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EXPLAINER

Unshackled From OTPs, Methadone Can Still Be Safe and Effective

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More than 200 people in the United States die each day of an opioid-involved overdose. Methadone is an evidence-based medication that helps individuals with opioid use disorder (OUD) reclaim their lives by curbing withdrawals and cravings. Compared to non-medication approaches, methadone:

- **1/3 Reduces illicit drug use by one third**
- **4x Quadruples treatment retention**
- **Cuts overdose risk up to 80 percent**

Furthermore, it is the country's most effective available therapy in the face of fentanyl.

However, of the 2.5 million to 7.6 million American adults living with an OUD, only 311,531 took methadone for the condition in 2020. Access is hampered by overregulation and a monopolistic system of "opioid treatment programs" (OTPs). OTPs are the only places individuals with OUD can currently get methadone, and they often make it difficult for patients to work or meet family obligations. They also offer care that is inconsistent at best and dehumanizing at worst. Even with recently relaxed rules governing how OTPs offer methadone, many patients still must submit to frequent drug tests and visit daily to take their medication under supervision. Almost 20 percent of Americans live at least 30 minutes from an OTP (versus 0.4 percent who live that distance from a pharmacy), and patients pay an average of $126 per week for treatment.

The Modernizing Opioid Treatment Access Act (MOTAA) would allow addiction medicine physicians and psychiatrists (specialists) to prescribe and pharmacists to dispense methadone for OUD. This shift could expand methadone access from fewer than half to nearly two-thirds of U.S. census tracts, many in rural areas. Despite methadone's life-saving potential, MOTAA opponents are concerned that this change would have unintended consequences. Here, we address three common fears about relaxing methadone regulations: diversion, overdose, and comprehensive care.

Improved Access Does Not Increase Diversion

Methadone, like many prescription medications, is sometimes diverted (sold, shared, purchased, or used without a prescription). However, research suggests that provider prescribing of methadone for OUD will not increase this phenomenon and could actually lead to its decline.

During the COVID-19 pandemic, the federal government relaxed restrictions on OTPs to allow distribution of more take-home doses to patients earlier in recovery. Although not all states or OTPs adopted these changes, where implemented, they did not lead to increases in methadone diversion or methadone-involved overdose relative to other opioids.

This is consistent with previous findings that increasing patient access to take-home doses does not increase diversion.

Furthermore, most diverted methadone in the United States was prescribed for pain, not OUD. This holds true in countries where methadone for OUD is not restricted to OTPs, suggesting that specialist prescribing and pharmacist dispensing are not the driving force behind diversion.

Finally, many people with OUD who seek and use diverted methadone do so because of treatment barriers related to the medication's overregulation. For example, some individuals use diverted methadone to stave off withdrawals—sometimes because they missed an OTP appointment due to illness or other issues—while others may self-initiate treatment when an OTP is inaccessible.

More Prescribers Means More Consistent, Personalized Access, Lessening Misuse and Overdose Risk

Methadone is not risk-free. Like all opioids, it can cause sedation, respiratory depression, and overdose if not used as prescribed. However, providers are well equipped to minimize these risks through proper prescribing and access. Only about 3 percent of people who died of opioid overdoses in recent years were in treatment.

When people with OUD are treated with insufficient doses of methadone, they may still experience debilitating withdrawals that lead them to misuse methadone or take additional substances. Due to the high opioid tolerance among people who use fentanyl, it is especially important for patients to access adequate, individual-appropriate doses of methadone. This increases their odds of staying in treatment and reduces their likelihood of misusing methadone or using illicit substances, both factors that reduce overdose risk.

Furthermore, it is noteworthy that people with OUD are much less likely to overdose on prescribed methadone than illicit opioids, especially in a market dominated by fentanyl. Unfortunately, the OTP-only system fosters care disruptions that increase overdose risk, but specialist prescribing could help reduce some of these problems. For example, individuals who miss a clinic visit—whether due to bad weather, work conflicts, or a family emergency—risk withdrawal symptoms, losing access to "take-home" doses, or terminated care. Any of these occurrences can drive people to misuse methadone or take other substances, amplifying the risk of overdose. However, with roughly 3,000 addiction medicine physicians and psychiatrists and over 61,000 pharmacies across the country (compared to about 2,100 OTPs), allowing specialist prescribing and pharmacist dispensing of methadone for OUD could improve access and continuity of care in ways that would reduce, not increase, overdose risk.

Specialist Prescribing Could Make Methadone Care More Comprehensive

Proponents of the OTP-only system argue that the programs ensure access to therapy (often required) and wraparound services. They claim that allowing office-based specialists to prescribe the medication without offering on-site counseling will leave patients flailing.

However, many patients do equally well on methadone alone compared to methadone plus behavioral therapy, leading experts to recommend individualized—rather than set or mandatory—counseling. With OTP prescribing clinicians seeing an average of 190 patients apiece and counselor caseloads often exceeding 50 patients the current U.S. system for methadone leaves little room for patient-centered care.

Furthermore, when unaccompanied by new programs or providers, efforts to limit these provider-to-patient ratios can prevent individuals from accessing methadone altogether. Allowing specialist prescribing and pharmacist dispensing of methadone for OUD would expand the prescriber pool and allow patients to work with their provider to develop an appropriate care plan.

Expanding methadone access beyond OTPs could also help integrate patient care, providing other health care providers with a more comprehensive view of patient health and treatment needs. Given the complexity of methadone dosing and comorbidities among people with OUD, increased transparency across practitioners would support patient safety and improve care.

Conclusion

Methadone is a proven medication for the treatment of OUD that improves a range of outcomes, from overdose risk to illicit drug use. Allowing specialist prescribing and pharmacist dispensing will help combat the overdose crisis without undermining the medication's efficacy or safety.

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