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DEA Takes a Small Step in The Right Direction By Permitting "Methadone Vans"

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Last week the Drug Enforcement Administration announced a new rule that permits mobile methadone clinics to operate at the end of this month. A ban on such "methadone vans" was imposed by the DEA in 2007.

As I explained here, methadone has been known since the 1960s to be an effective treatment for substance use disorder. In recent decades the Schedule 3 opioid buprenorphine, usually formulated to contain the overdose antidote naloxone and given sublingually (commonly known as Suboxone), has taken a position alongside methadone as an effective form of what is called Medication Assisted Treatment for addiction. Harvard addiction specialist and researcher Sarah Wakeman and her team reported last year in the *Journal of the American Medical Association* that MAT using either methadone or buprenorphine is the only approach to addiction that is associated with "reduced overdose and opioid-related morbidity compared with opioid antagonist therapy [naltrexone], inpatient treatment, or intensive outpatient behavioral interventions and may be used as first-line treatments for opioid use disorder."

Even though doctors in Canada, the U.K. and Australia have been prescribing methadone to their clinic patients for them to take home and use as directed since the late 1960s, the DEA places very severe restrictions on methadone treatment, regulating and licensing stationary clinics called Narcotics Treatment Programs (NTPs). Under DEA rules, patients must make daily visits to the NTPs and take their methadone in the presence of designated NTP staff. These onerous requirements hinder patient compliance and reduce access to treatment. In some cases, patients are expected to travel several miles every day to receive their dose of methadone.

The DEA temporarily relaxed some of these regulations for the duration of the COVID public health emergency, allowing "stable" patients a 28-day take-home supply of methadone—a tacit admission that the in-person medication requirement is counterproductive. Research published

earlier this year showed no evidence of increased methadone diversion to the black market as a result of the relaxed rules.

Under the new DEA rule, stationary "bricks and mortar" methadone clinics can operate mobile units once the units receive DEA approval. This will extend the reach of the methadone clinics, bringing them to people who would otherwise have to repeatedly travel long distances to receive treatment. The vans are not allowed to travel outside of the state in which their home base is licensed to operate. The rule also comes with strict requirements on the storage, administration, and documentation of methadone by the mobile units.

The new rule is a small step in the right direction. But a better move would be to allow health care practitioners to prescribe methadone to patients to take home, as was allowed during the public health emergency and is permitted when buprenorphine is used for MAT. A Boston-area pilot program in which primary care practitioners prescribed take-home methadone, reported in the *New England Journal of Medicine*in 2018, proved successful. Last year the National Academy of Sciences, Engineering, and Medicine urged policymakers to allow primary care practitioners to prescribe take-home methadone to patients in their clinics.

Recent evidence that members of Congress as well as the Biden Administration are gaining a newfound respect for harm reduction strategies might mean there's an opportunity to build on the new DEA rule and take it the further distance it needs to go.

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