It’s time to "make methadone great again!"

State of OAT in US

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Over a half-century ago Drs. Marie Nyswander and Vincent Dole published their experiences with 22 long-time heroin-addicted individuals treated with maintenance doses of methadone on the research unit of the Rockefeller Institute. Those extraordinarily favorable results were replicated just three years later with 750 patients. In the following decades results inevitably varied in different locations employing different policies and practices, but the overwhelming conclusion around the world has been that methadone maintenance is the "gold standard" of opiate dependence treatment. For example:

> **1983, US National Institute on Drug Abuse -** “To argue that methadone maintenance is not effective ... is to ignore the results of the best designed research and the consensus of varied group of experts.”
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> **2015, US Substance Abuse and Mental Health Services Administration - "**Methadone [maintenance] is safe and effective. It allows people to recover from their addiction and to reclaim active and meaningful lives."
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> **2008: World Health Organization -** “… therapies such as methadone remain the most promising method of reducing drug dependence.”

Nevertheless, misunderstanding and stigma associated with maintenance treatment continue to be the rule rather than the exception, in the US no less than anywhere else. The result: in the US "MAT [medication assisted treatment] is greatly underused. For instance ... the proportion of heroin admissions with treatment plans that included medication-assisted opioid therapy fell from 35% in 2002 to 28% in 2010" - years of unprecedented growth in dependence on opiate analgesics and heroin. Waiting lists of desperately motivated applicants often extend for months, assuming there are locally available programs to which one can apply.

Governmental restrictions on the use of methadone for addiction treatment are without precedent: mandatory *daily* clinic attendance during the first three months of treatment; specified frequency of urine toxicology testing; restrictive (and increasingly insurmountable) zoning laws precluding establishment of programs; limits on patient "capacity" duration of treatment; and the requirement under federal law to provide "... different forms of behavioral therapy services ... along with medical, vocational, educational, and other assessment and treatment services."

Perhaps most disconcerting are "rules" adopted by many methadone providers at their own initiative, including "termination" when patients demonstrate the pathognomonic feature of the condition being treated: use of substances of which the program disapproves, including alcohol, marijuana, and even prescribed anti-depressants.

In summary, the deterrents to entering and remaining in methadone maintenance treatment are enormous, and almost no one seems to care. This applies to governmental authorities, medication-based and "drug-free" treatment providers, and professional associations representing hospitals and physicians in all disciplines. There is widespread refusal to accept consistent evidence of

effectiveness of a treatment for which there is no alternative with comparable ability to attract and retain those who need help - and all too often die without it. Surely, this is an extreme illustration of the Semmelweis reflex - the "... tendency to reject new evidence or new knowledge because it contradicts established norms, beliefs or paradigms." And yet, even Semmelweis' evidence that puerperal fever was transmitted by physicians - an obviously highly offensive and initially quite preposterous notion - was accepted and acted upon in most European countries within less than 25 years (it took roughly 20 years longer for America to follow suit).

As for the future, to paraphrase Donald Trump advocates must continue more fervently than ever the fight to "make methadone great again!" This will require, finally, acceptance of addiction as a chronic, notoriously recidivist, as-yet incurable, medical condition to be treated like any other.