Liberating Methadone: A Roadmap for Change Conference Proceedings and Recommendations

June 2024

Contributors

National Coalition to Liberate Methadone
National Survivors Union
NYU Langone Center for Opioid Epidemiology and Policy (COEP)

Support for this project was provided by The Pew Charitable Trusts

Acknowledgements

Conference Organizing Committee

Noa Krawczyk, PhD
Caty Simon
Jordan Scott
Paul Joudrey, MD, MPH
Leslie W. Suen, MD, MAS
Aaron Ferguson, BSW
David Frank, PhD
Rachel Simon, MD
Simeon D. Kimmel, MD, MA
Danielle Russell, PhD
Kimberly L. Sue, MD PhD
Ximena Levander, MD, MCR, FACP
Louise Vincent, MPH
Ayana Jordan, MD, PhD
Robert Suarez
Tanya Russell
Nicholas Voyles
Ryann Koval, LPCA
Caroline Barnes, MPH

Conference Funders

The Pew Charitable Trusts
Vital Strategies
Bloomberg Philanthropies
Foundation for Opioid Response Efforts
National Institute on Drug Abuse
NYU Clinical and Translational Science Institute

Proceedings Report Organizing Committee and Support

Caty Simon
Jordan Scott
Noa Krawczyk, PhD
Sheri Doyle, MPH
Frances McGaffey, MPP
Megan Miller, MPH
Gabby Gayle

Post-Conference Working Group Participants

Louise Vincent, MPH
Nicholas Voyles
Corey Davis, JD, MSPH
Frances McGaffey, MPP
Hiawatha Collins
Irene Garnett BA, MLIS
Tracie M. Gardner, BA
Elizabeth (Libby) Jones, MSc
Simeon D. Kimmel, MD, MA
Rachel Simon, MD
Kimberly L Sue MD PhD
David Frank, Ph.D.
Aaron Ferguson, BSW
Paul Joudrey, MD, MPH
Abby Coulter, MPRA
Zoe Weinstein, MD, MS
Christopher Stock, PharmD
Leslie W. Suen, MD, MAS
Kathryn F. Eggert, PhD, LCSW
Daniel Schatz, MD

Report Reviewers

Brendan Saloner, PhD
Sally Friedman, JD
Jacqueline Seitz, JD
Charles Neighbors, PhD

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Abbreviations

Abbreviation	Term
ADA	Americans with Disabilities Act
BIPOC	Black, Indigenous, and Other People of Color
CBO	Community-Based Organization
CMS	Center for Medicare and Medicaid Services
DEA	Drug Enforcement Administration
FDA	Food and Drug Administration
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
MOUD	Medications for Opioid Use Disorder
MT	Methadone Treatment
NIDA	National Institute on Drug Abuse
OSHA	Occupational Health and Safety Administration
OTP	Opioid Treatment Program
OUD	Opioid Use Disorder
PCC	Person-Centered Care or Patient-Centered Care
PCP	Primary Care Provider
PWLLE	Person/People with Living and Lived Experience
PWUD	Person/People Who Use(s) Drugs
SAMHSA	Substance Abuse and Mental Health Services Administration
SOTA	State Opioid Treatment Authority
SUD	Substance Use Disorder
TA	Technical Assistance

Glossary

Term	Definition
provider(s)	Individual clinician and other personnel providing healthcare
provider organization	An entity or group that delivers health care services, staffed by clinicians and non-clinical personnel
shared decision making	An approach in which clinicians share the best available evidence and patients are supported to consider options to achieve informed preferences
opioid treatment program	Programs certified by federal and state governments to provide methadone and other services for opioid use disorder
methadone	Methadone is a long-acting full opioid agonist and a schedule II-controlled medication
problematic opioid use	Opioid use for which individuals could benefit from evidence-based medications such as methadone; more widely accepted by PWLLE who may not always identify as having an opioid use disorder or agree with the model of opioid addiction as a brain disease
person and patient-centered care	Treating patients as individuals and equal partners in the business of healing; this approach is personalized, coordinated, and enabling
State Opioid Treatment Authority	The state official responsible for oversight of OTPs.

Introduction and Report Summary

Each year, more than 100,000 people in the Unites States are dying from preventable overdose.[1] In 2022, it was projected that—barring drastic change—1.2 million more are expected to die of overdose by 2029.[2] This is greater than the number that died from COVID-19 as of February 2024.[3] Methadone treatment (MT) is one of the most researched and effective solutions to preventing overdose deaths, but it remains more difficult for most US residents to obtain than illicit fentanyl.

Methadone is a synthetic opioid that is highly effective at addressing problematic opioid use by reducing cravings and withdrawal symptoms. In 1971, the first MT program was established. In the succeeding decades, overwhelming research has demonstrated the effectiveness of methadone for decreasing overdose, reducing the transmission of infectious disease, mitigating the risks of problematic drug use, and improving substance use treatment retention.

Despite such overwhelming evidence, most US communities do not have access to methadone. Less than 25% of those who could benefit from MT receive it.[4] The current structures of the US methadone treatment system raise critical questions about healthcare access, stigma and criminalization, and the effectiveness of our current paradigms.

Liberating methadone to make it an accessible, effective, and ethical tool to improve the health of our communities requires a bolder vision. We need to address the dichotomous tensions that hold the treatment system hostage: autonomy versus paternalism, compassion versus criminalization, and health-focused strategies versus coercive ones. After years of ineffective and counterproductive responses to overdose—and decades of misdirected policy to address opioid use—the time has come to put methadone within reach of those who might benefit from it.

Too often, MT has been viewed through a lens of crime reduction and abstinence-based recovery rather than a holistic view of health. It is time to shift our focus toward viewing MT as a component of a comprehensive health strategy that includes mental, physical, and social well-being. It is also time to reframe conventional wisdom on why individuals use drugs. Substance use is influenced by a multitude of factors, including social, economic, psychological, and biological ones. A deeper understanding of these factors and how to address them can lead to more effective, compassionate, and holistic approaches to care.

Finally, it is time to reform what patient advocates call "the culture of cruelty" around methadone, in which the structure of treatment leads to punitive measures, stigmatization, and results in lack of compassion for people receiving care. The culture and structures that uphold it must be replaced with approaches that respect the dignity and autonomy of individuals seeking treatment.

In September 2023, a national conference, Liberating Methadone: A Roadmap for Change, was held to rethink our MT system, and to move towards critically needed reform. It was organized by a coalition of people with lived and living experience (PWLLE) of MT, healthcare providers, researchers, and others invested in methadone reform, and based on the value of co-leadership with directly impacted people. Across 2 days, more than 800 participants—including persons who use drugs (PWUD), persons in methadone treatment, researchers, clinicians, policy makers, and those who hold overlapping identities—exchanged ideas on how to improve access to and use of methadone to mitigate the risks of problematic opioid use. These conversations came at a critical point in time. As the street drug supply becomes increasingly dangerous and the overdose epidemic continues with unprecedented numbers of deaths driven primarily by opioids, access to a safe, effective, and well-studied opioid medication is paramount.

Over 2 days, panels covered 5 key topics: (1) gaps and opportunities in methadone research; (2) prioritizing community-engaged research on substance use; (3) the history of MT and opioid treatment programs (OTPs); (4) the current state of MT regulations and opportunities for reform; and (5) strategies for reforming and transforming MT. The conference also included skills-building workshops and 42 poster presentations on research, policy, practice, and lived experience around MT.

After the conference, two working groups were formed to synthesize, frame, and refine conference take-aways, producing the current set of recommendations to move the work of liberating methadone forward. The recommendations are grouped into six strategic focus areas. The first two—centering living and lived experience in policy and practice, and normalizing MT as healthcare— ground and guide the remaining ones. The others propose increasing person-centeredness in MT, improving OTP practices, creating alternatives to the OTP structure, and shifting public thinking about MT. Together, these six areas provide a path to liberating methadone, moving toward a more evidence-based and humane system of care.

The six focus areas are as follows:

1. **Centering living and lived experience in policy and practice.** It is critical to center people with lived and especially living experience in policymaking and practice. The strategies in the first focus area include placing PWLLE in decision-making roles to ensure that policies and practices are informed by those who understand the challenges firsthand, diversifying the workforce, and fostering community-engaged research to ensure that MT is responsive to the needs of those it serves.

2. **Normalizing MT as standard healthcare.** It is time to reframe MT as a standard healthcare practice. This involves establishing educational infrastructure for healthcare providers and opioid treatment clinicians to shift perceptions and improve the standards of MT practice. That infrastructure would educate healthcare providers to shift stigmatized perceptions, establish training on best practices and support for clinicians in OTPs, and promote MT as a legitimate and necessary medical service across multiple healthcare settings.

3. **Grounding MT in person-centeredness.** MT should prioritize the individual goals and safety of patients. The strategies in this focus area advocate for a person-centered approach to MT, which include framing treatment around patient-defined goals, redefining safety to

prioritize trust and ongoing connection to care over punitive measures, and collecting and analyzing data on person-centered outcomes.

4. **Improving OTP practices.** It is time to replace the culture of cruelty with a culture of care. The recommendations in the fourth area outline ways to improve OTP practices, such as reducing barriers to and burdensome requirements associated with their use, expanding telehealth options, enhancing comprehensive care services, increasing transparency and patient protections within clinic systems, and leveraging accreditation and financing structures to incentivize person-centered outcomes.

5. **Creating alternatives to the current opioid treatment system.** To expand access to methadone, alternatives to the traditional OTP model should be adopted, as they have been in other countries. This area describes strategies for expanding methadone prescribing to non-OTP clinicians, allowing pharmacists to dispense methadone beyond uses for pain, and adopting coordinated care models to support MT coordination across various healthcare settings.

6. **Shifting public thinking about MT.** Public perception of MT has been plagued by stigma and needs to change. Efforts should focus on amplifying success stories, raising awareness of MT's value, and reducing stigma, particularly in communities that have been disproportionately affected by the overdose crisis and the War on Drugs.

Since the conference, the Substance Abuse and Mental Health Services Administration (SAMHSA) has taken steps to update regulations related to OTPs. In its final rule on *Medications for the Treatment of Opioid Use Disorder*, issued in February 2024, SAMHSA removed some key barriers that kept many patients from being able to access and continue MT, and made some COVID-19-related regulatory changes permanent, including greater flexibilities on initial dosing and take-home schedules. Proposed legislation, the *Modernizing Opioid Treatment Access Act (MOTAA)*, would allow patients to be prescribed methadone by addiction treatment providers and pick up methadone in community pharmacies.

Critically, these changes and proposals begin to recognize the autonomy and expertise of the patient, centering patients in their own care. While these changes begin to scratch the surface, the recommendations in this report take a broader view for what it would take to expand access to methadone both inside and outside of the OTP structure. They take, as a fundamental value, that MT is healthcare, and as such, should be integrated into *all* channels people use to maintain their health.

The call to liberate methadone in the United States is a call to fundamentally change the way methadone is prescribed, dispensed, regulated, and perceived, with the goal of making it more widely accessible. We must ensure that methadone is available to all who need it, regardless of their location, socio-economic status, or background. This will require simplifying the ways in which individuals initiate and remain in treatment, easing restrictions on where and how methadone is dispensed, allowing more settings to offer MT, and changing public and professional attitudes toward it. This must be a collective effort, involving state and federal policymakers, clinicians, and researchers, and led by PWLLE. Only through these significant changes will methadone reach its true public health potential, reducing deaths and advancing health and dignity in our communities.

This report is of unique importance due to its perspective, grounded in living and lived experience. It provides insight into the implications of policy failures and systemic shortcomings that contribute to the ongoing crisis of overdose deaths. It transcends traditional academic research by offering an authentic, unfiltered examination of obstacles faced by those directly impacted by the issues at hand. It elevates the voices of the most affected, ensuring that their experiences and needs are at the forefront of the discourse, thereby promoting solutions that are more effective and humane. This approach challenges and enriches the conversation, advocating for a paradigm shift towards drug and health policies that genuinely address the needs of those most at risk, thereby embodying a crucial step towards real and impactful change.

The report is divided into three sections. The first provides a brief history of MT. The second summarizes the conference proceedings. The third focuses on a narrative of policy and practice recommendations that stemmed from the conference, with specific recommendations per target group summarized in a table at the end of each focus area. The report concludes with some thoughts on future directions.

Background

Methadone is a long-acting opioid agonist medication approved by the Federal Drug Administration (FDA) to treat problems related to opioid use. Like some other opioids (e.g. oxycodone, heroin, and morphine), methadone is a full opioid agonist, meaning it fully binds to opioid receptors in the brain. But unlike other opioids, methadone is long-acting; its effects are felt more slowly over a longer period. Because of this, it is highly effective at addressing problematic opioid use by reducing cravings and withdrawal.[5] Methadone can also be used for treatment of pain, which is not the focus of this report.

Methadone, when used as a treatment for problematic opioid use, is usually taken in liquid form, either formulated as a liquid at the outset, or as a diskette that is dissolved in water. In some cases it is also taken in pill form.[6] How one's body absorbs, processes, and clears methadone varies widely; it is typically taken daily, but frequency and dosage vary depending on the patient. When patients start methadone, it can take approximately 5 days to reach a steady therapeutic dose,[7] but this varies depending on the patient. Treatment length varies by individual, but it is recommended to be taken as a long-term medication; patients can and do safely take it for many years or indefinitely.[5]

Like other full opioid agonists, methadone at higher doses can lead to overdose via respiratory depression if it exceeds a patient's tolerance. Still, methadone overdose deaths are rare and make up less than 5% of overdose deaths.[8] Even when take-home dosing increased during the COVID-19 pandemic, a concomitant increase in the proportion of methadone-involved overdoses compared to other overdoses did *not* occur.[9,10] Importantly, overdose risk is much greater among patients who *can't* access or *stop MT* as they are more likely to use other stronger and unregulated opioids.[11] There is also increased risk of overdose among individuals who can't access methadone through treatment programs and instead access it on the illicit market.[12] As such, risks resulting from current U.S. restrictions on methadone, discussed in the next section, far exceeds the benefits.

History of Methadone in the United States

> There is an inherent tension between health and law enforcement that will likely never end. Resolving this value conflict in a way that accords with today's needs rather than those of the 1970s when methadone policy was developed, is the primary purpose of our work.
>
> —Conference participant

Methadone was first introduced in the United States in 1947.[13] In 1965, a landmark study was published highlighting the effectiveness of methadone to treat opioid use disorder (OUD).[14]

In 1971, the first MT program was established, which was closely supervised and managed federally. The same year, President Nixon declared the "War on Drugs."[15] In 1972, the FDA limited methadone dispensing to federally licensed clinics (which came to be OTPs) and established many of what would become long-held MT regulations, including restricted patient participation eligibility, required justification from physicians for high dosages, and designated standards for take-home doses.[14]

In 1974, Congress passed the *Narcotic Addict Treatment Act*, requiring medical professionals to obtain a separate Drug Enforcement Administration (DEA) registration to treat opioid addiction with opioids.[14] MT was predominantly focused on as a crime prevention strategy, primarily in Black communities, and policies were consequently driven by stated concerns about diversion, community safety, and methadone overdose.[16] Treatment programs were regulated by a set of punitive rules that perpetuated distrust of patients who were seen as "potential criminals."[17] The number of MT patients surged from 400 in 1968 to 80,000 by 1976.[18] In 1993, SAMHSA was included in oversight of MT programs, along with the DEA.[15] While these federal bodies set the minimum standards, states established additional policies often more stringent than federal standards.[17] Regulation of MT remained largely unchanged since its initial implementation, until recently.

In the succeeding decades, research repeatedly demonstrated the effectiveness of MT for decreasing overdose mortality,[19] reducing the transmission of infectious disease, mitigating risks of problematic opioid use, and improving treatment retention.[20–23] Despite such overwhelming evidence, not all communities have access to MT. Highly segregated Black, Indigenous, and other people of color (BIPOC) communities are far more likely to have OTPs than their predominantly white counterparts,[16,24] which helped maintain the status quo of highly punitive methadone policies. At the same time, our society disproportionately incarcerates BIPOC individuals in jails and prisons that often do not provide methadone.[25,26] People receiving MT, therefore, are often forced into cruel and painful withdrawal

TAKE HOME DOSES OF METHADONE

Take-home dosing in MT refers to the practice of allowing patients to take doses of methadone home, rather than requiring them to consume every dose under direct supervision at a clinic. This practice provides greater flexibility and convenience for patients, reduces the burden associated with daily visits to an OTP, and helps integrate treatment into their daily lives.

Take-home doses have been subject to strict regulations at the federal, state, and clinic levels, ostensibly to minimize the risk of diversion, misuse, or accidental ingestion by others. Factors that may determine an individual's eligibility for take-home doses include length of time in treatment, adherence to program rules, participation in compulsory counseling, urine drug screens indicating no drug use, and the person's overall stability, including housing and social support systems. The considerations for take-home doses can vary significantly across clinics. Methadone, when used as a treatment for opioid use, is the only opioid agonist with such strict regulations. While these restrictions have been framed as a way to prevent misuse, diversion, and the risk of overdose associated with methadone, in reality, this strict control is a significant barrier to treatment, based on stigma and discrimination rather than scientific evidence.

upon incarceration (despite Eighth Amendment protections against cruel and unusual punishment), and face increased risk of fatal and non-fatal overdose upon release.

In 2002, a second medication for opioid use disorder (MOUD), *buprenorphine,* was approved for prescribing across multiple health settings (not just OTPs). Buprenorphine prescribing greatly increased accessibility and utilization of these evidence-based medications over the past 2 decades.[4,27] However, these efforts targeted and primarily expanded access to buprenorphine in whiter, more affluent, and less rural communities.[28] As a result, BIPOC and low-income communities continue to be disproportionately impacted by the stringent requirements of MT,[17] while rural and tribal communities continue to lack of access to all medications for OUD.[28,29] Moreover, the increasing presence of fentanyl in the illicit opioid supply has led to challenges for many patients with high opioid tolerances to benefit from buprenorphine, highlighting a growing need for access to methadone, which is reported to be better tolerated by many who use fentanyl.[30,31]

In recent years, amid the COVID-19 epidemic—which introduced emergency flexibilities around methadone[32]—a growing movement largely composed of current and former methadone patients has pushed to remove unnecessary and harmful barriers to MT. In the United States, the National Survivors Union issued a letter advocating for opioid treatment reform, "*MAT and COVID-19 Treatment Recommendations,"* which was signed by more than 140 organizations.[33] That was followed by *The Methadone Manifesto*, which was published in the *American Journal of Public Health* as the first peer-reviewed paper by and for methadone patients.[31] Since then, the DEA has established new rules allowing mobile methadone units to dispense MT, and SAMHSA issued a new rule on *Medications for the Treatment of Opioid Use Disorder*, which updates MT regulations.[34] The SAMHSA rule removes key barriers to MT, and makes some COVID-19-related changes permanent. It allows for increased use of telehealth in certain circumstances. It also reduces restrictions on take-home dosing. This provides greater flexibility and convenience for patients and helps integrate MT into their daily lives.

Yet, even with these changes, there remain significant barriers to MT and further policy reform is critical. For the first time in US history, bills have been introduced by Congress that would allow for more drastic changes, such as MOTAA, which would expand access to MT by allowing physician prescribing and pharmacy dispensing of MT outside of OTPs. The recommendations in this report will inform these ongoing discussions.

Methadone as Health and Harm Reduction: Undoing 50 Years of Stigma

Every overdose death that we have is a policy failure. It's a failure of our treatment system. It's a failure of our regulations. —Conference participant

As of June 2023, there were more than 2000 OTPs in the United States, with approximately 650,000 individuals in MT.[34] However, a stark gap remains: Only a small percentage of those who could benefit from MT are currently receiving it. The current distribution of MT is

inequitable, with significant disparities across race, socioeconomic status, and geography.[35] MT stands as a symbol of both evidence-based practice and of practice gone awry. While it has been used for decades, its role as a medication for problematic opioid use has been marred by stigma and misunderstanding. Only by embracing a more holistic, equitable, and compassionate approach will it be possible to pave the way for a future where MT is widely perceived as useful, accessible to all in need, and patient centered.

Rethinking the purpose of methadone. Historically, MT has been viewed through a lens of promoting crime reduction and an abstinence-based view of recovery.[28,36] We must shift our focus to MT as a component of a comprehensive health strategy that includes mental, physical, and social well-being. MT should be recognized for its effectiveness as a safer alternative for many people at risk of dying from an illicit drug overdose. This pragmatic approach acknowledges the realities of substance use and aims to reduce harm, rather than focusing on abstinence as the only goal of MT. Many seek MT because it protects them from the harms of using criminalized opioids, rather than as a means to achieve traditional notions of recovery.[36] We must reframe our conventional wisdom on why people use drugs: Drug use does not occur in a vacuum; it is influenced by social, economic, psychological, and biological factors. A deeper understanding of these factors and how to address them can lead to more effective, compassionate, and holistic approaches to treatment.

Reforming the culture of cruelty. The culture that has evolved throughout the history of MT and its regulatory structure in the United States often involves punitive measures, stigmatization, and a lack of compassion. Despite good intentions among many providers, MT patients observe that in their experience, OTPs will often choose a more punitive measure even when a more permissive response is allowable by regulations and preferred by the patient. This culture and the structures that uphold it—often referred to by advocates as a "culture of cruelty"[31]—must be replaced with an approach that respects the dignity and autonomy of individuals seeking treatment. Bodily autonomy and person-centered care are key elements of this transformation.

Conference Proceeding Summary

We need to reset the public agenda and have a productive public dialogue.
—Conference participant

Hosted in September 2023 by the NYU Langone Center for Opioid Epidemiology and Policy, in partnership with the National Coalition to Liberate Methadone and National Survivors Union, the *Liberating Methadone: A Roadmap for Change* conference aimed to discuss and exchange ideas on how to improve access to and use of methadone to reduce the harms of opioid use. The goal was to break down traditional barriers between researchers, clinicians, policymakers, and PWLLE and create a shared space for collective understanding. Conference activities and scholarships were generously supported by multiple partnering institutes and organizations.

Opening Remarks: Introducing the Need to Liberate Methadone

The conference opened with poignant reflections on the challenges faced by individuals in MT who are so often met with stigma and discrimination and emphasized the need to center the experiences of directly impacted people to drive positive change. The session started with a compelling excerpt from *Naturally Noncompliant*, a National Survivors Union podcast that showcases stories of individuals in MT. A recording was played of a phone conversation with Louise Vincent, a disabled patient and patient advocate, who was calling to seek clarification on why she was being denied re-entry to a methadone clinic that could save her life. This story underscored both the lack and necessity of empathy and understanding in the MT process. A candid conversation between Louise and Aaron Ferguson, another patient advocate who works in outreach for a national methadone provider, underscored that MT should be healing, compassionate, easily accessible, and person-centered.

Panels

Panel 1: Gaps and Opportunities in Methadone Research
Panelists Chinazo Cunningham; Kelly Knight; David Frank; Paul Joudrey; Moderator Leslie Suen

This session reviewed what research has taught us about MT and the current system of care, discussed gaps in current research around MT, and identified some barriers and opportunities for moving from research to policy and practice. Panelists shared their thoughts about:

- Holding policy makers accountable by leveraging changes in federal regulations, utilizing mobile units to extend treatment to underserved areas, enhancing flexibility in dosing, and expanding MT in jails to promote equity for marginalized communities;
- Using MT as a harm reduction strategy to reduce the risks associated with obtaining street drugs, given the dangerous nature of the current drug supply, and being more supportive of those who wish to reduce drug use rather than insisting on complete

abstinence;
- Addressing barriers to access for homeless individuals, including transportation challenges, criminalization of substance use, and housing insecurity; and
- Recognizing the enduring impact of stigma across various fronts—in the public discourse, among policymakers, and within the medical community, as well as the need to address stigma using various strategies, including highlighting success stories of PWLLE.

Panel 2: Conducting Community-Engaged Research on Substance Use

Panelists Beth Meyerson; Marilyn Reyes; Bethany Medley; Ayana Jordan; Brandy Robinson; Irene Garnett; Hiawatha Collins; Steven Hernandez; Moderators Caty Simon; Sarah Brothers; Bianca Rivera

In this session, speakers highlighted the importance of equity and inclusivity when implementing community involvement in research, especially for marginalized groups. Panelists emphasized:

- The importance of community-engaged research for social justice, including building relationships with legislators and community members, addressing racism and structural barriers in healthcare, and advocating for change in a white supremacist system;
- The need for equitable hiring and payment in clinic research and vetting of researchers and community organizations to understand motivations and ensure trust and discretion; and
- Strategies to facilitate collaborations between researchersand PWUD-led organizations, and how to navigate challenges in forming partnerships, institutional delays, staffing difficulties, and potential for community exploitation.

Panel 3: How Did We Get Here?

Panelists: Zoe Adams; Aaron Ferguson; Joanne King; Sharon Stancliff; Moderator: Nyabingi Kuti

This session critically examined the history of MT and OTPs. Panelists described why MT regulations established during the height of the War on Drugs prioritized strict regulations centering crime prevention over patient care. Panelists also underscored the stigma associated with MT, especially in BIPOC communities. Panelists emphasized the necessity of:

- Shifting from a purely medical model of addiction treatment to a more holistic approach that considers social, economic, and structural factors;
- Acknowledging contradictions in our criminal justice and treatment systems in treating individuals who use drugs as both sick and morally culpable;
- Addressing racial disparities and the historical and ongoing impact of structural racism in substance use treatment services, especially in Black and brown communities; and
- Involving more people of color in leadership roles and media representation to effectively dismantle a racially biased treatment industrial complex.

Panel 4: Where are We Now?
Panelists Nick Voyles; Yngvild Olsen; Bridget Dooling; Moderator Ruth Potee

In this session, SAMHSA staff, clinicians, advocates, and legal experts reviewed recent regulatory changes that expanded take-home doses during the COVID-19 pandemic and discussed their successes and remaining challenges. Panelists called for continued momentum to support further reforms through policy advocacy, litigation, and grassroots organizing. They highlighted the need to:

- Address racism within the system and move away from a criminal justice-focused model;
- Encourage the federal government to make COVID-era flexibilities permanent;
- Encourage states to align with more flexible federal rules, and clinics to change restrictive policies from within to align with new federal policies; and
- Expand MT to pharmacy dispensing to remove barriers to care.

Panel 5: A Chance for Change: Where Could We Go From Here?
Panelists Louise Vincent; Ayana Jordan; Corey Davis; Congressman Donald Norcross (D-NJ); Moderator Kimberly Sue

The panel discussion focused on advocacy strategies that would help the liberate methadone movement achieve its objectives going forward. They recommended:

- Educating politicians about methadone and SUD and how some MT clinics protect profits over patients;
- Eliminating stigma and strict clinic policies and changing workplace culture inside OTPs to mitigate the "culture of cruelty";
- Allowing for broader prescribing powers and take-home doses and encouraging agencies like SAMHSA to change regulations quickly even in the absence of legislative reform; and
- Addressing structural racism, poverty, and criminalization in MT, including via expanded community organizing and representation of marginalized groups.

Skills-building Workshops

Five skills-building workshops were offered: Highlights are summarized in Table 1.

Poster Sessions

There were 42 concurrent poster sessions presented on a variety of topics that included both research presentations and reports from the community. Posters on reports from the community communicated insights from policy, practice, and lived experiences with methadone. Conference abstracts will be published in a supplement of the scientific journal *Addiction Science and Clinical Practice* in 2024.

Breakout Groups

Finally, conference participants were invited to engage in a facilitated dialogue about the most important ideas heard during the conference and to provide additional suggestions to inform recommendations for changes to MT policy and practice.

Table 1. Summary of Skills Building Workshops

Title Presenter(s)	**Highlights**
Becoming an Effective Drug Policy Reform Advocate: Bridging the Research-Policy Divide Sheila Vakharia and Aliza Cohen	• Explained why this moment is an essential one where academics and researchers can make an impact on drug policy. • Identified several ways that academics and researchers engage in policy advocacy.
Extreme Makeover Methadone Edition: Innovative Strategies for Integrating Methadone and Essential Health Services Aaron Greenblatt, Jessica Taylor, Kate Dunn, and Zoe Weinstein	• Provided strategies for co-locating high quality medical and psychiatric care with methadone treatment. • Described novel approaches to methadone initiation and titration that are allowable under current regulations. • Proposed modifications to traditional OTP models to improve access to methadone and other medications.
Demystifying Office-Based Methadone: Lessons from International Models Paxton Bach, Aaron Fox, Frances McGaffey, Bohdan Nosyk, Simon Fraser, and Rachel Simon	• Compared international models of methadone maintenance treatment • Examined the provider and patient experience of office-based methadone treatment. • Identified potential challenges of office-based methadone treatment in the US.
Surviving the Opioid Treatment Program System Aaron Ferguson and Nick Voyles	• Served as a safe place to share lived and living experience of the methadone system and stigmatizing clinic policies. • Created camaraderie and power along with other noncompliant methadone patients.
From Baby Steps to Giant Leaps– Advancing the Transformation of Methadone Law and Policy Kate Boulton and Derek Carr	• Described the legal framework governing methadone treatment. • Identified policy and practice changes already underway and strategies for effective administrative advocacy.

Post-Conference Working Groups

Following the conference, 2 post-conference workgroups were convened virtually to review and synthesize information collected during panels, workshops, and breakout sessions: the first group focused on recommendations for MT clinical practice and the second on recommendations for MT policy. Working group participants were selected and invited by conference organizers based on their expertise in methadone via clinical practice, policy. and/or lived and living experience. Priority focus areas that emerged are discussed in the next section.

Liberating Methadone: Recommendations

This section describes a comprehensive set of recommendations that arose from the conference and post-conference working groups. They are organized into six focus areas, summarized in Table 2.

Table 2. Summary of Recommendations by Focus Area

	Focus area	Recommendations
1	**Centering living and lived experience in policy and practice**	• Place PWLLE in decision making positions of power to set policies and practices. • Recruit, hire, and retain a more diverse workforce. • Support community-engaged research by facilitating partnerships between research/academic institutions and user groups, community organizations, and individuals; and by focusing on key research areas driven by needs of PWLLE.
2	**Normalizing MT as healthcare**	• Educate and support OTP clinicians and professional staff to shift thinking and standards of MT practice toward person-centered care. • Educate healthcare providers outside of OTPs to destigmatize MT and give them the necessary training to initiate and maintain methadone in their settings.
3	**Grounding methadone treatment in person-centeredness**	• Frame MT around patient-defined goals. • Redefine safety to prioritize evidence-based practices that keep individuals connected to care. • Collect and share data on person-centered outcomes.
4	**Improving OTP practices**	• Reduce barriers and burdensome requirements associated with OTP use. • Expand use of telehealth. • Enhance OTP programming and services to provide comprehensive care. • Increase transparency around clinic rules, standards, and patient outcomes and experience. • Develop oversight and financing structures to incentivize person-centered outcomes at OTPs.
5	**Creating alternatives to the OTP system**	• Allow and support physicians to prescribe methadone in office-based settings. • Allow and support pharmacies to dispense methadone for OUD. • Adopt and support coordinated care models that contribute to the provision of MT at other health care facilities.
6	**Shifting Public Thinking About Methadone**	• Address public misinformation about MT. • Target highly impacted groups with unique histories of stigma towards MT.

1 Centering Living and Lived Experience in Policy and Practice

Policies and practices around MT can be more humane, effective, and responsive when the experiences and voices of those directly affected are prioritized. Three key strategies can help to center this expertise.

1.1 Place PWLLE in decision making positions to set policies and practices.

PWLLE can challenge ineffective or harmful practices and advocate for ones that genuinely address the needs and rights of those in MT. Including PWLLE ensures policies and practices are evidence-based, holistic, and grounded in reality, complementing clinical, research, and other expert opinions.

When developing policy and practice, giving the first and last word to PWLLE should be the default. Several principles should guide this work. **First**, organizations at all levels—clinics, states, and the federal government—should ensure that PWLLE are not only consulted but are actively involved in all stages of policy development—planning, decision-making, implementation, and evaluation. **Second**, it is crucial for organizations at all levels to create spaces where PWLLE voices are heard and valued equally alongside those of clinical experts and policymakers, providing a platform for the most impacted to elevate their voice. **Third**, organizations at all levels should embrace a co-creative process where policies are developed collaboratively. This involves treating PWLLE as equal partners, placing them in key decision-making roles, and compensating them for their expertise. **Fourth**, organizations should ensure that they specifically center people with current experience of both drug use and treatment (not only those with past lived experience) as they will be able to comment in the most timely and relevant way on conditions on the ground. **Finally**, organizations should foster long-term sustainable relationships with communities and individuals of PWLLE, to maintain ongoing dialogue and involvement of PWLLE. Models for such engagement already exist in other areas of health care delivery. For example, federally qualified health centers must have boards where at least half the members are patients of the center. Similarly, the federal Ryan White HIV/AIDS Program requires each eligible metropolitan area to have a planning council with membership that is at least 33% individuals who receive Ryan White funded services.[37,38]

> I have spent a lot of time in spaces where I felt intimidated or was made to feel small. It's not a unique experience and if people want to know to improve practices, look no further. I don't have a college degree, am an out drug user, and my involvement with the planning of the Liberate Methadone conference (and this report) is an exercise in how simple solutions can be when we remove ego and greed. —Jordan Scott, conference participant

1.2 Recruit, hire, and retain a more diverse workforce within OTPs and other health services serving PWUD.

Individuals in MT are diverse; the workforce that serves them, in clinics and in the government, should reflect that diversity, especially of individuals most impacted by failed War of Drug policies, and those most impacted by the ongoing overdose crisis.

To start, organizations and government bodies should ensure that their workforce development initiatives align with best practices for diversity, equity, and inclusion in the behavioral health workforce.[39,40] Additionally, accrediting bodies and state agencies should ensure standards for peer certification align with federal recommendations, such as eliminating abstinence requirements and allowing people with involvement in the criminal legal system to gain certification.[41] Provider organizations should follow best practices for recruiting and retaining a diverse behavioral health workforce. Organizations of all types within an expanded MT system should view PWLLE not just as peer workers but as potential clinicians, pharmacists, and other core staff.

1.3 Support community-engaged research by facilitating partnerships between research/academic institutions and PWLLE groups and individuals and by focusing on key research areas driven by needs of PWLLE.

In many ways, those closest to the problem are most knowledgeable about where evidence is needed, and how best to gather it. When conducting MT research, it is critical that PWLLE are included as active partners, by engaging drug user groups, community-based organizations (CBOs), or individuals. Support for these partnerships must be built into the research infrastructure, from funding to investigator team to research setting.

OTPs and their patients are often subjects of research.[42] When research is being conducted with people in MT as subjects, the entire research process needs to involve PWLLE, from the genesis of the research question and prioritizing of what gets studied, to the collection of data, analysis, interpretation of results, and dissemination. Academic and research partners must share power and co-create research agendas with PWLLE. This includes paid research roles, co-authorship, and dissemination. Wherever possible, PWLLE should be given preference in hiring as data analysts, epidemiologists, research assistants, survey analysts, and qualitative interviewers. Research subjects and peer researchers should be compensated with a living wage for their labor and expertise, and not merely with gift cards, as is often standard practice. *Simon et al.[42] provides a summary of recommendations on community driven research that shares power with PWLLE.*

Funders and academic institutes can also support CBOs in building capacity to propose research questions, write research proposals, and grant applications. Federal agencies often set guidelines and standards on how research is funded, and how programs are monitored and evaluated. Federal agencies can partner with drug user organizations so that their expertise is included when federal research funding guidelines are established. When granting

funds related to MT, PWLLE should be included in grant development, reviewing grant submissions, and in the scoring processes. One metric to include in the scoring of research proposals is the degree to which the research is community engaged and driven. In media, conferences, and other public venues, federal agencies such as SAMHSA and the National Institute on Drug Abuse (NIDA) can highlight research that exemplifies these principles, where PWUD/PWLLE have been involved in all elements of the research enterprise. Last, some of the ways in which research is currently funded disincentivizes meaningful partnerships with PWLLE and CBOs. Federal grantors such as National Institutes of Health (NIH) could decrease red tape around funding and reporting, including making sub-awards easier to manage, and match indirect rates for CBOs to that of universities, hospitals, and research institutes.

In addition, specific topics driven by needs of PWLLE should be prioritized for future research. **First,** while methadone has been studied extensively and its effectiveness thoroughly documented,[43–45] much less work has assessed OTP operations, particularly as related to person-centered outcomes. A recent review of nearly 700 articles analyzed the most frequently used quality measures for OUD treatment and found that only 2 of 31 measures were person-centered, despite national guidelines emphasizing person-centered care metrics.[46] New person-centered data and analyses are needed to better understand and document OTP experiences and outcomes. **Second,** there is a need for research documenting the trauma that OTPs cause—the processes through which this happens and the effects on patient health and outcomes. **Third**, we know that only a small proportion of people who qualify for MT receive it. Some research has begun to document where these disparities exist, including in rural communities,[47,48] and more study needs to be devoted to better address these gaps in access.

Examples of specific recommendations for this focus area and the corresponding target group for implementing recommendations are included in Table 3.

> This movement for reform comes after decades of struggle on the part of methadone patients and is in their honor. The roadmap for change began through survival activism among directly impacted people who use drugs amid COVID-19 and the worst overdose crisis the US has ever faced. Centering the voices of our people who are directly impacted at this conference ushered in a new era of methadone activism, one that is poised to reform methadone to be responsive to the healthcare needs of people who use drugs. Only an opioid treatment system that is humanistic and patient centered can truly saves lives.
>
> — Aaron Ferguson, conference participant

Table 3. Specific Recommendations for Centering Living and Lived Experience in Policy and Practice

1.1: Place PWLLE in decision-making positions to set policies and practices.	

Provider organizations	• Establish fairly compensated and diverse patient advisory boards and hire peer workers with lived and living experience to institute:
	  • Shared decision-making processes for all clinical decisions.
	  • Low-threshold processes for challenging abusive practices or discharge decisions.

State governments	• Require OTP clinics to establish patient advisory boards as part of state licensing practices. • Establish a state OTP oversight and leadership board with greater than 50% of people on MT to guide policy and serve as a venue to address concerns raised by clinic patients and patient advisory boards. • Develop a standard process for patients to document and report traumatic and abusive incidents and practices at OTPs. Create institutional protections for those who report negative experiences.
Federal government	• Establish a federal methadone community advisory board, led by PWLLE who can oversee patient boards and provide guidance for OTP clinics and, state and federal officials.
1.2: Recruit, hire, and retain a more diverse methadone provider and peer workforce.	
Provider organizations State governments Federal government	• Actively reach out to communities and educational institutions that serve underrepresented groups, and use diverse platforms to advertise positions, ensuring a wider reach. • Engage with community leaders and organizations to address hiring challenges of PWLLE from diverse groups, incentivize inclusive hiring policies, and proactively address challenges. • Offer opportunities for career advancement and professional growth that are accessible to all employees, regardless of their background. • Eliminate background requirements, pre-employment drug screening, and abstinence requirements. • Include diversity of workforce as a metric for evaluation of OTPs by licensing agencies and state opioid treatment authorities (SOTA).
1.3: Support community-engaged research by facilitating partnerships between research/academic institutions and user groups, community organizations, and individuals.	
Provider organizations	• Create partnerships with key stakeholders, including patient and drug user advocacy groups, CBOs, and researchers to identify needs and collaborate on research.
State governments	• Integrate and acknowledge PWLLE-led research in state materials. • Require that community-engaged research includes mechanisms to compensate PWLLE for their participation, both as participants and research advisors.
Federal government	• Engage PWLLE in NIH grant application development, review, and scoring processes; and highlight exemplary research involving PWLLE. • Incorporate metrics that value robust community-engaged research methodology in research grant applications and reviews, based on best practices. • Decrease red tape around funding and reporting for grants to facilitate research collaborations with community groups of PWLLE, including making sub-awards easier to manage.
Researchers	• Co-create/share power with PWLLE in creating research agendas and supporting the capacity development of CBOs to write research and grant proposals. • Recognize research contributions of PWLLE through co-authorship and paid research roles. • Establish standards for disseminating data and findings to the communities included in the research. • Focus research on areas prioritized by PWLLE, including person-centered outcomes, trauma related to OTP experiences, and disparities in access to MT.

2 Normalizing Methadone Treatment as Standard Healthcare

While evidence-based, MT for problematic opioid use is not currently a standard healthcare practice; that is, MT cannot be provided by licensed clinicians who are eligible to prescribe controlled substances for other chronic conditions. Rather, it is isolated within its own separate clinic system. If methadone for OUD were to be broadly understood as a medication (as opposed to a "drug"), MT could be integrated into the broader healthcare, which would greatly increase access. Individuals seeking and receiving MT could be seen as taking steps toward improving health, and experience less stigma and discrimination. Medical settings outside of OTPs, such as nursing homes, would not exclude patients receiving MT, allowing patients to get the services they need. In essence, to "normalize MT as standard healthcare" means to treat it as a regular, accepted part of medical care, reducing barriers to access and ensuring that it is treated with the same legitimacy and seriousness as other forms of healthcare.

2.1 Educate and support OTP staff to shift thinking and standards of MT practice toward person-centered care.

OTP clinics have high staff turnover, staff with limited experience, and workforce shortages.[49] There is a need for enhanced education and training for providers and staff who work within clinics, to improve their practices and to foster more PCC. OTP staff should additionally receive training in broader delivery of MT as healthcare as described below.

2.2 Educate and support healthcare providers outside the OTP system, including clinicians and pharmacists, to shift their thinking and prepare them to provide MT.

To successfully expand access to MT, it is essential to shift thinking about MT among general healthcare providers and to support providers in transforming their practices. Both require updating the initial education that healthcare professionals receive and enhancing ongoing training in integrating MT into the practice of general healthcare. Right now, education and training on medications for opioid use disorder (MOUD), and methadone specifically, among different healthcare professional groups is very rare.[50]

Clinicians. Nationally, curricula are needed for the education, training and support on MT that promotes the integration of MT into standard healthcare practice. These curricula should be created by seasoned MT providers and PWLLE and center the experiences of PWLLE using a critical lens. This is not common practice. For example, SAMHSA's recently released *Core Curriculum on Substance Use Disorder*[51] did not explicitly involve input from PWLLE. All basic curricula on methadone need to additionally address methadone stigma, and the role it plays in accessing treatment, treatment retention, and risk. The target audience

should range from primary care providers (PCP) to hospitalists to nursing home staff, as well as those working at accrediting bodies. As with all medical education, individuals need ongoing education and support to learn innovations in what works best as research develops. To provide quality care for PWUD, clinicians need to understand the changing drug supply, the complications of new drugs, and how these may require changes in clinical practices. These changes may include higher doses or providing more split doses, which allow a patient to take methadone twice a day so they can maintain a stable level of medication in their bodies. Healthcare staff also need information about unique needs patients may have, such as supporting wound care. Models such as Project Extension for Community Healthcare Outcomes (Project ECHO), a collaborative model of medical education and care management that helps clinicians provide expert-level care to patients wherever they live,[52] could be particularly applicable. PWLLE must be engaged in developing training curricula and in providing training and support for providers, along with physicians experienced in MT who can teach and mentor newer providers.

Pharmacists. To support a comprehensive MT system that includes prescribing and pharmacy dispensing of methadone across multiple settings (see focus area *Creating Alternatives to the Opioid Treatment System*), pharmacists and pharmacy students must also be included as targets for initial and continuing education on MT. Pharmacists should receive education about methadone as part of their initial training and continuing education, focusing on the pharmacology of methadone, its therapeutic use, prescribing for special populations (eg, pregnant women), and the management of potential side effects. Training should also cover the psychological and social aspects of drug use; emphasizing the importance of a compassionate, non-judgmental approach to patient care; the dispensing of harm reduction supplies; the use of naloxone for overdose reversal; and the importance of care models that connect individuals with additional support services, if so desired. Training must also be included on changes to the regulatory landscape, documentation requirements, and approaches to managing methadone within the pharmacy setting.

Examples of specific recommendations for this focus area and the corresponding target group for implementing recommendations are included in Table 4.

Table 4. Specific Recommendations for Normalizing Methadone Treatment as Healthcare

2.1: Educate and support OTP staff to shift thinking and standards of MT practice toward person-centered care.	
Provider organizations	• Prioritize educational training created and facilitated by PWLLE. • Provide routine training for MT staff, which should include providing stigma-free, trauma-informed care; cultural competence and humility; understanding risks of withdrawal and discharge from treatment; and specialized service training for marginalized patient groups led by PWLLE within those groups—including patients who are in the sex trades, houseless, or disabled.
State governments	• Require and incentivize clinics to provide the above training for their providers annually. • Consult with PWLLE to develop curricula and TA documents for provider staff training, while ensuring PWLLE are properly compensated for their time and knowledge.
Federal government	• Develop guidance documents on key competencies for OTP staff which would inform the development of a set of minimum standards and training materials.
2.2: Educate and support general healthcare providers to shift their thinking and prepare them to provide MT.	
Medical & professional societies	• Incorporate education on overdose, stigma, MT, and buprenorphine in training curricula for service providers, including but not limited to physicians, nurses, social workers, and pharmacists. • Develop training materials and provide continuing education and training for all licensed clinicians to use MT appropriately and demystify misconceptions about methadone. • Engage PWLLE and clinicians who have experience providing methadone to train other providers via Project ECHO and other mechanisms.
Federal agencies	• Create a task force of providers and PWLLE to help develop curricula on the value of MT and the dangers of stigma for training service providers as well as administrators working across multiple healthcare settings: primary care, hospitals, nursing facilities, pharmacies, and others.

3 Grounding Methadone Treatment in Person-centeredness

Increasingly, healthcare is moving towards PCC.[53,54] Healthcare providers work collaboratively, through processes such as shared decision making, to develop care plans that are informed by the patient's goals and values.[53,55] Research has shown that PCC can lead to improved health outcomes, including better management of chronic conditions, increased patient satisfaction, and potentially lower healthcare costs by focusing on preventive care.[54] Substance use treatment systems have been slower to adopt this approach and traditionally have been program-centered.[56] But a systematic review found links between patient centeredness in substance use care and improved outcomes, including decreased substance use;[57] others have found that PCC can also improve retention, patient empowerment, and other substance use treatment outcomes.[58]

Several PCC guiding principles can frame and inform a more person-centered approach to MT:

- Provide care in ways that are best for the patient, decided collaboratively with the patient.

- Eliminate all unnecessary hurdles to treatment, including the expectation of abstinence when not a patient's goal.
- Make lowest-barrier policies that prioritize retention over an abstinence standard.
- Offer direct support services and/or help patients navigate the social service system.
- Acknowledge and address the structural and social determinants of health.
- Replace the culture of abstinence-only as the only desired outcome of treatment with support for varied approaches to health and wellness.

3.1 Align methadone treatment to patient-defined goals

Research findings highlight that a major reason for discontinuing MT is patients' perception of control exerted by the program and lack of autonomy in setting treatment goals.[59,60] Rather than a one-size-fits-all approach, in PCC the provider *collaborates with* the patient through shared decision making to determine the goals of treatment, and other important decisions such as dosing and length of care.[56] Goal setting should occur at initiation and be revisited periodically because an individual's goals may change over time.

Goals of MT. PCC does not presume abstinence is the goal, nor does it presume eventually discontinuing MT is the goal. Providers should continue to offer MT as long as patients would like to receive it as it will help stabilize and provide protection from overdose and the dangerous street supply. MT programs should also provide harm reduction services known to reduce overdose and other harms, including risk reduction education; fentanyl test strips; safer injection, smoking, and sniffing supplies; and naloxone.

Dosing. The appropriate dose of methadone varies significantly among individuals; and patients are the true experts in their own body's response. Unfortunately, many OTPs systematically provide doses below evidence-based amounts, and this problem is worse in clinics that serve a high proportion of Black patients.[61] Providers should ask patients about their preferred dose. They should also discuss and address the risks, benefits, and side effects of particular doses. Until recently, federal rules mandating initiation doses of 30 milligrams or lower posed a challenge to providing clinically effective initiation doses (up to 30 milligrams), but the updated SAMHSA rule[34] increased the initiation dose up to 50 milligrams, with the possibility of a higher dose based on clinical reasoning. Still, efforts are needed to educate OTPs on this change, since many are reluctant to induce patients in accordance with the new rule. Moreover, SAMHSA's *Treatment Improvement Protocol 63: Medications for Opioid Use Disorders*[7] still does not reflect best practices in the context of a drug supply poisoned with fentanyl. SAMHSA should convene a working group composed of PWLLE and clinicians to update these guidelines.

The federal government can play an important role in encouraging PCC by developing a methadone-specific patient's bill of rights. Introduced in the early 1970s, the American Hospital Association patient bill of rights listed 12 expectations patients should have regarding their care[62]; a similar document specific for MT could establish a baseline of expectations nationally.

CLINIC ABOLITION

Although the recommendations in this section focus on improving OTP practice, during the conference there was significant dialogue about whether the aim should rather be the abolition of OTPs altogether. It is important to acknowledge that, regardless of the path forward, harm has been done to individuals in the OTP system as it currently exists.

The perspective presented in this report is that a multi-pronged approach to methadone delivery is necessary to promote access to the most people. That means improving the existing OTP practices while creating alternatives to that system.

A segment of the population that OTPs serve prefers that service and would opt to continue care. Improving OTP practices supports that choice. Furthermore, through improving many of the structures and processes of OTPs, they may better meet the needs of patients and serve them more holistically, more fairly, and more compassionately. This section details the changes that would help OTPs reach that goal.

3.2 Redefine safety.

There is a need to redefine how MT providers and regulatory agencies think about safety, shifting away from a hyper-focus on the risks of diversion towards more person-centered approaches that prioritize retention and ameliorating the risk of overdose when patients leave care.[63,64] Providers should institute "retention-first" policies that promote flexibility and prioritize encouraging patients to come back. Federal and state regulatory and licensing agencies play a crucial role in overseeing OTP practices and can help shift OTP priorities to focus on preventing overdose. This includes facilitating increased access to overdose reversal medications, supporting low-barrier services, and recognizing that methadone accessed via a treatment program, despite some of its risks, is still a much safer supply of opioids than the unregulated street supply.

3.3 Collect and share data on person-centered outcomes.

Measures of success in MT should be person-centered, developed by and with PWLLE, and prioritize patient safety, health, and wellbeing over measures of crime and abstinence. The EQullTable Care taxonomy sets forth six areas for patient-centered quality measurement: patient experience and engagement; quality of life; identification of patient risks; interventions to mitigate patient risks, treatment, and care coordination.[46] These can be a starting point for conversations with PWLLE on data to collect and analyze. MT patients should also have access to outcomes data and metrics, and data collected by programs and the state should be shared back transparently, while ensuring patient confidentiality. When findings are disseminated, they should be in a format that is easy to interpret and easily accessible, with key take-aways that are action oriented and not overly scientific or statistical.

Examples of specific recommendations for this focus area and the corresponding target group for implementing recommendations are included in Table 5.

Table 5. Specific Recommendations for Grounding Methadone Treatment in Person-Centeredness

3.1: Frame treatment around patient-defined goals.	
Providers	• Make dosing decisions around patient's preferred dose regimens and allow rapid dose escalation individualized to patient needs. • Offer harm reduction services such as safer syringe and smoking supply distribution to all patients.
State governments	• Promote PCC in clinical guidelines and regulations. • Develop payment models that incentivize PCC. • Ensure state policies prioritize patient decision making in regards to care continuation, including not defining discontinuation of MT as a goal of care.
Federal government	• Develop a federal "patient's bill of rights" to align MT with patient-defined goals. • Revise TIP63 to include new guidance for dosing in the context of a fentanyl-contaminated street drug supply. • Require that all guidelines are reviewed on an annual basis to reflect the most accurate information. • Revise policies around release of information back to pre-2020 standards requiring informed consent upon each instance of information release to and by OTPs to ensure rigorous patient oversight over disclosure of information.
3.2: Redefine safety to prioritize evidence-based practices that keep individuals connected to care.	
Providers	• Institute a "retention-first" policy, to prioritize patients returning to treatment. • Provide overdose reversal medications and training to patients.
State governments Federal government	• Prioritize preventing overdose in MT policies and practice by retaining patients in care. Termination of care should not be premised on continued substance use, missed appointments, or lack of participation in ancillary services. Any such termination should be documented and the patient should have the right to appeal the decision. • Fund the distribution of overdose reversal medications across care settings.
3.3: Collect and share data on person-centered outcomes.	
Providers	• Share data collected with patients and the community served to facilitate ongoing discussions on improving person-centered practices.
State governments	• Require programs to collect and publicly report data on person-centered measures of success that prioritize safety, health, and well-being, on an annual basis.
Federal government	• Promulgate person-centered outcome measures as drivers of standards of care in federal policy.
Researchers	• Collaborate with PWLLE to identify and refine person-centered outcome measures including those patient-reported outcome measures utilized regularly by OTPs.

4 Improving Practices within Opioid Treatment Programs

OTPs should be therapeutic spaces where people can seek improvements to their health and wellbeing, rather than places of control and surveillance. There is much that can be done to improve OTP practices so that they are more humane and better meet patient needs, are less driven by security and crime prevention, and less siloed from other healthcare. While policy changes to allow additional settings to prescribe and dispense MT are critical (see *Creating Alternatives to the OTP Clinic System*), much can be done immediately to improve OTP settings.

4.1 Reduce access barriers and burdensome requirements for OTP use.

Anyone who wants to be in MT in a structured environment should be able to access an OTP, regardless of geography, ability to pay, or treatment goals. However, we know that only a fraction of individuals who meet criteria for OUD can access methadone,[65] only 20% of US counties have an OTP, and many languish on waitlists due to a shortage of available slots.[66] OTP locations should be expanded to facilitate access, and policies/practices adjusted to ensure care is low-barrier and person-centered.

Access to OTP could be expanded by:

- Expanding locations and hours of operation (eg, 24-hour clinics open during afternoon/evening hours).
- Allowing for same-day intakes and guest dosing.
- Easing state and local restrictions to opening new clinics, such as removing limits on the number of allowable clinics, zoning restrictions, and reducing accreditation requirements.
- Continuing to ease restrictions around mobile medication units and providing funding to support their expansion.

OTPs could shift from program-centered to person-centered by:

- Decreasing their culture of surveillance by reducing or eliminating security guards and metal detectors and easing requirements for government identification.
- Not requiring more than the federally mandated number of urine screens, removing observed urine testing, and switching to less intrusive oral swab testing whenever possible.
- Removing restrictions around dosing during titration and maintenance to meet the needs of each individual patient. As fentanyl has become ubiquitous in the drug supply, a higher dose, both at initiation and maintenance, is often required to prevent withdrawal.
- Eliminating requirements and restrictions on take-home dosing. Easing restrictions would allow patients more autonomy, ease their ability to find and maintain employment, and reduce transportation barriers for those who must travel far distances.[59] Even after the 2024 changes in the federal rule, the ability for individuals to take medications without the on-site supervision of a clinician is extremely limited.

- Allowing for dispensing of other forms of methadone, including both liquid and pill form. The liquid formulation can impose barriers on individuals and formulation changes may be associated with worse pain and withdrawal.[67]
- Eliminating universal requirements for counseling and instead aligning counseling and other ancillary services with patient preferences.

There are changes that state and federal agencies can make that would allow for improved access and OTP practices. Practices that are not evidence-based or patient centered should be removed (eg, urine drug screens) and a more centralized system of creating and disseminating proper treatment guidelines could guide implementation of many of these changes. The DEA can disincentivize use of security guards at OTPs by refocusing regulations and audits from security concerns to create a safer therapeutic environment. State and local governments can revise policies to reduce restrictions on OTP locations and operations and remove caseload caps on OTPs and providers. Both federal and state governments can incentivize and fund mobile methadone units, and clarify guidelines on what services are permissible at mobile versus fixed medication units.

4.2 Expand use of telehealth.

Since the COVID-19 pandemic and with the new SAMHSA 2024 federal rule, many restrictions have eased around use of telehealth to provide MT, which has been a welcomed change among patients.[68,69] But for telehealth to be possible, many clinics will need to upgrade their information technology, and ensure patients have access to phones or computers (via applying to grants or other funding) and a consistent and reliable WiFi connection. State and federal governments can help fund these upgrades and provide incentives for clinics to increase use of telehealth for both induction and ongoing care, by setting equal reimbursement for telehealth and in-person visits. Federal regulations should allow use of low-barrier technology, such as audio only, and not require video visits as many patients don't have access to a smartphone or broadband.

4.3 Enhance OTP programming and services to provide comprehensive care.

Currently, OTPs are separated from the rest of the healthcare system, and coordination between OTPs and other providers is uncommon. Few services are provided at OTPs beyond methadone, and some of those that are, such as screening and treatment for the Hepatitis C virus (HCV), are not reimbursed at parallel rates to those delivered outside of the OTP setting.[49] One way that practices can improve is by adding services that address the broader health and wellbeing of patients, allowing OTPs to serve as drug user health hubs.[31] States could allow clinics to bill for other healthcare services, such as HIV testing, wound care, or HCV treatment, so individuals can get their healthcare needs met in one place, rather than having to travel from provider to provider. Additional services could include primary care, mental health care, infectious disease screening and treatment, harm reduction, and

wound care. For harm reduction supplies to be effectively available at OTPs, some states that have restrictions around the provision of harm reduction supplies must remove them. Where services cannot be offered onsite, OTP staff can refer patients to these services elsewhere, and provide warm handoffs while engaging the patient in the process.[70] OTPs can promote the role of peer support services to facilitate connections to such additional resources.[71]

4.4 Increase transparency around OTP clinic rules, standards, and outcomes.

Patients often report inconsistency and a lack of clarity around OTP rules and standards.[58] At the OTP level, clinics could address this by making clinic rules and standards clearly and easily accessible to all patients at intake or making them available online. OTPs could also have processes to ensure they are enforcing clinic rules consistently and fairly and holding employees accountable to them. State and federal authorities could also support transparency by requiring that OTPs post rules, standards, and guidelines of their clinics publicly (similar to how the Occupational Safety and Health Administration [OSHA] requires employers to post health and safety information).

State and federal agencies could collect data on the outcome of clinic practices (eg, dosages and take-home practices) and patient satisfaction and make aggregate summaries by OTP available to the public. Outcomes should be reported by race/ethnicity, gender, disability, housing, insurance, geography, and other key variables to be able to address any inherent disparities. They can also showcase model OTPs that are successfully transparent in their clinic operations at SAMHSA, SOTA, and other funder-sponsored events. As an analogy, all hospitals that receive federal funding are required by the Centers for Medicare and Medicaid Services (CMS) to track and report on key indicators of healthcare quality, safety, and equity. Data is posted online which allows the public to compare hospitals.[72] CMS could also adopt similar 5-star quality rating systems for OTPs as they do for nursing facilities, which could increase transparency and further incentivize OTPs to adopt patient-centered outcomes.[73] It is important to ensure that the increased collection of data on MT does not result in increased criminalization of individuals on MT, or use of the data for punitive reasons. Federal and state agencies should review privacy laws and make changes if necessary, so that these data cannot be used to harm individuals on MT.

Finally, the *Americans with Disabilities Act* (ADA) can be leveraged and strengthened to better protect people with SUD, particularly those out of treatment. OTPs are frequently out of compliance with the ADA when they do not adequately serve patients with disabilities, for example by failing to provide ASL interpreters for deaf and hard of hearing patients, or refusing flexibility with take-home dosing for people with mobility impairments.[74] Many clinics' layouts are also not accessible to mobility impaired patients.

4.5 Develop oversight and financing structures to promote person-centered care.

Many systems are already in place that accredit OTPs to ensure they are compliant with federal and state guidelines. These systems can be capitalized on to improve OTP practices and update OTP accreditation standards based on person-centered outcomes and with input from PWLLE. There is room for states to have more power to act as patient advocates and hold individual programs accountable to best practices, and SOTAs should institute community OTP oversight boards that include PWLLE. The authority of SOTAs to sanction programs or enforce clinic practices should be clarified by SAMHSA through generation of publicly available guidance.

Similarly, financing structures should be designed to encourage the prioritization of low-barrier, PCC based on updated quality metrics. Specifically, financing should not incentivize in-person visits, which can result in clinic's restricting the use of take-home dosing and telehealth. For example, New York state effectively uses payment structures to incentivize best practices, requiring less counseling, fewer in-person visits, and fewer urine drug screens. The Medicare bundled payment structure should be updated to incentivize best practices in care.

Examples of specific recommendations for this focus area and the corresponding target group for implementing recommendations are included in Table 6.

> The National Coalition to Liberate Methadone conference was a truly one of a kind experience that helped me to listen and prioritize the experiences of people on methadone. It has led to many important questions and conversations at my own opioid treatment program about the culture of cruelty and ways that we can both immediately improve the care for people on methadone in this moment as well as advocate for new ways for people to access methadone outside of the clinic system. I am grateful to the conference for creating a safe space for these change conversations to occur.
>
> — Kimberly Sue, conference participant

Table 6. Specific Recommendations for Improving Opioid Treatment Program Practices

4.1: Reduce access barriers and burdensome requirements for OTP use.	
Providers	• Decrease the culture of surveillance. • Switch from urine screening to less intrusive oral swabs for drug testing. • Limit mandated counseling appointments. • Use shared-decision making for clinical decisions, including appropriate and adequate dosing. • Allow for same-day treatment initiation and guest dosing. • Allow for multiple types of identification, including non-photo. • Expand clinic hours. • Allow for multiple methadone formulations. • Ease restrictions around take-home dosing to prioritize patient need. • Eliminate bottle return requirements for take home dosing.
State governments	• Ensure state laws are no more restrictive than federal requirements. • Ease restrictions on opening new OTPs, including working with local governments to reduce restrictions (removing zoning restrictions, accreditation requirements, costs). • Reduce caseload caps on OTPs and providers. • Fund and facilitate mobile methadone van usage. • Allow OTPs to bill for other services (eg, HIV testing, wound care, HCV treatment). • Reform Medicaid MT payment models which disincentivize PCC, such as payments for daily dosing, and realign with new federal rules. • Fund services such as transportation and childcare to lift barriers to accessing care. • Ensure that publicly funded transportation to OTPs is easily accessible, timely, and accountable to patient review of practices, with rigorous background checks for drivers.
Federal government	• Remove requirements for drug screens. • Allow for full agonist prescribing, especially during methadone titration to address withdrawal. • Establish a more centralized system of creating and disseminating MT guidelines. • Issue federal government guidelines mandating what treatment access should look like. • Clarify requirements (or lack of requirements) for security guards and other surveillance mechanisms. • Provide funding and technical support for mobile methadone. • Encourage states to align policies with the federal regulations. • Require accrediting bodies to update standards to reflect revised federal rules. • Revise Medicare MT payment policy to align with new federal rules and serve as a model for state Medicaid agencies and private payers. • Have SAMHSA provide OTP guidance to align with person-centered approach to MT. • Require and enforce that all ancillary services such as counseling, case management, and recovery supports, are optional for patients to receive MT.
4.2: Expand the use of telehealth at OTPs.	
Providers	• Upgrade information technology infrastructure. • Facilitate telehealth technology for patients in need including phones, minutes, and WiFi access. • Allow for audio-only group and individual counseling telehealth attendance.
State governments	• Provide guidance and financial incentives for clinics to increase their use of telehealth for induction and ongoing care. • Allow OTPs to use telehealth. • Fund information technology upgrades to support OTP scale-up of telehealth. • Expand telehealth allowances to use the lowest barrier tech for initiation and continuation of care, removing mandatory requirements for video as SAMHSA's final rule allows. • Ensure telehealth visits are reimbursed at the same rate as in-person (telehealth parity).
Federal government	

4.3: Enhance OTP programming and services to provide more comprehensive care.	
Providers	• Collaborate with CBOs to provide appropriate peer services and to decrease the risk of role drift and harmful power differentials that can happen in clinical settings. • Add primary care services and additional medical services (HIV, HCV, and wound care). • Include harm reduction supplies, equipment, and training at OTPs for both staff and patients. • Provide warm handoffs and linkages to mental health services and social services.
State governments	• Remove restrictions on and/or fund provision of harm reduction supplies. • Promote equitable reimbursement rates for services provided inside and outside the OTP setting.
Federal government	• Remove remaining bans on funding harm reduction supplies such as syringes.
4.4: Increase transparency around OTP clinic rules, standards, and patient outcomes and experience.	
Providers	• Make clinic rules and standards clearly and easily accessible to all patients, and ensure providers enforce rules consistently and fairly. • Strengthen human resource policies to include graduated sanctions (including termination) for employees who do not follow person-centered protocols. • Collect satisfaction surveys from patients to track person-centered outcomes.
State governments	• Require public posting of rules, standards, and guidelines (similar to OSHA posters). • Collect and routinely review and report data about OTP practices and outcomes, including patient satisfaction rates by clinic.
Federal government	• Showcase exemplar OTPs at events sponsored by funders/SAMHSA/SOTAs. • Strengthen the ADA to better protect active illicit drug users within the definition of people protected by the act. • Require OTPs to collect and publicly report data on practices and outcomes, while protecting individual patient privacy.
4.5: Develop oversight and financing structures to incentivize person-centered outcomes at OTPs.	
Providers	• Track and report on key person-centered outcomes and quality measures.
State governments	• Develop payment mechanisms that incentivize prioritization of low-barrier, PCC (eg, do not incentivize in-person visits). • Institute community OTP oversight boards that include PWLLE to hold individual programs accountable to best practices.
Federal government	• Update Medicare bundled payment structure to incentivize PCC. • Require PCC accreditation, that includes PWLLE integrated into the process. • Give additional guidance to SOTAs about the scope of their work, how far their power extends and ensure they can oversee implementation for practice.

5 Creating Alternatives to the Current Opioid Treatment System

Methadone should be readily available to everyone who needs it and at multiple touchpoints with the healthcare system. Ensuring access to person-centered MT on demand in the United States will require expanding MT availability beyond the OTP system. While much care within OTPs can be improved, most counties still do not have an OTP, nor the necessary resources to establish one.[66,75] To expand MT to non-OTP settings, we can look at how individuals in other countries access MT. We can also build on lessons learned from offering buprenorphine across multiple healthcare settings. Three key strategies are highlighted for creating effective alternatives access points for MT.

5.1 Allow and support physicians to prescribe methadone in office-based settings.

All healthcare professionals qualified to prescribe other controlled substances should also be able to prescribe MT for OUD. Currently proposed legislation being considered in Congress—*MOTAA*—would significantly further this goal by enabling addiction-board certified physicians to prescribe methadone with pharmacy-dispensing. While this legislation proposes an important step, an ideal MT policy would go even further, by allowing MT prescribing not just by specialized addiction treatment providers but also PCPs, nurse practitioners, and physician assistants, which are much more widely accessible in the United States.

Ensuring uptake of methadone among general practitioners and provision of safe and high quality MT would require collaboration from insurance companies to cover this benefit, and providing these groups with additional incentives and support, including support from medical boards, connections with addiction treatment providers and OTPs, similar to what was done with buprenorphine hub and spoke models.[76,77]Additionally, federal agencies can bolster provider training and support through existing pathways established after the passage of the *Medication Access and Training Expansion Act*,[78] and other clinical support resources and tools. The federal government could fund research and pilot programs to assess the effectiveness and safety of allowing a broader range of practitioners to prescribe MT. Early studies might examine the impact of expanded prescribing on access to MT, barriers and facilitators to prescribing, and whether prescribing in office-based or primary care settings enhanced person-centered outcomes.

5.2 Allow and support pharmacies to dispense methadone.

Allowing pharmacies to dispense methadone in tandem with office-based prescribing will greatly normalize and facilitate the integration of MT into daily life and regular routines.[79] This will equate MT to any other medication and make it far more easily accessible, especially for those who live far from OTPs.

Supporting dispensing of MT in pharmacies will require updating regulations (eg, through legislation such as the MOTAA) and developing patient-centered guidelines and policies.

Additionally, professional associations and state and federal agencies can provide pharmacist training and support, and other support resources and tools. Pharmacies will additionally need to develop the necessary infrastructure such as secure storage for methadone, dispensing protocols, and systems for methadone tracking and dispensing. Given past experiences with difficulty patients sometimes experience accessing buprenorphine in pharmacies,[80] we can anticipate and proactively address challenges to MT pharmacy dispensing. Key challenges to address include ensuring insurance coverage of medications and addressing reticence among pharmacies/pharmacists to stock and dispense medications. It is also important that pharmacies that dispense methadone have measures in place to protect patient privacy.

5.3 Adopt and support coordinated care models that facilitate the provision of MT at other health care facilities.

There are several models of coordinated care programs that offer treatment with buprenorphine—along with provider and community education, support services, and coordination of care with other medical and social needs.[81,82] Examples from a scoping review of models of buprenorphine care, focused on primary care and behavioral healthcare settings include office-based treatment, one-stop shop, Project ECHO, medical home, and nurse case managers.[83] Adapting those models for MT—and creating new ones— may assist more individuals and communities with diverse needs. Provider organizations, state and federal agencies all have a role to play in adopting and implementing coordinated care models for MT.

Important steps to support coordination of care across healthcare settings include:

- *Cultivate partnerships for low-barrier methadone access in carceral settings.* Providers should focus on building relationships with local jails and correctional facilities to provide continuation or initiation of MT, bridging the gap between incarceration and community care.
- *Build partnerships for methadone prescribing in rural and under-resourced settings.* Creating partnerships with rural healthcare providers, telehealth services, and mobile clinics can increase methadone access in areas where it is traditionally unavailable. This could involve training rural healthcare providers in methadone prescribing and management, and establishing referral systems to specialized care when needed.
- *Develop policies supporting methadone treatment integration.* State agencies should create and promote policies that facilitate the incorporation of MT into various healthcare settings, including primary care, psychiatry, and emergency departments. This includes easing regulatory barriers and supporting credentialing processes for providers.
- *Coordinate data sharing systems among providers.* Implementing systems for seamless data sharing among healthcare providers can improve care coordination and patient outcomes. This requires the development of privacy-compliant, interoperable systems that allow for real-time access to patient information, and that track patient-centered outcomes. Patients should have control and consent of what data is shared, with whom, and under what circumstances.

- *Fund the development of coordinated care models for MT and guidelines for replication.* Federal and state governments should fund the development and adaptation of coordinated care models that can significantly improve patient outcomes.[84] Guidelines should be developed around best practices for integrated care models, data sharing protocols, and strategies for overcoming common barriers to care coordination.
- *Offer state-level grants or incentives.* Grants or financial incentives for healthcare facilities that incorporate MT into their service offerings can accelerate the expansion of treatment availability, particularly in areas with high opioid overdose rates.
- *Empower palliative care providers.* Policies should empower palliative care providers to prescribe MT for OUD, given the role of palliative care for individuals with complex medical needs.
- *Ensure Medicaid eligibility for office-based MT providers.* CMS needs to classify office-based MT providers as an eligible service within Medicaid, ensuring that patients receiving MT can access comprehensive services under a single coordinated care model.

Examples of specific recommendations for this focus area and the corresponding target group for implementing recommendations are included in Table 7.

6 Shifting Public Thinking About Methadone

Shifting public discourse to address stigma and misperceptions around MT is crucial to allowing changes in policy and practice to take root and spread. A well-informed and engaged public is more likely to support evidence-based policies. Unfortunately, there is a deep misunderstanding about methadone as a proven, effective treatment that saves lives.

We need to take MT out of the shadows, and reduce the stigma associated with it. Exposing the sometimes cruel and abusive aspects of the system is necessary to build support for a more compassionate and effective approach. This includes highlighting hardships patients face due to overly strict regulations, inadequate access, and stigmatization as well as highlighting the barriers that the fragmented system creates for individuals. Additionally, we need to tell positive stories about lives lived while taking methadone that directly challenge common negative stereotypes; by presenting real-life examples, these stories can dispel myths and misconceptions. Such stories also provide tangible evidence of the effectiveness and positive impact of MT, to complement statistics and research.

6.1 Addressing public misinformation about MT.

Despite methadone being one of the most studied medications and its effectiveness being well-documented, many communities hold onto the misperception that methadone is harmful and causes physical damage.[85] This misinformation can deter individuals from seeking MT and contribute to a preference for other forms of treatment that may be less effective or accessible. Another enduring misperception is that someone on MT is just substituting one drug for another, thus perpetuating the cycle of problematic opioid use.[85]

Table 7. Specific Recommendations for Creating Alternatives to the Current Opioid Treatment System

5.1: Allow and support physicians to prescribe methadone in office-based settings.	
Providers	Following federal action to expand methadone prescribing privileges: • Diversify and expand OTP workforce to include more providers who are DEA-licensed and have been trained in person-centered and trauma-informed MT. • Develop and adapt medical workflows across multiple healthcare settings (eg, primary care, hospitals) to incorporate MT intro routine practice.
State government	Following federal action to expand methadone prescribing and dispensing privileges: • Prevent any additional state policies that may limit methadone prescribing. • Support state medical boards to provide resources to clinicians to add methadone prescribing to their practice. • Incentivize providers to prescribe methadone and provide training for new prescribers. • Ensure coverage of methadone in essential health benefits under insurance plans. • Allocate funding for TA and training for new prescribers; replicate models that have been effective in expanding buprenorphine (eg, hub-and-spoke, centers of excellence, nurse care model)
Federal government	• Amend federal policies to allow methadone prescribing privileges for OUD to all DEA-licensed providers. • Ensure coverage of methadone in essential health benefits under federal insurance plans. • Fund research and pilot programs to assess the impact of allowing a broader range of practitioners to prescribe methadone and dispense in pharmacies on overdose.
5.2. Allow and support pharmacies to dispense methadone.	
Pharmacies	Following federal action to expand methadone prescribing and dispensing privileges: • Develop infrastructure and systems for tracking and dispensing methadone for OUD. • Work with methadone suppliers to ensure uninterrupted access.
State government	Following federal action to expand methadone prescribing and dispensing privileges: • Prevent any additional state policies that may limit methadone pharmacy dispensing. • Incentivize pharmacies to stock and dispense methadone for OUD, and provide financial support for start-up costs, including hiring PWLLE to mitigate stigma and assist patients with navigating pharmacy pickup.
Federal government	• Provide guidance on stocking and distributing agonist treatment to ensure pharmacies can provide methadone and buprenorphine without fear of unwarranted DEA investigation. • Amend the *Controlled Substance Act* and administrative policies to allow methadone pharmacy dispensing for OUD. • Allocate funding and resources for TA and training for pharmacists. • Develop guidance on agonist stocking and dispensing in pharmacies and person-centered models for entities to fulfill requirements in diversion safety plans.
5.3: Adopt and support coordinated care models that facilitate the provision of MT at other health care facilities.	
Providers	• Establish mechanisms to coordinate care for MT patients across multiple health settings, including OTPs, pharmacies, acute care facilities, and outpatient services. • Coordinate care for MT for patients interacting with non-medical systems of care, including social service providers (eg, housing shelters) and carceral settings. • Build partnerships to support methadone prescribing in rural and under-resourced settings. • Create referral pathways with specialty addiction treatment providers to enable referrals to higher levels of care and serve as a step-down care provider as needed.
State government	• Develop policies that support the integration of MT into various healthcare settings. • Coordinate systems for data sharing among different providers. • Provide state-level grants or incentives for facilities to incorporate methadone treatment, including skilled nursing homes and palliative care providers .
Federal government	• Provide guidance on collaborations between MT providers, primary care clinics, hospitals, and mental health services to create a seamless network of care.

This fails to recognize the role MT plays in saving lives because patients are no longer forced to deal with a poisoned street drug supply. It also fails to recognize how MT can reduce chaotic use, allowing individuals to function in daily life. In many communities, there is a prevalent myth that OTPs increase crime rates in their vicinity. However, evidence suggests the opposite, showing that areas surrounding OTPs may actually experience less crime.[86] These myths contribute to "not in my backyard" campaigns, which block the expansion of MT in communities that could benefit from it, and overly concentrate these services in largely marginalized and disenfranchised communities.

To address misinformation about MT, providers can hold open events in collaboration with PWLLE to invite families of patients and other community members to raise awareness about the benefits of MT. Additionally, providers can collaborate with CBOs, media channels, and a variety of publications to share expert insight, advocate for wider acceptance of MT, and share their evidence-based research to combat misinformation.

State governments can allocate funds to educate the public about MT through media campaigns, educational and training opportunities, and sharing stories of individuals who have benefited from MT. State governments can also explore avenues to address the spread of demonstrably false information about methadone treatment. Similarly, the federal government can utilize various training and media channels to educate the public about the benefits of MT. Governments should also ensure that the public has clear and accessible data on the effectiveness and safety of methadone and fund fact-checking organizations to promote the spread of accurate information about MT.

6.2 Targeting highly impacted groups with unique histories of stigma towards MT.

While MT stigma is incessant across most communities, three key groups experience unique circumstances and should be targets of stigma reduction and expansion of person-centered MT.

BIPOC communities that have experienced harms of drug war and oversaturation of treatment services. The oversaturation of substance use treatment in BIPOC communities has led to a sense of being targeted or overwhelmed by such services, which often are coercive, carceral, not culturally responsive nor aligned with the community's perceived needs.[87] Combined with a history of systemic discrimination and inadequate healthcare services, there is skepticism towards MT and OTPs. This, along with myths and misperceptions about methadone have significant implications for whether MT is sought and how individuals on MT are perceived within the community. Providers should collaborate with CBOs and peer support groups that have already established trusted relationships with BIPOC communities to help PWLLE share their positive experiences with MT and serve as role models who can address concerns and reduce stigma. Both state and federal governments should invest in broad anti-stigma campaigns around methadone that address diverse groups, but particularly BIPOC communities that have experienced disproportionate harms of the drug war.

Underserved rural communities that have experienced high overdose rates with low access to health services. Residents of rural communities also have misperceptions about MT, which can significantly impact access and use in areas where OTPs are available–and the future establishment of office-based services. "Not in my backyard" misperceptions may be particularly problematic in rural communities, where there is also a lack of historical access to methadone. Social networks are often tighter knit; the fear of being judged for seeking MT can be particularly discouraging. Rural areas typically have fewer healthcare resources, including fewer providers who are knowledgeable about MT; stigma in the community can discourage healthcare providers from offering it as a treatment option. Fueled by myths about crime and social decay, there is often resistance against establishing OTPs in rural areas. This resistance exacerbates scarcity of treatment options available to rural residents, meaning individuals often have to travel long distances to access MT; methadone patients in certain rural areas need to drive about 44 minutes on average to the nearest treatment program, a significant barrier to MT.[88] Both state and federal governments should invest in anti-stigma campaigns around methadone addressing the lack of access to services experienced by rural communities using clear, concise language to emphasize the positive outcomes associated with treatment. Governments can also collaborate with local organizations to conduct discussions to understand and address specific concerns and misconceptions held by rural communities.

Drug court and other legal system staff. Strong fallacies among specialty courts and other criminal legal system staff and judges about methadone significantly impact access to MT for criminal-legal system-involved individuals. A common misperception is that methadone is a drug that replaces one addiction with another, failing to recognize methadone's role in stabilizing individuals and reducing illicit opioid use.[89] There is skepticism about the efficacy of MT and concerns about the potential for diversion. Some court personnel view methadone and other forms of MOUD as rewarding criminal behavior rather than as legitimate medical treatments. Others may have more negative attitudes toward methadone (an opioid agonist medication) compared to extended-release naltrexone (an opioid antagonist), due to fears of misuse and a lack of understanding of the pharmacological benefits of agonist treatment. Due to these misperceptions, most drug and other specialty courts do not offer MT as an option for participants.[90] For participants who are already in MT upon entering courts, these attitudes can create barriers to continuing their treatment. This discontinuation can lead to increased risk of overdose because of a return to use of street drugs. Addressing these misperceptions through targeted education and training for court staff can lead to access to this life-saving treatment for court participants, ultimately improving their health and criminal legal outcomes.

Examples of specific recommendations for this focus area and the corresponding target group for implementing recommendations are included in Table 8.

Table 8. Specific Recommendations for Shifting Public Thinking About Methadone Treatment

6.1: Address public misinformation about MT.	
Providers	• Hold open events in collaboration with PWLLE to invite families of patients and broader members of the community to visit MT programs and raise awareness about benefits of MT. • Facilitate support groups for PWLLE's family members. • Engage key community members (eg, local recovery communities, businesses, and elected officials) to combat stigma and misinformation and gain collective buy-in. • Collaborate with local news channels or publications to share expert insights and patient testimonials about the positive impact of MT using language that avoids jargon and stigma. • Partner with medical organizations and those dedicated to promoting harm reduction and advocating for wider acceptance of MT as a legitimate medical intervention. • Contribute to research efforts and share data on the positive outcomes associated with MT to strengthen the evidence base and counter misinformation.
State government	• Create up-to-date informational material on MT targeted at families of PWLLE to share at OTPs, primary care settings, emergency rooms, and other healthcare settings. • Collaborate with key community members to develop culturally relevant messaging that resonates with local communities and prioritize educational and training opportunities. • Host town halls, panel discussions, and Q&A sessions with medical professionals and PWLLE to address public concerns directly and share success stories. • Explore legal avenues to address the spread of false information about MT. • Allocate state funds specifically dedicated to educating the public about MT (eg, media campaigns, community outreach programs, and educational materials).
Federal government	• Use various media channels (TV, radio, social media) to educate the public about benefits of MT and reduce stereotypes by portraying accurate and diverse experiences of MT. • Partner with trusted organizations (eg, medical professionals, public health agencies, recovery organizations) to amplify the message and ensure credibility around MT benefits. • Provide resources and funding for fact-checking organizations to debunk false claims and promote the spread of accurate information about MT online.
6.2. Target highly-impacted groups with unique histories of stigma towards MT	
Providers	• Collaborate with CBOs and peer support groups that already have established relationships and trust within the target populations. • Train and support individuals to share their positive experiences with MT with target groups with low MT access, providing relatable role models who can reduce concerns and stigma. • Provide information about MT in multiple languages and utilize culturally relevant communication styles that resonate with the target audience. • Address common misconceptions and worries specific to the target groups, such as job discrimination, housing instability, or child custody concerns.
State governments Federal government	• Develop anti-stigma campaigns and trainings that target BIPOC and rural communities and consider common beliefs or norms that influence attitudes towards MT. • Work with tribal, religious and other community leaders to address cultural beliefs and traditional healing practices that may create resistance to MT, and collaboratively identify ways to position these beliefs and practices as complementary to MT. • Engage in efforts to increase knowledge and awareness among jail, prison, drug courts, and other criminal legal systems in coordination with agencies that oversee legal system entities. • Conduct research or focus group discussions to understand specific concerns or misconceptions held by the targeted groups regarding MT. • Enforce existing laws that protect individuals from discrimination based on their participation in MT programs (eg, ADA). • Allocate grants and resources specifically for organizations serving highly impacted groups to conduct educational campaigns and provide support services that address MT stigma.

Conclusion

This is the only medication that will save your life that's tougher to get than the drug that's putting you in that position. —Louise Vincent, conference participant

The call to liberate methadone is a call to fundamentally change the way methadone is prescribed, dispensed, regulated, and perceived, with the ultimate goal of expanding equitable access and reducing overdose, suffering, and health harms. The aim of this conference and report is to transform the MT system to make it more equitable, inclusive, and responsive to the needs of those most impacted by the overdose epidemic. **Placing PWLLE in decision-making roles** promotes equity and the democratization of policy-making processes. **Normalizing MT as a standard healthcare practice** challenges widespread stigma and discrimination around the medication and promotes equitable treatment within healthcare systems. **Grounding MT in person-centeredness** emphasizes the importance of tailoring treatment to individual needs and goals, reducing barriers to access and prioritizing the connection of individuals to care. **Improving OTP practices, enhancing patient care, and increasing transparency** within clinics helps ensure that programs are accountable and responsive to patient needs. **Expanding who can prescribe methadone and allowing pharmacists to dispense it** will widely expand access and to care, particularly for underserved communities. Finally, **shifting public discourse to dispel stigma** and misperceptions will allow MT to become a regular and widely accepted practice.

We hope this report serves as a call to action, urging the substance use treatment and healthcare communities, policymakers, researchers, community leaders, and other key key publics to recognize critical priorities for reform. As overdoses continue to rise, now is the time to learn from those on the front lines to expand access to this life-saving treatment. It is our shared responsibility to take steps towards implementing the proposed recommendations and continue to engage in thoughtful and collaborative efforts towards improving health and well-being in our communities.

References

1. National Institute on Drug Abuse. Drug overdose death rates. Published June 30, 2023. Accessed March 4, 2024. https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates

2. Humphreys K, Shover CL, Andrews CM, et al. Responding to the opioid crisis in North America and beyond: recommendations of the Stanford-Lancet Commission. *Lancet*. 2022;399(10324):555-604.

3. Centers for Disease Control and Prevention. COVID data tracker. Centers for Disease Control and Prevention. Published 2024. Accessed March 4, 2024. https://covid.cdc.gov/covid-data-tracker

4. Krawczyk N, Rivera BD, Jent V, Keyes KM, Jones CM, Cerdá M. Has the treatment gap for opioid use disorder narrowed in the US?: a yearly assessment from 2010 to 2019. *Int J Drug Policy*. 2022;110:103786. doi:10.1016/j.drugpo.2022.103786

5. Methadone. Centers for Disease Control and Prevention. Accessed February 25, 2024. https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/methadone

6. NASADAD & AATOD. *Technical Brief: Census of Opioid Treatment Programs*. National Association of State Alcohol and Drug Abuse Directors (NASADAD); 2022. https://nasadad.org/wp-content/uploads/2022/12/OTP-Patient-Census-Technical-Brief-Final-for-Release.pdf

7. Substance Abuse and Mental Health Services Administration. *Medications for Opioid Use Disorder: Treatment Improvement Protocol (TIP) Series 63*. Substance Abuse and Mental Health Services Administration; 2021.

8. Harris RA, Long JA, Bao Y, Mandell DS. Racial, ethnic, and sex differences in methadone-involved overdose deaths before and after the US federal policy change expanding take-home methadone doses. *JAMA Health Forum*. 2023;4(6):e231235. doi:10.1001/jamahealthforum.2023.1235

9. Brothers S, Viera A, Heimer R. Changes in methadone program practices and fatal methadone overdose rates in Connecticut during COVID-19. *J Subst Abuse Treat*. 2021;131:108449. doi:10.1016/j.jsat.2021.108449

10. Jones CM, Compton WM, Han B, Baldwin G, Volkow ND. Methadone-involved overdose deaths in the US before and after federal policy changes expanding take-home methadone doses from opioid treatment programs. *JAMA Psychiatry*. 2022;79(9):932. doi:10.1001/jamapsychiatry.2022.1776

11. Sordo L, Barrio G, Bravo MJ, et al. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. *The BMJ*. 2017;357:j1550. doi:10.1136/bmj.j1550

12. Madden ME, Shapiro SL. The methadone epidemic: methadone-related deaths on the rise in Vermont. *Am J Forensic Med Pathol*. 2011;32(2):131-135. doi:10.1097/PAF.0b013e3181e8af3d

13. Drug fact sheet: methadone. Published online 2022. Accessed January 15, 2024. https://www.dea.gov/sites/default/files/2020-06/Methadone-2020_0.pdf

14. Davis CS, Carr DH. The law and policy of opioids for pain management, addiction treatment, and overdose reversal. *Indiana Health Law Rev*. 2017;14(1). https://doi.org/10.18060/3911.0027

15. Boss R, Chalk M, Conrad L, Croze C, Polk L. *Transforming the Role of Opioid Treatment Programs: Opportunities, Considerations, and Choices in a Time of Crisis*. Technical Assistance Collaborative; 2023.

16. Goedel WC, Shapiro A, Cerdá M, Tsai JW, Hadland SE, Marshall BDL. Association of racial/ethnic segregation with treatment capacity for opioid use disorder in counties in the United States. *JAMA Netw Open*. 2020;3(4):e203711. doi:10.1001/jamanetworkopen.2020.3711

17. Pew Charitable Trusts. *Improved Opioid Treatment Programs Would Expand Access to Quality Care*. Pew Charitable Trusts; 2022.

18. Adams Z. History of methadone. Presented at: Liberating Methadone: A Building a Roadmap and Community for Change; 2023; New York, NY.

19. Schwartz RP, Kelly SM, O'Grady KE, Gandhi D, Jaffe JH. Randomized trial of standard methadone treatment compared to initiating methadone without counseling: 12-month findings. *Addiction*. 2012;107(5):943-952.

20. Mattick RP, Breen C, Kimber J, Davoli M. Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. *Cochrane Database Syst Rev*. 2014;2014(2):CD002207.

21. McNamara KF, Biondi BE, Hernández-Ramírez RU, Taweh N, Grimshaw AA, Springer SA. A systematic review and meta-analysis of studies evaluating the effect of medication treatment for opioid use disorder on infectious disease outcomes. *Open Forum Infect Dis*. 2021;8(8):ofab289. doi:10.1093/ofid/ofab289

22. Schwartz RP, Gryczynski J, O'Grady KE, et al. Opioid agonist treatments and heroin overdose deaths in Baltimore, Maryland, 1995-2009. *Am J Public Health*. 2013;103(5):917-922.

23. Timko C, Schultz NR, Cucciare MA, Vittorio L, Garrison-Diehn C. Retention in medication-assisted treatment for opiate dependence: a systematic review. *J Addict Dis*. 2016;35(1):22-35.

24. Hansen HB, Siegel CE, Case BG, Bertollo DN, DiRocco D, Galanter M. Variation in use of buprenorphine and methadone treatment by racial, ethnic, and income characteristics of residential social areas in New York City. *J Behav Health Serv Res*. 2013;40(3):367-377.

25. Pew Charitable Trusts. Racial disparities persist in many US jails. Published May 16, 2023. Accessed March 5, 2024. https://pew.org/44DtVUh

26. Rising J, Whaley S, Saloner B. *How the Drug Enforcement Administration Can Improve Access to Methadone in Correctional Facilities and Save Lives*. Johns Hopkins Bloomberg School of Public Health; 2022.

27. Jones CM, Campopiano M, Baldwin G, McCance-Katz E. National and state treatment need and capacity for opioid agonist medication-assisted treatment. *Am J Public Health*. 2015;105(8):e55-e63. doi:10.2105/AJPH.2015.302664

28. Mitchell P, Curtin KM, Magliocca NR. Race, rurality and geographic accessibility to medication for opioid use disorder in the US. *J Maps*. 2023;19(1):2270632. doi:10.1080/17445647.2023.2270632

29. Krawczyk N, Garrett B, Ahmad NJ, et al. Medications for opioid use disorder among American Indians and Alaska natives: availability and use across a national sample. *Drug Alcohol Depend*. 2021;220:108512. doi:10.1016/j.drugalcdep.2021.108512

30. Silverstein SM, Daniulaityte R, Martins SS, Miller SC, Carlson RG. "Everything is not right anymore": buprenorphine experiences in an era of illicit fentanyl. *Int J Drug Policy*. 2019;74:76-83. doi:10.1016/j.drugpo.2019.09.003

31. Simon C, Vincent L, Coulter A, et al. The methadone manifesto: treatment experiences and policy recommendations from methadone patient activists. *Am J Public Health*. 2022;112(52).

32. Methadone Take-Home Flexibilities Extension Guidance. SAMHSA. Published November 2021. https://www.samhsa.gov/medications-substance-use-disorders/statutes-regulations-guidelines/methadone-guidance

33. Vincent L, Tilley J, Levenson B, Vakharia S. Nation's leading drug policy experts demand medication assisted treatment and COVID-19: treatment reforms. Published online April 13, 2020.

34. SAMHSA. Medications for the treatment of opioid use disorder. Federal Register. Published February 2, 2024. Accessed March 4, 2024. https://www.federalregister.gov/documents/2024/02/02/2024-01693/medications-for-the-treatment-of-opioid-use-disorder

35. Stroud C, Posey Norris SM, Bain L, eds. The history of methadone and barriers to access for different populations. In: *Methadone Treatment for Opioid Use Disorder: Improving Access Through Regulatory and Legal Change: Proceedings of a Workshop*. National Academies Press (US); 2022. Accessed March 4, 2024. https://www.ncbi.nlm.nih.gov/books/NBK585210/

36. Frank D. "I was not sick and I didn't need to recover": methadone maintenance treatment (MMT) as a refuge from criminalization. *Subst Use Misuse*. 2018;53(2):311-322. doi:10.1080/10826084.2017.1310247

37. Center for HIV Law & Policy. Ryan White planning councils and advocacy model. Published online 2013.

38. Health Resources & Services Administration. Board composition. *HRSA Cent Program Bur Prim Health Care*. Published online April 2023. https://bphc.hrsa.gov/compliance/site-visits/site-visit-protocol/board-composition

39. Antezzo M, Manz J, Mette E, Purington K. State strategies to increase diversity in the behavioral health workforce. *Natl Acad State Health Policy*. https://nashp.org/state-strategies-to-increase-diversity-in-the-behavioral-health-workforce/

40. National Council for Mental Wellbeing. Diversity, equity and inclusion: emerging opportunities for the behavioral health workforce. Published online 2022.

41. SAMHSA. National model standards for peer support certification. Published online March 2023. https://www.samhsa.gov/about-us/who-we-are/offices-centers/or/model-standards

42. Simon C, Brothers S, Strichartz K, et al. We are the researched, the researchers, and the discounted: the experiences of drug user activists as researchers. *Int J Drug Policy*. 2021;98:103364.

43. Farre M, Mas A, Torrens M, Moreno V, Cami J. *Retention Rate and Illicit Opioid Use during Methadone Maintenance Interventions: A Meta-Analysis*. Centre for Reviews and Dissemination (UK); 2002.

44. Johansson BA, Berglund M, Lindgren A. Efficacy of maintenance treatment with methadone for opioid dependence: a meta-analytical study. *Nord J Psychiatry*. 2007;61(4):288-295.

45. West SL, O'Neal KK, Graham CW. A meta-analysis comparing the effectiveness of buprenorphine and methadone. *J Subst Abuse*. 2000;12(4):405-414.

46. Kelley AT, Incze MA, Baylis JD, et al. Patient-centered quality measurement for opioid use disorder: development of a taxonomy to address gaps in research and practice. *Subst Abuse*. 2022;43(1):1286-1299. doi:10.1080/08897077.2022.2095082

47. Bonifonte A, Garcia E. Improving geographic access to methadone clinics. *J Subst Abuse Treat*. 2022;141:108836.

48. Furst JA, Mynarski NJ, McCall KL, Piper BJ. Pronounced regional disparities in United States methadone distribution. *Ann Pharmacother*. 2022;56(3):271-279.

49. Foundation for Opioid Response Efforts. *Program Advisory Meeting: Imagining a More Patient-Centered Approach to Methadone Treatment: Executive Summary*. Foundation for Opioid Response Efforts; 2023.

50. Davis CS, Carr D. Physician continuing education to reduce opioid misuse, abuse, and overdose: Many opportunities, few requirements. *Drug Alcohol Depend*. 2016;163:100-107. doi:https://doi.org/10.1016/j.drugalcdep.2016.04.002

51. Substance Abuse and Mental Health Services Administration. *Core Curriculum Elements on Substance Use Disorder for Early Academic Career Medical and Health Professions Education Programs*. Accessed May 8, 2024. https://www.samhsa.gov/sites/default/files/core-curriculum-report-final.pdf

52. Project ECHO. https://www.ahrq.gov/patient-safety/settings/multiple/project-echo/index.html

53. Coulter A, Oldham J. Person-centered care: what is it and how do we get there? *Future Hosp J*. 2016;3(2):114-116. doi:10.7861/futurehosp.3-2-114

54. Santana MJ, Manalili K, Jolley RJ, Zelinsky S, Quan H, Lu M. How to practice person-centered care: a conceptual framework. *Health Expect Int J Public Particip Health Care Health Policy*. 2018;21(2):429-440. doi:10.1111/hex.12640

55. Tonelli MR, Sullivan MD. Person-centered shared decision making. *J Eval Clin Pract*. 2019;25(6):1057-1062. doi:10.1111/jep.13260

56. Rastegar DA. Patient-centered care in opioid use disorder treatment. In: Wakeman SE, Rich JD, eds. *Treating Opioid Use Disorder in General Medical Settings*. Springer International Publishing; 2021:1-7.

57. Davis EL, Kelly PJ, Deane FP, et al. The relationship between patient-centered care and outcomes in specialist drug and alcohol treatment: a systematic literature review. *Subst Abuse*. 2020;41(2):216-231.

58. Marshall K, Maina G, Sherstobitoff J. Plausibility of patient-centred care in high-intensity methadone treatment: reflections of providers and patients. *Addict Sci Clin Pr*. 2021;16(1):42.

59. Frank DMG, P. P, C. D, Walters SM, Curran L, Guarino H. It's like 'liquid handcuffs": The effect of take-home dosing policies on Methadone Maintenance Treatment (MMT) patients' lives. *Harm Reduct J*. 2021;88.

60. Reisinger HS, Schwartz RP, Mitchell SG, et al. Premature discharge from Methadone Treatment: Patient perspectives. *J Psychoact Drugs*. 2009;41(3):285-296.

61. D'Aunno T, Park S (Ethan), Pollack HA. Evidence-based treatment for opioid use disorders: a national study of methadone dose levels, 2011-2017. *J Subst Abuse Treat*. 2019;96:18-22. doi:10.1016/j.jsat.2018.10.006

62. Hunt P. AHA patient's bill of rights. APRA. Published November 13, 2018. Accessed March 4, 2024. https://www.americanpatient.org/aha-patients-bill-of-rights/

63. Clausen T, Anchersen K, Waal H. Mortality prior to, during and after opioid maintenance treatment (OMT): a national prospective cross-registry study. *Drug Alcohol Depend*. 2008;94(1-3):151-157.

64. Heimer R, Black AC, Lin H, et al. Receipt of opioid use disorder treatments prior to fatal overdoses and comparison to no treatment in Connecticut, 2016-17. *Drug Alcohol Depend*. 2024;254:111040.

65. Pew Charitable Trusts. Federal agencies have substantial authority to boost methadone access. Published August 11, 2022. Accessed March 4, 2024. https://pew.org/3STA20W

66. Krawczyk N, Joudrey PJ, Simon R, Russel DM, Frank D. Recent modifications to the US methadone treatment system are a Band-Aid—not a solution—to the nation's broken opioid use disorder treatment system. *Health Aff Sch*. 2023;1(1):qxad018. doi:10.1093/haschl/qxad018

67. Greer AM, Hu S, Amlani A, Moreheart S, Sampson O, Buxton JA. Patient perspectives of methadone formulation change in British Columbia, Canada: outcomes of a provincial survey. *Subst Abuse Treat Prev Policy*. 2016;11:3.

68. Saloner B, Krawczyk N, Solomon K, et al. Experiences with substance use disorder treatment during the COVID-19 pandemic: findings from a multistate survey. *Int J Drug Policy*. 2022;101:103537. doi:10.1016/j.drugpo.2021.103537

69. Hunter SB, Dopp AR, Ober AJ, Uscher-Pines L. Clinician perspectives on methadone service delivery and the use of telemedicine during the COVID-19 pandemic: a qualitative study. *J Subst Abuse Treat*. 2021;124:108288. doi:10.1016/j.jsat.2021.108288

70. Agency for Healthcare Research and Quality. Warm handoff. Published 2023. Accessed March 5, 2024. https://www.ahrq.gov/patient-safety/reports/engage/interventions/warmhandoff.html

71. Substance Abuse and Mental Health Services Administration. *Incorporating Peer Support into Substance Use Disorder Treatment Services (Tip 64)*.; 2023. Accessed March 5, 2024. https://store.samhsa.gov/sites/default/files/pep23-02-01-001.pdf

72. Centers for Medicare & Medicaid Services. Five-star quality rating system. Accessed May 12, 2024. https://www.cms.gov/medicare/health-safety-standards/certification-compliance/five-star-quality-rating-system

73. Centers for Medicare & Medicaid Services. Hospital quality initiative public reporting. Accessed May 12, 2024. https://www.cms.gov/medicare/quality/initiatives/hospital-quality-initiative/hospital-compare

74. James TG, Argenyi MS, Guardino DL, et al. Communication access in mental health and substance use treatment facilities for deaf American sign language users. *Health Aff (Millwood)*. 2022;41(10):1413-1422. doi:10.1377/hlthaff.2022.00408

75. Joudrey PJ, Halpern D, Lin Q, Paykin S, Mair C, Kolak M. Methadone prescribing by addiction specialists likely to leave communities without available methadone treatment. *Health Aff Sch*. 2023;1(5):qxad061. doi:10.1093/haschl/qxad061

76. Brooklyn JR, Sigmon SC. Vermont hub-and-spoke model of care for opioid use disorder: development, implementation, and impact. *J Addict Med*. 2017;11(4):286-292. doi:10.1097/ADM.0000000000000310

77. Reif S, Brolin MF, Stewart MT, Fuchs TJ, Speaker E, Mazel SB. The Washington State Hub and Spoke Model to increase access to medication treatment for opioid use disorders. *J Subst Abuse Treat*. 2020;108:33-39. doi:10.1016/j.jsat.2019.07.007

78. HR2067 - 117th Congress (2021-2022): MATE Act of 2021. Published October 19, 2021. Accessed May 22, 2024. https://www.congress.gov/bill/117th-congress/house-bill/2067

79. McCarty D, Bougatsos C, Chan B, et al. Office-based methadone treatment for opioid use disorder and pharmacy dispensing: a scoping review. *Am J Psychiatry*. 2021;178(9):804. doi:10.1176/appi.ajp.2021.20101548

80. Kazerouni NJ, Irwin AN, Levander XA, et al. Pharmacy-related buprenorphine access barriers: an audit of pharmacies in counties with a high opioid overdose burden. *Drug Alcohol Depend*. 2021;224:108729. doi:10.1016/j.drugalcdep.2021.108729

81. Boston Medical Center. BMC OBAT: the Massachusetts Model. Accessed March 5, 2024. https://www.addictiontraining.org/about-us/bmc-obat/

82. State of Vermont. Hub and spoke | Blueprint for Health. Accessed March 5, 2024. https://blueprintforhealth.vermont.gov/about-blueprint/hub-and-spoke

83. Korthuis PT, McCarty D, Weimer M, et al. Primary care-based models for the treatment of opioid use disorder: a scoping review. *Ann Intern Med*. 2017;166(4):268-278.

84. Pew Charitable Trusts. *Care Coordination Strategies for Patients Can Improve Substance Use Disorder Outcomes*.; 2020.

85. Rigg KK, Weaver R, Kusiak E. Attitudes toward methadone treatment among Black/African Americans: implications for engagement and retention. *Am J Orthopsychiatry*. 2023;93(6):476-485. doi:10.1037/ort0000692

86. Boyd SJ, Fang LJ, Medoff DR, Dixon LB, Gorelick DA. Use of a 'microecological technique' to study crime incidents around methadone maintenance treatment centers. *Addiction*. 2012;107(9):1632-1638. doi:10.1111/j.1360-0443.2012.03872.x

87. Andraka-Christou B. Addressing racial and ethnic disparities in the use of medications for opioid use disorder. *Health Aff (Millwood)*. 2021;40(6):920-927. doi:10.1377/hlthaff.2020.02261

88. Joudrey PJ, Chadi N, Roy P, et al. Pharmacy-based methadone dispensing and drive time to methadone treatment in five states within the United States: a cross-sectional study. *Drug Alcohol Depend*. 2020;211:107968.

89. Andraka-Christou B, Gabriel M, Madeira J, Silverman RD. Court personnel attitudes towards medication-assisted treatment: a state-wide survey. *J Subst Abuse Treat*. 2019;104:72-82. doi:10.1016/j.jsat.2019.06.011

90. Matusow H, Dickman SL, Rich JD, et al. Medication assisted treatment in US drug courts: results from a nationwide survey of availability, barriers and attitudes. *J Subst Abuse Treat*. 2013;44(5):473-480. doi:10.1016/j.jsat.2012.10.004