

Film Screening and Q&A—Liquid Handcuffs: A Documentary to Free Methadone

A conversation with David Frank and Helen Redmond

Moderator: Daniel Wolfe

Recorded: February 10, 2020

ANNOUNCER:

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DANIEL WOLFE:

I am Daniel Wolfe, I co-lead our work here on harm reduction, International Harm Reduction Development and we-- s-- support work in most of-- maybe all of the countries-- featured. I guess I should say in-- in introducing that-- this is not meant to be an exhaustive catalogue of all the ways that methadone is used in the world.

But it is-- a very useful and insightful-- catalyst for conversation about how methadone is used and how it could be used. And so, I hope we'll continue that-- after-- the movie is over. So-- I just wanted to acknowledge the two co-directors-- and actually, I'm going to ask them-- one of them, Helen will be on the panel, but I'm gonna ask them both just to-- introduce themselves to you now.

MARILENA MARCHETTI:

Hi, everyone. Thank you for coming. My name is Marilena Marchetti, co-director of the film. And I guess that's all you need to know about me (LAUGH) for now, so thank you for coming.

HELEN REDMOND:

Hi, m-- (APPLAUSE) yes. My name is Helen Redmond and I am the other co-director. I'm also a licensed-- clinical social worker and I've been working with people who use drugs for well over a dec-- a decade. And-- ended up working with a lot of people who were using heroin.

And one of my jobs was to help them to get into methadone. I'm also a journalist and I write about drugs-- for the website-- filter. So thank you all for coming and please stick around because we really wanna get your feedback on the film. We really believe art should be interactive and it isn't just what we say, but we really wanna know. We know there's a lotta expertise in this room. So thanks again for coming. (APPLAUSE)



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DANIEL WOLFE:

Yeah. And my thanks to both of you and to all of you for coming. Just to note that-- our third panelist will be David Frank, who actually has some lived experience of methadone, so we-- don't want to privilege one form of expertise over another.

But I do see in the room anoth-- quite a number of people here, who have either been prescribers or patients or people who have worked with prescribers and patients. So I'm looking forward to the conversation. And with that-- we will begin. Before we get to the conversation, actually, David, you weren't here-- at the beginning, would you mind introducing yourself for us?

DAVID FRANK:

Okay. Yeah-- my name's David Frank. I'm a sociologist who studies drug use, particularly opioids-- overdose and in particular, methadone maintenance. I'm currently a post doc at NYU. I'm also a person who uses drugs-- particularly opioids and heroin and methadone. And I've been on methadone maintenance for probably about 18 years now. Yeah, nice to see you all.

DANIEL WOLFE:

Thank you. And Helen-- you introduced yourself at the beginning, but-- maybe let me just start with a question for both of you. So you know, in discussing illegal drugs, we often talk about drug set and setting as important. And one of the things I really appreciate about the film is it makes it so clear that actually the setting and the set-- in some sense determines the efficacy also of medication, but we hardly ever talk about that.

David, first question is for you, you-- so you mention using methadone and then-- and other opioids and a few people in the film talked about, quote, "using on top" or-- you know, topping up. Some other people in the film-- like, people in the film were mixed about whether or not-- you know, the aims of treatment. What, for you, is the aim of treatment?

DAVID FRANK:

I mean, that's a great question. A complicated question. For me, the most-- I guess the-- the easiest answer, and this is I think a big misconception about methadone, I didn't get on methadone to get off of drugs or to get off of opioids.

I got on methadone maintenance because of external pressures having to do with the war on drugs or heroin's illegality. I mean, you-- sometimes I say only half kidding-- that I got on methadone maintenance to get access to opioids. Outside-- actually, not kidding at all. I got on methadone maintenance to get access to opioids outside of the war on drugs.

It was really-- I-- I-- I realized at-- early on-- I-- I mean, that I loved opioids and-- and I liked-- I wanted to live my life using them, I functioned very well on them. But I realized that was just not happening under the-- under the system. And-- and as the years wore on and the pressures of criminalization added up-- I eventually-- not that I realized it all of the time, but-- but I realized I was gonna have to find some way that I could do this legally every day. And that-- that's what methadone was to me. I think it's a treatment for the war on drugs more than a war-- a treatment for addiction.

DANIEL WOLFE:

Okay, so Helen-- you traveled around the world and so you've seen lots of incarnations of the war on drugs. I guess for you, what struck you as-- so Portugal is probably the quote "most liberal" place you went in terms of the criminalization regime.

So I think many of you know you can have up to ten days' worth of any drug in Portugal without-- criminal penalty-- although you do have to see one of those guys, the guy who said that thing about WiFi. You have to go see someone like him and he'll tell you about drugs and-- and their potential dangers. What-- if you were making changes to the system-- in any country that you went-- what changes would you make? Like, what changes would you make to Portugal, for example, or did you-- or did you think they got it right?

HELEN REDMOND:

Okay, can people hear me? Okay. (SIGH) So I-- I think the thing that-- in making the film and then in editing and looking through all the footage that just kinda stood out was how the U.S. system has been exported around the world to a greater or lesser degree.

And countries have modified this sort of, you know, U.S. model. That-- that was a thing that felt very depressing, that other countries weren't able to really break out of-- of a clinic system. And in-- in Britain, which-- I mean, I think the pharmacy is actually (SIGH) the best model.

Because everybody goes to-- to a pharmacy, right? They're community hubs.

People buy groceries there, makeup, all of that, but then the problem and we-- we call this Liquid Handcuffs Light, is the supervised consumption at the pharmacy. So if they find another way to-- to control you.

In-- in Portugal-- I've been there-- a bunch of times and they're really trying to evolve-- their-- their system, but it's the same thing, right? You're going to a van six days a week and then you can scale back. And there's no country that has it on prescription. And I think that is what the film, we want people to take away from it. We want prescription parody and we want clinics to close.

They are a relic of another era. They are not what-- it is not the way that we should provide methadone to people in the 21st century, especially-- and everybody here knows this, we have an opioid overdose crisis and people can't get methadone. So prescription parody.

DANIEL WOLFE:

Okay. I actually am so aware of the enormous amount of expertise in the room. And-- you know, I see people here like Ernie Drucker, who-- who was a pioneer of methadone at Montefiore or Bruce Trig, who helped get some-- one of the first methadone programs in jail.

Or Marie, who has great-- expertise on-- on systems of substitution treatments in France or Howard Josepher, who ran a pioneering program or Graham, who's done so much-- and Sharon Stancliff. So there is, like, a huge amount of expertise in the room. So-- if-- if it's okay with you guys, I actually wanna open it up for questions or statements. If-- if you wouldn't mind--

HELEN REDMOND:

Yes.

DANIEL WOLFE:

--keeping it brief. One of the things we all know, especially about drugs, is that people have a lot to say, but there-- since there are a lot of people in the room, I've asked the-- the holders of the microphone to grab it back if you-- go on too long. But if you wouldn't mind-- indicating if you have something to say, and maybe we'll take a couple of questions and statements and then turn back to the panelists. So yeah, just raise your hand. Yeah? Please, here in the front.

GORDON SKINNER:

My name is Gordon Skinner. First off, thank you to the film makers and certainly to OSF for hosting this. My question is, from your perspective, who is your audience and who is your audience not? And what is the pushback that you're receiving from either one of those two positions? And not diametrically opposite, but they do (NOISE) inform the direction, the tenor and the scope of your film.

DANIEL WOLFE:

Okay, great. Let's take a couple more questions and then come back. But that's an excellent question.

ERNIE DRUCKER:

Hi, my name is Ernie Drucker and I-- started a methadone program at Montefiore Hospital in the Bronx in 1968-- with 1,000 patients that I ran for 30 years. And-- in that time, heroin users and crack users who were-- most of those who were involved in it-- had the ability to get the methadone easily-- and-- the-- it was paid for by the state.

And I was impressed in this movie that it touches all the different points that need to be touched about the complications not just of the system for dealing with drug use, but drug use itself. Because at the base of all this is the reason people use drugs is because they want to feel better about themselves and about life with those drugs.

And the fact that it doesn't work out that well is like people-- driving cars that don't have steering wheels. (LAUGH) Cars are a good thing to have, though, and-- but drugs are a good thing to have. And the medications that have taken the place of-- of-- of some of the-- the opioids, for example-- that-- that methadone represented in my own 30 years of experience with it was very impressive to see.

When it was readily available, people used that as the platform for their own well-being. And-- for example, none of our patients got HIV while on the program-- over the course of many, many years. So-- it seems to me that the movie and the issues that it raises at every level are really worth-- putting into a fr-- a framework where all of us who were interested in this, including the patients and the families, could have the ability to meet about this and discuss it and come out with-- an approach to these issues-- from the point of view of the users and their families who have-- who-- you know, never-- it's the criminalization it-- that's-- that's the basis for the war on drugs has made it

impossible to do what needs to be done with drugs.

Because we c-- you know, the whole world has used drugs forever. Animals use drugs. (LAUGH) And-- we ought to be able, if we could-- and I wanted to ask Daniel about this, if-- if-- if-- Sorros' (PH) foundation would sponsor-- the creation of a working group based on this kind of discussion of these issues that would meet regularly and-- and chew on these issues and come out with solutions of different parts-- or at least proposals about them. That's the next step of this. It's take-- take this movie very seriously. I'm very impressed by it. And of course, it covers-- it touches all the bases that need to be touched and they can't be ignored--

DANIEL WOLFE:

Okay--

(OVERTALK)

ERNIE DRUCKER:

I'm-- I'm personally involved in-- in the-- work on these-- hemp-based-- drugs-- CBDs and I'm going to work with the people in Florida who manufacture it to see if we can get the right use of CBDs to help people manage their opioid use or their methadone use.

It-- you know, it-- none of that's been done. Likewise, with-- with-- with-- marijuana and the legalization of marijuana-- I was the first met-- person in New York State to get a medical marijuana pass out of the state. And I had injured my leg and I was using CBD in combination with it. So-- and-- and there's a lot to be done.

I think-- I-- first, I think we have access to actual solutions and the war part of it-- is-- is relevant, but there are-- we know, we-- we win the wars, we lose wars, we settle them, we don't. And that's what could go on here. And I think this movie and-- and the work of people like Daniel and others who have-- here at-- at Open Society over the years have-- have-- have been able to at least discuss this freely.

And maybe we can structure it in some way that it becomes a working group that's going to solve these problems, and 'cause that's-- and-- and, you know, minimize the criminality of it. Use the new medications that are available-- and-- and record that and give-- 'cause the whole premise that people shouldn't use drugs, of course, is the-- is the-- is the-- is the failure of this.

It's not true. People are using these drugs because people live in-- a world full

of-- of-- of-- contradictions and things that-- anxiety that you can't deal with if you're just a mere human being. And these drugs were-- are meant by people to help deal with that.

And-- and I think they can be developed to get by the-- the psychopathology of our social structure, the injustice of our social structure that is the norm. So I think-- I think it can be a very positive outcome.

DANIEL WOLFE:

Thank you. And we'll come back later. And actually, I'm interested in your suggestion of the working group. But it also goes to the first question about, like, who gets to craft the solutions and who decides what the solutions are. So-- I think we had a colleague here, yeah, please.

UNIDENTIFIED MALE:

So I guess I would say-- this is contrarian, but--

DANIEL WOLFE:

Also, welcome.

UNIDENTIFIED MALE:

--I think this film should be for people who aren't experts in the field. It should be informative and I felt it utterly failed to do that. It was really confusing to me. It was not well made. I didn't understand-- I don't know what methadone does, really.

I don't know why it's good or why it's bad. I don't know what its effect on people is. And I've s-- you know, I think I've spent some time with Louie shooting him and he was an active user at that time, and he was functional, so I understand that idea. But I felt the film was really unclear in what it was trying to accomplish and what it's suggesting as a solution.

DANIEL WOLFE:

All right. So let's actually go to the panelists. Oh, let's take one more question then we'll go to the panelists.

UNIDENTIFIED FEMALE:

Hi. I just had one thought in regard to the power dynamics. So I work at an opiate treatment program and I thought it was really important that they shed light on the power dynamics between-- staff and clients. And I would be curious in terms of how we can-- strive for some balance in those power dynamics.

And also note that let's say in New York City, there aren't many methadone clinics, so how do we also raise awareness and also in-- in the same vein, make sure that patients' voices are being heard-- even though there isn't much accessibility?

DANIEL WOLFE:

Thanks. So over to you guys. So a range of questions. Who's the-- who's the film for and not for? And we had, on the one hand, a methadone expert saying it touched on all the right points and someone who said he didn't understand sort of the basic points or premise. The power dynamics in the clinic and then Ernie's point about a working group, like, who can work out solutions?

And I guess I would put it to you guys to answer any of those in any way that you want. (LAUGH) But I am-- I am curious, particularly curious about the who's it for and not for, and also, the-- who do you think holds the solutions? Like, I-- I take the point about abolishing the clinics. But like, yeah, where does the power to make positive change lie? So David.

DAVID FRANK:

Wait, what role-- which is the question? (LAUGHTER)

HELEN REDMOND:

Any one you want.

DANIEL WOLFE:

Any one you want. Who's it for? Power dynamics in the clinic, who has the power to make change?

DAVID FRANK:

Well, the-- the power-- power-- power dynamic. Well, I-- I mean, I think-- yeah, you know, there are-- there are some big answers, which are, you know, abolish the clinic system. And I do think that's-- that's number one. I think you maybe even-- well, actually, a bigger one is-- you know-- legalization and regulation of drugs, I think.

And-- and as we mentioned, this-- this idea that people shouldn't be taking drugs-- at the bottom of all this. But more sort of pragmatic-- solutions, you know, why do we gotta see a counselor every month? I-- I-- you know, I-- I've seen so many in my 18 years and it's just a total crap shoot.

Some of 'em have been really cool. Some of 'em have been horrible. Almost all of them have been very uneducated about drug use. But what-- I mean, it's-- it's-- that would be one-- one way of getting rid of the power dynamic-- 'cause that's how it's mostly expressed I think is through the counselor-- relationship. That's usually the point of contact.

And-- and yeah, you get-- I mean, they have so much power. That's so much power. I mean, they-- you know, they could tell you to do what-- I've-- I've been told to go to N.A., I've been told to go to church, I've been told to volunteer in my community. Yeah, they got a lotta power.

HELEN REDMOND:

Yeah, I'm-- I'm glad you brought that up because it's something that-- I-- I've seen when I've been in methadone clinics and people have-- have told me about who have been on methadone and I-- I h-- I don't want people who work in methadone clinics-- I hope that they are not-- offended by this film.

Although I think some people who work in-- in clinics will-- will feel that. And-- there is this horrible power dynamic. And I don't-- I don't actually think there are many ways to-- change that-- that power dynamic. I-- I think the cl-- clinic system, as long as it exists, you can do some reforms here and there.

But I don't think that that is the way. And I think the only way is to end the clinic system. I think what happens-- it isn't just in methadone clinics, it's in all institutions. What happens to people who work inside of a system where there is that horrific power imbalance, as-- as Erin-- O'Malley-- O-- O'Mara said.

And that is, if you stay in it long enough, you come to accept the urine talks, the-- the mandatory counseling. If you're late-- you don't-- you don't get medicated. You-- you end up accepting that. And I've seen that over and over again. And I-- I had a student who told me a story about when she worked in a methadone

clinic.

And somebody was late and the door was closed, because if you m-- miss the medication window, that's pretty much it. And this person smashed the glass, it was a glass door, and smashed through the door. And when she was telling me this, I was thinking about the person who was doing that.

But I was thinking about the staff who were on the other side of the door. What happened to those people, the staff, that they wouldn't open the door? That they wouldn't say this is so fucked up that we're not letting this person in? We have to change this, right?

And this is what happens to people when you work in institutions where abuse becomes normalized, in-- in prisons and jails, in-- in psychiatric institutions. And it's-- it's really troubling to me. Again, I think people who work in methadone go in with the best of intentions, but that structure changes you.

In order to survive and do your job and do the paperwork and you-- you know, the talk screen, that means you go back to six days a week. If you don't do it, what-- what-- do you still have your job, you know? So I understand the constraints that staff is under. So that's why I feel like the clinic system, it has to go.

DANIEL WOLFE:

So the-- the question of who the film is for or not for?

HELEN REDMOND:

It's-- it's for everybody. It's for everybody. Unfortunately, we are still in the midst of an opioid overdose crisis that is touching hundreds of thousands. Not only the people who have overdosed and died and overdosed and survived, but their families, their community.

So we want everybody-- to see this film. We started with the Harm Reduction Community because that's-- that's our fam. And we wanted to get the input-- about-- about the film and-- and go back and look at it and-- and make edits. So we started with the Harm Reduction Family, but we are going to NIDA at-- at the end of this month-- the National Institutes on Drug Abuse, and we're doing a screening there.

And Nora Valco is gonna be watching this film and we're gonna make-- the argument at NIDA about abolishing clinics. And to the point about the work in groups and-- and all of that-- I think what-- what we're thinking about right now is we actually have to build-- a movement, an advocacy movement, it-- that is

explicitly political and is made up of people who are on methadone, people who were on methadone, allies, family members, basically, anybody who wants to.

And we're not-- we're not naive enough to believe that this isn't gonna be a hell of a fight. Because there are financial interests that are invested in the clinic system, there's ideological-- you know, investment in continuing the clinic system. There is the DEA, right?

They won't even do methadone vans, right? So we're not naive to believe it's not gonna be a hell of a fight, but we believe it's a fight worth having. This is a system that has to go. We have to be able to get-- people have to be able-- it has to be easier for people to get methadone than heroin in this country.

DANIEL WOLFE:

So I see a number of hands. I-- the first--

HELEN REDMOND:

And feel free to disagree with all of that.

DANIEL WOLFE:

And the first hand I want to call on is Marilena, who's a co-director of the film since-- oh, were you-- were you--

MARILENA MARCHETTI:

I was playing with my hair.

DANIEL WOLFE:

Oh, you were playing with your hair? Never mind. (LAUGHTER) So-- in the middle, please, Sharon. (LAUGH) (BACKGROUND VOICE) Let the record show that if you weren't playing with your hair--

(OVERTALK)

DANIEL WOLFE:

Oh, battery dead.

SHARON STANCLIFF:

Though I did finally hear David Frank, it's been a long time, I'm Sharon Stancliff. I used to be medical director of a methadone clinic in Harlem and I now one day a week prescribe buprenorphine in-- in a shelter-- a federally qualified health center, so primary care.

And I just-- I kind-- I just wanted to bring up a few points about the science. The science says counseling really doesn't do very much for people. I have-- and-- and I love counseling. I've been in c-- I'll bet everybody in this room has been in counseling.

But in terms of mandatory counseling, there is nothing that says that helps. The second thing is-- there's this I guess premise that if you are using other drugs and you get to take home your methadone or buprenorphine, you're selling that in order to get the other drugs. It's probably true some of the time, I don't know.

But there's nothing-- there is federal regulations about methadone, but there's nothing in buprenorphine that says I have to make my decisions about giving everybody a month's supply when they come to my primary care clinic, based on the other drugs they're taking.

But the fear I see and the-- the, like, gee, it looks like you dipped your buprenorphine in your urine because there's nothing there but-- but-- we check for the metabolite. And they're like, but I thought you'd throw me out of the clinic if I-- it's like, no, but-- but if you're taking fentanyl I'd like you to know-- I mean, it can be-- I don't like urine testing.

But-- but it's kind of standard, so it's hard. And the thing I wanna say, I love the idea of the work group. I mean, I don't think we can abolish the clinics because methadone is a medicine, it's not a money maker, and I-- if I were given a choice, I would choose methadone over buprenorphine, if a country could only have one or the other, I think.

I think it's probably the better medicine, but there's no money in it. Not to say I love the clinic system, but I think, you know, I've heard from former federal officials, it's time to re-look at the regulations. I really think that a coalition of-- of former government people may-- well, eventually current government people, that might change, people that have the experience is a really good idea. Ernie.
(LAUGH)

BRUCE TRIG:

Yeah, hi-- Bruce Trig. I was-- a methadone medical director in-- New Mexico-- for a while and now I do consulting, mainly on buprenorphine. So what Ernie Drucker didn't mention is that-- he did a study that I was involved with in New Mexico, where stable people-- were-- who were on methadone were-- referred to a primary care clinic after a year.

And-- and they had a social worker who coordinated their care and they picked up their methadone at a pharmacy. And people loved it and the outcomes were excellent. And he repeated that-- we're in Pennsylvania, as well. And-- and nothing ever came of it in part because I think people thought buprenorphine was gonna be the solution.

But-- we know that-- it's-- you know, for a complex condition, it's good to have two medicines and they both have certain strengths and weaknesses. But we know from the experience of the United States that we could do-- an office-based-- opioid treatment that would-- get-- get people out of this endless cycle of-- spending years and years going every day to clinics.

DANIEL WOLFE:

So let me ask you guys, 'cause I-- I have a fear-- I will confess that I have a fear when you show this film to NIDA, that they will say, well, luckily that's why we have buprenorphine. And not only that, that's why we have long-acting formulations.

And in fact, if you're so interested in freeing people from the clinic, why don't you give them one of these formulations? Either an opioid blocker like Naltrexone or - the-- one of the new buprenorphine implants or injectibles that will make them only come back once a month or once every three months or-- et cetera. So-- you know, what would you say to someone who said, why bother with methadone at all? Let's just go to buprenorphine or Naltrexone.

DAVID FRANK:

Me? Yep--

DANIEL WOLFE:

Sure.

DAVID FRANK:

Sure, yeah. And I do wanna point out what-- I'll save my 28-day comment, but remind me to just mention something about 28-day clinics. You know, I think it goes back to this giant misconception about why people get involved with methadone. And you know, it gets very complicated when you talk about the medical model and the disease model.

And sometimes it could be a good thing and sometimes it could be a bad thing. But this idea so dominates-- the way we think of problematic drug use that we almost forget about the fact that these are kind of oppressed citizens who are-- are experiencing structural legal harm that accounts for a lot of their harms.

And that that is a lot of why they go to these clinics. And-- and you know, like-- again, this idea of, like, a blocker. Like, that's the last thing I want. (LAUGH) Like, I-- I want to feel my methadone. That's why I go there. That's why, you know, that's-- that's the whole point is I want my opioids.

Not that I don't want my opioids. So yeah, I think that there's this-- you know, I think that we-- we-- we need a critical assessment of the idea of addiction as the sole way we understand all of this, because it's really-- lacking. And-- and we need to look at more pragmatic ideas of why people who use illegal drugs experience problems and how particularly substitution treatments function in that context.

Right now whenever anyone says, like, oh, you're swapping an illegal drug for an illegal drug, that's perceived as a bad thing and I understand it's mostly used as a bad thing. But it also illuminates this idea that, yes, I-- my-- my problem isn't the pharmacology of heroin, it's that you all make it illegal and won't get off my back. So yeah, I swapped an illegal drug for a legal drug and therein was the solution--

HELEN REDMOND:

28 days.

DAVID FRANK:

Ah, thank you. There are very few and far between clinics, Montefiore in the Bronx is one of 'em-- where you can get 28-day take homes, if you're considered a model patient. And somehow, I wormed my way into that qualification years ago and have been grandfathered into it.

And so, now I only go once every 28 days to pick up my methadone. I don't see

a counselor. I see a doctor who's aware that I'm not abstinent, but is also aware that I'm doing really good (LAUGH) on this program. So there are ways of, like, letting some light into the system. And-- and we can maybe expand on some of those.

HELEN REDMOND:

Naltrexone-- the injections are-- did you say they are trying to work on an implant or-- for Naltrexone?

DANIEL WOLFE:

So they-- they have an implant on Australia and they're-- NIDA just gave a \$2.7 million grant to someone to develop the-- the implant also in the U.S. But there are buprenorphine implants and injections also, yeah.

HELEN REDMOND:

Right. Right, the Naltrexone is incredibly expensive. So if you're talking about, you know, there-- there's no money to be made and you know, it's like, why-- why are they finding money and a lot of money, 'cause it's on patent to-- to do research around Naltrexone, when we have a medication, when we have m-- methadone, which is inexpensive.

And what, 40, 50 years of-- studies that show it's the gold standard. And what I would say to NIDA if-- if that does come up, it's like, we can talk about Naltrexone, we can talk about buprenorphine, but we have to talk about the methadone clinic system. Because that's what the majority of people are getting for opioid substitution. Although-- a new study just came out showing once again that far too few people are on these medications and that's because of a lot of what David was talking about, discrimination, stigma--

DANIEL WOLFE:

Every day. (BACKGROUND VOICE)

HELEN REDMOND:

Going every day. People-- people-- people are horrified. I mean, I-- I would put a

challenge out to anybody here who believes that we need to keep the clinic system. I want you to take the methadone challenge and go to a clinic six days a week for a year.

See how-- see what happens to your life, right? The other thing about methadone clinics is, you know, the NIMBY, "not in my backyard," the-- the fierce resistance to having methadone clinics in-- in communities. And also-- the other big problem with methadone, this is all outside of-- the clinic, is the drug dealers who set up pill mills outside of methadone clinics.

They know where they are. They know they essentially have a captive audience. And they know that people are coming there who are still vulnerable to relapse and maybe want some Benzos or maybe want, you know, some Suboxone or whatever.

And that is the other value in-- in getting rid of the clinics, is you get rid of the NIMBY. No one's saying, I don't want those people in my neighborhood. I was recent-- it was last year, we-- they tried to get a methadone clinic opened in Harlem.

And the community rallied against it. It's gone when you don't have a clinic system. The drug dealers will-- I don't know, maybe they'll set up in front of CVS, good luck, right? That-- that's-- those are just two more reasons, very powerful reasons, I think-- to-- to really rethink abolishing methadone clinics. Did I-- did I answer that?

DANIEL WOLFE:

Yes, you answered it--

HELEN REDMOND:

Right, I-- I will tell that to Nora Volco later this month. (LAUGH)

DANIEL WOLFE:

Look. So-- I know-- I have-- I see-- another hand here, and I don't know if there's anyone else who wants to make an intervention, but-- yeah? So here and here.

ZENA KUGEMOSKA (PH):

Hi, I think I'm the youngest person out here. (LAUGH) So basically, my name is

Zena Kugemoska (PH). I am still a high school student, but I'm very into politics. And I don't come from New York. I don't come from the States, not even from North America.

And I would just-- I would like to make a comment that the movie was actually really, really informative. And it will definitely support my project later this year and for my global politics higher level course. So thank you so much. And it was a really, really great job.

DANIEL WOLFE:

Thank you. And can I ask you where you do come from?

ZENA KUGEMOSKA (PH):

I'm from Poland, born and raised. I moved to Canada alone at the age of 17. I am leaving-- I'm living in (UNINTEL) Quebec and my own, but here I am.

DANIEL WOLFE:

Welcome.

UNIDENTIFIED MALE #2:

So if-- the film is an advocacy-- excuse me, an advocacy piece-- I think that one of the-- by virtue of the compare and contrast by other countries that you've-- illuminated, one of the things that I would hope to have a deeper dive into would be those individuals like David-- as self-professed, being a functional-- user.

Because that, aside from the power rink and privilege dynamics that, you know, exist between the user and the clinic, we also have to then take into account class and race and how that informs access and how that informs a lack of access.

And how those systems are in place or designed to, one, keep an individual on a drug, and why those drugs and why those clinics are in areas that are not accessible or that are not in the p-- in the-- in the eye (PH). You're not gonna see a methadone clinic on 5th Avenue, on Madison Avenue, on Park Avenue.

But you will see one in Bushwick, you will see one in East New York. And so, what does that look like? How does that play itself out? And what are the-- what's the conversation that we need to have and the conversations that we are

not having that prevent them from being more visible, in a manner that actually becomes proactive and empowering?

DANIEL WOLFE:

Thanks. And I think, actually, that's a good question to end on, which is-- David, you mentioned the-- the 28-day carries if you're lucky enough or skilled enough to maneuver the system.

DAVID FRANK:

Sure.

DANIEL WOLFE:

So I'm curious, both how you do it, but also, to what extent do you think that things like class, race, education play into, like, how the clinic treats you-- once you're there?

DAVID FRANK:

Ah, I mean, you can't overstate it. It's-- it's-- it plays into everything. I mean, I'm a sociologist, of course I'm going to say that. But-- but yeah, I mean, it's totally obvious and to who-- the one that gets written most about is who gets-- funneled into Bup (PH), ri-- as opposed to methadone.

But it's-- happens-- in everything-- I mean, in the minutia much more. I mean, I would-- just to use myself as an example, there's no way I would have been able to manage to convince these people to give me the 28 days, particularly, since I am a drug user still-- if I wasn't white and if I wasn't a graduate student-- and then later-- a graduate of graduate student.

Yeah, yeah, there's-- there's-- you-- you can't understate it. I'm super privileged. And I've-- I've managed to make my life on methadone a little easier because of it. It's still-- I mean, m-- my privilege aside, when I-- I always fear if I have to leave from New York or if I have to go another city-- but yeah, I'll still be better off than-- than-- than the people who aren't white and the people who aren't-- you know, and considered-- professionals, whatever. I mean, yeah, yeah, at my methadone clinic now they call me Doctor Frank. So I mean, I'm super privileged. You can't overstate it. And it's gone a long way.

DANIEL WOLFE:

Helen, same question to you, not about getting 28-day carries, but about, like, class, race, privilege and the-- the interplay both in the clinic and making the whole idea of methadone less stigmatized or more stigmatized, I guess is really the point.

HELEN REDMOND:

Yeah, I-- I think some people here are familiar with the-- work of Doctor-- Doctor Helena Hansen-- at NYU, and she writes about who gets methadone and who gets-- Helena Hansen. (BACKGROUND VOICE) Right. And she-- she has-- she already has-- yeah, okay, I'm thinking of somebody else.

And so, there's no-- there's no question that racism-- race and class runs-- it-- it doesn't matter what you're looking at. I mean, I consider methadone-- healthcare, but if you look at all of healthcare, you see how race and class plays out. People of color don't get-- you know, listed for transplants at the rate that white people do.

You look at the rates of disease, breast cancer, just go down the line, and I think this is pretty well known in terms of methadone and buprenorphine, who is getting it. So if you're-- a person who is homeless, a person of color-- you know, you're disadvantaged in so many ways.

How-- it's much more difficult for you to comply with the methadone regimen. (BACKGROUND VOICE) You know? Your-- you know-- and again, it's structural. So in order for you to comply with the onerous regulations that most clinics have in place, you're gonna fall short.

Whereas, if you're white and you have more support, you're gonna be able to get to that clinic. You're gonna be able to get that Metro card. Every-- on-- on every level, you can see how it breaks down by race and class. And for me, that's just one more reason to end the clinic system.

Because if all healthcare providers who have prescription capabilities can just write-- a prescription for methadone, I think we can make a huge dent in the racism and the classism. Not to say it'll go away entirely because we know that, we know that-- with legalizing marijuana, we know that people of color still are arrested at higher rates. But it-- it is a major fundamental reform I think that would break open-- and really challenge that racism, if you could just get a prescription. I'll leave it at that.

DANIEL WOLFE:

So with that-- we are now at time. Let me just offer thanks-- to both panelists-- really appreciate it. (APPLAUSE)

DAVID FRANK:

Thank you all.

DANIEL WOLFE:

And also, to all of you. I don't know if-- you have all signed up for-- if you get notices about-- events at-- at here at OSF, but-- please do sign up if you haven't. And-- thank you for coming.

* * *END OF TRANSCRIPT* * *