National Alliance for Medication Assisted Recovery, Inc.

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April 8, 2020

Mark Parrino, MPA | President
American Association for the Treatment of Opioid Dependence, Inc. (AATOD)
225 Varick Street, Suite 402
New York, New York 10014

Dear Mark,

The National Alliance for Medication Assisted Recovery (NAMA Recovery) has had the privilege and responsibility of representing the collective voices of individuals in medication supported recovery since 1988. Of the estimated 500,000 patients whose interests we represent, greater than 380,000 of them are estimated to be enrolled in opioid treatment programs (OTPs) receiving methadone, buprenorphine, or naltrexone as part of their treatment for opioid use disorder. We recognize that the pharmacology of methadone in particular necessitates a structured delivery system – especially during times of induction and/or instability due to the co-occurring illicit use of other sedatives such as benzodiazepines or chronic alcohol use. We maintain that in the current environment of a national emergency, a coordinated disaster response demands a critical and objective risk vs. benefits assessment. The system of care needs to be flexible in such a way so that the least likely harm to patients takes priority in every decision that is made.

NAMA Recovery has received numerous reports from across the country that indicate the majority of OTPs are working to implement the March 16, 2020 guidance (updated March 19, 2020) from the Substance Abuse and Mental Health Services Administration (SAMHSA) that allows for a 28 day supply of take home medication, "for all stable patients in an OTP," and up to a 14-day supply of take-home medication, "for those patients who are less stable but

who the OTP believes can safely handle this level of take-home medication."

NAMA Recovery also acknowledges and appreciates the March 20, 2020 guidance to OTPs from AATOD that highlights the critical importance of infection control plans and procedures during this national emergency, addresses the importance of and ways to facilitate the protection of program staff and patients, acknowledges that individuals living with opioid use disorder are, "already vulnerable based on pre-existing conditions," and highlights the utility of curbside dosing and coordination between SAMHSA, state authorities, and programs.

NAMA Recovery specifically appreciates AATOD's acknowledgement in the March 20, 2020 guidance that the consideration of providing exception take-home medication, "is based on individual risk/benefit assessments." It is well documented that patients enrolled in services at OTPs have a greater likelihood of pre-existing chronic health conditions, including hypertension, diabetes, asthma, chronic liver disease, chronic obstructive pulmonary disease (COPD), pain, and stroke. The risk for some of these conditions is more than doubled among individuals with substance use disorders (SUDs). This is critically important for OTPs to consider in their "risk/benefit assessment" for emergency take home medication and other protocols, such as curbside dosing and facility social distancing, as the Centers for Disease Control and Prevention (CDC) lists these very conditions as potentiating, "higher risk for severe illness from COVID-19."

It is with this knowledge and understanding that we write to detail our concern around growing reports of irresponsible and potentially abusive OTP practices that we are receiving daily from patients, family members, program staff, and NAMA Recovery officers and advocates. Although NAMA Recovery has been an organization comprised of medication assisted treatment patients *and health care professionals* that are supporters of quality opioid maintenance treatment since our founding in 1988, it is unprecedented in NAMA Recovery's history to receive communication detailing concerns from OTP staff in volume that now totals nearly one-third (⅓) of all our COVID-19 related contacts. Some individuals in medication supported recovery have expressed to NAMA Recovery as well as to the media that they feel it would be safer to go out and use street drugs than to continue to be put in high risk situations at their OTP that greatly increase the likelihood of exposure to COVID-19.

We have summarized the recurring themes that continue to surface in individual communications from OTP patients, their families, program staff, and other stakeholders below. Much of the correspondence has included photographic and/or video evidence. When considering the significant volume of communication from patients, their family, and providers it is important to remember that every patient report typically represents exponentially more patients who either do not know to whom they can complain and/or are fearful of retaliation and being discharged from care that they do not speak up. The regularity of these reports across multiple states suggests that many of these concerns are systemic and widespread within the OTP system across the United States.

1. In-person take home call backs and medication counts

1.1. Reports from numerous individual patients and family members of patients that span eight (8) states have reported OTPs continuing to perform **in-person** take home call backs and medication counts.

1.2. We are directly aware of at least two (2) state opioid treatment authorities (SOTAs) who have given guidance that any take home call backs and medication counts should be performed only via technology when they are critical in the view of the treating clinician. All programs should adopt this practice until the COVID-19 national emergency has ended.

1.3. The increased risk of exposure from performing **in-person** take home call backs and medication counts at a time it is critical to decrease the total number of patients in the programs to increase social distancing puts individuals in medication supported recovery at unnecessary risk for exposure to COVID-19.

2. Lack of implementing social distancing protocols and infection control procedures inside and outside the program

2.1. Reports from numerous individual patients as well as OTP staff from seven (7) different states have reported that **NO** social distancing protocols are being implemented inside **OR** outside the program.

2.1.1. Two nurses from different regions of the country who work for different companies have expressed significant concern that is causing them to consider resigning from their positions due to lack of social distancing protocols, basic infection control, and access to proper PPE. Nurses are critical members of the treatment teams that deliver essential services to individuals with opioid use disorder; This is alarming.

2.1.2. Numerous patients with chronic medical conditions, including chronic pulmonary conditions, have reported that receiving medication assisted treatment with methadone is the most likely reason they may be exposed to COVID-19, as they report their OTP is the one place they cannot avoid which continues to ignore the importance of social distancing protocols.

2.1.3. Patients from multiple states have reported there are, “no social distancing protocols whatsoever” (to quote one patient from Minnesota) and that patients are forced to line up for medication administration very closely and that waiting room seating has not been rearranged to ensure individuals are spaced at least six (6) feet apart.

2.1.4. Patients and program staff from not less than six (6) states have expressed concern over the lack of basic screening protocols to assess for individual symptoms as well as any potential exposure to COVID-19.

2.1.5. Patients and program staff from not less than seven (7) states have reported that ***in-person*** **group counseling** sessions continue to be offered and, in at least four (4) reported cases that span three (3) different states, *mandated*.

2.2. Reports from numerous individual patients and family members as well as OTP staff from twelve (12) different states have reported situations in which an OTP may have implemented social distancing and basic infection control procedures

inside the program but continue to facilitate an environment on clinic property *outside the program* that fails to ensure social distancing and facilitates increased risk for exposure to COVID-19.

2.2.1. Patient, family members, and OTP staff representing thirteen (13) unique OTPs spanning five (5) different states have reported specifically that programs are only allowing between 5 - 10 patients inside the facility at a time (depending on the size and layout of the building), but that patients are being forced to line up in close proximity outside the OTP as they await entry into the program.

2.2.2. These individuals have expressed significant concern that patients may be exposed to COVID-19 before ever entering the facility, significantly reducing the effectiveness of any efforts inside the program. These situations have also been covered by the media (see here and here) as well as publicly documented on social media, leading NAMA Recovery to be further concerned that patient confidentiality is being compromised while such practices simultaneously fuel additional stigma against individuals enrolled in medication assisted treatment for opioid use disorder as well as their treatment.

3. Lack of implementation of emergency take-home doses, especially for individuals who have chronic medical conditions

3.1. Reports from five (5) different patients from OTPs from three (3) states involve patients who have chronic pulmonary disease and are forced to continue attending their OTP daily. Individuals with chronic lung diseases are among the highest risk for COVID-19 infection.

3.2. Multiple individuals with chronic health conditions from OTPs spanning six (6) states who have recently tested positive for THC alone - or their family members - have reported to NAMA Recovery that their recent positive toxicology tests for THC are being cited as the reason they must continue attending the clinic daily or every other day. These patients clearly meet the "less than stable" category for up to fourteen (14) take home doses of medication, and their pre-existing chronic health conditions make the risk of COVID-19 infection significantly greater than any perceived risk of granting take home methadone or buprenorphine to an individual who has tested positive for THC.

4. Patients with a documented positive test for COVID-19 being required to continue normal attendance at programs without encouraging patient quarantine and implementing chain of custody protocols as authorized by the March 30, 2020 guidance from SAMHSA related to individuals with the Coronavirus

4.1. Perhaps among the most alarming direct reports NAMA Recovery has received have come from two patients in the same state, and one concerned OTP staff member from a different state, that report patients who have documented positive tests for COVID-19 still regularly attending the OTP under their pre-COVID-19 phase levels without being encouraged to quarantine.

4.2. The two patients in the same state who have tested positive for COVID-19 are concerned they will spread the virus to other patients and their community but are unable to quarantine because the Program Director advised they could not "figure out" how to implement chain of custody protocols.

4.3. The concerned OTP staff member - who happens to be a Program Director - reports that the company who owns the OTP refuses to allow implementation of chain of custody so that the patient may appropriately quarantine because they do not have documentation of the positive test direct from the healthcare entity who performed the test despite the patient exhibiting minor symptoms and self-reporting their confirmed positive status.

In conclusion, NAMA Recovery recognizes that many patient-centered and ethical OTPs are following SAMHSA guidance around the provision of extended take home doses of medication and the implementing of critical social distancing protocols – such as curbside dosing and extended medication hours – and NAMA Recovery's support of the expansion of medical maintenance/office-based methadone treatment for patients first stabilized through an OTP does not indicate a lack of support for the OTP system overall. Medical maintenance, or office-based methadone treatment, has been available in the United States since the 1980's. Dr. Marie Nyswander ran one of the first such programs in the country. Sadly, medical maintenance is woefully underutilized and has rarely been available outside of a select few cities, and that is an unfortunate reality during the current COVID-19 crisis.

NAMA Recovery is keenly aware of the very real dangers associated with the illicit use of benzodiazepines, chronic alcohol consumption, and/or other sedating substances for individuals in medication supported recovery, most especially individuals whose treatment medication happens to be methadone. Assessing for problematic use and impairment is of critical importance for patient safety, and that can be effectively accomplished outside overly punitive and in-person toxicology testing that could expose an individual to COVID-19. Toxicology testing may be a helpful tool within a skilled provider's clinical decision making process, but positive toxicology tests alone do not correlate to the "abuse" of substances (which is the wording of the related SAMHSA criteria for the provision of take home medications), do not prove impairment since they could indicate the single or non-problematic use of a substance from up to a week prior to the test, and are too often used in a punitive, non-clinical way. At the present time, punitive toxicology testing and toxicology tests being utilized in conjunction with **in-person** take home call backs and medication counts are putting patients, their families, and our communities at an unnecessary and increased risk of exposure to COVID-19.

Lastly, we fully understand provider concerns around the potential for overdose due to methadone's unique pharmacology. All things in medical care come down to a risk/benefit analysis. The risks of exposure to COVID-19 for a population that is more likely than the general public to have chronic health conditions is a significant and verifiable risk to consider in light of the fact there is no objective evidence or data to suggest that OTP patients divert and/or abuse exception take home doses during emergency situations.

These concerns must be addressed urgently to protect patients, their families, program staff, and our communities at large.

We appreciate the longstanding and productive relationship NAMA Recovery has had with AATOD for many years, and - on behalf of more than 380,000 patients enrolled in OTPs across the United States - we thank you for taking the time to hear patient concerns and ask that AATOD assists NAMA Recovery in facilitating positive change in these areas.

Because treatment works,

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