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A chance to do it better: Methadone maintenance treatment in the age of Covid-19

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ABSTRACT

Methadone maintenance treatment (MMT) in the United States, and particularly the clinic system of distribution, is often criticized as punitive, over-regulated, and misaligned to the needs of many patients. However, changes to the regulations that COVID-19 caused may have provided an opportunity for improving service. This commentary uses literature and my own experience to provide a brief description of how MMT programs responded to the threat of Covid-19 and how such responses fit into the larger context of attempts to reform treatment. It discusses, in particular, opportunities for liberalizing “take-home” doses and implementing office-based MMT.

Methadone maintenance treatment (MMT) in the United States (U.S.), and particularly the clinic system of distribution, is often criticized as punitive, over-regulated, and misaligned to the needs of many patients (Frank, 2018, 2019; McElrath, 2018; Novick et al., 2015). However, as someone who both studies, and has been on MMT for approximately 15 years, I am hopeful that changes to the regulations that COVID-19 initially caused may have given us a chance to do it better.

Because of strict regulations that require daily attendance for most patients (Borisova & Goodman, 2004; Peterson et al., 2010), methadone clinics are often characterized by crowded rooms and long lines, and, thus, states quickly recognized them as dangerous sites of potential disease transmission (The Substance Abuse and Mental Health Services Administration [SAMHSA], 2020a, 2020b, 2020c). SAMHSA responded by instituting amended guidelines allowing clinics to provide a greater number of “take-home doses” to a greater number of patients, thereby reducing the need for daily attendance (Knopf, 2020; SAMHSA, 2020a). The new policy allowed clinics, whose take-home guidelines had previously been governed by differing state and local regulations, blanket exceptions to allow all “stable” patients the ability to receive 28 days of take-home medicine (SAMHSA, 2020b). Patients seen as less stable, but still capable of handling their doses, were eligible for 14 days of take-home doses (SAMHSA, 2020b). Clinics were also given greater latitude in allowing family members or other trusted sources to pick up medication for those in quarantine (SAMHSA, 2020c).

Although these changes were adopted for public health reasons linked directly to COVID-19, they may also represent ground gained for

patient advocacy and harm reduction groups. Such organizations, who argue that take-home regulations are far too restrictive, point out that previous research has linked MMT’s low rates of use and retention to its time-consuming, intrusive nature (Frank, 2018; Nolan et al., 2015; Open Society Foundation, 2010; Strike et al., 2013). Moreover, qualitative studies have demonstrated the tremendous difficulty of maintaining a job, school, or stable life while forced into a system of endless daily attendance—often early in the morning and for many hours at a time (Frank, 2019; Gerra et al., 2011). When the threat of COVID-19 is reduced most participants who have been enjoying the benefits of expanded take-homes will not want to revert to pre-COVID-19 regulations, and forcing them to do so would almost certainly lead to increased drop-outs.

My own experience also supports the need for greater use of, and access to, take-homes for people on MMT. Since I was lucky enough to begin treatment at a clinic that used a harm reduction approach, I was able to access take-homes despite my occasional use of substances, eventually earning the maximum amount of 28 days. It was only because of the freedom that take-homes provided that I was able to transition from a life on the street to something more stable. Had I been forced to attend the clinic every day, for years on end, I not only would have never been able to attend school and earn my PhD, I would have almost certainly left treatment and returned to daily heroin use. Yet before COVID-19, programs offering 28-day take-homes were so rare, that few patients were even aware they existed. In fact, there are patients who fly from out of state, every 28 days, to attend the same New York City clinic that I do, because they are unable to find that service any closer to where

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they live.

Thus, it is critically important that researchers take advantage of this unique opportunity by collecting data on how patients have experienced changes to their treatment. If the results of such studies align with previous research, these data can be used to argue for a less punitive approach that may ultimately lead to better rates of patient use and retention. Since MMT is associated with a number of benefits, including reduced rates of overdose (Degenhardt et al., 2009; Gerra et al., 2011; Sordo et al., 2017), reduced transmission of blood-borne viruses like HIV and HCV (Litwin et al., 2009; Nolan et al., 2014; Palepu et al., 2006; Uhlmann et al., 2010), and recidivism (Bellin et al., 1999; Macswain et al., 2014), greater participation could have significant public health value (Bellin et al., 1999). Moreover, the implementation of these regulatory changes has to be examined in greater detail. Early reports suggest that states adopted SAMHSA's mandate to expand patients' access to take-home doses unevenly, and questions remain about how clinics determined which patients met the revised take-home criteria (Filter Magazine, 2020; Trad et al., 2020).

Although regulators and clinicians are likely to be concerned that more take-homes will lead to increased rates of overdose, diversion, and illegal substance use, previous research has complicated these claims by framing diversion as a response to the heavy-handed regulation of people on MMT (Harris & Rhodes, 2013; Havnes et al., 2013). For example, Harris & Rhodes describe diversion as an "indigenous harm reduction strategy" and demonstrate its role in "helping participants to manage their drug use, prevent withdrawal, cement social relationships, and inadvertently protect against hepatitis C transmission" (Harris & Rhodes, 2013). Overdose and illegal substance use have also been linked to the strict rules that govern MMT by contributing to its inaccessibility and corresponding low rates of use and retention (Frank, 2018; Langendam et al., 2001). For example, a friend who had been in MMT for two years and was receiving weekly take-homes, described treatment as a lifechanging experience. Since starting MMT, he had obtained a job, an apartment, and was enrolled in classes at a local college. Yet when he had to move to another state, his new clinic demanded that he stop using cannabis and revoked his weekly take-homes. Not surprisingly, the sudden need to commute every morning to a clinic located 45 min away significantly impacted his ability to work and continue attending classes, as well as his overall attitude toward treatment. Although he tried to plead his case, after numerous unsuccessful attempts, he eventually quit, angry and frustrated, telling me that MMT is structured in a way that prevents rather than facilitates recovery. Within months he died of a fentanyl-involved overdose.

In contrast, I have seen patients flourish under the less restrictive COVID-19 guidelines. Friends have joyously described the advantages of their newfound freedom, including the ability to prepare their children for the school day; not having to fear showing up late to work on a daily basis or having to lie to their employers as to the reason; or even just spending a morning in bed without needing to rush to their clinic every day. As one MMT provider who supports expanding access to take-homes told me, "I had a patient just yesterday tell me she's going on vacation for the first time in 10 years, because she actually has the medication supply and doesn't have to worry about that."

Patients have also reported that receiving take-homes makes them feel less stigmatized and more a part of legitimate health care provision. Thus, allowing people greater access to take-homes may result in increased patient confidence, and greater levels of trust and cooperation between patients and treatment providers.

People who study medication for opioid use disorder, myself included, have also argued that now is the ideal moment to begin offering methadone maintenance in an office-based setting, similar to the way that buprenorphine is managed (Filter Magazine, 2020; Frank, 2020). Scholars and advocates have pointed out that in addition to problems specific to COVID-19, the clinic system itself is both stigmatizing and poorly suited to address the diversity of patients' needs (Bonuck et al., 2003; Filter Magazine, 2020; Frank, 2020)—particularly

the many who utilize MMT as a way of reducing the harms of active substance use rather than to become abstinent (Frank, 2018, 2019).

Research has also demonstrated the clinic systems' particular vulnerability to unforeseen catastrophes such as this current pandemic. For example, social scientists described how a large number of New York- and New Jersey-area patients had to go without service for days when their clinics closed during Hurricane Sandy, often with no advance notification or backup plan to help them find alternative providers (Elliott et al., 2017; Matusow et al., 2018; McClure et al., 2014). Moreover, because of stigma against people on MMT, and people who use drugs generally, many of those seeking help from hospitals and other medical providers were met with cold indifference (Bonuck et al., 2003).

Alternatively, office-based treatment settings allow for a less stigmatizing treatment experience that can be better tailored to patients' individual goals (LaBelle et al., 2016; Weinstein et al., 2017). There is even evidence that some people on MMT switch to buprenorphine, despite a preference for methadone, solely because the clinic system makes the latter impossible as a long-term solution (McClure et al., 2014).

During the last 15 years, I have seen too many people discharged from treatment or leave in abject frustration because of the rigid enforcement of outdated regulations. All too often, these individuals have subsequently died from an opioid-involved overdose. Yet MMT, if practiced in a common-sense manner that aligns with the real-world needs and goals of people on the program, has the potential to save many lives. Thus, while COVID-19 has exacerbated many of the problems with MMT, it has also provided an opportunity to pause, and reimagine treatment in a different, and better, way.

Declaration of competing interest

The author reports no conflicts of interest. The author alone is responsible for the content and writing of this article.

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