

THE METHADONE MANIFESTO

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The Urban Survivors Union Methadone Manifesto is a document written collaboratively by members of the Urban Survivors Union (USU) methadone advocacy and reform team, an organizing team composed of current and former methadone patients and our allies. We have come to a consensus on many policy issues based on our shared scholarship and lived experience. However, we are all different people, from different socioeconomic backgrounds, with differing and evolving ideologies, and these differences may be apparent to any reader who compares and contrasts different sections of the document. This text reflects our collaborative writing process. Furthermore, the Manifesto is a living document which is subject to change and elaboration. We in no way intend the current version of the Manifesto to be a comprehensive statement on all of our methadone policy stances and analyses, and we expect to continue to add to and amend this text long after its release.

We hope that this text will inspire further community directed research on topics relating to methadone which have suffered from little study, led by groups of people who use drugs and methadone patients working in alliance with academic researchers.

While much of this text is based on citations from peer-reviewed literature, the USU methadone advocacy and reform group also sought to fill in research gaps on vital areas in methadone treatment through experiential knowledge, knowledge based on our own experiences as well as our experiences advocating for hundreds and thousands of other methadone patients. For example, while there is little research on how patients in pre-existing relationships are treated by clinics and how people with ambulatory disabilities have difficulty accessing clinic facilities, we reported on these topics based on our combined years of accumulated knowledge as patients, advocates, and organizers. Methadone is a form of harm reduction, and the history of harm reduction is the history of impacted, endangered communities creating a body of prophylactic practices to save each other's lives. Sex workers,<1> people who use drugs (PWUD),<2> and people with disabilities,<3>,<4> as well as colonized and racialized peoples,<5>,<6> all find value in using first-person and community accounts to challenge oppressive dominant narratives and power structures which rely on the invocation of the unassailable, distant "expert." We are the experts here, whether or not there have been resources invested into conducting formal research to document some of our conclusions. We hope that this text will inspire further community directed research on topics relating to methadone which have suffered from little

study, led by groups of people who use drugs and methadone patients working in alliance with academic researchers.

Please contact methadone@urbansurvivorsunion.org to discuss this work and methadone advocacy and reform with the USU methadone advocacy and reform team.



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Call to Action

While methadone is the most effective treatment legally available for those diagnosed with opioid use disorder (OUD) it is the most stigmatized and the most heavily regulated. Methadone significantly reduces the risk of overdose, HIV and HCV infection, and is the only safe supply available to people who use drugs (PWUD) in the United States. Over 1.6 million people meet the criteria for OUD in the U.S. and less than a quarter receive methadone treatment. Even during an adulterant and overdose crisis combined with a COVID-19 pandemic, we continue to experience barriers which keep PWUD from accessing treatment. We are traumatized as we try and access treatment because many people believe we are simply substituting one drug for another. This results in shame and stigma in practices and in the recovery community. We are watching our loved ones die and our community decimated. Our trauma demands this collaborative living document detail the culture of cruelty that continues to shame, stigmatize, and kill.

While the rest of the world responds to this crisis with safe supply options and evidence-based treatment, here in the US we have doubled down on drug war policy and coercive, abstinence-based treatment options, many of which increase our risk of death. We are the only national drug users union in the United States and we present this manifesto as our vision for change.

Our goal requires the elimination of the clinic system. Methadone dispensing should not be limited to tertiary healthcare sites, and ample evidence from Canada, Europe, and Australia demonstrates the efficacy of pharmacy and primary care dispensing models.

Throughout this document, we go over the failings of the current system and outline specific steps clinics can take to improve without major policy changes. Our next project will be the design of a model methadone clinic in this regulatory context because we know we need immediate and drastic reform.

The manifesto highlights human rights violations such as punitive responses to urine drug screenings; useless, time-consuming, mandated counseling; high barriers to take-home dose provision; stringent admission criteria and arduous intake processes; dose capping; onerous and rising clinic costs and exploitative charging practices; transportation difficulties; lockbox requirements; limited dosing hours; accelerated tapering schedules for administrative discharge; and lack of patient autonomy in determining treatment plans.

We talk about the problems we have faced as disabled people, sex workers, houseless people, pregnant and parenting people, people of color, and members of the LGBTQ community.

We also discuss the pandemic. COVID-19 hit and the world economy closed. Businesses scrambled to develop safer policies allowing them to remain open and provide essential health services. Unsurprisingly, methadone clinics behaved as if nothing had changed. Our group shared stories from around the country confirming that we were forced to choose between withdrawal and COVID-19 infection risk. We were being forced to fill waiting rooms and wait unmasked for our doses. Many PWUD were already confused about the reality of COVID-19, and clinics were reinforcing their confusion. The clinics acted in line with their corporate model that reduced our treatment to a profit motive---we are nothing but a commodity to them.

Urban Survivors led the charge for the implantation of relaxed federal methadone guidelines required to keep us safe during COVID-19. We knew that the bottom would not fall out if methadone was treated like any other medication. The fear that these relaxed guidelines would lead to uncontrollable diversion and overdose came to nothing. Urban Survivors Union championed the relaxed take home guidelines suggested by the Substance Abuse and Mental Health Administration (SAMHSA). Our open letter in support of these guidelines and further reforms, which was signed on to by organizations at the highest levels of drug policy and the recovery community and covered by multiple media outlets, secured our place at the table.

This manifesto would not be complete without addressing the criminal injustice system. Many of our members are sitting in jails and prisons right now, forced to undergo painful and humiliating detox in a cage without our prescribed medication. Too many of us live the stories told of correctional officers laughing while our cellmates beg for help and we risk death from dehydration and aspiration. Drug courts and jails torture PWUD and justify this torture as necessary.

We demand that clinics eliminate the deadly culture of cruelty and implement only the bare minimum of federal and state regulations. People on methadone must become active decision makers in the ir treatment environment and our treatment goals must be respected. Abstinence is not the only indicator of success. Successful treatment must always be measured by our behavior, not the chemical content of our urine.



ABSTRACT

Methadone is the most optimal treatment legally available for those diagnosed with opioid use disorder (OUD) in the United States. As an OUD treatment, it significantly reduces the risk of overdose, HIV and HCV infection, and general morbidity and mortality. Yet, although in 2019, approximately 1.6 million people met the diagnostic criteria for OUD in the U.S., and these numbers are increasing, only 408,550 people received methadone treatment.<7> Even during a fentanyl crisis, an overdose crisis, and a worldwide COVID-19 pandemic which exacerbates these problems, a draconian patchwork of federal

and state regulations and methadone program protocols present punitive barriers to care which keep uptake and retention low. In this collaborative living document, Urban Survivors Union, the national drug users union in the United States, envisions models of low-barrier methadone dispensing which could make it available to a much broader swathe of PWUD.

Ultimately, our goal is the elimination of the clinic system. Methadone dispensing should not be limited to tertiary healthcare sites, and ample evidence from Canada, Europe, and Australia demonstrates the efficacy of pharmacy and primary care dispensing models.

However, throughout the majority of this document, we go over the failings of the current system and outline specific steps clinics can take to improve, even barring major policy change. We discuss punitive responses to urine drug screenings, time consuming mandated individual and group counseling, high barriers to take-home dose provision, stringent admission criteria and arduous intake processes, dose capping, onerous clinic costs and charging practices, transportation difficulties, lockbox requirements, limited dosing hours, accelerated tapering schedules for administrative discharge, and lack of patient autonomy in determining treatment plans, among other problems. We also analyze the methadone clinic system using an intersectional framework, identifying racial disparities in treatment as well as particular difficulties groups such as disabled people, houseless people, pregnant and parenting people, and sex workers experience accessing care. Finally, we point out how drug courts and institutional settings can deprive PWUD of methadone access and we suggest methadone reform appropriate for COVID-19 conditions. We make detailed recommendations for more accessible and humane care in each problem area.

In sum, we encourage clinics to adhere to the bare minimum of federal and state regulations in order to provide unimpeded access to life-saving methadone treatment for the largest number of PWUD possible.

The COVID-19 pandemic has disproportionately affected people who use drugs (PWUD), who are at high risk of negative health consequences from the disease, including hospitalization and mortality.⁸ In this pandemic, it is critical to remember that we are still in the midst of an overdose crisis. PWUD also face the introduction of an entirely new range of synthetic drugs into the illicit drug supply, leaving us unable to protect ourselves. Since 1999, 770,000 people have died from drug overdose in the United States, with over 70,000 overdose deaths in 2019 alone.⁹ More recent data indicates approximately 81,230 overdose deaths from May 2019 to May 2020; the highest number ever recorded in the United States during a 12-month period.¹⁰ This represents a catastrophic death toll, including many potentially preventable casualties. Moreover, these numbers only capture overdose rates. HIV¹¹ and HCV¹² rates are also rising steadily among PWUD, and we can only guess at the broader death toll associated with injection-related infections and other injuries connected to the Drug War.

Methadone maintenance treatment (MMT), reduces overdose rates as well as providing people who use opioids the opportunity for long-term stability and growth.¹³ It has been shown to reduce hepatitis C transmission by as much as 50%,¹⁴ and it lowers injection-related HIV risk-- newer evidence even demonstrates that MMT is associated with more days spent with an HIV viral load below 1500

copies/mL.<15> Methadone is the most optimal treatment legally available for problematic opioid use in the United States. Its efficacy as a life-saving drug is supported by decades of data.

<16> ,<17> ,<18> ,<19> ,<20> ,<21> ,<22> Shifting from relying on an unstable and poisoned drug supply, risking arrest, and experiencing chaotic use to stable, legal dosing is a catalyst for broad psychosocial improvements for many people.<23> Although methadone has also been proven as one of the most cost-effective treatments for those diagnosed with OUD,<24> ,<25> it is unpopular among some PWUD and consistently hamstrung by low rates of uptake and retention.<26> In the United States, 1.6 million people were estimated to meet the diagnostic criteria for OUD in 2019, and these numbers are currently increasing. However, in 2019, only 408,550 people received methadone treatment in the United States. Since MMT is associated with reduced rates of overdose, arrest, and transmission of viruses, its poor use rates represent a significant public health problem.

Despite methadone's efficacy, methadone clinics and their policies are killing PWUD by insisting on severe barriers to treatment,<27> ,<28> though patient satisfaction is a significant predictor of treatment program retention.<29> In order to prevent further loss from the overdose crisis, the MMT system must dismantle barriers to access for the vast majority of PWUD.<30> We have a right to healthcare. We should not have to "earn" it, nor die by overdose when we "fail" by design.

Drug policy in the United States has never been about protecting people from the harms of substance use but has instead served to marginalize population groups.<31> ,<32> ,<33> ,<34> The current system criminalizes PWUD, demands that people who use opioids experience extensive suffering, and perpetuates a culture of cruelty. The current abstinence-based mechanism has no middle ground;<35> people are expected to be fully well (abstinent) or fully sick (experiencing chaotic use). This rigid dualism is not realistic.<36> ,<37> Many people have the capacity to live their lives while using substances,<38> ,<39> but simply lack the opportunity to do so, forcing them towards chaotic use. PWUD are regularly treated like children with little agency; we are ignored, rarely taken seriously, and deemed unworthy of making decisions for ourselves.

We need a complete overhaul of the present drug treatment system, which is largely criticized by scientific and empirical evidence.<40> PWUD and their families have been manipulated, misled, and mistreated by a structure based in fear, moralism, and outdated science. This is our call for truth, reconciliation, and restorative justice to ensure the continued rehabilitation of the collective health of PWUD. PWUD have endured widespread blame, mistreatment, and loss of freedom, all leading to endemic self-hatred and continued cycles of self-destruction.

Urban Survivors Union (USU) is the only national drug user union in the United States. We have four chapters and over thirty affiliate groups made up of people who use drugs, people in the sex trades, and people who have been targeted by the war on drugs. We believe those closest to the problem are best suited to identify solutions. We will not be sidelined and silenced as the nation's collective drug user voice while hundreds of thousands of our peers, family, and loved ones die. We will not sit back in the midst of a global pandemic, a fentanyl crisis, and an overdose epidemic while clinics undermine the rights and health of PWUD. With the death toll climbing as a result of COVID-19 increasing overdose risk and with fentanyl and analogues that are created to compete with prohibitory laws further contaminating the drug supply, drug users demand that health officials honestly assess and improve our failed drug treatment system and give us a seat at that table.

Ultimately, we believe the methadone clinic system should be eliminated. Methadone dispensing in the United States should not be limited to tertiary healthcare sites. This system has led to too many punitive obstructions to access. Rather, methadone patients should be able to choose to receive treatment through primary care prescription, pharmacy dispensing, or clinics. However, until we achieve such meaningful choice for American methadone patients, there are many steps that can be taken to ameliorate the current situation. Through the remainder of this document, we will outline the failures of the current system and propose easy, sustainable, and safe harm reduction solutions for reforming methadone treatment.

Barriers to Treatment

Research shows that clinics regularly withhold access to methadone as a form of punishment,<41> putting people at risk for a multitude of negative outcomes.<42>,<43> There are no other systems in society in which people with a medical condition are at constant risk of being pulled off their medication and forced into withdrawal. This is a violation of human rights and the Hippocratic oath. Methadone clinics create a culture of cruelty, suspicion, and antagonism in which patients are guilty until proven innocent.

The methadone treatment system currently stands detached from true patient success, which should be defined as the reduction of harm in each patient's life in a self-defined way. We need to push back against the idea that patients must earn their right to opioid agonist treatment by following one prescribed path. This clinic ideology proves that opioid dependence is still being treated with moral censure.<44>

Moreover, cutting someone off methadone precipitously is a form of torture, as the drug is long-acting and leads to painful withdrawal that can last for months.<45>,<46> We need stronger protection for patients to prevent them from being discharged and tapered off too quickly for not being abstinent from illicit or licit drugs, breaking bureaucratic clinic rules, or simply for not being able to pay fees. Clinics should only discharge patients for violence against others, and even then the process of tapering them off should be long and humane. Patient health must always be prioritized above the profit motive or punitive moralism.

All this considered, a number of barriers to treatment exist in the current system, including:

Drug Screening

Patients should be judged on their behavior rather than the content of chemicals in their system. Punishment tied to toxicology results is not associated with positive outcomes.<47>,<48> Patients may also experience hostility from clinic staff based on urinalysis or drug swab results. This is a clear indicator of a system built on the need for control and regulation, as compared to a basis of health, dignity, and respect.<49>

If chaotic behavior is noted, there are multiple factors that could be the cause of such behavior outside of the substance content of a patient's urine. Personal relationships, job difficulties, family issues, and underlying health conditions<50> may all play a part in a patient's behavior, just as they do for any

person. When people in environments outside the methadone clinic are seen exhibiting behavior that may be viewed as chaotic or “off,” an observer’s explanation for such behavior is rarely immediately illegal substance use. The might of the clinic has created a power dynamic in which patients are at the mercy of the institution to interpret their actions and intentions, using that interpretation to inform patient care.

Many clinics institute monitored weekly drug testing, despite federal regulation calling for drug screening only eight times per year.<51> A number of clinics own their testing labs, so they simply bill themselves for the excessive drug tests and labor.<52> ,<53> ,<54> Toxicology screening and analysis represent a substantial expense associated with MAT, and its elimination would dramatically reduce overall treatment cost.<55> It frequently falls on the patient to contest a false positive, revealing massive oversight on the part of the clinic. Finally, observed drug testing is humiliating, as people are often observed during urine testing by staff and other clients.<56> Observed specimen collection may also re-traumatize patients who have experienced physical and psychological trauma.<57>

Furthermore, the clinic practice of livestreaming urine toxicology screenings for clinic staff members to monitor is a violation of privacy and a security risk. As we have all seen just in the last few months,<58> the technology used in camera surveillance has been exploited time after time. The Verkada hack alone showed us that hospitals, jails,<59> banks and schools are all vulnerable. How can we trust that opioid treatment programs are not open to the same hacks? Methadone programs claim the urine screenings are simply observed over live video and not recorded, but that does not mean the footage is not obtainable through such hacks. The idea that programs would be willing to risk exposing an already stigmatized group of people to even more trauma and humiliation, breaching HIPPA (the Health Insurance Portability and Accountability Act) and federal confidentiality requirements for OTPs (42 C.F.R. §2), all in the name of stopping diversion, is chilling evidence of the clinic culture of cruelty. As advocates, we have observed clinic staff in groups watching such livestreams in violation of policies mandating only one observer. In some instances, staff made degrading comments about patient’s bodies, particularly the bodies of trans people. Such exposure is potentially retraumatizing for disabled people, trans people, sex workers and trafficking survivors who have been filmed against their will or had their filmed content pirated, and many others.

Until toxicology requirements are eliminated, to meet current federal regulatory standards, clinics should utilize saliva/oral fluid/swab testing, a much less invasive form of drug screening which can provide immediate results. Positive results should never occasion punitive action on the part of the clinic---e.g., the suspension of take-home dosing. Instead, toxicology results should merely be one factor among many to inform discussion between patient and staff on the individual’s treatment plan. The only time that drastic consequences should follow the result of a drug screen is when the patient tests negative for methadone itself. In such a case, the possibility that the patient has reduced or no tolerance to methadone poses a significant risk should the patient be dosed as usual. In this situation, the patient’s dose should be temporarily reduced while peak and trough testing is immediately conducted.

Privacy

According to SAMHSA guidelines, requiring patients to carry a lockbox can potentially advertise the fact that the patient is carrying a large amount of methadone or another item of value. Thus, it not only violates their confidentiality, it also endangers them.<60> There is no scientific evidence tying this

mechanism to positive outcomes. Instead, it forces patients to procure additional funds to access their medication.

Response to Drug Use and “Drug Seeking Behavior”

People should never be discharged for using drugs, as drug use is not an inherently negative action. Drug seeking behavior should be viewed as the result of an unstable dose and treated as such.<61> Clinicians and counselors should collaborate with patients to adjust dosing and address patients’ unmet needs appropriately.<62> Patients should personally set goals for improving their substance use on their own terms, rather than being viewed through the binary of abstinence or failure.

Punishment and Discharge

Using a patient’s dose as a punitive tool to force compliance with clinic rules (e.g. patients unable to produce a urine specimen are made to sit and drink water until they are able to do so, without being dosed until then) is another example of clinics abusing their power. Forcing patients into doing what is required of them by withholding their medication, denying it to them if/when they are unable to comply, is a blatant human rights violation which would not be acceptable in any other field of medicine. Dangers are inherent in cutting someone off their medication, including increased risk of withdrawal and subsequent overdose.

Intake

The intake process must be shortened, or at least broken up into more manageable sections over a period of days. The current system forces prospective patients, who are likely experiencing acute withdrawal, to answer repetitive questions for five to six hours before they can take their medicine, despite SAMHSA guidelines recommending efficiency in the intake process.<63> Also, many questions are unnecessary and/or outdated, and add nothing of inherent value to the patient’s treatment.

Dosing Hours

Methadone clinic dosing hours differ widely from clinic to clinic and sometimes change from one month to the next. SAMHSA’s Federal Guidelines for Opioid Treatment Programs states that clinics must “[p]rovide services during hours that meet the needs of the overwhelming majority of patients, which includes hours outside of the traditional 8:00 a.m. to 5:00 p.m. Monday through Friday work schedule.”<64> However, many clinics only offer limited morning dosing, with some going so far as to only offer 5 a.m. to 7 a.m. dosing on weekends.

Clinic hours are usually determined without any buy-in from the people the clinic serves. Dosing hours are designed based on clinics’ assumptions of what clients need or want, or based simply on staff and management convenience. This is highly problematic for many patients who find that their daily routine and employment obligations are curtailed by the need to attend during limited dosing hours. Clinics must adopt new practices, such as interviewing their participants on what hours best suit them and accordingly arranging those hours of operation. Low-threshold clinics with expanded hours of operation report higher patient satisfaction.<65>,<66>

Transportation

The substantial distances that many patients must travel to access treatment represents a tremendous barrier<67> ,<68> that limits access to treatment for patients who do not own cars or live in major metropolitan areas. Currently, only patients enrolled in Medicaid or state Medicaid expansion programs

are able to access transportation assistance.<69> Even these patients must often make a special request for transportation through their primary care office by listing a valid medical reason for being unable to use public transportation, even when no viable public transportation is available to reach the clinic's location. Exceptions are only made on a case-by-case basis if the patient lives over 50 miles away from the nearest clinic.<70> Moreover, the driving companies contracted by transportation brokers for state or federal medical insurance to arrange these rides are notorious for fraudulent billing practices;<71>,<72>,<73>,<74>,<75>,<76>,<77>,<78>,<79>,<80>,<81>,<82> little oversight in hiring, often exposing patients to sexual and verbal abuse by drivers;<83> and overloading transport schedules for profit, thus adding hours of travel time to patients' days, placing them in overcrowded vehicles in unsafe conditions, and forcing them to risk car accidents<84> in vehicles which are speeding to make appointment times. These circumstances also exacerbate COVID-19 transmission risk among PWUD trying to access the clinic, many of whom may be at higher risk of complications if they contract the virus.

Cost

While Medicaid expansion programs and Medicaid cover the cost of services offered at many clinics, many independently charge for take-home doses. Patients who are suddenly unable to pay are often left without medication for those days, or they are only allowed to "charge" a few days' worth of doses. Some clinics do not even allow charging, leaving those unable to afford payment with no choice but to go without medication on days the clinic is closed. If they are still unable to pay after this point, they are forced into a financial detox, during which their dose is drastically and quickly lowered. This practice essentially pushes patients towards the use of street opioids and increased overdose risk as punishment for their indigence.<85>,<86>,<87> Federal guidelines clearly state that no patient should be discharged from any facility while they are physically dependent on methadone or any other medication approved for use in opioid agonist treatment unless the client is provided the opportunity to detox from the drug.<88> The accelerated tapering schedule clinics employ to financially detox patients does not meet these standards: it does not allow patients to detox sufficiently from long-acting opioids like methadone, leaving them in a state of physical withdrawal which can last for months.

Use of Other Medications

Many clinics' benzodiazepine policy is punitive (e.g. if someone tests positive for benzodiazepines ["benzos"], many clinics limit their dose to 40mg; if someone not prescribed benzos tests positive for them, their dose is immediately dropped to 40mg and will not be increased until the patient tests negative for benzos). In many clinics, even patients with legitimate benzodiazepine prescriptions are prohibited from earning take-home privileges, and are not allowed the opportunity to find a stable dose.

Patient Autonomy

Clinics should not continue to push every patient towards the same antiquated practices (e.g. 12-step and abstinence-based treatment)<89>,<90> regardless of their individual goals. Abstinence-based treatment assumes that all people seeking drug treatment have the desire to stop using drugs and to remain completely substance-free. A person who expresses any other treatment goal is often told they

are not ready for treatment and subsequently denied access. Meanwhile, the multibillion-dollar drug treatment industry remains unmoved as people who use opioids chaotically fall prey to deceptive marketing practices that preach abstinence as the only real route to recovery, exposing them to incredible overdose risk when they relapse.<91> Instead of exclusively promoting this failed, deadly abstinence model, clinic treatment should be an opportunity to implement harm reduction and patient-centered practices.

Our experiences in the field and our discussions with hundreds of methadone patients reveal that treatment plans rarely reflect patient goals.<92> In fact, many treatment plans are written for us by clinic counselors. We are asked to sign them without even knowing what we are signing, often with our dose for that day held in the balance.

Patient autonomy should be a primary goal of every clinic, as the ethics and efficacy of coercive rehabilitation are highly questionable.<93> Treatment plans must be personalized to the patient's self-assessed needs.<94> Each patient should be able to come up with their own plan for abstinence or moderation. Patients must be involved in the creation of their treatment plan, as well as their long- and short-term goals, and be given the opportunity to periodically reevaluate and adjust these goals to reflect their individual strengths, barriers, and needs. Prioritization of patients' raised concerns and observations should be a vital part of this practice. A relationship of trust between patients and the clinic must be established to ensure a successful treatment experience.

A counselor's role should be limited to that of a resource in creating an individualized treatment plan. While a patient may bounce ideas off the counselor and receive assistance with the organizational aspects of their case, the counselor should not intervene beyond supporting the patient's ideas and goals. The counselor should not make statements which dictate or control the patient's plan for themselves.

Clinics should proactively generate infrastructure for a patient advisory council so that patients can collectively advocate for their rights. These advisory councils should have meaningful decision-making power and oversight of quality of care. In addition, patients should be able to coordinate and facilitate patient-only peer support groups. The establishment of these entities should be prioritized at all clinics. Additionally, patients should be made aware, and frequently reminded of the process for filing complaints and official grievances. Patients should receive support, not reprisal, when this grievance process is utilized.



Methadone in Drug Court Programs

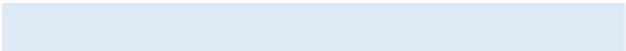
Although drug courts are often touted as progressive alternatives to more punitive models of criminal justice, they are not based on a public health approach to substance use. Rather, as part of the criminal justice system, drug courts utilize the notion that people who use drugs are both 'bad' and 'sick' to justify a coercive, abstinence-based model that often harms rather than helps people who use drugs. For example, drug courts require that participants plead guilty to their initial charge rather than opt for a lighter sentence through plea bargaining – this can then be used to apply harsher sentences to

individuals who “relapse” while on the program, a common outcome for people who are dependent on opioids.<95>

Despite overwhelming evidence in support of opioid agonist treatment such as methadone, a recent study found that only 50% of drug courts made any type of agonist therapy available to opioid-dependent individuals and only 26% offered methadone maintenance treatment (MMT) as an option.<96> Findings also showed that court officials often maintained negative views of MMT, including the belief that it interferes with the ability to drive a car and “rewards criminals for being drug users.”<97> Drug courts also place healthcare decisions primarily in the hands of attorneys and judges, rather than substance use professionals, allowing them to make decisions based on their own personal beliefs rather than clearly established evidence. For example, when a California drug court judge who believed that methadone fails to “break the cycle of addiction” required a defendant to stop MMT against his own wishes and those of his doctor, that defendant died two months later of a heroin-involved overdose.<98>

As a drug users union and a methadone advocacy team, we categorically oppose the criminalization of drug users, even through diversion programs which purport to be kinder, gentler carceral systems, the way drug courts disingenuously brand themselves. As such, we call for an end to the use of drug courts and their replacement with non-carceral approaches to addressing substance use. However, while drug courts continue to exist, they must not be allowed to make medical decisions for participants on the best course of drug treatment for them. Drug courts should maintain close ties with local methadone clinics in order to fast track participants into their treatment.

These courts must not be able to hold suspended sentences over defendants’ heads, throwing them back into jail if they test positive in drug screens. The broad consensus among even abstinence-based drug treatment professionals is that “relapse” is a normal part of recovery. If we accept even this less progressive model, then punishing people for going through a standard stage in their recovery process seems ludicrous and cruel. Right now especially, when jails and prisons are high risk environments for COVID-19 transmission, it is a human rights violation to condemn drug court participants to that peril in a setting where there is also likely no evidence-based drug treatment available to them.



Methadone in State Institutions

It is cruel and unusual that incarcerated people on methadone are denied their medication and forced into withdrawal,<99>,<100>,<101> despite OAT’s proven success as an intervention in criminal justice settings.<102>,<103>,<104> This is especially concerning given the many opioid withdrawal-related deaths that have occurred in lockups and jails because of easily preventable issues such as dehydration.<105>,<106>,<107> Individuals who are dependent on opioids should have the opportunity to start or continue treatment when incarcerated, rather than suffering through withdrawal in lockups, jails, and prisons.

Patients who use opioids and are incarcerated, or admitted to a hospital or other institution, should be evaluated for withdrawal symptoms. They should be given the option to receive methadone if appropriate based on their symptoms. Patients who are also experiencing severe pain should be treated

for both their withdrawal symptoms and their pain, especially since such individuals likely have a high tolerance for opioids.

Recommendations

Dosing

There should not be restrictions on patients' doses (e.g. maximum cap, blind dosing, financial detox).<108> Clinics enforcing a maximum dosing cap are denying patients the right to be medicated toward a state of comfort and function.<109> Treatment at less than a patient's optimal dose does not prevent withdrawal and often encourages supplementation with polluted, illicit street supply.<110> Higher starting doses, based on patients' self-reported needs, result in the fewest negative outcomes, including mortality.<111>,<112> ,<113> ,<114> ,<115> ,<116>

Those terminated due to the inability to make payments (i.e. involuntarily discharged or placed on financial detox) are subject to chaotic choices because they must seek alternative sources of medication in order to remain functional. The resulting source is often illicit supply that is highly polluted, unstable, illegal, and thus extremely dangerous.<117>,<118> ,<119> This is particularly so during the pandemic, as COVID-19 interferes with illicit drug market infrastructure,<120>,<121> causing additional reliance on synthetic opioids, such as fentanyl, and potentially poisonous cuts, such as procaine.<122>

Lastly, the brand of methadone offered by clinics is subject to change without notice, leaving patients in a constantly powerless position.<123> The efficacy of particular brands, such as Methadose, vary depending on the patient. This can lead to instability in dose efficacy and encourage risky behavior to fend off withdrawal symptoms.<124>

Take Home Doses

Take home doses have been shown to improve outcomes.<125> Specifically, increased access to take-home medication helps patients maintain employment without having to worry about budgeting time for long lines, unscheduled meetings with prescribing doctors, and random urine screens.

In an effort to increase access to methadone take homes, we recommend elimination of two practices. First, lock boxes have not been proven to protect medication from non-prescribed individuals, but rather advertise a patient's participation in MAT.<126> No other medication including more short-acting opioids, is required to be transported via lockbox. Secondly, bottle return requirements for take home doses are punitive and unnecessary. We understand that federal regulations mandate the creation of a diversion control plan for each opioid treatment program as part of its quality assurance plan, but bottle return requirements as provisions within these plans are arbitrary (42 C.F.R. 8.12 (c) (2)). There is no evidence that these requirements improve patient health, but they do create additional barriers to treatment.

Secondly, we believe that take-home dosing should not be limited to those with a long track record of negative drug tests, nor should they be suspended for positive drug tests. There is not much data yet on how clinics have implemented relaxed SAMHSA guidelines during COVID-19 and dispensed take-homes

to large numbers of patients who might not otherwise qualify for them, but it seems so far that there have been no dramatic increases in either diversion or overdose as a result.<127>

Overdose Prevention

Clinic staff should be required to participate in overdose and naloxone training. Additionally, training must be offered to patients, and injectable and nasal naloxone supplied without charge. However, many clinics have adopted mandatory training as another opportunity to punitively mandate time-consuming classes which they can then bill to Medicaid expansion or private health plans.<128> Clinics should offer voluntary training by harm reduction contractors, as well as naloxone distribution, so as to encourage safer use but not punish patients who choose not to participate.

Drug/ Substance Use

Patients should not be discharged from a program designed to help them stop using drugs for using drugs. Instead, the clinic should respond to illicit use by reevaluating patients' treatment plan and dosing. Since it is known that higher doses of methadone result in fewer incidents of illicit use,<129> ,<130> an increase in dose should be considered and discussed with the patient.

Counseling

There should be no forced individual or group counseling as the evidence simply does not demonstrate that counseling contributes to positive outcomes.<131>,<132> ,<133> ,<134> Additionally, a trusting relationship cannot be formed with counselors because they often are the same people who conduct urinalysis screenings and/or enforce punitive bureaucratic consequences. As such, the relationship feels far more like one with a probation officer than with a medical professional. Despite these facts, federal guidelines require two counseling sessions per month during the first year of treatment, and one counseling session per month for all subsequent years,<135> and Medicaid and Medicare recently expanded therapeutic and group requirements.<136> Policy must eliminate this barrier to treatment and focus on the true cause of positive outcomes: properly dosed medication.<137>

Pregnancy

Methadone is the best and safest option for people with opioid use disorder during pregnancy and breast/chest feeding.<138>,<139> Results are difficult to quantify, but there is some indication that when a pregnant person withdraws from opioids, it may cause the uterus to contract and may bring on miscarriage or premature birth,<140> especially in the first trimester.<141> Methadone's ability to prevent withdrawal symptoms helps pregnant people better manage problematic opioid use while avoiding health risks to both pregnant people and their babies. By blocking cyclic withdrawal symptoms associated with short-acting opioids, opioid agonist treatment can provide a more stabilized intrauterine environment.<142>,<143>

Acute detoxification/ medically supervised withdrawal is also contraindicated during pregnancy because the chances of returning to illicit opioid use for pregnant patients range from 59 to 99%.<144> ,<145> Due to increased tolerance, the risk of overdose is much higher after detox, threatening both the pregnant person and the fetus.

People on MMT can still breastfeed and should be encouraged to do so. Research has shown that the benefits of breastfeeding outweigh the effects of the small amount of methadone that enters the breast milk.<146> ,<147> Numerous studies have demonstrated a strong association between breastfeeding

and improved NAS (neonatal abstinence syndrome) symptoms in infants, with a reduction in need for infant opioid tapering and shortened hospitalizations.<148>,<149>,<150> In addition, there are benefits such as strengthened parent-child bonding and increased parent self-esteem.<151> These factors are invaluable to both parent and baby, especially in the days immediately following delivery, when stresses related to the stigma and bias from pediatric doctors, nurses, and other medical staff surrounding parents on methadone are often so blatant.

Pregnant patients face stigma within the methadone system and are too often left to their own devices when it comes to education, support, resources, and pregnancy centered care. In our experience, methadone programs also often neglect to adequately advocate for pregnant patients dealing with stigmatizing and dangerously misinformed practices by medical providers or child welfare services because of their methadone treatment.

The needs of pregnant patients must be met with willingness, compassion and genuine interest by staff that are adequately educated and trained on up-to-date evidence-based practices for methadone and pregnancy. OTPs have a responsibility to pregnant patients to implement adequate programs and offer resources that focus on support, education and awareness in all areas of pregnancy and delivery. This includes networking with local OBGYNs and hospitals to ensure healthy, positive, and supportive experiences of pregnancy and delivery. It is extremely important to also hold space in OTPs to assist pregnant patients on hospital issues around mandatory reporting of neonatal drug use and possible child separation via child welfare services that can arise during the critical first days after delivery and up until the baby is discharged.

Parenting Patients

Parenting patients receiving methadone agonist therapy make up a significant part of the MMT population in the U.S. With this group of individuals come very specific and unique needs for access to MMT, retention within the program, and both individual- and family- centered progression.<152> Unfortunately, these needs are often underprioritized.

Usually, it is only during pregnancy that the parenting patient's needs are prioritized. However, this is not motivated by concern for the childbearing patient's wellbeing but rather their wellbeing in relation to their fetus. For example, clinics will not discharge a patient during the perinatal period regardless of compliance or ability to pay for treatment services. Yet if the balance is not brought current once the baby is born, the childbearing parent will often be financially discharged during the postpartum period, a time when they are significantly more likely to suffer from depression, anxiety, and postpartum mortality.

Parenting patients face barriers to treatment including but not limited to transportation, childcare, additional financial costs, legal or family court cases, open child welfare cases, housing, and educational needs.<153> All these issues have the potential to heavily impact the parenting patient's ability to maintain their autonomy and success in methadone treatment.<154>

Many clinics do allow children into the building with parents as they line up to dose while barring them from the dosing window itself. Qualitative research seems to associate those who practice not allowing children on the premises with problems of retention for parenting patients.<155> We would recommend that clinics further support parents by not only allowing children into the building, but also providing free childcare on site for patients—something parenting patients have also suggested in

qualitative research.<156> Navigating long lines, toxicology screenings, counseling appointments, and dosing can be difficult enough without also having to tow one's children along to do so, and as patients and advocates we have observed that parents can be scapegoated for their restless children's behavioral issues by both staff and other patients.

Parents are one of many groups of patients with unique socioeconomic and psychosocial circumstances that influence treatment needs. Currently, parenting patients' needs are not seen in the clinic system as the impactful and weighted entities that the data shows they are. There must be an authentic and genuine focus on ancillary services centered on the socioeconomic and psychosocial needs of parenting patients.

For one, clinics should create infrastructure for non-mandated, patient-led parenting support groups in which parents can draw strength and resources from the community, while also allowing this population easy access to a wide array of additionally supportive, non-coercive services. Research has also suggested that integrated programs for parents and children in treatment increase patient retention and can provide long-term benefits, which we also recommend on a non-mandated service basis.<157> ,<158> ,<159>

Parenting Patients and Mandated Reporting by Clinics

Parenting patients can suffer from clinic-initiated intervention from child protective services, which often lead to negative outcomes for both patients and their children.

SAMHSA Treatment Improvement Protocols from 2000<160> discuss a child abuse mandated reporting exception to federal regulations ensuring opioid treatment program patient confidentiality without explicit written consent from a patient (42 C.F.R. §2). This exception applies only to initial reports of child abuse or neglect. Opioid treatment programs may not respond to follow up requests from child protective service agencies or subpoenas from courts, even if documents are requested in relation to civil or criminal court proceedings stemming from the opioid treatment program's initial report. In making the initial report of suspected abuse to a child protective service agency or other designated agency, the OTP staff member should provide only the basic information required by state mandatory reporting law. The OTP staff person may give their name and the name of the program, and if the law requires it, they must. No other information should be disclosed without the client's written consent.

Though this TIP chapter was written 20 years before the protections of 42 C.F.R. §2 were significantly eroded as part of the CARES Act, nothing in the recent changes to 42 C.F.R. §2 protections of opioid treatment program patient confidentiality seems to apply to the restrictions on mandated reporting referred to above.<161>

However, in our experiences as methadone patient advocates, we have witnessed overbroad interpretations of even these narrow reporting requirements. For example, one methadone advocate heard from a poor mother of color reported to her state's child protective service agency by her clinic for not fulfilling bottle return requirements on her take-home dose bottles---in a way which did not allow her children any access to the take home dose bottles or endanger them in any way. This practice of hasty reporting is made all the more complicated by the fact that states have wildly differing laws on whether neonatal drug use or parental drug use in general in and of themselves constitute child abuse or neglect.<162>

When evaluating clinic reporting of parenting patients to child protective service agencies, it is important to consider data from a 2017 meta-analysis of 44 articles.^{<163>} The meta-analysis found that in 73% of the studies, mandatory reporter participants mentioned negative experiences with the reporting process, including adverse child outcomes: the child was not removed from harm and the abuse continued or intensified; the child was removed from harm but the foster care environment was worse than the family-of-origin environment; and child death followed a report or being removed from the family of origin. A 2016 study using data from the nationally representative 2011–2012 National Survey of Children’s Health concludes that children in foster care are much more likely to experience depression and anxiety, learning disabilities, speech problems, hearing and vision problems, developmental delays, asthma, attention-deficit/hyperactivity disorder (ADHD), and many other health issues than children living with 2 biological parents and children living with never-married biological single mothers.^{<164>} The fate a mandated reporter often leads a child into may not be the one they envisioned for that child when they first decided to intervene.

Our recommendation is for clinics to take into account the long history of the violation of reproductive rights of racialized people and PWUD, especially PWUD of color.^{<165>} ,^{<166>} Clinics should create technical assistance and training programs for their staff designed and led by organizations such as Movement for Family Power and the Bronx Defenders, teaching their staff to reflect on how definitions of abuse can be colored by cultural differences and perceptions of criminality.

Racial Disparities

Methadone is often racially coded as an opioid agonist treatment for long-term opioid users in urban communities of color while buprenorphine is constructed as a treatment for middle-class white suburban opioid users with short illicit opioids use careers. In fact, in a 2016 cross-sectional study of 3142 counties or regions in the U.S., counties with highly segregated African American and Latinx communities had more facilities to provide methadone per capita, while counties with highly segregated white communities had more facilities to provide buprenorphine per capita.^{<167>} Many smaller studies also demonstrate an association between buprenorphine availability and white, high-income neighborhoods and methadone availability and lower-income neighborhoods populated by people of color.^{<168>} ,^{<169>} ,^{<170>}

But even beyond this racist, classist binary, there are racial disparities within methadone treatment itself. For example, urinalysis is not applied equally to all patients—one study found that Black patients were more likely to receive urinalysis than white patients (10.4% vs. 4.1%)^{<171>} while another study demonstrated that among the subset of patients who had at least one urinalysis test, Black patients underwent a significantly higher number of such tests.^{<172>}

Early studies also showed that clinics which serve a higher number of Black patients are more likely to dispense less efficacious doses below 60 mgs.^{<173>} ,^{<174>} In fact, these clinics were also more likely to have patients on doses below 40 mgs and less likely to have patients on doses above 80 mgs.^{<175>} Urban clinics which serve a higher percentage of Black patients were hypothesized to often be under-resourced when it comes to staff and funding. Thus, they may be less likely to keep up with best practices or to have the capacity to afford training or educational sessions that could improve their practices. There is also a paucity of recent research on this topic. As such, it is imperative for researchers to gather data that examines this gap.

Thus, evidence demonstrates that Black patients experience more of the barriers to methadone retention and treatment efficacy than other patients, while also enduring more surveillance from the clinic system. In order to effectively respond, clinics should conscientiously track internal data on race and drug screening and aggressively correct racial disparities as they manifest. Black patients should also be appointed to well-compensated positions on clinic racial equity committees or any position of leadership within the clinic where they have decision-making power, in which they could help identify further barriers to care for their communities. Moreover, public health departments and state opioid authorities should invest resources in support for clinics in poorer urban areas, providing more training and resources to help them adhere to best practices. To be clear, we support efforts to broaden access to buprenorphine and buprenorphine/naltrexone treatment to urban communities of color, so long as resources are also invested in maintaining and broadening access to methadone in those communities as well.

Disability and Medical Need

The Americans with Disabilities Act (ADA) ensures that people with disabilities have the same rights and opportunities as everyone else. This includes people diagnosed with addiction to alcohol and people diagnosed with opioid and substance use disorders. While the Americans with Disabilities Act has some inequitable stipulations as part of their coverage, it also states that current drug users can't be denied health care,^{<176>} which is inclusive of MMT/MAT – though this has yet to be tested in the courts.^{<177>}

The varied use of the term "disability" in the scientific literature makes it challenging to conduct systematic reviews of health issues among people with disability. Utilizing general disability search terms has been suggested as an efficient way to ensure a broad capture of the literature related to disability. A 2018 study found that there were not a lot of results when looking for the overlap between disability and opioid use,^{<178>} which makes it challenging to identify the gaps in service accessibility of methadone for disabled clients.

Another 2018 study found that prescription opioid use among people with disabilities was not well characterized, and examined opioid use, misuse, and use disorder, reason and source for last prescription opioid misuse, and receipt of prescription opioid treatment among people with and without disabilities.^{<179>} (This is according to this study's definition of the terms "misuse" and "use disorders.") The study found that adults with disabilities were significantly more likely than adults without disabilities to experience past year prescription opioid use (52.3% for those with disabilities compared to 32.8% of those without), misuse (4.4% compared to 3.4%), and use disorders (1.5% compared to 0.5%). People with disabilities were significantly more likely to misuse opioids for pain and to receive opioids from a healthcare provider. Despite this demonstration of disparities between disabled and able-bodied individuals, the study also found that disabled people diagnosed with opioid use disorder were less likely to receive treatment for prescription opioid use. This carries into the methadone delivery system as well and highlights the need for intentional expansion and increased accessibility so disabled individuals can access methadone treatment.

There are an extremely limited number of research studies investigating the intersections of ambulatory disability and issues with accessing methadone treatment. This sheds light on the need for there to be more patient-centered research that integrates harm reduction as a practice for integrating methadone access to understudied communities. Despite there being limited published research, we as members of Urban Survivors Union harbor a wealth of knowledge and experience of barriers to methadone

treatment due to ambulatory disabilities. These include program locations not having ramps for wheelchairs, bathrooms not having appropriate safeguards so that those with disabilities can safely use the restrooms, and programs not having flexible hours to accommodate individuals that have to travel under special circumstances because of their disability. We have also observed that curbside dosing because of acute illness or disability is difficult to obtain, and the wait to be dosed is often considerable. It is vital that these experiences are uplifted and prioritized by programs as well as considered for future research to improve accessibility amongst those that are in highest need for treatment.

Furthermore, people with a variety of medical conditions are often inaccurately interpreted as intoxicated by clinic staff at dosing windows. Epilepsy, high blood sugar in type 1 diabetics, and brain injuries can all mimic alcohol intoxication, for example. Federal regulations (42 C.F.R. § 8.12 (d)) require that opioid treatment program staff members who dose patients with methadone be registered nurses or other medical professionals licensed to prescribe opioids. However, we have observed that the medical knowledge that staff members at dosing windows employ often seems to be limited to monitoring patients for signs of intoxication and scoring them on the Clinical Opiate Withdrawal Scale (COWS). We have even seen such failures in judgement around mental health as methadone program staff refusing to dose a patient because they were crying, therefore agitated and possibly high on stimulants.

We recommend that patients who are disabled be fast-tracked through the intake process and provided take home medication quickly to accommodate various accessibility limitations complicated by COVID-19 and additional risk factors. We also recommend that for whatever in-person visits to facilities which are necessary, all methadone program facilities be made as accessible as possible to those with mobility issues. A council of patients with ambulatory disabilities should be hired to advise methadone programs on development of any new facilities, and given decision making power over issues pertaining to the buildings and grounds.

Patient Relationships in Treatment

Many patients who attend opioid treatment programs do so with individuals they have existing relationships with. Whether they enter the program together or connect through shared experiences once in the program, these relationships play a significant role in our lives and our opioid agonist treatment. These relationships vary in nature from platonic to familial to intimate, each with its own level of importance to the individuals but with many shared issues within the clinic system. Because of common difficulties accessing transportation to clinics, sometimes these are relationships of convenience and necessity as people establish carpools in order to be able to dose and attend counseling appointments. Unfortunately, although all these relationships and their dynamics vary, considerations from the clinic staff and policy regarding each patient and these relationships often do not. There is a fundamental lack of effort and focus within the clinic system where these relationships and their variations are concerned.

We have observed both members of a couple being treated punitively by methadone programs if they believe there is a problem with one partner's "compliance". One member of a couple missing a call back for take home bottles, testing positive on a drug screen, or missing counseling sessions or groups can often be used by programs to respond to both patients with the same or similar disciplinary measures. We have witnessed patients losing their take home bottles because their partner experienced a recurrence---justified by clinicians by federal regulations for take home eligibility criteria which mandate

the stability of the home environment and the patient's relationships (42 C.F.R. § 8.12 (h) (4) (i)). Less often, we have also seen these guilt-by-association tactics carried over to the treatment of friends, family, or members of shared carpool, making retention harder for all parties.

Confidentiality and impartiality in therapeutic settings seem to be standards that methadone programs can adopt or discard at their convenience when it comes to this issue. Knowledge revealed by one partner in confidential treatment by the clinic can be used against---and thus disclosed to--the other partner. And yet, methadone programs often refuse to allow couples and families to attend the same counseling groups, doubling the burden of transportation and time commitment within a household.

As our own experiences as patients and advocates have informed us, there are several key factors that contribute to the diff One important example to focus on is the way that programs do not separate individuals when it comes to problematic issues, but refuse to keep the individuals connected where it would positively impact both their treatment and their relationship.

It's important to note that we found in our attempts to locate empirical data or studies specific to this topic--patient relationships in methadone treatment---that this is an area of opioid agonist treatment research that is woefully understudied. Policies that make it difficult or impossible for people to attend their clinic with friends, partners, and children are another aspect of treatment that is conspicuously ignored by scholarly literature. These gaps not only speak to the lack of focus on how people on methadone conceptualize and use treatment, they also help frame peoples' difficulties with treatment as resulting from individuals' willful non-compliance rather than due to an organizational structure that is misaligned to the needs of its patients. More research on how structural issues like this negatively affect patients would not only help to improve methadone treatment, but would also help to shift the power dynamic towards a patient-centered model rather than the current top-down approach to treatment. We hope that more community-directed research is conducted on these problems, and recommend this as one of many topics for review by patient councils with true oversight over methadone program policies.

Houseless Patients

As we have made clear throughout this document, methadone and Opioid Agonist Treatment (OAT) programs in general are often difficult to navigate. When trying to access OAT and treatment services, unhoused people experience an extra layer of difficulty. The following conditions make even the thought of trying to access opioid agonist treatment a traumatic event: comorbidities, scarce resources to meet basic needs, minimal support, and lack of access to specialty care. In short, it is nearly impossible for persons in the homeless population to navigate this clinical system.

Studies show that abuse, past trauma, and undiagnosed behavioral problems contribute to being both unhoused and meeting the diagnostic criteria for opioid use disorder (OUD).<180> Unhoused people are at especially high risk for meeting the criteria for opioid use disorders.

They are disproportionately affected by the overdose crisis, experiencing overdose rates up to 30 times higher than the general population.<181> ,<182> ,<183> This high risk is aggravated by limited access to opioid agonist treatment and overdose prevention. The medical community often denies basic care to this population, claiming unhoused people are drug seeking or hard to treat.<184> ,<185> This leaves unhoused people with low access to medical care for even basic needs, let alone OAT.<186>

Transportation is a particular barrier for houseless and low-income people's admission into methadone programs. As we have discussed elsewhere in this document, the about 1500 methadone clinics currently operating in the US are located far from many rural communities, often pushed into the edge of town by discriminatory state and municipal zoning practices and located far from public transportation. There are often long wait lists for clinic admission, and it is difficult for houseless patients to secure reliable transportation to an intake appointment far into the future. For those houseless people who do manage to be admitted to methadone programs, transportation to daily dosing quickly becomes a problem. Forms for non-emergency transportation to medical appointments funded by Medicaid, Medicare, or state Medicaid expansion, such as Masshealth's PT1 form, often cannot be filled out without a stable pickup address. If a patient loses housing or needs to move precipitously, we as advocates have observed that it often takes several layers of bureaucracy for such public health plan transportation to register a new address. Moreover, again, such public health plan facilitated non-emergency transportation can take months for a patient to push through the system through their primary care provider---if the patient is able to qualify for such services at all.

In our experience, houseless patients quickly accumulate a series of missed doses after being unable to arrive to the clinic on time or secure transportation at all. Their doses are lowered or even halved because of a few days' absence, and finally, they face termination through accelerated administrative detox after the missed doses continue to pile up. At this point, many houseless patients give up hope and simply stop dosing all together, precipitously lowering their opioid tolerance, raising their overdose risk, and enduring protracted methadone withdrawal.

A houseless patient cannot even hope to earn take home dosing privileges, eliminating the burden of their daily trip to the clinic. One of the eight federal eligibility criteria for take-home dosing is "the stability of the patient's home environment" (42 C.F.R. § 8.12 (h) (4) (i)).

Several studies of unhoused people and OAT show that with primary care based/office based opioid treatment (OBOT) most, if not all of the barriers unhoused folks have to OAT are greatly lessened or removed entirely.<187> ,<188> ,<189> Unfortunately, buprenorphine was used for these studies due to the limitations of the stringent, non-evidence-based methadone regulations which we discuss throughout this text. Once again, we come up against the same barriers as we do in almost all areas of methadone treatment. Methadone in a primary care setting, as part of a primary care doctor's toolbox for those diagnosed with OUD, could start to stem the tide of the overdose epidemic houseless people suffer from disproportionately.

In the meantime, methadone programs should show special consideration to houseless patients and make an extra effort to accommodate their needs. Mobile methadone programs---which have also been shown to help retain houseless people in methadone treatment by literally meeting them where they're at---should be expanded.<190> Programs should provide effective referrals to housing and help fast track forms facilitating transportation to the clinic without necessitating a home address as a pickup location. Clinics should act as health and service hubs, providing for other basic needs for houseless opioid using patients who are stigmatized in so many other health care and service settings. Methadone programs should help compensate for these gaps in resources and treatment by offering hygiene supplies, tents, bus passes, and other such items, for example.

Finally, individual clinic case management should not be biased against houseless patients. For one, federal regulations which determine that unhoused people lack the necessary stability to meet take -

home dosing eligibility criteria simply because they are houseless should be actively lobbied against by methadone programs.

Patients Working in the Sex Trades

There is evidence that survival sex work is associated with poor opioid agonist treatment engagement and retention for patients and even with early withdrawal from low-threshold treatment.^{<191>},^{<192>},^{<193>},^{<194>},^{<195>} In fact, one large study found that sex trade involvement was negatively associated with methadone maintenance. In many studies, sex working methadone patients have proven to be more likely than non-sex working methadone patients to have less education and higher rates of incarceration, STIs, psychological distress, childhood sexual abuse, partner abuse, and current stimulant and alcohol use.^{<196>},^{<197>} Given the greater vulnerability of sex working methadone patients, the paucity of research and policy addressing how to engage and retain this population in methadone treatment is concerning.

Our experiential observations as drug user and sex worker activists on the ground identify several problem areas within methadone treatment for sex working patients. Dosing hours can be inconvenient for all working patients, but early morning hours can be particularly difficult for workers in the sex trades who not only generally work nights but also often do not have set working hours. Since many methadone program policies mandate halved doses after two days of missed attendance and withheld doses and onerous reinstatement processes after three or four missed days, the consequences of such inconvenient scheduling can be severe for patient retention.

More generally, in our experience, methadone clinic counseling sessions can often be hostile environments for patients in the sex trades. As a rule, methadone clinic counselors are not given evidence-based training on sex work. They are thus likely to have erroneous views such as conflating all sex work with trafficking or understanding sex work as a consequence of psychological issues rather than seeing it as an economic survival strategy. This may engender a therapeutic environment in which sex working patients hesitate to disclose a central facet of their lives to their counselors. If a patient does take the risk of disclosing, we have observed that counselors may use involvement in the sex trades as a sign of instability, disqualifying the patient from take-home dosing eligibility. Counselors may also urge patients to quit sex work before they are ready, before they have a viable economic alternative to the sex trades, or simply before they want to transition to another career. Moreover, our experiences as patients and activists have demonstrated that biopsychosocial assessments in methadone clinic counseling often have a very traditionally heteronormative framing, such that a sex working patient may feel shamed and degraded in the context of these implied values. Since both internalized and external stigma^{<198>} have been associated with negative impact on sex worker health,^{<199>},^{<200>} including high HIV rates and bad mental health outcomes,^{<201>} this is alarming.

We recommend that clinic staff receive training by sex worker organizers in sex worker health and safety, as defined by sex worker health projects such as St. James Infirmary. We further recommend that since many people who use opioids and participate in the sex trades often have little contact with healthcare systems outside of their treatment in the opioid treatment programs, methadone clinics could become a valuable, non-judgmental space to offer sex worker specific health resources and referrals such as condoms and lubrication, post exposure prophylaxis (PEP), pre-exposure prophylaxis (PrEP), OB/GYN care, and mental health treatment by providers who are sensitive to sex worker issues and respectful of sex worker agency.

Primary Care Prescribing and Pharmacy Access

Given that only 1,500 methadone clinics, most clustered in urban areas, exist in the United States, primary care prescribing would substantially broaden the scope of this life-saving treatment.<202> At the very least, if clinic doctors were able to offer primary care in addition to methadone treatment, patients would have expanded access to healthcare in a country in which drug users often have difficulty accessing many forms of treatment due to stigma and poverty. This move towards community-based treatment would better serve the needs of people who use drugs.

Pharmacy dispensing is another viable option. Nine out of ten people in the U.S. live five miles or less from a pharmacy, and there are about 67,000 pharmacies in the nation.<203> Research has found a 13.9 minute median difference in drive time for most subjects between the ride to a chain pharmacy and a methadone clinic.<204> This drive time difference is much larger for people in rural areas.<205> Offering methadone dosing at pharmacies would increase methadone treatment availability by a substantial amount, and reduce barriers to treatment, especially for rural Americans. Further, it would encourage methadone patients to take advantage of vaccination and other health services offered at pharmacies. Pharmacy dispensing systems have been used for decades in the UK and Australia, with positive attitudes reported from participating pharmacists as well as patients.<206> ,<207> ,<208> ,<209> ,<210>

Accessibility & Buprenorphine

Innovation is required to increase accessibility to methadone. Clinics should broaden dosing hours and allow unscheduled appointments to avoid forcing patients to take a depressant first thing in the morning. Patients should also be allowed to utilize telehealth and other technological advancements in an effort to reach a wider population.

Public health funding allocation seems to be trending towards buprenorphine/ buprenorphine naloxone treatment, since this medication can be prescribed in primary care settings outside of the regulatory structures of the methadone clinic system and presents as safer because of its low ceiling dose and limited potential to cause respiratory depression (although respiratory depression risk in methadone treatment is commonly highly overstated). But for many of us, buprenorphine and buprenorphine - naltrexone are simply not the right opioid agonist treatments.<211> For patients whose goal is not abstinence from other opioids, buprenorphine's high affinity for the mu receptor, displacing any pre-existing opioids, presents a juggling act to avoid precipitated withdrawal. Buprenorphine's weaker efficacy and low plateau dose also means it is not preferable for those with heavier dependence, a population which has grown as non-pharmaceutical fentanyl analogues have replaced heroin in street supply.<212> ,<213> And it is very difficult for existing methadone patients on efficacious doses of more than 70 mgs to transition into buprenorphine/buprenorphine naloxone treatment, requiring stabilization at a very low methadone dose (SAMHSA medical officials recommend 30 mgs or less)<214> ,<215> and slow, low dose induction on buprenorphine/buprenorphine-naloxone.

Access to methadone has become more vital than ever since the widespread proliferation of fentanyl in illicit street opioids and its contribution to the overdose crisis. For many of us, methadone is our safe supply in the absence of a legal, safer short-acting opioid made widely available.<216> Fentanyl's ubiquity has made induction on buprenorphine and buprenorphine -naloxone treatment more difficult, with more instances of precipitated withdrawal.<217> While there is limited evidence that the implementation of micro-dosing/the Bernese method would ameliorate this problem<218> as well as

some of the abovementioned difficulty in transitioning from methadone to buprenorphine/buprenorphine naltrexone, in the meantime, since few buprenorphine prescribers in the US practice this method, access to methadone is even more crucial.

Urban Survivors Union endorses access to all opioid agonist treatments available, and we support the complete removal of the data-x waiver system<219> as well as state restrictions<220> artificially limiting buprenorphine prescription in the U.S. However, we believe the solution to the problem of restricted methadone access is not simply greater access to buprenorphine/buprenorphine-naltrexone, which is currently available through prescriptions in a primary care setting. The solution is greater access to both opioid agonist treatments with a meaningful choice provided to patients on what the better treatment is for each individual.

Low Threshold Treatment

As discussed throughout this text, methadone patients in the U.S. experience many barriers to treatment, including long waitlists, inflexible eligibility requirements, lack of access through primary care, and prohibitive costs.<221> Patients also experience treatment design barriers which make retention difficult, such as zero- or low-tolerance illicit drug ingestion policies, frequent toxicology requirements, mandated counseling, low patient autonomy, and dosing caps.<222> In harm reduction terminology, these sorts of barriers define what is referred to as high-threshold treatment. High-threshold treatment is characterized by an abstinence-based model and a high level of both treatment accessibility and design barriers, while low-threshold treatment is characterized by a focus on harm reduction and the minimization of both accessibility and design barriers.<223> In sum, all methadone treatment in the US should be regarded as high-threshold because of the regulatory limitations of the clinic system, but some clinics are still more high-threshold than others.

Long waitlists may in part be a side effect of high demand and short supply, with ballooning numbers of OUD patients attempting to find a slot in one of only about 1500 methadone clinics in the US. This may not be entirely due to shortcomings in clinics themselves: methadone clinics and opioid users are stigmatized to the point that it is difficult to build new clinics in neighborhoods which display NIMBY (Not In My Backyard) attitudes and towns, cities, and counties which often complicate zoning issues in direct defiance of the Americans with Disabilities Act.<224> Furthermore, many would-be new clinics, especially those without significant financial resources, may find it difficult to meet DEA, SAMHSA, and state regulatory standards. However, no other branch of medical providers besides drug treatment workers display the implicit belief that patients should prove their willingness to be in treatment by going through a series of tests or hardships, such as the requirement to call every hour on the hour for a free bed in detox in order to be fast tracked into outpatient methadone treatment from there. Often, high-threshold methadone treatment providers still believe that waiting lists serve a function on their own, demonstrating “motivation” and forcing patients to value treatment obtained with difficulty.<225> Yet, the World Health Organization, the Joint United Nations Programme on HIV/AIDS, and the United Office on Drugs and Crime position on substitution maintenance therapy is that positive treatment outcomes depend on timely entry into treatment.<226>

Some methadone clinics also still have very inflexible admission criteria, only admitting adults who have “failed” at abstinence-based treatment. Although some states in the U.S. do allow adolescent methadone treatment, the treatment is still rarely prescribed to this age group, though there is considerable evidence that methadone is linked to high treatment retention within this population.<227> Many clinics only admit patients whose toxicology screens test positive for opioids upon intake, disallowing preventative admission. Even SAMHSA guidelines recommend that only adults who have been diagnosed as suffering OUD for one year should be admitted.<228>

Of course, as discussed elsewhere in this document, lack of access to methadone through primary care and pharmacy dispensing defines the U.S. clinic system. This is to our detriment, considering how this model has expanded treatment availability dramatically.<229> In Canada, after the introduction of office-based methadone prescription in 1996, there was a huge increase in access to methadone throughout the country.<230> Methadone patient numbers grew in British Columbia from 2,800 in 1996 to 13,000 in 2012.<231> In Ontario, the increase was from 700 to almost 30,000.<232> Methadone treatment in primary care settings has also been linked to higher retention, higher patient satisfaction,<233> lower mortality,<234> and a decrease in behaviors associated with health risk and criminalization<235> as compared to treatment in specialized settings.

Low-threshold methadone treatment has been organized in a variety of ways throughout its global history, from the methadone by bus project in Amsterdam in the 80s<236> to a computerized program in Zurich in the 90s which allowed clients to dose at an unmonitored station, choosing their dose from within a permitted range.<237> Again, the regulatory obstructions of the clinic system make implementation of most of these models currently impossible in the United States, but these innovative strategies could inspire more flexible systems reaching more underserved populations after significant reforms are made.

Research demonstrates higher effectiveness on the part of low-threshold methadone treatment, however it is defined.<238> Even falling short of a transition to a primary care/pharmacy dispensing model, lower-threshold clinics are more likely to accommodate high risk populations such as the long term unemployed, injection opioid users, heavier opioid users, and housing insecure patients.<239> In a randomized control trial, patients selected from a long waitlist to a high-threshold methadone clinic in New York City to enter low-threshold methadone treatment---medication provision and HIV education without mandated counseling services---were also more likely to reduce their illicit opioid use and to still be in treatment at a 16 month follow up than the control group of patients on the waiting list.<240> Existing data also suggests that the punitive tendencies of high-threshold clinics often sabotage treatment efficacy. For example, withholding patients’ doses because of missed or late appointments or other failures to comply merely forces patients back into more dangerous illicit opioid use for the day the dose is withheld.<241>

Clinics are stymied by federal and state regulations from providing truly low-threshold treatment in terms of both treatment accessibility and treatment design barriers, but they should endeavor to provide treatment which is as low-threshold as possible.

Federal Policy

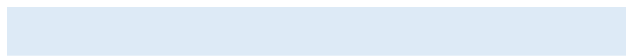
To level the playing field, fewer regulations beyond the federal level should be allowed. In the current system, clinics have autonomy to enforce site-specific regulations with no evidence to support their

efficacy. Regulation at the federal level should inform state policy in an effort to centralize methadone dispensing.

COVID-19

In March 2020, Substance Abuse and Mental Health Services Administration (SAMHSA) released guidance to methadone clinics to facilitate sheltering-in-place and social distancing, suggesting the provision of 28 days of take-home doses to patients deemed “stable,” and the provision of 14 days of take-home doses for patients who are “less stable” but who the clinic “believes can safely handle this level of Take-Home medication.”^{<242>} On April 21, 2020, SAMHSA published an extended FAQ which reiterated March’s guidelines while also allowing for broader use of telehealth within methadone treatment.^{<243>} No evidence has emerged of increased diversion and overdose among populations of patients who have received COVID-19 take-home bottles, though we have observed uneven implementation of these COVID-19 take-home guidelines among methadone programs nationwide (Brothers S, Palayew A, Strichartz K, et al., unpublished data, October 2020).^{<244>} A 2021 paper published in the *Journal of Substance Abuse Treatment* on community led research conducted by one of our chapters, North Carolina Survivors Union, also found surprisingly little self-reported diversion among methadone patient subjects.^{<245>} Many methadone patient advocates support the permanent institution of these relaxed guidelines.

On April 9th, 2020, Urban Survivors Union released an open letter to stakeholders which garnered 140 organizational signatories as well as such individual signatories as Obama-era drug czar Michael Boticelli. We advocated for further reforms of the methadone clinic system and opioid agonist treatment as a whole to protect patients from COVID-19 transmission and to make treatment more accessible, considering evidence which demonstrates that COVID-19 has exacerbated the overdose crisis. In order to avoid drug poisoning as well as COVID-19 transmission, we suggested the suspension of administrative discharge for the duration; referrals to COVID-19 testing at methadone clinics as well as the posting of plain language information on the virus; the broadening of primary care and pharmacy methadone dispensing; the suspension of toxicology requirements to reduce in-person visits and in-person visit times; the sanctioning of telehealth methadone induction; and the waiving of DEA restrictions on mobile units to accommodate sequestered, quarantined, and distant patients. We believe these steps would prevent further loss of life during this difficult period and point the way toward the commonsense reforms of the system as a whole which we have recommended throughout this text.



Conclusion

This text is a call for drug user and methadone patient organizing towards broader methadone dispensing in the United States, and a call for stakeholders to give us a place at the decision-making table. The relaxed COVID-19 SAMHSA guidelines allowing for expanded take home dosing eligibility

established in the spring of 2020 are the most policy change the methadone clinic system has seen in decades. A huge opportunity for patient organizing for greater reform has arrived, and we as a community of patients and people who use drugs must seize it---and it is morally and medically imperative for medical providers, researchers, legislators, and the treatment industry to support us in doing so.

In conclusion---since a personal story can often be more powerful than all the accumulated data in the world--- we would like to leave you with two stories about what two Urban Survivors Union members suffered because their access to methadone was obstructed:

Story One

“How did I get back here again?”, I wondered to myself as I tried to make sense of the sickening feeling in the pit of my stomach. It felt like my intestines were rotting from the inside out. My legs felt creepy-crawly-restless and all of my muscles were beginning to cramp. I was pouring sweat but freezing cold. That damn knot in the pit of my stomach just kept growing bigger every minute. It had been over 24 hours since I’d had anything, and if I didn’t get something soon I was pretty sure I was going to die.

What I really needed, and wanted, was methadone. But that would be out of the question again today, since my husband and I had gotten to the clinic too late to start the intake process. Never in my life had I thought that 6:30am would be “too late” to start anything, but then again it seemed like I was wrong about a whole lot of things in my life lately. I knew I desperately needed to do something different, or I would die.

Hell, I already had died 4 or 5 times that I knew of. Things had gotten really bad for my husband Jason and I. We knew getting into the methadone clinic would not be a simple process. By this point in my life I had realized that anything worth doing wouldn’t be easy. But this was just ridiculous.

My life already consisted solely of shooting dope and doing a laundry list of illegal things to get said dope. There wasn’t anything else. We were totally consumed by chaotic drug use. It wasn’t fun or exciting-- we were miserable. We wanted out, and we talked about what it was going to take to get there. Going to the methadone clinic seemed like the best possible option, so we made the decision and made plans to realize it.

On Sunday night, we got as much dope as possible to try to last through the night and morning. This was the only way we could show up at the clinic at 5am and start the long process of paperwork, endless questions, and doctor’s exams without getting totally sick from withdrawal in the process.

We had talked to someone on the phone who gave us what we thought was the correct information. Too bad the 1-800 number we called and the actual methadone clinic had nothing to do with one another, and didn’t communicate at all. When we got there at 5am, the lobby, waiting room, and dosing area were all jam-packed with people who seemed as desperate as we were.

We talked to a staff member and she told us the clinic had a waitlist due to the epidemic. It was springtime of 2016, and the opioid epidemic was in full swing. She gave us some preliminary paperwork to fill out, made copies of our ID’s, and wrote our names on a clipboard. Then she told us to come back on Thursday...NEXT Thursday, not this one.

My breath caught in my throat. 3 days I could have handled. But 10 days? Every single day of our miserable existence consisted of stealing lawn equipment out of people's open garages to take to the pawn shop so we could get enough money for dope to not be sick.

I walked out of the clinic, defeated, and one look at Jason's face told me he felt exactly the same. We didn't want to be living this life anymore.

I'm not sure how, but somehow we made it another 8 days without getting arrested. The staff member from the clinic had tried to call Jason's phone, but we had pawned it for money to get well one day. I was so glad I'd insisted that we keep at least one phone between us, though, and as soon as I saw the number from the clinic pop up on my phone's screen, I answered.

The counselor informed me that we had been bumped up on the admittance list, because some of the other people in front of us hadn't shown up to do their intake. I assured the woman on the other end of the line that we would definitely be there the next morning at 5am. Jason and I were so relieved. We actually had enough dope to last until the next morning, so now all we had to do was wait.

The next morning, we went to the clinic and began the long process of intake. There are countless questionnaires, more paperwork, releases to sign, and a doctor's exam, so the prescription for your methadone can be written and the order submitted into their in-house pharmacy at the clinic. We got a good chunk of all of that done when the counselor informed us that the doctor wouldn't be there that day, so we wouldn't be able to have our exams and the prescriptions written until the next day.. which also meant we wouldn't be able to start our methadone until the next day. I was definitely disappointed, but on the other hand, even though the situation sucked, I felt somewhat accomplished and also hopeful. We left the clinic and struggled through another day.

The days that we could get money from our families or otherwise avoid breaking the law were like little bright spots in an otherwise dark and dismal world. It was so nice to just be able to call our dealer and already have the money, as opposed to having to do a series of sketchy, risky things to acquire it. Most of the time, I would be the getaway driver after Jason grabbed the lawn equipment out of someone's open garage or off their grass. He really didn't like for me to participate more actively because he didn't want me to get into trouble, and I loved him for that. We had just recently gotten engaged and would soon be married.

The next morning, we were back at the clinic again, although not quite as early since we had finally finished all the required paperwork. At this point, all we needed was the doctor's exam and the prescription order.

But when we got to the front desk to check in, the people behind it were whispering among themselves. It was obvious they knew something we didn't, and I asked what was going on. The receptionist informed us that the doctor wasn't there because of a family emergency, and that he wouldn't be back for another day or two. I remember asking her exactly when to come back so that we could start our medication.

By this point I was stressed beyond belief and Jason was downright angry. Why didn't these people seem to understand that they were playing with our lives, our sanity, our happiness and even our freedom? But it's not like I could just come out and say, "Well listen, we've been stealing to support our habit so y'all need to hurry the hell up". I asked the receptionist 2 or 3 more times to please make sure

she was telling us the right day to come back so that we would finally be able to start our medication. She assured us that if we came back on Sunday, the doctor would definitely be there and we'd be able to start dosing, no problems.

So we struggled through another weekend, begging and stealing just so we could get well. Anyone who has used opioids for an extended amount of time will tell you that once you pass a certain point, you shoot dope to not be sick... you don't really get high anymore. Well, unless you can afford to, which we clearly could not.

By this time, it had been a 3-week long process for us to be admitted into the methadone clinic and things were getting worse for us each and every day. Our whole life was consumed by doing whatever we had to do in order to get dope to get well.

On Saturday, Jason came back to the house freaking out. He had parked our car a few parking lots over, backed in with the license plate removed. Somebody had seen him running from their neighbor's garage and called the cops. This was exactly what we had been trying to avoid, and I couldn't help but think about how the people who worked at that damn clinic had dragged their feet this whole time. If they had done what they got paid to do, we could've started our methadone weeks ago. But people are unable to care about or understand these things until it affects them or someone they love directly. It felt like nobody at that damn clinic gave a shit about us or what we were going through, about how badly we wanted to stop using.

On Sunday morning, we headed back over to the clinic to try to start our methadone again. The previous night had been awful. We'd ended up with very little money, so therefore very little dope, and were stuck at the house unable to do anything about it. We had to leave the car parked with the tag off because we just couldn't risk getting arrested. Not when we were so close to being able to start our methadone and fixing this mess we had gotten ourselves into.

When we pulled up at the clinic, I already had an uneasy feeling, and it wasn't just the dope-sickness starting to creep in. Something in the back of my mind told me there would be yet another problem, and that we wouldn't be able to dose that morning either, and I was exactly right. The receptionist who had told us to come back on Sunday wasn't there, of course. Neither was the doctor. A counselor came out from the back offices to talk to us and seemed confused as to why we would even be there trying to see the doctor on a Sunday.

It was at this point that I completely lost my shit. Usually, Jason was the angry one, but this time it was my turn. I was fuming mad, I was livid. It takes a whole lot to make me that way, but I was there.

I started crying because I was so frustrated. I began yelling at the counselor and asking her why the hell it had taken 3 weeks for us to be able to start our methadone. I remember that about the time I was screaming at her about how completely unacceptable this was, the security guard moved to her side and began trying to diffuse the situation, trying to get me to calm down.

I'm usually very calm and understanding, but these people had to understand that they had pushed me past the brink of sanity these past few weeks. I told the counselor that I understood it wasn't her fault; I had never even seen this staff member before. But I pleaded with her to let the powers that be know that we had been trying to start our medication for weeks now. I couldn't take any more of this; I felt

like I was seriously losing my mind. I just wanted to be able to go to the clinic and take my medicine every morning so I could feel like a semi-normal person and not a piece of shit criminal junkie.

The counselor gave me her word that she would make sure we would get to see the doctor and begin dosing the next day, on Monday morning. And for the first time, somebody that worked there gave a shit and kept their promises.

The next morning when we came back, the program director came up to us personally and apologized. Apparently there had just been a series of unrelated, unfortunate events that had resulted in me and Jason getting the worst possible outcome imaginable. We both saw the doctor, who apologized and explained there had been a death in his family and he'd had to leave town unexpectedly. He put the order in for our prescriptions, and we went to the dosing area and waited for what felt like another 50 years.

And then, finally, we were both called up to the dosing window and allowed a small amount of magical pink liquid that prevented us from being sick for most of the day. It was nowhere near enough, but it was a start. Finally, after hell and half of Georgia, it was a start.

If only it had come sooner. Another couple weeks after that, we got arrested. All our illegal activities had caught up with us, and even though we had stopped, it ended up being too little, too late.

Story Two

"Wake up!" my wife screamed for the thousandth time, her normally calm speaking voice edging into anger. The rubber band in her hair signified her readiness for combat.

It was almost 7 a.m. and in order for our mighty red Civic to get to Indianapolis, an hour and 15 minutes away, we had to leave early. The clinic was notorious for arbitrarily closing their doors right at 10:30 am for an hour and half.

I got up, washed my hands and face, and got dressed. I almost made it to the front door, but forgot I needed the bank tight security lock bag containing my 27 empty take home bottles, that all-important blue nylon bag that held my bottles of joy. The clinic was so far away, and I'd forgotten that bag enough times only to have to drive all the way back that that lesson had finally sunk in. My wife grabbed the keys, we got our coffee, and hopped in the car for our monthly ride to the clinic.

I had been at this clinic off and on since I was 18. It had been my 40th birthday last week. I'd been through at least 15 counselors, four directors, and about a hundred nurses. More people had handled my urine than I can count. (Ah, urine, that vital fluid, the end all be all of a MAT patients' fate. I'd gotten a couple false positives in the past and racked up large bills proving they were false.)

I was going on 10 years during this stretch of being in the clinic. I was full of confidence because I knew I wasn't using, and I knew I had all my bottles with the right dates on them---I knew that I was okay.

I walked up to the 10-person line formed outside, which was small, considering the line sometimes stretched in a meandering crisscross around the large parking lot. I checked my cracked-screened phone and breathed a sigh of relief: 9:25 am.

But as I passed through the crowd barriers and up to the nurse's station, I realized this was not a nurse I knew well. Her panda-covered scrub top was crisp and new. This is always a moment of dread for any clinic patient. Will she be kind? Will she be mean? Will she want my pee?

I decided to go with patented institutional personality 1, Courteous and Polite, since that is my affective go-to at clinics. I handed her all my bottles and watched as she counted them. She set them in front of her and everything seemed to be going fine. But then her beady eyes turned to something one could only see from her vantage point.

"This lid is not right!" she exclaimed. All joy fled at her weirdly gleeful exclamation.

I told her that the lid had to be right because a clinic nurse had given it to me.

"We'll see about that," she replied.

I was petrified. How could my years of work be jeopardized by a person so eager to dole out punishment? Her squared shoulders and the hands balled on her hips told me right away that this was gonna be a long fight.

After a lot of back and forth, the nurse still insisted that the bottle lid was wrong. I was sent to my counselor to talk about my bottle lid problem.

I explained to my ex-pastor counselor that I had seen the lid and that it was an old lid of the type that the clinic had been using a couple of months ago. He put out his smooth hands to me and started a prayer. His generic ministrations felt like a death knell.

"Damnit," I thought, "I'm fucked."

The battle waged for weeks, with me on daily dosing and the clinic going through the motions. I took pictures of that exact type of lid in a box labeled "lids" in the clinic office. I provided endless proof of my good record. Nothing seemed to matter.

Eventually we had a big meeting with the director and the State Opioid Treatment Authority (SOTA). The SOTA was a tower of a man with a bevy of gold rings that would shame a pimp. He had an easy manner born from struggle. We shared a lot of the same life experiences dealing with drug use brings. The SOTA was on my side and stated that the state was ok with giving me back my take homes. I was being backed by authority---that was a new experience for me.

Yet the clinic director, acting on all the wisdom she'd accumulated in her 28 years on this Earth and her 3 years in the MAT biz, said she could not prove that it wasn't diversion and so took my take homes. The SOTA was blown away, and it showed in the wringing of his giant hands.

The triumphant clinic director offered me a week of take homes instead of taking all 28. This was a courtesy, she said. I told her there was a special place for people like her.

The SOTA actually sat there the whole meeting and stuck up for me, exclaiming that the state would go to bat for me at the federal level if needed. But in the end, the clinic won. The SOTA still tried in vain to comfort me and offered a lot of good-hearted suggestions.

But I was absolutely done. I'd resisted the temptation to raise my dose as high as I could go. I was actually slowly tapering my dose. I had even bought into the idea that higher doses meant I was trying to get high. God, I could have used an introduction to harm reduction right then.

I had been in a great place in my life. I had just bought a house, got my kid through 20 surgeries, and married the most amazing human I had ever met. I was trying to get off SSI and look for work. This clinic fiasco was one of the most debilitating things that had ever happened to me.

In the end, I went back to cadging quack doctors for methadone pain prescriptions. I would rather trust the lies I'm telling them than the lies the clinic tells.

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