



ASAM

American Society of Addiction Medicine

PUBLIC POLICY STATEMENT ON METHADONE TREATMENT OF ADDICTION

Background

Opioid addiction is a complex disease involving physiological, psychological, genetic, behavioral, and environmental factors. It shares features of other drug addiction but often requires unique treatment strategies. No single treatment approach is effective in all cases. Methadone maintenance is effective and safe and is an integral part of addiction treatment; other opioid agonists are effective as well (see ASAM Public Policy Statement on Buprenorphine for Opioid Dependence and Withdrawal). Opioid agonist pharmacotherapy with methadone is especially useful for injection users of heroin. Ideally, methadone treatment for addiction includes behavioral, psychodynamic, and 12-step approaches combined with pharmacological interventions to provide a broad spectrum treatment for opioid-addicted persons.

ASAM supports the following:

- 1. For many patients with opioid addiction, maintenance treatment with an opioid agonist is effective as a long-term modality. Discontinuation of methadone maintenance carries substantial risk associated with relapse to intravenous drug use. Discontinuation of methadone maintenance should be attempted only when strongly desired by the rehabilitated patient, and conducted with adequate supervision and support. Individuals with addiction who have been discontinued from methadone maintenance should be carefully followed in a clinical setting and encouraged to participate in an ongoing program of recovery. In the event of relapse or impending relapse, additional therapeutic measures should be used including, when appropriate, prompt resumption of methadone maintenance treatment.**
- 2. Methadone maintenance should include the following modalities in addition to the provision of the drug itself: psychological and vocational services, medical care, and counseling.**
- 3. Arbitrary caps on the number of patients who can be treated by a physician, the dosage of medication which is allowed, or the duration of treatment with methadone are not supported by medical evidence and should not be imposed by law, regulation, or health insurance practices. Similarly, pre-determination**

of methadone dosage by program policy is inappropriate. Dosage should be individually determined by a well-trained clinician based on subjective and objective data and be adequate for the individual patient in all cases. This is particularly the case for pregnant women, for whom dosage should be carefully titrated to assure the elimination of illicit opioid use. Inadequate dosing, sometimes deriving from arbitrary low-dose policies, is associated with significant risk of relapse to illicit opioid use, placing the person with addiction into dangerous health circumstances, and, in the case of pregnant women, placing the fetus in significant danger.

- 4. Methadone treatment of addiction is a crucial resource to decrease the spread of HIV and Hepatitis B and C infection. Financial resources should be available to accommodate those seeking treatment; wait lists (developed in lieu of timely access to indicated methadone maintenance services) are potentially dangerous for the public health. All government and privately funded insurance plans should cover the costs of methadone treatment for addiction. Funding should also be available to train staff to provide good quality comprehensive care for persons with opioid addiction.**
- 5. Methadone maintenance is an established treatment for pregnant opioid dependent patients and may be initiated at any time during pregnancy. Methadone discontinuation is rarely appropriate during pregnancy. When attempted, methadone discontinuation should be undertaken slowly under close monitoring and only in the second trimester. Individual dose determinations are more appropriate than arbitrary low-dose policies that often contribute to relapse to heroin use and to misuse of alcohol and other drugs during pregnancy. Provision of prenatal care, including high-risk maternal-fetal medicine care when indicated and available, is important for opioid addicted pregnant women. Proper nutrition, ongoing individual, family, or group counseling, to include prenatal and parenting classes, should be offered along with methadone maintenance.**
- 6. Methadone patients need access to inpatient and outpatient treatment for medical, surgical, psychiatric, and non-opioid chemical dependency conditions without interruption of methadone maintenance. When methadone patients are referred to medically monitored or clinically managed addiction rehabilitation services, they should not be excluded from consideration for admission on the basis of their being prescribed a pharmacological therapy for addiction.¹**
- 7. Persons incarcerated in jails or prisons who are under an established plan of care for opioid addiction that includes methadone maintenance should be able to continue the treatment plan for their chronic disease of addiction despite their legal status. Abrupt discontinuation can precipitate undesirable opioid**

¹ See ASAM's Public Policy Statement on "Pharmacological Therapy for Alcohol and Other Drug Addiction," October 2006 (available on www.asam.org).

withdrawal syndrome. (See ASAM Public Policy Statement on Access to Appropriate Detoxification Services for Persons Incarcerated in Prisons and Jails.”) Discontinuation of methadone treatment for incarcerated individuals carries all the public health risks of discontinuation of methadone in any other patients: the integrity of the treatment plan for the patient’s chronic disease of addiction should not be threatened by jailing or imprisonment.

- 8. The medical direction of methadone treatment programs for addiction should be provided by physicians who have received training in and can demonstrate expertise in addiction medicine. Medical Directors of methadone treatment programs who have not received certification in addiction medicine or addiction psychiatry should pursue such certification. Specialized training in addiction medicine provides the thorough working knowledge of both laboratory and clinical research which form the basis for methadone treatment of addiction.**
- 9. Nurses and other health care professionals working in methadone treatment programs for addiction should receive special training and supervision in the medical and pharmacological aspects of addictive diseases and methadone treatment.**
- 10. Federal, State, or institutional level regulations and guidelines which pertain to methadone treatment for addiction should emphasize performance-based standards of care, relying on clinical judgment and scientific data in the determination of treatment; encourage the development of new clinical strategies; promote individualized treatment planning; foster destigmatization and ensure patient rights.**
- 11. Research related to methadone treatment should be supported, including work that will contribute to improved quality of methadone treatment of addiction.**
- 12. Methadone can be an effective and safe medication utilized in treatment plans for acute and chronic pain, for both patients who have opioid addiction and patients not diagnosed with or needing services for addiction. When using methadone and other opioid analgesics for the treatment of health care conditions other than addiction, physicians must recognize the potential for misuse of the prescribed agent. It is the duty of the treating physician or other prescribing health care professional, as well as other clinical staff in the treatment team, to take all necessary steps to prescribe responsibly, to monitor patients carefully, and to carefully document their activities, so as to prevent and/or quickly identify opioid diversion by patients for uses unauthorized by and unintended by the prescriber.**

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