Methadone and Mixed Messages

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As a physician licensed to prescribe narcotics, I am legally permitted to prescribe the powerful opioid methadone (also known by the brand name *Dolophine*) to my patients suffering from severe, intractable pain that hasn't been adequately controlled by other, less powerful pain killers. Most patients I encounter who might fall into that category are likely to be terminal cancer patients. I've often wondered why I am approved to prescribe methadone to my patients as a treatment for pain, but I am not allowed to prescribe methadone to taper my patients off of a physical dependence they may have developed from long-term opioid use, so as to help them avoid the horrible acute withdrawal syndrome. I am also not permitted to prescribe methadone as a medication-assisted treatment for addiction. These last two uses of the drug require special licensing and permits and must complying with strict federal guidelines.

The synthetic opioid methadone was invented in Germany in 1937. By the 1960s, methadone was found to be effective as medication-assisted treatment for heroin addiction, and by the 1970s methadone treatment centers were established throughout the US, providing specialized and highly structured care for patients suffering from Substance Abuse Disorder. The Narcotic Addict Treatment Act of 1974 codified the methadone clinic structure. Today, methadone clinics are strictly regulated by the Drug Enforcement Administration, the National Institute on Drug Abuse, the Substance and Mental Health Services Administration, and the Food and Drug Administration. These regulations establish guidelines for the establishment, structure, and operation of methadone clinics, in most cases requiring patients to obtain their methadone in person at one fixed site. After a period of time, some of these patients are allowed to take methadone home from the facility to self-administer while they remain closely monitored. This onerous regulatory system has led to an undersupply in methadone treatment facilities for patients in need. Furthermore, the need for patients to travel, often long distances, each day to the clinic to receive their daily dose has been an obstacle to their obtaining and complying with the treatment program.

Earlier this month addiction specialists from the Boston University School of Medicine and Public Health and the Massachusetts Department of Public Health argued in the *New England Journal of Medicine* that community physicians interested in the treatment of Substance Abuse Disorder should be allowed to prescribe methadone to their patients seeing them in their offices and clinics. Doctors have been allowed to prescribe the opioid buprenorphine for medication-assisted treatment of addiction for years, and in recent years nurse practitioners and physicians'

assistants have been able to obtain waivers that allow them to engage in medication-assisted treatment as well.

The authors noted that methadone has been legally prescribed by primary care providers to treat opioid addiction in other countries for many years—in Canada since 1963, in the UK since 1968, and in Australia since 1970, for example. They state:

Methadone prescribing in primary care is standard practice and not controversial in these places because it benefits the patient, the care team, and the community and is viewed as a way of expanding the delivery of an effective medication to an at-risk population.

Policymakers serious about addressing the ever-increasing overdose rate from (mostly) heroin and fentanyl afflicting our population should take a serious look at reforming the antiquated regulations that hamstring the use of methadone to treat addiction.

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