interesting to think about, the community not being ready for, the grants that that's, uh, a capacity building issue that needs to be done. It's really wonderful that, your organization was able to come in, and support that.

[00:11:11] Michael Donovan: I want to kind of orient a little bit because we could go in so many directions. Speaking of supply and demand around, uh, fentanyl and the, uh, incursions across borders, this is such a multifaceted challenge, a wicked problem that I really want to try to stay as focused as we can, even though my mind is running in different directions.

[00:11:29] Michael Donovan: But, I'd love to talk a little bit about, the concept of addiction, as chronic brain disease and, some of the, the misunderstandings associated with that. And then also, getting to that piece, on, stigma that you mentioned, Denise, really thinking about, how the, the concept as you changed over time as, when MAT or Buprenorphine were, available.

[00:11:49] Michael Donovan: There's potentially a stigma around even, the medication, right? I'd love to talk about maybe Dr. Kawasaki, if you'd talk about the misunderstandings around chronic brain disease, that would be maybe a good place to start.

[00:12:05] Sarah Kawasaki: Sure. So, addiction in this country really up until about 20 years ago was treated like it was an acute problem that needed an acute answer. So a good analogy would be like a knee replacement. You need a knee replacement. You go into the hospital, they change out your knee, and you're finished. Similarly with substance use disorder, and in particular, opioid use disorder, people would be sent to your prototypical detox facility for 28 days and they would give them counseling.

[00:12:48] Sarah Kawasaki: They maybe would give them some medicine to help with symptoms of withdrawal, and then after 28 days, they spit you out into the community with no aftercare, no real investigation into what support systems would be needed to maintain that sobriety. It would sort of be like if we did that for high blood pressure where we, instead of starting somebody on medicine right away, we would send them to a 28 day facility where we

would feed them unsalted clay for 28 days, and then at the end of 28 days do no investigation as to the kinds of food that would be available in their neighborhood and send them out in the community. Never mind that there are these award-winning medicines that can prevent stroke and dialysis. If they needed those medicines, we would say you were weak and you couldn't do it on your own.

[00:13:51] Sarah Kawasaki: And that's exactly what we did for opioid use disorder for a really long time. So we had methadone since the seventies and buprenorphine came out in the two thousands to be able to be prescribed out of doctor's offices and still a lot of the social stigma said, you know, we need to make sure that people have access to the 28 day detox programs because that's the gold standard.

[00:14:18] Sarah Kawasaki: When really all the survival statistics found that specifically for opioid use disorder medication is what kept people alive. Hand over fist. If these were cancer studies, it would not even be ethical to have placebo control trials anymore. So, um, wasn't even close. So for the longest time as. A physician, I would be reading, you know, obituaries of people who died from overdoses.

[00:14:50] Sarah Kawasaki: And in my head I was like, why aren't they on treatment? I mean, it was sort of like if I kept reading AIDS obituaries today when we have quite incredible treatment for HIV these days. So, you know, it wasn't until about 10 years ago where the journalism really shifted. Suddenly people were asking, why aren't people on these meds?

[00:15:17] Sarah Kawasaki: What's going on with the stigmatization of the medication and where, how can we make it better? Um, I think even within. The treatment community and with the doctors there was demonization of methadone preference for buprenorphine and not everybody is one size fits all. We have 20 different medicines for blood pressure and we have about a hundred different ways to treat depression.

[00:15:48] Sarah Kawasaki: But we have two working medicines to treat opioid use disorder for a really lethal illness. And it's important that we look at objective evidence instead of relying on feelings.

[00:16:04] Sarah Kawasaki: That was long-winded, and I don't even know if it was the question you asked.

[00:16:09] Michael Donovan: I love it. It was, it was really, really robust and comprehensive, and I think it really showed, the challenge of where public opinion and prejudice and stigma, can then contributes further and further along into a spiral, uh, a wicked spiral that, that doesn't end up supporting, those who are in need.

[00:16:28] Sarah Kawasaki: I want to try to, I can tell you, do you mind if I tell a quick story about how I, how I first met Denise?

[00:16:30] Michael Donovan: Oh, please. Absolutely.

[00:16:59] Sarah Kawasaki: So I, um. I came to Central Pennsylvania in 2016. I was introduced to a lot of the treatment providers in the area, and one of them was the RAISE project. Um, additionally, with all these grants coming out of the state, instead of the Pennsylvania Coordinated Medication Assisted Treatment grant, I Immediately got to working with the RAISE project and, started working with peers that came out of the organization. And initially there was a lot of insistence on the use of Naltrexone, which was an opioid antagonist for, individuals with opioid use disorder. And when we got the money for this grant, I remember meeting with you, Denise, and saying, Hey, um, hey, so we have this money and I'd really love to work with your organization and how can I convince you that Buprenorphine and methadone help people and not trade in one addiction for another? And Denise from the outset was completely amenable to all sorts of, information and suggestions and already knew it, to her credit, she was thinking ahead of her time. But, um, but I'll have Denise speak to that interaction.

[00:18:08] Denise Holden: It's when, well, I remember too when we met, and I have to say, of all the people I've worked with, Sarah is one of the kindest, most intelligent and least arrogant people I've ever met in my entire life. And she's so smart and knows so many things. I've learned so much from her. Um, because I had a little bit of, stigma myself against methadone when I first met her, and she explained to me. What a great medication it was and how many lives it saved. And it was just great working with her and our peers went to the program she was running and, you know, worked with them. And that, that's the key is, is putting the peer into the equation along with the treatment provider and the doctor.

[00:18:50] Denise Holden: And because individuals who suffer from any kind of addiction, you know, are un they, we don't trust anybody, and you could tell us the sky was blue. If you're a, a psychiatrist or a doctor, and we're not gonna believe you, but if someone in recovery says, Hey, I did the same thing you did, and the sky is blue, then we'll believe that.

[00:19:11] Denise Holden: And so you, you build that rapport with them and then you work as a team with the doctor and you know, the individual and the treatment program and, and you, you start getting a, a working relationship for everybody and the person being treated is told the same thing by every single person that they run into.

[00:19:31] Denise Holden: And then they start to believe that message that they're getting, that maybe they can change and, and maybe their life would be better and maybe they can stop using and maybe they can stop stealing their kids' toys at Christmas time so they can continue to get high and they can become better parents and they can overcome the trauma, you know, that they experienced as, as, as children.

[00:19:54] Denise Holden: And, 'cause that's a big stumbling block for a lot of people that are trying to get clean and, you know, when they get that kind of approach and treatment from everybody that's in their, in their treatment team, you know, they start to get better and, and, and believing in themselves is, just a magical thing.

[00:20:13] Denise Holden: Once that starts happening, you start seeing great changes happen.

[00:20:23] Michael Donovan: Thank you both for sharing such a wonderful anecdote, and really have seen that a trust is the foundation for much of this. And you brought to light Denise as well, you know, that stigma is, is multi-directional that, that folks in the, the peer recovery community may have a stigma against medical providers, uh, may have a, a stigma against law enforcement.

[00:20:43] Michael Donovan: There's, there are a number of different places where, working on talking the same language and, and trying to meet where you can and can go a long way, to reducing that prejudice and, and getting to a place where mutual outcomes, are positive for all. I wanna to be fair, and talk a little bit about the situation that's a particular challenge.

[00:21:05] Sarah Kawasaki: Sorry to interrupt, but to be fair, there's, there's really good reason if a peer has, quote, unquote, bias or stigma against medical professionals and law enforcement. This is a very marginalized population who has all too frequently been made to feel like their addiction is their own faults and a lot of physicians and advanced practitioners have treated individuals with substance use disorders horribly. Those stories get propagated in the community and people develop genuine fear and substantiated fear of medical personnel and medical advice, and that's the work of an addiction medicine doc is to recognize it, validate it, acknowledge it, and help to undo it.

[00:22:03] Michael Donovan: Yeah. Another example of you know, working across and within and on the boundaries of sectors is really so important, to getting into outcomes that are positive because working purely in an environment of the medical community is leaving out those in, in recovery leaving out law enforcement and, how the, the entire system of recovery could be improved in different ways.

[00:22:26] Michael Donovan: I want to go a little bit further into, uh, of the very complicated space of co-occurring addictions or, co-occurring, uh, disorders, for example, and how that's unpacked in the medical community, and then also from peer recovery. How are you able to do your best to isolate one, challenge that, and, and attack it in different ways.

[00:22:51] Michael Donovan: I'd be curious to hear a little bit of that. And then also, Denise, I'd love to hear afterwards a little bit of, you know, your experience, with co-occurring disorders as well, but Dr. Kawasaki, maybe from your perspective first.

[00:23:05] Sarah Kawasaki: Sure. I was taught in medical school, and a lot of people were taught in medical school that you can't diagnose mental illness as long as a person is actively using substances, and you need to ideally wait for somebody to stop using substances for a certain number of weeks before getting an accurate psychiatric picture.

[00:23:29] Sarah Kawasaki: And so I went through my bubble and my channels and thought, well, this is very cut and dry. If they're using substances, it's for sure substance induced and we have to wait until the clouds part in order to see what's going on underneath. Flash forward and I'm working in practice, it is really hard to have individuals with co-occurring illness stop their substance use disorders for long enough to make a diagnosis, and chances are they've been given diagnoses when they were younger, which may or may not be accurate.

[00:24:09] Sarah Kawasaki: But in the end, the risk of starting many, if not most of these meds is far, far lower than the risk of letting untreated mental illness continue. So, the new school of thought is you treat both at the same time and you eventually, when the clouds start to part, you peel away what meds are unnecessary. And so as long as you're using one of the hundreds of meds, I mean, I'm sure it's less, but it feels like hundreds of meds to treat individuals with the least possible side effects and harm as possible. Once their substance use is under control, you can see whether their mental illness alleviates, in other words, is purely substance induced versus comes out more or was masked or medicated by the substances they were using.

[00:25:14] Sarah Kawasaki: And so, um, I strongly feel that treatment needs to start right away, even if it's messy because people need the maximum support right out of the gate.

[00:25:31] Michael Donovan: Denise, how does the peer recovery community really address these, really complex challenges? And, I'd love to hear, from you, just your, your background in it.

[00:25:41] Denise Holden: Well, I totally agree with, uh, Sarah that they do need to be treated at the same time right away, and there's been a lot of, uh, bad things that happened to people over the years in treatment facilities where I remember in the early eighties when I went into treatment, they made all, everybody that was taking a mental health meds stopped taking them, and people literally were coming apart.

[00:26:05] Denise Holden: It was, it was awful, and they, we've learned some things over the years, thank goodness. And so in the recovery peer world, we don't try to treat mental illness because we're not clinicians. We don't wanna make any mistakes, so we support them in whatever avenues that they're involved in.

[00:26:28] Denise Holden: And so we don't try to make them stop taking their mental health meds, but then there's, and there are a lot of people who have both, you know, that experience both, but not everybody does. And so there, there are some misconceptions about that as well, that everybody that uses drugs also has a mental health issue and vice versa.

[00:26:49] Denise Holden: Because they can exist on their own too, but we don't try to in, you know, tell them to stop taking it or you don't need to do this. Oh, you know, you got diagnosed when you were using drugs, so you probably don't have a mental illness. We try to support them in whatever, you know, situation they're currently en engaged in and, and not detract from that or try to meddle where in things that we don't understand.

[00:27:16] Denise Holden: So, it's, it's very interesting to watch people though as they evolve and become clean and stable on both, in both arenas and how they blossom and flourish. And so that, that's our goal is just to help that. Occur naturally and support it and encourage it.

[00:27:40] Michael Donovan: Such important work. Thank you so much for that.

[00:27:43] Michael Donovan: You touched on something, Denise, that I think we both, both of you could really give our, our listeners a little information on, around misconceptions. We've talked about them a little bit before and you know, the stigma associated with prejudice, um, and you know, some big ones that, that you mentioned around the assumption that those who are are abusing substances are, are also mentally ill in some ways, you know, these co-occurring challenges. But what are some from your experiences? Just some major misconceptions that you're hearing in, the clinic insofar as you can say and, uh, you know, out, out in the world.

[00:28:21] Michael Donovan: And that could be, uh, for Dr. Kawasaki to start.

[00:28:25] Sarah Kawasaki: Sure. I'd say the biggest one is that if you're no longer using illicit opioids, and now you're on methadone, you have traded in one addiction for another, same with buprenorphine. I think that that trading in one addiction for another is the biggest myth.

[00:28:46] Sarah Kawasaki: It has been used by people at the highest level of politics, it has been used to drive policy for a really long time, and it's just simply not true. Addiction is a complex behavior that is also seen on MRI scans of the brain. So it's in the Mesocorticolimbic tracts where, um, you know, addiction really revolves around pathologic craving and unwanted wanting that keeps you using in spite of very severe consequences to work, to personal freedom, to personal health, to personal safety, and to family. And that involves selling your body for drugs, stealing whatever it takes to get hold of that next. Dependence means anything that your body needs to sustain its health, and so we can say that somebody depends on methadone because it is given in a controlled setting in a, in a licensed facility with quality controlled medicines under the supervision of a physician and we can say that about methadone, but we can also say that about any medicine for any chronic illness because if you were on blood pressure medicine or diabetes medicine and you stopped those medicines, you would still need to be seen in the emergency room with consequences from not being on them.

[00:30:18] Sarah Kawasaki: So, depending on a medicine is very different from being addicted to a medicine, and so sometimes people will also erroneously call babies born from mothers using opioids, addicted babies. As far as I know, they're not capable of selling their bodies for drugs. So those babies are born dependent and just like we can depend on any medicine that's administered through a clinic. People are dependent on methadone and buprenorphine, but they are not engaging in the risky behaviors that are found in addiction.

[00:31:05] Michael Donovan: Thank you. Anything from you, Denise, on misconceptions.

[00:31:10] Denise Holden: We run into the same kind of thing. Uh, and I, I already mentioned how people from the recovery community and other, you know, who did it through abstinence, uh, and still go to certain meetings and, you know, for support, think that people are exactly what she said, addicted to methadone or addicted to buprenorphine.

[00:31:29] Denise Holden: And we try to address that by pointing out the fact that we're, that these medications save people's lives. They become better parents, uh, that they stop stealing their children's toys. They stop committing crimes to get high. They start working. They start becoming productive and contributing members of society.

[00:31:54] Denise Holden: They, you know, buy houses. Their lives improve and they stop killing themselves through u the use of drugs or, you know, engaging in behaviors that caused them harm or could kill them. And we just keep repeating that over and over and, you know, use, use the examples of how, how this person's life, you know, used to be over here and now look at them now.

[00:32:23] Denise Holden: Does that look like an active addiction to you?

[00:32:31] Michael Donovan: I want to pivot to a, a really, really challenging area here as we discuss, the challenges around ever increasing funding scarcity to support programming, uh, to support these, these individuals who, are in recovery or, hopefully on the path to recovery. How do we work in an environment of ever increasing economic scarcity for, for this type of program, while at the same time working to deliver equitable service to communities that are, are hard to reach? Whether they be rural, geographically distributed, uh, whether they be, people of color who have a, maybe have a history of, prejudice or fear, well-founded fear of being involved with a law enforcement or, or the medical community. It's really around how do we make our interventions as cost effective as possible, or what do we look for that, that really effective silver bullet, right? There's no silver bullet, of course, but how do we deliver the best care and the best way to keep people, on track? There's a big one. It's mm-hmm. Uh, it's complex, and there may not be an answer, but I thought we'd bring it up as, as it's a challenging environment right now.

[00:33:49] Sarah Kawasaki: Yeah. Um, I think that there's several barriers, and some of them can be resolved locally and some of them need to be resolved systemically. The original barriers not so long ago when it was not funding that was a barrier, was getting addiction to be seen as a treatable illness that can be treated in various different medical male use, such as when they're admitted to an acute hospitalization for any reason or if they are seen in the emergency department for any reason.

[00:34:31] Sarah Kawasaki: And um, where patients can get started on medicine and continue later in a different treatment setting. All of that has really, changed. I think the landscape has really changed dramatically. The emergency room is now very well equipped and aware of patients coming in, reporting withdrawal, and starting them on medicines.

[00:34:57] Sarah Kawasaki: They're aware that this is lifesaving treatment, this is settled science. They know that they can, treat them effectively and safely when they're in the emergency room. Many more treatment facilities have opened, including outpatient treatment. Addiction is starting to be more and more integrated into primary care services so that it doesn't need to become a separate, physician visit that somebody needs to make or fit into their busy lives.

[00:35:28] Sarah Kawasaki: There's low barrier treatments that are available in different vulnerable communities such as mobile clinics or, convalescent treatment for individuals who are unhoused, people going into different communities. However, a lot of that treatment relies on grant funding and it relies on people who are in positions to be able to fund those programs who really believe in those programs.

[00:36:00] Sarah Kawasaki: Part of, uh, these treatments is the ongoing investigation for future treatments because again, we only have two working medicines to treat opioid use disorder. How do we expand our armament to be able to treat individuals. There needs to be robust funding continuing for research. So, Denise had mentioned the substance abuse mental health services administration as the, fire starter for the raise project, SAMHSA no longer exists, and I'm worried that, centralized funders like SAMHSA will, um, let a lot of the progress we've made slip back. Additionally, research in general is being threatened because of the overhead reduction in grants, um, from about 65% to 10%, and so that's a huge, huge drop. And um, this means that huge machines and buildings and people that make all these studies possible will be challenging to continue.

[00:37:16] Sarah Kawasaki: Because these are economies that universities are used to working in that's gonna take a toll not only in cancer research, but also addiction research and all kinds of different research. And that has real chilling and cascading effects as well. And finally, a lot of these treatment programs that have off opened depend on Medicaid because Medicaid insurance treats the poorest individuals in the United States, but it's also the treatment for individuals with substance use disorders in many of these treatment facilities. And if we see substantial cuts to Medicaid, it's going to be a death spiral, not only in allowing individuals to have access to treatment, but allowing treatment facilities to exist in the first place.

[00:38:11] Michael Donovan: Thank you for such a comprehensive response. I think it, it's really such, a good summation of some of the challenges, in front of us, uh, currently. Denise, any thoughts, on, solving the multi-billion dollar question here?

[00:38:26] Denise Holden: I don't know how to solve it, but I do know that there's a great deal of fear right now because as Sarah said, the one of the largest funders is ceasing to exist now and because of those fears, we are, we're a nonprofit organization and we offer many, many services for a variety of people. We work with children and youth programs, so parents that are in danger of losing their children, we help them stop using drugs and, and get clean. We work in emergency rooms, and do a warm handoff so people that come in from an overdose can immediately be sent to treatment.

[00:39:05] Denise Holden: We have training and education, and several door to door programs, uh, prison, prison medication programs, all kinds of programs. In Florida, we go into the homeless camps, which are huge down here because you can live outside in Florida almost all year round, except when there's a hurricane.

[00:39:28] Denise Holden: And the, the addiction problem is enormous. We are the kind of organization that work with people that no one else wants to work with. A lot of times they are at the end of their, there's nowhere else to go down. And if that funding is lost, so will those people be because of the fear from like the state funders and the county funders.

[00:39:54] Denise Holden: Now all our contracts, which would be due, July one, because we run on a fiscal year of July one through June 30th. Instead of giving us the normal process where we write a new budget and you know, we submit the new services that we wanna offer to these funders, they're all saying, look, we're gonna give you a six month extension right now.

[00:40:16] Denise Holden: Hoping, praying that that funding stays intact. And if it does, then maybe in six months we can review it and, you know, go through the normal process. Or maybe there won't be any funding because everyone right now is afraid of the cuts coming down the road and who's gonna be next to go. So these are vital services that should not ever stop, but are very much in danger of being discontinued at this point. And we're all just praying and hanging on a hope and a prayer that things are gonna get better and not worse. So that's where we're at, and I don't have, well, there would be a solution if all the rich people in the world donated a lot of money to the poor people in the world, but that probably isn't gonna happen.

[00:41:08] Denise Holden: So that would be the only thing I can think of at this point.

[00:41:12] Michael Donovan: We have a lot of work to do and a lot of a lot of support to be given. It, it really is so valuable that, that you all are doing the work that you are doing. So, really grateful for that, and, to bring to light the, uh, precarious state that so many people are in.

[00:41:29] Michael Donovan: I do want to think about the other side of the coin here. What about, what's hopeful for you? What is hopeful for you both in your own experiences, thinking about the next year? And one thing I did want to make sure to bring up is, you know, some of this complex, data that is coming through and I was wondering if you all could demystify it for our listeners, but the understanding that roughly a 27% drop in overdose deaths in, the US, as of last year, so lowest level since 2019, according to, the Centers for Disease Control and Prevention. We're talking about 30,000 fewer people who lost their lives last year to overdose. So if we have to think about some, silver linings, we, I'd like to unpack that a little bit if we could.

[00:42:23] Denise Holden: I can speak to that a little bit. So. I, I really hope that, that it is not misconstrued that opioid use disorder has gone away because of the reduction in overdoses. That is not the case, but what has happened is almost everybody in uh, recovery, community organizations and also in treatment programs have been given access to Narcan, and we have

literally saturated everyone. Um, we take it to emergency rooms. We give it to every participant that comes in the door, whether they're in recovery or not. We make it available in vending machines, in police departments, or on the corner in different towns throughout the United States. We hand it out at every training that we do, and we have, like I said, literally saturated the market so people are able to stop the overdose as it happens. And so I think that is a large contributor to the reduction in in overdoses and overdose deaths in the United States.

[00:43:38] Sarah Kawasaki: I think there's a lot to be hopeful about. I think we've made a lot of strides in terms of overdose reduction because of naloxone availability. I think that the advent of new and different treatments, such as injectable buprenorphine has certainly helped to play a role, um, because I do think that that has protected people from some overdose deaths, at the same time.

[00:44:07] Sarah Kawasaki: The pandemic has significantly abated and so people are no longer isolating and they can, you know, rejoin, uh, groups that they had been missing for a long time. And the numbers that we saw from people relapsing after sustained recovery was huge during the pandemic. And that may have been a self-limited circumstance because of what was going on in society at the time. But I also think that the increased funding that we've seen for peers, the interconnectedness that we see between addiction clinics and general medical clinics, the care coordination that we're seeing between emergency departments and inpatient facilities and outpatient facilities.

[00:44:58] Sarah Kawasaki: Now, the treatment that we're seeing that's suddenly available in different settings, and, medication that's now available in inpatient settings for treatment, induction versus detox has really made a big difference. I think that people know more people now who are on medicines, the medicines are becoming less stigmatized.

[00:45:24] Sarah Kawasaki: All that stuff is really, really important. I am optimistic. You know, I hope addiction is eminently treatable. You know, we need to be able to provide the care that, given the tools to provide the care to people who need it, when they want it and when they need it. And we need to be able to do that.

[00:45:49] Sarah Kawasaki: So, so I'm looking forward to that. I Worry about our funding sources moving forward. There are significant private sector funds that are becoming available because of the opioid settlements. That said, sometimes they're going into the hands of, uh, individuals who don't really understand what's gonna give them the most bang for their buck in terms of, uh, treatment availability and kinds of treatments to be available.

[00:46:23] Sarah Kawasaki: And by that I'm speaking specifically about medication and, um, I am continuing to do this work. You know, I want, I think what makes me continue to do this work in the face of all these challenges is being able to help individuals. At the end of the day, it's, you know, me in the room with a patient and being able to tell them that they can regain their lives back without getting severely ill themselves is a tremendous relief to them, and it's incredibly inspiring to me.

[00:47:05] Michael Donovan: Thank you both. It does show that there is some, silver lining that we can kind of orient towards and try to motivate our actions too. And to that point, I, do want to try to address what can our listeners do to think about. How they could be involved in supporting those, with substance use disorder, those in the recovery community to support destigmatization and overall effective responses.

[00:47:32] Michael Donovan: I mean, just off the top of my head, the big one, there seems to be some policy levers that need to be pulled. So, I think that, uh, our listeners could certainly be thinking about, connecting with, their Congress people, whether they are, in Washington or, Harrisburg or Tallahassee or, everywhere else thinking around how we could be directing funding, how we can advocate for, funding being, left untouched or even increased. And also interesting, Dr. Kawasaki, around the point on focusing on directing opioid settlement funds to evidence-informed practices and interventions.That's a, a more subtle uh, ask, I could say.

[00:48:11] Michael Donovan: And then also, you know, thinking around, the higher education community, thinking about the, collegiate recovery community, at Penn State, their sister programs in, other communities. Those are just some ideas, but I, I don't know if either of you had some other contributions to put in there around how we could give some efficacy, and some, kind of actual self-actualization here for our, listeners.

[00:48:38] Denise Holden: You were absolutely right, people need to call their senators and their representatives, and tell them, don't take that funding away. Please support what's going on, increase the funding. Those are definitely helpful. Advocacy has done a lot, and has made this whole thing possible. That's how it got started in the first place.

[00:49:02] Denise Holden: People tend to not look at, there are many other things that are important too. And so they don't wanna, just focus on substance use disorder, but I think they need to realize that it does affect every aspect of society, every corner of it, every family, whether it's one of your loved ones or not, that's engaged in it.

[00:49:25] Denise Holden: The behaviors of the people that are affect everything that you do. The cost of your insurance, your medical costs, everything is affected by that, and so it is very important that we don't lose the funding. And that we find new ways, new avenues of funding. To get it, to keep it in place.

[00:49:48] Sarah Kawasaki: I do think that there is significant moral injury that comes from trying to find funding to do what's basic and what should really just be necessary for all patients experiencing substance use disorder. It's disheartening that I need grants to pay for bus tickets so that people can come to clinic every day and get their treatment.

[00:50:18] Sarah Kawasaki: It's really frustrating that patients who are in treatment don't have housing. I want my patients to be able to have access to a shower. I want so much for patients, and these are just basic human dignities that we are resourceful enough certainly to keep

searching for funds, but if societally we're not moving in that direction, it can become very, very, disappointing and harmful for the people doing this work because ultimately we wanna be able to have these things to offer people, and if we can't offer them, what, you know, how much good are we actually doing? And I wanna make sure that people can live sustainable lives or at least survive to the point where they can sustain themselves.

[00:51:26] Sarah Kawasaki: And that initial survival is where is the space in which Denise and I work. And that needs to be adequately funded for the rest to be possible.

[00:51:43] Michael Donovan: We, we all need to think a little more lately about how we can go back to our common humanity and think about the reduction of suffering of others, as much as possible and bring that change to our daily lives and, to our our systems that we're all a part of. I do want to be thoughtful of, our time and I want to provide, my guests with opportunities for, any, closing reflections, fully open-ended, anything that you'd like to, leave our guests with.

[00:52:17] Sarah Kawasaki: I just wanna say that people are treated and get better every day from substance use disorder, it is possible to recover. It's possible to recover on little to nothing, but it's also possible to recover on heavy medicines, and either way, it's still recovery. If you have your life and you have your ability to regain employment, to get housing again, to reconnect with family who wouldn't jump at the chance.

[00:52:50] Sarah Kawasaki: And it's, you know, I love doing my work. Whenever I tell people what I do, they initially say, oh, that must be so challenging, and I say, it's so satisfying to see people do well because it is. People do well more often than they don't, and so as long as they start treatment, they can get better.

[00:53:12] Denise Holden: And I agree a hundred percent recovery is possible.

[00:53:16] Denise Holden: And we're walking right next to you, and you may not even know it, that people that had a past that was filled with all kind of criminal behaviors and, and life threatening illnesses are now working next to you, parenting next to you treating you as your doctor, as your attorney, as the teachers that work with your children, there's a lot of recovery everywhere, and it's very important that we continue to make that option possible for people to turn their lives around.

[00:53:44] Denise Holden: And, I'm just really grateful that we had this opportunity to, to discuss this. So thank you Michael and Dr. Kawasaki.

[00:53:56] Michael Donovan: The Pleasure's Mine. Yes. Thank you. Thank you. And with that we'll bring this episode to a close. I was able to hear and see the passion that both of, these individuals bring to their work.

[00:54:08] Michael Donovan: And, I hope our guests will be able, to absolutely hear it, over the airwaves. Many, many thanks to my guests and thanks for their important work to Dr. Kawasaki

from Penn State Health and Denise Holden, the founder and CEO of the Raises project. Thank you both for your time today and the important work, that you all do.

[00:54:30] Michael Donovan: And, we'll be, thinking about how we can bring our common humanity back to the forefront more and more. Thank you.