CONNECTING CARE PODCAST // EPIDSODE #6 // TRANSCRIPTS

Strengthening Methadone Programs: A Harm Reduction Perspective

Dr. Alex Walley:

Many individuals accessing methadone treatment experience stigma and structural challenges that complicate access and retention.

Hiawatha Collins:

Before we can talk about governments and agencies and things like that, we have to talk about society as a whole. I honestly believe that the stigma that's associated with recovery, with methadone, we have to address that and educate people on that, first and foremost.

Dr. Alex Walley:

You're listening to Connecting Care. I'm Alex Walley, an HIV primary care doctor and an addiction medicine specialist in Boston, Massachusetts. I'm joined again by my colleagues, Dr. Jessica Taylor and Dr. Sim Kimmel. On today's podcast, we are excited to speak with Hiawatha Collins, to talk about methadone and the role it can play in treating opioid use disorder.

Dr. Alex Walley:

You're listening to Connecting Care, the intersection of HIV and opioid use disorder. I'm Alex Walley and I'm an HIV primary care doctor and addiction medicine specialist in Boston, Massachusetts. I'm joined again by my colleagues, Dr. Jessica Taylor and Dr. Sim Kimmel. Today, we are super excited to be joined by Hiawatha Collins, who's the community mobilization coordinator at the National Harm Reduction Coalition and the board chair for VOCAL-NY.

Dr. Alex Walley:

He is also a patient treated with methadone at an opioid treatment program. Welcome, Hiawatha, we are grateful to you for agreeing to join us. Today, we want to focus on methadone and what role it can play as a treatment for people with opioid use disorder and people with HIV, or at high risk for HIV. You have expertise, as a harm reductionist and someone with lived experience taking methadone. Let's get into it, because we have a lot of questions for you. First, tell us a little bit about the Harm Reduction Coalition and VOCAL-NY and your roles there.

Hiawatha Collins:

Yes, Alex, thank you very much for having me. Once again, my name is Hiawatha Collins and I am with the National Harm Reduction Coalition, which is a national organization that, basically, we provide technical assistance. We provide trainings for individuals, we have resources on our website for individuals. Anything that has to do with policy, advocacy around harm reduction issues. The implementation of overdose prevention programs, the setting up of user unions and/or helping with the state and/or county health departments, when it comes to providing assistance around syringe access or anything like that.

Hiawatha Collins:

This is what we do. We provide community-based organizations with trainings and technical assistance around various issues that they may need. I am the board chair for VOCAL-NY at this time. VOCAL-NY is basically a grassroots organization that builds power for individuals with impacted by HIV/AIDS, the drug war, mass incarceration, homelessness and a few other issues. They have won various campaigns here lately around the 30% rent cap, housing, Housing For All, syringe access and a few other bills here in New York State, just to name a few.

Hiawatha Collins:

You know, one thing about VOCAL-NY is that it's a dues-paying membership-led organization. It means a lot, to be a part of something that works with the community, both in my personal and professional life.

Dr. Jessica Taylor:

Thanks Hiawatha. I'll second Alex, that we're so excited to have you here today.

Hiawatha Collins:

Thank you.

Dr. Jessica Taylor:

I was wondering if you'd be willing to tell the group a little bit about when you were first treated with methadone, and what that experience was like?

Hiawatha Collins:

When I was first treated with methadone, I didn't know a lot about it. I heard about it. You know, the whole thing is that it's a life-saving experience for a lot of people. Even for me, in my case, because I was going through a lot, things was happening. Things were changing in my life and instead of using, I decided to get into recovery.

Dr. Jessica Taylor:

Thank you. You know, we've been hearing in Boston, a lot of us that are doing addiction treatment or in advocacy roles, about a lot of people who have a preference for starting methadone, compared to buprenorphine or Suboxone right now. That relates to the fact that most of the opioids on the street right now are fentanyl. I'm curious if you could share with the audience, just who may be less familiar, why it is that some people might prefer methadone over buprenorphine or vice versa? And when people might make a choice to go for one medication or the other?

Hiawatha Collins:

I'm going to be honest, and I'm going to say, for me, I'm so glad that there is a choice and people have an option, have a choice of not just one or the other. As long as people have a choice and both of them are available no matter where they go, both of them should be available, is my opinion. But now, the thing is that when individuals choose one or the other, some people may need more structure. Some people, let's say for instance, an individual may go into a said program and when they go into the said program, they tend to find other things that they may get at that said program.

Hiawatha Collins:

They may tend to get groups, get other medical care treatment while they're there. Have HIV testing. Other said groups, as I've stated, and they may need more structure, they get their primary care there. There's different things that goes on there. Now, someone who may choose buprenorphine may need less structure, okay? So, they go in, they start the process, they go see their primary care doctor. They get the buprenorphine. They may get two weeks and then they get 30 days. Then, every 30 days, they go see their doctor. So, they get less fracture.

Hiawatha Collins:

It's all on within a person, a person desires or may need or what may be better for the said individual, and compared to needing more structure, less structure, more interaction with folks, because sometimes, some people who attend a methadone clinics and programs, certain programs, their only interaction with said other people is when they go to the same program. So, this is where they hear about other job opportunities, other training opportunities and things like that.

Hiawatha Collins:

This is their little network. Where someone who is more stable or more introverted or whatever the case may be, they may find that they want to be by themselves. They don't want everybody to know about them and they have other said resources that they can use. They're more connected to said other people. So, either one is good for either people, but like I said, I do believe everybody should be offered a choice.

Dr. Jessica Taylor:

Absolutely. Choice is so important in treatment and in treatment success and keeping people in treatment.

Hiawatha Collins:

Yes.

Dr. Jessica Taylor:

I was wondering if you could share a little more with folks that might be listening, that know a little bit less about the fentanyl that's on the street right now, basically everything that we're hearing about in Boston is illicitly manufactured fentanyl. Including contaminating stimulants and benzos and other types of drugs. We're hearing that getting onto buprenorphine or Suboxone has gotten harder in the last couple of years. Would you be able to say a word about why that is, for folks that might be new to the addiction realm or may not understand what's changed?

Hiawatha Collins:

The thing is that a lot of people are, in New York, and not just in New York and Boston, it's all over the place. This fentanyl is hitting hard. There's people who are, we use the term opiate-naive. This basically means that individuals do not, or have not ever used an opioid, but let's say they use powdered cocaine. Now, they go and use this powdered cocaine and all of a sudden, there's fentanyl in their powdered cocaine.

Hiawatha Collins:

Now, this may lead them to, say, an emergency room, because they overdosed, because they were opiate-naive. This opioid, this fentanyl within that said product, and now, over time, by constantly using that same product, now they have an opioid habit and a cocaine addiction. Now, it's like, "Okay, I'm not using that, but now I have to start another whole program, because I was using something that I didn't know was in something else that I'm using."

Hiawatha Collins:

So, people are a little standoffish, because they are like, "I don't use opioids. I never used opioids." When someone explains to them that, "Okay, you never used opioids, but you used this other product and the opioid, the fentanyl, was in that said product and that leads you to have the issue that you have now." They don't really understand that and some people don't want to really relate to that, because they don't really believe it. Because they never intentionally went out to use the said fentanyl or that said opioid.

Hiawatha Collins:

The thing about it is, that it's even in the Xani bars, the Xanax, you know what I mean? It's in so many different things out there right now. In the heroin, according to DEA, it's in 80% of the heroin in the area and on the East Coast. So, no matter what, you're getting some type of fentanyl. The thing about it, the worst part about it is, it's not like it's regulated or anything like that. So, you don't know the concentration of the fentanyl and how much is in it.

Hiawatha Collins:

All you know is that it's in that said supply chain. We don't know whether it's cross-contamination or whether it's actually in the said product, but you have a lot of people who are, as I stated, opiate-naive, who never used an opioid who are coming down with issues around opioids, because they may have used cocaine or Xanax or something like that, which is non-opioids, to then have a opioid addiction. Actually, opioid addiction, they use them both. One substance with two substances in it.

Dr. Jessica Taylor:

I think that's an incredibly important message for public health professionals, which is that we need to be doing opioid overdose prevention in anyone using substances.

Hiawatha Collins:

Period, yes.

Dr. Jessica Taylor:

Not just people that identify as using heroin and fentanyl.

Hiawatha Collins:

Yes. Definitely. You know, with that, it becomes like, okay, here in New York, the city health department has a team that goes out and they try to go to the bars in a certain community. They mainly talk about the fentanyl in the Xanax and the powdered cocaine. Especially the cocaine, because a lot of people are coming into the ERs and having an overdose and they don't have any record, any history of opioid use. They will even say that, "Yes, I had a night out, I've used powdered cocaine."

Hiawatha Collins:

Well, in some cases, even crack cocaine and they ended up in the ER from an opioid overdose, because that product that they were using, that substance that were using was saturated with fentanyl. So, the moral is that anyone that is using any substance right now, should be aware of fentanyl and should understand how they respond to a fentanyl/opioid overdose. Just to make themselves be aware. There's a whole 'nother conversation, but we'll have that at another time, around safe supply, legalization and things like. I'm an advocate, so you know I got to throw that stuff out there.

Dr. Sim Kimmel:

Thank you for bringing that up. The risk from overdose because of fentanyl is so much greater and the access to methadone is even more important than it's ever been before.

Hiawatha Collins:

Yes.

Dr. Sim Kimmel:

You mentioned that, when you first started a methadone treatment, that it was a challenging period. You mentioned that the dose was a little bit low. Could you talk us through a little bit about what the process of starting methadone is like and what it's like to be a patient on methadone?

Hiawatha Collins:

The process when you start out, you go into, I mean, it's different all over the place. Sometimes you have to be on a waiting list, sometimes the waiting list is short, sometimes in rural parts of the country and rural parts of even this state, people have a long waiting list, which has to change, because any time anyone is ready to get into recovery or in any way, shape, form or fashion, they should be allowed to.

Hiawatha Collins:

There should be some process for them to do so. You know, if they don't get a chance to do it today, and I hate to say it like this, but they may not be able to get a second chance. Then, people don't recover and don't get a second chance. But, for me, the process was simply going in to a said facility. I went, they told me the hours that they did induction, what is called, basically, induction. I came back the next day, in between those times.

Hiawatha Collins:

I had to take a physical. After taking a physical, I then was given a set of instructions, met with a counselor, I met the doctor. All of this stuff. Then, I went in about eight o'clock, about between 11 and 12 that same day, I was receiving my first dose. First dose, at that time, was 30 milligrams. The reason why they give them the 30 milligrams is because no matter how much really it is you've been using, they want to make sure that you get adjusted to this new medication. That is going to sit with you.

Hiawatha Collins:

When you've come back the next day, they start to go up, until you get what they deem to be comfortable. Now, the process, during the induction phase, people must understand that you're going to be going up 5 to 10 milligrams every couple of days. Until you stabilize, but, now once you "stabilize", then your dose may come down or it may go up, depending on how you resting, how you sleeping. How your body feels and everything like that.

Hiawatha Collins:

So, just because, let's say, if you stop at 60 or 70 and live on that for three days and you're comfortable for those three days, that don't mean that it'll stay there. That means that you could either go up or down, because now they're going to ask you certain questions like, "Are you sleeping? How are you? Are you lethargic?" Things like that. If you're lethargic, then they're going to come down. If you're not lethargic and you're not resting well, you're not eating, you're not drinking water.

Hiawatha Collins:

All these other things come into play, which should be discussed, because now your diet, your water intake, your liquid intake, all of this comes to play a part, is when someone is getting their body back together, because now you have to think about the getting used to, getting this other said substance now is not there. Now, you want to get used to, make sure that you're sleeping properly, that you're not getting these body aches and things like that.

Hiawatha Collins:

Most importantly, especially for anyone who use opioids, no one wants to go into withdrawal. So, that's the main thing. If you do, I'm going to be honest, some people go out and use, but the thing is not to use excessively, because you want the methadone to do what it needs to do. That is to get you to the point where you don't have to use and you're comfortable, so that you can make it to the next day. Some people say the methadone lasts in the system for 24 hours, but there are places, where once you get stable on a methadone, everybody's different. It could be viable in your system anywhere from 24 to 72 hours.

Hiawatha Collins:

That's a very good thing, because if you happen to be out and miss a dose, you won't be, even though you won't get sick the next day and you don't have to panic. So, there's a lot of misinformation about, "Oh, I missed my dose. I have to do this. I have to do that." Be careful, it's not the truth. You don't have to. Some of it is a mind thing and hearsay thing, but just pay attention to your body, talk to your doctors and those included with you. You'll get the right information for you. Don't believe all the hearsay. In the military, we used to call it scuttlebutt. Don't do that, believe your doctor and talk to your doctor. Go through what you need to go through for you.

Dr. Sim Kimmel:

Thanks for sharing all those details. We know that that early period is riskier for people than later on, when people are able to have a dose that really blocks their craving. Once people have a blocking dose and they're at an effective dose, tell us a little bit about what that's like, to be part of a methadone clinic, to be receiving methadone. What do you do when you travel? Tell us what your experience has been like a little bit.

Hiawatha Collins:

Well, my experience has been, basically, when you first start out, you're going to go daily. So, you're going to have to go every day to the said clinic. Depending on your livelihood and what you do, you're going to go to group. You may talk to a counselor once every two weeks or whatever the case may be. You know, I have to say, the groups, the counselor, you may be asked to talk to a vocational counselor. You may be even asked to speak to someone within mental health.

Hiawatha Collins:

Every six months, you're going to have a physical. Every six months to at least once a year, you're going to have a complete physical. They're going to schedule that for you and they're going to let you know everything, blood work to everything, HIV, hep C testing and all of that. We can change it, I'll refuse if you want to, but at least they offer it to you. For me, that's the most important thing, to know and to be offered these said tests.

Hiawatha Collins:

The one thing about it is, me personally, I didn't like going every day, but it is what it is. But, going every day and then sometimes, I mean, it's different wherever you go. Some places require you to do urinalysis every so often. Some of them are what you'd call supervised, some of them are not. There's different things going on with that. The one thing, that there's different rules at different places, you can't get take-homes until you've completed at least 90 days with no substance detected in your test.

Hiawatha Collins:

Once you get take-homes, you get every couple of days, then you go up to every other day, then you go to three days. Then, the next thing you go is to a week. Then from a week, you can go to two weeks, but you have to maintain those substances. Then, anytime you go to the doctor, you have to let them know, or if you're given any medications or anything like that.

Hiawatha Collins:

There's different rules at different clinics. You know, some rules I totally understand, some I don't. Some of them, I don't think really need to be, but that's just me, because I don't think someone should lose anything that they have obtained, because it takes a lot of work to obtain days off. It's hard to get those things in. Sometimes, in a lot of cases, it's even harder for individuals to get, unless if they have family members who live in Boston, and I'm in York and I may want to go to a wedding or a funeral in Boston, it's harder for me to get those take-homes for that.

Hiawatha Collins:

Let's say I'm going up there for four days, it's hard for me to get take-homes. Or, the next thing that I would have to do is to try to arrange, with a clinic that's in Boston, because I'm going to Boston to meet there. Then, I have to go to the clinic while I'm there on vacation, or at the said event, daily, until I get back home or whatever the case may be.

Hiawatha Collins:

Sometimes, any type of recovery is personal to people, sometimes. It's unfortunate that there's stigma and judgment within the said recovery itself. Sometimes, you may not want people to know, even family members to know that you're in recovery. Especially if you're going on a trip or something like that. But, it varies for everyone and it's just the process. Some people need more structure, some people don't, as I stated earlier. But, the person should be included a little bit more in their said recovery, because it is their recovery.

Dr. Alex Walley:

Hiawatha, the travel doses that you talked about, do you have to pay for those separate?

Hiawatha Collins:

Thank you for that question. Thank you, thank you. I forgot that. Sometimes, there is a fee that is included in that. That's the fee to the visiting said clinic, because, you know, it varies all across the state. I've traveled to San Diego, Colorado, Austin, Texas, Indianapolis. I've traveled a lot of places and the prices varied. They went from $10 each dose to $25-30 each dose.

Dr. Alex Walley:

So, not only vacation do you have to show up every day at a clinic, you also have to pay money to get your...

Hiawatha Collins:

Yes.

Dr. Alex Walley:

Okay.

Hiawatha Collins:

Yes, yes. That was beautiful. Now, I didn't include that in, thank you very much for that. Yes, you have to pay money. The only way you don't have to pay money is if your home clinic actually gives you the bottles to take with you while you're on vacation or away and you don't have to pay. But, if you have to use that other said clinic, then a lot of times, you have to pay. Some clinics will give you a waiver and will waive the fees, if it something like a convention, something work related, or do you try to get your job to pay for it? But, that's another conversation.

Dr. Alex Walley:

Great. I've been a doctor at a methadone clinic since 2007. I've seen how, despite all these hassles and rules and regulations you just described, methadone is life-saving and life-improving. Many patients who take methadone for a long time hide it. You actually were alluding to this. They hide it from the people they work with and even their family and friends. Why is methadone so stigmatized? What do you think we can do about it?

Hiawatha Collins:

If you noticed, in the beginning, I said, "It saved my life." It is life-saving and it definitely is. The why, why do people hide? It is because of how people get treated, outside and sometime even inside of the clinic. There are people who will, I mean, there's names, "The Methadonians". You know, it's the only medication, notice I said, it's the only medication that you could take, whereas someone is going to judge you, because you're taking that said medication.

Hiawatha Collins:

It's really a shame, because someone's recovery is their recovery and no one should be, I feel, no one should be ashamed to be in recovery. It's okay, but it's the stigma that go along with the past life, the past history of being a active or former user and then getting themself into recovery. Oh, so now you got to go into and talk about what you used to do.

Hiawatha Collins:

Now, there are those people that say, "Oh, so you went from one drug to another drug?" "No, no. I went from one drug to a medication that helps me to function every day, so that I can do what I need to do.

So I can take care of my family, so I can go to work. So I can drive, so I can do whatever I need to do, just like everyone else." I mean, when someone takes high blood pressure medication, they're not judged, they're nor criticized, they're not ridiculed.

Dr. Alex Walley:

Hiawatha, I want to dig down a little bit more on that, okay? Push it a little bit further. So, I've heard some patients and people who use drugs describe methadone is liquid handcuffs, or say it's no better than jail. I think that these views stem from the methadone treatment system's history as a tool of social control for people who use drugs. Especially black people who use drugs. Methadone has these coercive, punitive elements that I think, to some people, they've told me it can feel like incarceration. How have you experienced and coped with these coercive and punitive elements of methadone?

Hiawatha Collins:

Me personally? By being an advocate. By advocating, by trying to make change. I'm not just going to sit by and think that, because something there, even though it saved my life, even though it is something that is very much needed, it could be a whole lot better process for any and everyone, okay? Just because the law, these rules are there, don't make them right.

Hiawatha Collins:

Can you imagine what it's like to want to do better, for yourself, and you can't even go to go to a loved one's funeral? Do you know what it's like to have someone tell you, not only can you not go to a funeral, but I mean, okay, the bottom line is this, let me regress for a second. When you go in, you have security guards outside the door. You got to walk past the security guards. These security guards, they're supposed to be HIPAA and all of this stuff, but they see you come in. Every day, but how do they treat people that come in there?

Hiawatha Collins:

Some of them are young, some of them are older. How do they perceive, or what have they been told their jobs were? They look down and belittle people who are coming in to help themselves. It's the shame of it is, it's not just the security, okay? It's some of the people that actually work at some of these places, some of these facilities. They think that you're subhuman or less than a person, because you're in a said program and bettering yourself.

Hiawatha Collins:

They don't know your educational level, they don't know your work history. They don't know anything. All they know is that you're a person in line. When you're in line, there are some things where I was once told that my job, my livelihood, was not important. My recovery was more important than my livelihood.

Hiawatha Collins:

Well, then I asked him, "Well, how am I going to pay my rent? Where am I going to sleep at? I was homeless. I'm not going back to being homeless. So, you're asking me to choose between my job and homelessness. That's what you're asking me to do." "No, I'm not asking you to do that. I'm asking you to make a choice." "But, I'm making a choice. I come in late a couple of times, because of work, okay? I call, I try to do everything I need to do, but because of the rules, if I'm not able to be there by a certain time,

then you want restrict me? I'm already going six days a week, so what, really, could you do to me?" You know what I mean?

Hiawatha Collins:

I mean, that was the mentality that I had at the time, but then, I almost walked off. But, it's like, "Why would I walk off something that's working for me? It's not their recovery, it's my recovery." You have these people who don't understand, you know, that you have real-life issues going on. The urinalysis, what does a urinalysis have to do with my recovery? All it's going to tell you is what's in my system. It's not going to tell you what type of person I am. It's not. It's not going to tell you how I am as a person, you know what I mean?

Hiawatha Collins:

Even when it comes down to other social and economical issues, urinalysis, "You can't get housing, because." "You can't keep your kids, because." What is this? What did we come down to as a society? As people, looking down on other people that are trying to do the right thing. This is the whole thing. When it comes down to standing outside in a line, coming someplace every day, being looked down upon by some of the staff that are in these said facilities.

Hiawatha Collins:

Like I said, most of the people that are there are not mandated, they're there because they want to be there. But, the liquid handcuffs part is that, "Man, I can't even get a job or I can't get a better job, because I have to come here first. Then, I got to go travel how far to go get that? Then I tell you I have a job and I ask you about take-homes. You want to talk about my urinalysis?"

Hiawatha Collins:

Everybody's recovery is different. Some people may not be in it to actually be 100% abstinent. To each his own. Some people may be in it, like I said, to save their life. Literally. Okay, it saved your life, but they may occasionally, and let's use the term dip and dab. Okay, fine. They occasionally dip and dab, but they're not sharing, they learned, they got educated. They're doing a whole lot better. So, the program did what it was supposed to do.

Hiawatha Collins:

It's doing what it's supposed to do, but now, if they take the urinalysis and they have anything in their system, they lose everything that they got. They use that punitive approach to everything. "Oh, I was at work, I came late." Or, "I missed the meeting with the caseworker, with the counselor." So, guess what? Now, you lose dates or you're suspended. You put on probation or you get kicked out.

Hiawatha Collins:

One of the worst things right now, is women in MOUD right now. I say the worst thing, it's because, especially during COVID right now, schools being closed, childcare. Some people actually had to leave their children with strangers outside, because they couldn't bring their children inside the clinic. Or, if they bring their children, "You can't come to this program. You no longer a client of this said program, because you have to bring your kids." I mean, really?

Hiawatha Collins:

So, there's a lot of punitive things. When it comes to the control of said minority, people of color, black, brown, indigenous people of color, it was a social constraint. They're basically control, to disillusion and to, how you say, facilitate. I mean, I'm not even going to say control, but the disenfranchisement of said black, brown, indigenous people of color.

Dr. Jessica Taylor:

Hiawatha, you're describing a lot of profound structural barriers to getting into methadone in the first place. To being able to stay on, that clearly put up a lot of barriers to a lot of people. One thing I've been involved in, is that we have a hospital-based fridge clinic, which has traditionally been a buprenorphine program. But, recently, in March of this year, we started being able to use methadone for emergency opioid withdrawal management, for up to 72 hours.

Dr. Jessica Taylor:

We're able to set up partnerships with local opioid treatment programs or methadone programs, to rapidly get people into a methadone clinic within three days. So, we started this, you know, slowly. We wanted to learn about the new protocols, start pretty slowly. The demand has been overwhelming. I think, in part, because it's a pathway to same-day methadone access, to first treat the emergency opioid withdrawal and also get into a clinic within three days.

Dr. Jessica Taylor:

Which, even in a city, like the one I work in, where we have a lot of resources for addiction treatment, the waiting lists often are much longer than that. So, we thought a lot, you know, just about how to change these structural barriers that drive a need for a protocol like ours, which, it's frankly a workaround. It's a Band-Aid. It's really, we're a small program. We can't meet the needs of everyone that needs access to methadone.

Dr. Jessica Taylor:

I'm wondering if you could say more about how systems, how departments of public health, how governments could do more to make methadone more accessible and to improve the experience for people, once they get onto methadone?

Hiawatha Collins:

Can I step back? I totally understand the question, but I want to step back for a second. Before we can talk about governments and agencies and things like that, we have to talk about society as a whole. I honestly believe that the stigma that's associated with recovery, with methadone, we have to address that and educate people on that, first and foremost. Because those, the same people in society are the ones that are making the decisions.

Hiawatha Collins:

So, if society as a whole is educated, if these myths that are within society is dispelled, and then, after we educate and we dispel the myths, then we talk about policies that include those individuals that are using these said facilities and these programs. If they are a part of the decision-making process, then, and only then, will we have something a whole lot better. Because, a lot of times, the people that think that they're making the right decisions, they've never been involved or needed a said program.

Hiawatha Collins:

So, how do they know what the people that are using the said program are going to need? Those people who are sitting on the start lines, who never been in, if they had a clearer understanding of what the programs were for, how beneficial they were, how many lives they've saved. But then, they also have to hear the other number. The other number of how many people have stayed away from methadone and buprenorphine, because of the alienation, the stigma, the meds. How many of those people then passed?

Hiawatha Collins:

Once they hear both of those numbers, because I mean, maybe I'm, oh, too altruist or utopianistic or whatever the case may be. I believe that people, honestly, want people to live and not die. If people hear that number, then they'd be like, "Hold up, wait a minute. There has to be a better way." But, there really is a better way.

Hiawatha Collins:

We all have to do better, by respecting people, giving people a second chance and allowing them to make mistakes without judgment. Showing people compassion, love, dignity and respect, regardless of color, race, religion. We are all human being. If you cut me, you cut you, whatever, we all going to bleed red. A lot of this racist, social, economic bias towards said individuals, we have to do away with it. This society, we need to treat people with dignity and respect, regardless of their social, economical standards. Regardless of race, creed or color. We have to do better by each other, as human beings.

Dr. Sim Kimmel:

You really put it beautifully. Especially the way that you're talking about stigma. A lot of the policies are rooted in stigma, right? During the COVID pandemic, several regulations were relaxed and liberalized, to increase access to methadone programs and to enable social distancing requirements. What are the lessons learned at these methadone clinics during the pandemic that we can continue to apply going forward?

Hiawatha Collins:

I pray and I hope that Samson and everyone else who are decision-making bodies actually look at home delivery. Especially for elderly and home-bound individuals, number one. Number two, people don't need to come every day, just because of their urinalysis. I know, I want 28 days, but 14 days works. We can give people 14 days, have them come back and they're going to be all right.

Hiawatha Collins:

Now, there are other things, because telemedication came alone. Telemedication is something that worked well, not only in New York, across the country, but it could work a whole lot better. Of course you want people to take urinalysis, I'm against it, but okay. You know, if I was a doctor, yes, I would want to make sure that you're taking your medication and how much, your levels and things like that. So, okay. Urinalysis, but they don't have to be taken every week. My god. You know what I mean?

Hiawatha Collins:

Urinalysis, they could be less of those. You could give people more take-homes, it's going to be okay. Telemedication, you can work and improve upon. These things could change and these things have been advocated for. A lot of these have been advocated for, for the past 5, 6, 7, almost 10 years. They came along with COVID overnight. The only thing was, that when it came about, there was so much confusion.

Hiawatha Collins:

So, setting a precedent and making sure that it is not just a recommendation, but policy. It becomes policy that individuals have to follow. Then, also, with some of the changes that are going to happen, ensure that you have participant advisory committees or boards, so that you can have your said facility work in a unison with the people that's using their said facility. Because if you're just dictating and making the rules and they're not a part of that, they don't feel a part of it.

Hiawatha Collins:

I think recovery belongs to the said individuals using the program and they need to be included in the decision-making process. They need to be heard and validated, you know, not just as a figurehead to say that we got it, but legitimately hear what your clients, what your participants are saying. Allow them to be a part of the decision-making process and their own recovery. Because once you do that, then guess what? Your program will thrive. They will bring other people into your program. They'll talk about your programs.

Hiawatha Collins:

They'll talk about the doctors, the nurses and how good they all are. You know what I mean? Definitely implement harm reduction into all of these programs. Please implement harm reduction into all of your programs. Harm reduction, it's the way to go, you know what I mean? Because it's person-centered. You can't have harm reduction without practice and principle. So, you've got to have both of those and bring them together. Treating people with dignity and respect, including them, person-centered. Those types of things.

Dr. Alex Walley:

Hiawatha. Today, you provided keen insights into how methadone works and how it can be better, both in your role as a harm reductionist and an advocate and your experiences as a patient. So, we are super grateful. You also planted seeds for future ideas for podcasts, like on state supply how to support users unions, which are something I think we're going to have on our list, which we know our Strengthening Systems of Care audience needs to hear more about.

Hiawatha Collins:

Thanks.

Dr. Alex Walley:

So, I want to just say thank you. I think we covered a lot of ground today. There's always more to talk about with methadone than the concomitant stigma and drama that comes with it. So, note that we did not touch on everything, but I think we really hit on a lot and I'm excited for our audience to learn from you like we did today. So, just want to say thank and look forward to future discussions.

Hiawatha Collins:

Thank you for having me. I really appreciate this opportunity to be a voice for advocates and for people who are using the said program. Thank you for just giving me the opportunity and allowing me to be a voice. I hope to see you all again soon. Have a good day. Take care, everyone. Thank you.

Dr. Jessica Taylor:

Thanks Hiawatha.

Dr. Alex Walley:

You're listening to Connecting Care. Our program was produced today by JSI and Boston Medical Center. Connecting Care is supported by the HERSA-funded project, Strengthening Systems of Care For People With HIV and Opioid Use Disorder. The project aims to enhance system-level coordination and networks of care among Ryan White, HIV/AIDS, program recipients and other federal, state and local entities. You can learn more about the project and find resources at www.ssc.jsi.com.