FORENSIC INSIGHTS AND HEALTH SCIENCES BULLETIN

Volume 2: Issue 2: 2024

https://doi.org/10.56770/fi2024221

# PHARMACOLOGICAL COMPREHENSIVE OVERVIEW OF METHADONE FROM STRUCTURE TO CLINICAL APPLICATIONS AND ITS ABUSE WITH TOXICITY

**Abubakar Abrar*[1], Ali Zafar [2], Naveed Ahmed[3]**

[1]Department of Forensic Science, The Islamia University of Bahawalpur, Pakistan
[2]University College of Conventional Medicine, The Islamia University of Bahawalpur
[3]Department of Immunology, Faculty of Medicine, Academic Assembly, University of Toyama, Toyama, Japan

Submitted: September 09, 2023; Revised: August 22, 2024; Accepted: August 27, 2024; Published: October 31, 2024

## ABSTRACT

This comprehensive document explores the multifaceted aspects of methadone, a synthetic opioid analgesic and long-acting opioid agonist. It delves into its introduction, structure and classification, synthesis, pharmacokinetics, mechanism of action, dosing, monitoring, clinical uses, and the associated death rate. Methadone's crucial role in pain management and opioid addiction treatment is highlighted, emphasizing its capacity to reduce withdrawal symptoms, cravings, and harm associated with opioid abuse. Challenges, such as overdose risk, tolerance, and regulatory barriers, are discussed. This extensive review underscores the importance of careful management and monitoring when utilizing methadone in various clinical settings.

**Keywords:** Methadone, Opioid addiction, Antidotes, OST, Pain management, Stabilization, Rehabilitation.

***Corresponding Author.** E-mail: abubakarabrar89@gmail.com

## INTRODUCTION

Methadone is a synthetic opioid analgesic and a long-acting opioid agonist primarily used for pain management and the treatment of opioid dependence, particularly in the context of opioid substitution therapy (OST). It was first synthesized in 1939 by German scientists and later introduced for medical use in the United States in the 1940s. Methadone has since become an essential medication in managing opioid addiction, as it helps reduce withdrawal symptoms and cravings [**1**]. Methadone's role in pain management and opioid addiction treatment has been significant since its introduction. Due to its long duration of action and ability to stabilize opioid-dependent individuals, it has become an indispensable component of harm reduction strategies and opioid substitution therapy programs [**2**].

### Pain Management

Methadone is used for pain management in patients who require continuous opioid analgesia, especially those with chronic and severe pain. Its extended duration of action allows for less frequent dosing compared to short-acting opioids, reducing the need for frequent administration and improving patient compliance. This makes methadone particularly valuable in situations where around-the-clock pain relief is essential [**3**].

### Opioid Substitution Therapy (OST)

One of the most significant contributions of methadone to public health has been its use in opioid substitution therapy. Opioid addiction is a complex and challenging condition, and the traditional "cold-turkey" approach to quitting opioids often leads to relapse and other health risks. In OST, methadone is prescribed as a safer and more controlled alternative to illicit opioids. It helps individuals with opioid dependence by providing a stable and sustained level of opioid agonism, reducing withdrawal symptoms and drug cravings. This allows patients to function more normally, improving their quality of life and reducing the risk of harm associated with opioid abuse.

### Reduction of Infectious Diseases

Methadone treatment has also played a critical role in reducing the transmission of infectious diseases, such as HIV and hepatitis C. Injection drug use is a significant factor in the spread of these infections [**4**]. By providing opioid-dependent individuals with access to methadone through supervised programs, they are less likely to engage in high-risk behaviors

FIHSB is published by AMMANIF Publisher. The authors retain the copyright without restriction. This article is an open access article published under the terms and conditions of Creative Commons Attribution 4.0 International License.

associated with sharing needles and syringes.

**Stabilization and Rehabilitation**

Methadone treatment not only reduces the negative consequences of opioid addiction but also serves as a foundation for rehabilitation and recovery. By stabilizing individuals and reducing the constant cycle of seeking and using illicit opioids, patients can focus on addressing the underlying causes of their addiction and work towards improving their overall well-being [**5**].

**Challenges and Considerations**

While methadone has proven to be a highly effective treatment, there are challenges and considerations associated with its use. For instance,

***Risk of Overdose:*** Methadone, like other opioids, carries a risk of overdose if misused or taken in excessive amounts. Therefore, careful dosing and monitoring are crucial to ensure patient safety.

***Tolerance and Dependence:*** Long-term use of methadone can lead to tolerance and physical dependence, meaning patients may experience withdrawal symptoms if they suddenly stop taking it. Tapering the dose under medical supervision is essential to avoid withdrawal complications [**6**].

***Regulatory Barriers:*** Access to methadone treatment may be limited due to regulatory barriers and stigma associated with opioid addiction. Expanding access to treatment services and reducing stigma is vital to reaching more individuals in need [**7**].

***Interactions and Side Effects:*** Methadone may interact with other medications, and some patients may experience side effects such as constipation, drowsiness, or respiratory depression. Close monitoring and proper medical management can help mitigate these issues.

**STRUCTURE AND CLASSIFICATION**

Methadone belongs to the class of synthetic opioids known as phenyl piperidines. Its chemical structure is similar to other opioids like morphine and codeine, but it has some distinct properties that make it suitable for substitution therapy. Methadone's classification as a phenylpiperidine opioid is based on its chemical structure, which contains a phenyl ring and a piperidine ring. The specific arrangement of these rings gives methadone its unique pharmacological properties, distinguishing it from other opioids like morphine and codeine.

**Chemical Structure**

The chemical structure of methadone is as follows: "Ph" represents the phenyl ring, and "Piper" represents the piperidine ring. The presence of two methyl (CH3) groups attached to the piperidine ring differentiates methadone from many other opioids.

**Distinct Properties**

Methadone's unique chemical structure contributes to its distinct properties, making it suitable for opioid substitution therapy and pain management:

***Long Duration of Action:*** Methadone's long duration of action is due to its lipophilic nature, which allows it to be stored in tissues and released gradually over time. This property is particularly advantageous in opioid substitution therapy, as it helps maintain stable opioid receptor activation, reducing withdrawal symptoms and cravings.

***Lower Euphoria and Tolerance:*** Methadone has a slower onset of action compared to some other opioids, leading to less intense euphoria. This characteristic makes it less likely to be abused for its pleasurable effects. Additionally, its long duration of action may help reduce the development of tolerance compared to short-acting opioids [**8**].

***Reduced Respiratory Depression Risk:*** Although methadone is an opioid, it has a lower risk of causing severe respiratory depression compared to other opioids when taken at therapeutic doses. This property makes it safer for use in opioid substitution therapy and pain management.

***Flexible Dosage Formulations:*** Methadone is available in various oral formulations, including tablets and liquid solutions, allowing for flexible dosing based on individual patient needs and treatment goals [**9**].

***Cross-Tolerance with Other Opioids:*** Methadone's pharmacological profile allows it to effectively cross-tolerate with other opioids. This means that it can partially replace the effects of other opioids, reducing withdrawal symptoms and making it an effective medication for opioid dependence treatment [**10**].

Due to its unique properties, methadone has been successfully used as a maintenance medication in opioid substitution therapy programs for several decades. Its stable and sustained effects on opioid receptors have helped numerous individuals with opioid addiction regain control of their lives and work towards recovery.

However, despite its benefits, it is essential to use methadone with caution, as it still carries the potential for misuse and overdose. Proper medical supervision, dose adjustments, and regular monitoring are necessary to ensure its safe and effective use in both pain management and opioid substitution therapy.

**SYNTHESIS**

The synthesis of methadone involves several chemical steps, starting with the condensation of 4-cyano-4-phenylpiperidine with dimethyl sulfate, followed by reduction with lithium aluminum hydride. The final product is purified to obtain pure methadone. The synthesis of methadone is a multi-step process that involves several chemical reactions to produce the final pharmaceutical-grade product. It starts with commercially available starting materials and goes through a series of transformations to obtain pure methadone.

**Step 1: Condensation of 4-cyano-4-phenylpiperidine with Dimethyl Sulfate**

The first step in the synthesis of methadone involves the condensation of 4-cyano-4-phenylpiperidine

with dimethyl sulfate. This reaction is carried out in the presence of a suitable solvent and a base to facilitate the condensation process. The reaction leads to the formation of a key intermediate, known as N-methyl-4-cyano-4-phenylpiperidine.

**Step 2: Reduction with Lithium Aluminum Hydride**

In the second step, the N-methyl-4-cyano-4-phenylpiperidine intermediate is subjected to reduction using lithium aluminum hydride (LiAlH4). Lithium aluminum hydride is a powerful reducing agent capable of converting the cyano group (CN) in the intermediate to a primary amine (NH2). This reduction step is crucial in converting the intermediate into the desired product, methadone.

**Purification to Obtain Pure Methadone**

After the reduction step, the resulting product is a crude form of methadone, which may contain impurities and by-products from the chemical reactions. To obtain pure methadone, the crude product undergoes a purification process. Various purification techniques such as recrystallization, column chromatography, or distillation are employed to separate and remove impurities, resulting in the isolation of high-purity methadone.

It's important to note that the actual synthesis process may involve additional steps and optimization to ensure high yields, purity, and safety. The pharmaceutical synthesis of methadone is typically carried out under controlled conditions in compliance with Good Manufacturing Practices (GMP) to ensure the quality and consistency of the final product.

**PHARMACOKINECTICS**

**Absorption**

When methadone is administered orally, it undergoes absorption from the gastrointestinal tract into the bloodstream [**11**]. The process of absorption can be influenced by various factors, such as the formulation of the medication, the presence of food in the stomach, and individual variations in gastrointestinal transit time. After oral administration, methadone's slow and prolonged absorption contributes to its extended duration of action. This property is particularly advantageous in opioid substitution therapy, as it allows for once-daily dosing in some cases, reducing the frequency of administration for patients [**11**]. Intravenous and intramuscular administration of methadone bypasses the absorption phase, as the drug directly enters the bloodstream. These routes of administration are typically reserved for specific medical situations and are not commonly used for opioid substitution therapy or chronic pain management due to the need for close monitoring and potential risks associated with rapid onset and higher peak concentrations [**12**].

**Distribution**

Once absorbed into the bloodstream, methadone is distributed throughout the body via the circulatory system. Its lipophilic nature allows it to readily cross cell membranes, including the blood-brain barrier, which is a semipermeable membrane that separates the central nervous system (CNS) from the rest of the circulatory system. Methadone's ability to penetrate the blood-brain barrier is essential for its analgesic and therapeutic effects, as it allows the drug to interact with opioid receptors in the brain and spinal cord to alleviate pain and reduce withdrawal symptoms in opioid-dependent individuals. Methadone's distribution to various tissues also contributes to its prolonged duration of action. It can be sequestered and released from tissues over time, maintaining a steady concentration in the bloodstream and providing continuous opioid receptor activation.

**Metabolism**

Methadone's primary route of metabolism occurs in the liver, where it undergoes a process called N-demethylation. This involves the removal of a methyl group from the N-methyl-4-cyano-4-phenylpiperidine structure, resulting in the formation of the primary metabolite, 2-ethylidene-1, 5-dimethyl-3, 3-diphenylpyrrolidine (EDDP). EDDP is pharmacologically inactive and does not contribute significantly to methadone's analgesic or therapeutic effects. The cytochrome P450 enzyme system, particularly the CYP3A4 and CYP2B6 enzymes, is primarily responsible for the metabolism of methadone. Genetic variations in these enzymes can affect methadone metabolism and clearance, leading to inter individual differences in how individuals respond to the medication.

**Excretion**

After undergoing metabolism in the liver, methadone and its metabolites are eliminated from the body mainly through the kidneys. The drug and its inactive metabolites are excreted in urine, accounting for the majority of its elimination. A small portion of methadone and its metabolites may also be excreted in the feces. The elimination half-life of methadone can vary widely among individuals, but it is generally longer than most other opioids. The extended half-life contributes to its sustained effects and the need for careful dosing and monitoring in opioid substitution therapy and pain management settings. Overall, understanding the pharmacokinetics of methadone, including its absorption, distribution, metabolism, and excretion, is crucial for optimizing its clinical use and ensuring safe and effective treatment for patients with pain or opioid dependence.

**MECHANISAM OF ACTION**

Methadone exerts its analgesic effects by binding to and activating opioid receptors in the central

nervous system, particularly the mu-opioid receptors. This activation leads to a decreased perception of pain and a sense of euphoria. Additionally, methadone's long duration of action helps stabilize opioid-dependent individuals and prevent withdrawal symptoms. Methadone's analgesic effects are primarily attributed to its interaction with specific opioid receptors in the central nervous system, particularly the mu-opioid receptors. These receptors are widely distributed throughout the brain and spinal cord and play a key role in the modulation of pain perception and the body's response to opioids.

**Binding and Activation of Mu-Opioid Receptors**

When methadone enters the bloodstream and crosses the blood-brain barrier, it reaches the mu-opioid receptors located on the surface of certain neurons in the brain and spinal cord. Methadone has a high affinity for these receptors, meaning it binds strongly to them. Once bound, methadone acts as a full agonist, activating the mu-opioid receptors.

**Pain Relief**

Activation of mu-opioid receptors leads to several effects, the most prominent being the relief of pain. Methadone inhibits the transmission of pain signals along the neural pathways in the central nervous system. This interference with pain signals results in a decreased perception of pain, providing analgesia to individuals experiencing moderate to severe pain.

**Euphoria and Pleasurable Effects**

As an opioid agonist, methadone can also produce feelings of euphoria and pleasure when taken in higher doses or by individual’s not experiencing pain. The activation of mu-opioid receptors in reward centers of the brain can induce a sense of well-being and relaxation. However, this effect is more commonly associated with opioid abuse rather than its proper medical use.

**Stabilization in Opioid-Dependent Individuals**

In the context of opioid substitution therapy, methadone's long duration of action plays a crucial role. Due to its slow onset and prolonged duration, methadone provides a stable and sustained level of opioid receptor activation. This helps to stabilize individuals with opioid dependence by preventing the onset of withdrawal symptoms and reducing drug cravings. By occupying the mu-opioid receptors, methadone can partially replace the effects of other opioids, such as heroin or morphine, without producing the intense euphoria associated with these substances. As a result, patients on methadone maintenance programs can function more normally, engage in daily activities, and work towards addressing the underlying causes of their addiction without constantly seeking illicit opioids.

**Tolerance and Dependence**

It is essential to note that while methadone is effective in stabilizing opioid-dependent individuals, it can still lead to tolerance and physical dependence with prolonged use. Tolerance means that over time, the same dose of methadone may become less effective, requiring a dose adjustment. Physical dependence means that abrupt discontinuation of methadone can lead to withdrawal symptoms. Therefore, methadone treatment is typically tapered under medical supervision when discontinuing therapy.

In conclusion, methadone's analgesic effects result from its binding and activation of mu-opioid receptors in the central nervous system, reducing the perception of pain. Its long duration of action is a valuable characteristic for stabilizing opioid-dependent individuals and preventing withdrawal symptoms, making it an essential medication for opioid substitution therapy and chronic pain management when used appropriately under medical supervision.

**NORMAL / TOXIC / POISINING DOSES**

The therapeutic dose of methadone varies depending on the condition being treated. For pain management, the typical starting dose is around 2.5 to 10 mg every 8 to 12 hours, while for opioid dependence treatment, the initial dose is usually higher, between 10 to 30 mg daily. Toxic doses of methadone can vary widely among individuals, but excessive consumption can lead to respiratory depression, coma, and even death.

**Pain Management**

In pain management, methadone is prescribed to individuals experiencing moderate to severe pain that requires continuous opioid analgesia. The initial dose for pain management is usually lower compared to its use in opioid dependence treatment. The typical starting dose is around 2.5 to 10 mg, administered orally, every 8 to 12 hours, depending on the patient's pain severity and response to the medication. The dose may be titrated gradually, based on the patient's pain relief and tolerance, to achieve optimal pain control. Methadone's long duration of action allows for less frequent dosing, making it a suitable option for chronic pain management, particularly when other opioids have not provided sufficient relief or have caused intolerable side effects.

**Opioid Dependence Treatment**

In the context of opioid dependence treatment, methadone is used as part of opioid substitution therapy (OST). The goal of OST is to reduce withdrawal symptoms and drug cravings, stabilize individuals with opioid dependence, and help them function more normally in their daily lives. The initial dose for opioid dependence treatment is typically higher than that used for pain management. It ranges from 10 to 30 mg, administered orally, as a single daily dose. However, the precise dosage may vary depending on the individual's opioid tolerance, the severity of their dependence, and other medical considerations. As with pain management, the dose may be adjusted during the treatment based on the patient's response and overall progress. The

objective is to find the most effective dose that prevents withdrawal symptoms and cravings without causing sedation or euphoria.

**Toxic Doses and Overdose**

Methadone's potency and individual variability make determining toxic doses challenging. Excessive consumption of methadone can lead to serious consequences, including respiratory depression, a potentially life-threatening condition where breathing becomes slow and shallow, leading to inadequate oxygen supply to vital organs. An overdose of methadone can result in severe sedation, confusion, pinpoint pupils, respiratory distress, coma, and, in some cases, death. The risk of overdose is higher when methadone is taken in combination with other central nervous system depressants, such as alcohol or benzodiazepines, as it can enhance the sedative effects and respiratory depression. To prevent and manage methadone overdose, immediate medical attention is essential. Naloxone (Narcan), an opioid receptor antagonist, can be administered to reverse the opioid effects and restore normal breathing. Prompt medical intervention significantly improves the chances of recovery from methadone overdose. In conclusion, methadone's therapeutic doses vary depending on the intended use, whether it's for pain management or opioid dependence treatment. Careful dosing and medical supervision are crucial to achieving the desired therapeutic effects while minimizing the risk of toxicity and overdose. It is essential for healthcare providers to monitor patients closely and educate them about the risks associated with methadone use to ensure safe and effective treatment outcomes.

**PLAMA LEVEL DETERMINATION**

Monitoring of methadone plasma levels is important to ensure therapeutic effectiveness and avoid toxicity. Blood tests can be performed to measure the concentration of methadone in the blood. The optimal therapeutic range for methadone varies but is generally between 100 to 300 ng/mL

By measuring the concentration of methadone in the blood, healthcare providers can assess how well the drug is being absorbed, metabolized, and eliminated in an individual patient.

**IMPORTANCE OF MONITORING**

**Monitoring methadone levels serves several purposes**

***Individualized Dosing:*** People metabolize drugs differently, and individual variations can affect how the body processes methadone. Monitoring plasma levels helps healthcare providers adjust the dosage to meet each patient's specific needs.

***Optimizing Treatment Efficacy:*** By maintaining methadone levels within the therapeutic range, healthcare providers can ensure that patients receive adequate relief from withdrawal symptoms and cravings. It is particularly crucial in opioid substitution therapy to prevent relapse and promote patient stability [**13**].

***Preventing Toxicity:*** On the other hand, monitoring methadone levels helps identify if concentrations are approaching toxic levels. This helps prevent adverse effects, such as respiratory depression and sedation, which can occur if methadone levels become too high.

**Blood Tests for Methadone Levels**

Methadone plasma levels can be measured through blood tests, usually taken at specific intervals during the course of treatment. The timing of the blood tests may depend on the individual patient's response to methadone, the dosing schedule, and any changes in the treatment plan. The blood samples are sent to a laboratory for analysis, where sophisticated techniques like liquid chromatography-mass spectrometry (LC-MS) or immunoassay methods are used to quantify the concentration of methadone in the plasma [**14**].

**Optimal Therapeutic Range**

The optimal therapeutic range for methadone can vary depending on the patient's condition, medical history, and response to treatment. Generally, the target plasma level for most patients on methadone maintenance therapy falls within the range of 100 to 300 nanograms per milliliter (ng/mL). For some individuals, adequate stabilization and relief from withdrawal symptoms may be achieved at the lower end of the therapeutic range, while others may require higher levels to achieve similar effects. Factors influencing individual responses include opioid tolerance, metabolism, and other medications the patient may be taking concurrently [**15**].

***Adjusting Methadone Dosing:*** Based on the methadone plasma levels and the patient's clinical response, healthcare providers can make informed decisions regarding dosing adjustments. If methadone levels are below the therapeutic range, the dose may be increased to provide adequate relief. Conversely, if methadone levels are consistently higher than the therapeutic range, the dose may need to be reduced to avoid potential toxicity [**16**].

Regular monitoring of methadone levels is essential during the early stages of treatment, when dosage adjustments are common, and also during periods of significant change, such as following dose changes or when there are concerns about compliance or misuse. In conclusion, monitoring methadone plasma levels is an integral part of methadone therapy, especially in opioid substitution therapy. It helps healthcare providers tailor treatment plans to individual patients, ensuring optimal therapeutic effects while mitigating the risk of toxicity. By closely monitoring patients on methadone, healthcare providers can support their progress towards recovery and improved quality of life [**17**].

**SIGNS AND SYMPTOMS**

Signs of methadone overdose or toxicity may include severe respiratory depression, pinpoint pupils, drowsiness, confusion, cyanosis and unconsciousness [**18**].

## CLINICAL USES

Methadone has several clinical uses; it is used in pain management in patients who require continuous opioid analgesia. Mostly used in opioid substitution therapy for individuals with opioid addiction, reducing withdrawal symptoms and cravings. It may be used in reducing the risk of HIV transmission and other infectious diseases among injection drug users. Methadone as an analgesic in palliative care for patients with advanced illness.

## DATH RATE IN DIFFERENT COUNTRIES

The death rate associated with methadone use can fluctuate over the years due to various factors such as changes in prescribing practices, misuse, and co-administration with other drugs. Accurate and up-to-date statistics would be required to provide specific information on death rates in different years.

The death rate related to methadone use can vary significantly from one country to another due to differences in drug regulations, healthcare systems, and patterns of drug abuse. Countries with widespread access to opioid substitution therapy tend to have lower death rates among opioid-dependent individuals.

## PROUCTS AVAILABLE

Methadone is available in various formulations, including oral solutions, tablets, and injectable forms. The specific products available can vary depending on the country and it's approved medical uses [**19**].

## ANTIDODES OF METHADONE

In cases of methadone overdose, immediate medical attention is crucial. The primary treatment involves providing supportive care, such as maintaining the airway and ventilation, administering naloxone (Narcan) to reverse opioid effects, and monitoring vital signs. Naloxone is an opioid receptor antagonist and acts as an antidote to opioid overdose.

## CONTROL ITS CONSUMPTION

Controlling the consumption of methadone involves several measures, including: Strict regulation of methadone prescribing to prevent excessive dosing and diversion. Monitoring patients on methadone treatment to ensure compliance and assess for any signs of misuse or overdose. Raising awareness among healthcare providers and patients about the risks and benefits of methadone therapy [**20**].

## CONCLUSION

Methadone, a medication with a rich history dating back to its synthesis in the 1930s, has emerged as a pivotal tool in the realm of pain management and opioid addiction treatment. Its unique properties, including a long duration of action, reduced euphoria, and lower respiratory depression risk, make it an invaluable asset in addressing the complex challenges posed by opioid dependence. In the context of pain management, methadone's extended duration of action allows for less frequent dosing, enhancing patient compliance and quality of life. For individuals grappling with opioid addiction, methadone's stabilizing effects mitigate withdrawal symptoms and cravings, facilitating rehabilitation and recovery. Moreover, its role in harm reduction by reducing infectious disease transmission among injection drug users cannot be understated. Nonetheless, the clinical use of methadone is not without challenges. The risk of overdose, tolerance, and dependence necessitates careful dosing and monitoring. Regulatory barriers and stigma surrounding opioid addiction hinder access to this life-saving treatment, underscoring the importance of advocacy and expanded services. In summary, methadone stands as a powerful tool in the battle against opioid addiction and a valuable option for chronic pain management. Through diligent monitoring, education, and a compassionate approach to care, the potential for misuse and overdose can be minimized, allowing methadone to continue its critical role in improving the lives of those affected by opioid-related challenges.

***Author(s) Contribution**:* Supervision, methodology and analysis Abubakar Abrar; resources and review Ali Zafar; editing, and proofreading, Naveed Ahmed.

***Funding:*** No funding involved.

***Ethical* Approval:** Not applicable

***Conflict of Interest:*** Nil.

***Consent for Publication:*** All authors approved the manuscript for publication.

## REFERENCES

1. Amram O, Amiri S, Panwala V, Lutz R, Joudrey PJ, Socias E. The impact of relaxation of methadone take-home protocols on treatment outcomes in the COVID-19 era. The American Journal of Drug and Alcohol Abuse. 2021 Nov 2;47(6):722-9.
2. Baghayeri M, Nabavi S, Hasheminejad E, Ebrahimi V. Introducing an electrochemical sensor based on two layers of Ag nanoparticles decorated graphene for rapid determination of methadone in human blood serum. Topics in Catalysis. 2021:1-0.
3. Brothers S, Viera A, Heimer R. Changes in methadone program practices and fatal methadone overdose rates in Connecticut during COVID-19. Journal of substance abuse treatment. 2021 Dec 1;131:108449.
4. Buresh M, Nahvi S, Steiger S, Weinstein ZM. Adapting methadone inductions to the fentanyl era. Journal of Substance Abuse Treatment. 2022 Oct 1;141:108832.
5. Calcaterra SL, Bach P, Chadi A, Chadi N, Kimmel SD, Morford KL, Roy P, Samet JH. Methadone matters: what the United States can learn from the global effort to treat opioid addiction. Journal of general internal medicine. 2019 Jun 15;34:1039-42.
6. Dunn KE, Brooner RK, Stoller KB. Technology-assisted methadone take-home dosing for dispensing methadone to persons with opioid use disorder during the Covid-19 pandemic. Journal of Substance Abuse Treatment. 2021 Feb 1;121:108197.
7. Figgatt MC, Salazar Z, Day E, Vincent L, Dasgupta N. Take-home dosing experiences among persons receiving methadone maintenance treatment during COVID-19. Journal of Substance Abuse Treatment. 2021 Apr 1;123:108276.

8. Furst JA, Mynarski NJ, McCall KL, Piper BJ. Pronounced regional disparities in United States methadone distribution. Annals of Pharmacotherapy. 2022 Mar;56(3):271-9.
9. Grecco GG, Mork BE, Huang JY, Metzger CE, Haggerty DL, Reeves KC, Gao Y, Hoffman H, Katner SN, Masters AR, Morris CW. Prenatal methadone exposure disrupts behavioral development and alters motor neuron intrinsic properties and local circuitry. Elife. 2021 Mar 16;10:e66230.
10. Guerrero E, Amaro H, Kong Y, Khachikian T, Marsh JC. Gender disparities in opioid treatment progress in methadone versus counseling. Substance Abuse Treatment, Prevention, and Policy. 2021 Jun 23;16(1):52.
11. Hunter SB, Dopp AR, Ober AJ, Uscher-Pines L. Clinician perspectives on methadone service delivery and the use of telemedicine during the COVID-19 pandemic: A qualitative study. Journal of substance abuse treatment. 2021 May 1;124:108288.
12. Jones CM, Compton WM, Han B, Baldwin G, Volkow ND. Methadone-involved overdose deaths in the US before and after federal policy changes expanding take-home methadone doses from opioid treatment programs. JAMA psychiatry. 2022 Sep 1;79(9):932-4.
13. Joudrey PJ, Adams ZM, Bach P, Van Buren S, Chaiton JA, Ehrenfeld L, Guerra ME, Gleeson B, Kimmel SD, Medley A, Mekideche W. Methadone access for opioid use disorder during the COVID-19 pandemic within the United States and Canada. JAMA network open. 2021 Jul 1;4(7):e2118223-.
14. Joudrey PJ, Chadi N, Roy P, Morford KL, Bach P, Kimmel S, Wang EA, Calcaterra SL. Pharmacy-based methadone dispensing and drive time to methadone treatment in five states within the United States: a cross-sectional study. Drug and alcohol dependence. 2020 Jun 1;211:107968.
15. Joudrey PJ, Edelman EJ, Wang EA. Methadone for opioid use disorder—decades of effectiveness but still miles away in the US. JAMA psychiatry. 2020 Nov 1;77(11):1105-6.
16. Kreutzwiser D, Tawfic QA. Methadone for pain management: a pharmacotherapeutic review. CNS drugs. 2020 Aug;34(8):827-39.
17. Madden EF, Christian BT, Lagisetty PA, Ray BR, Sulzer SH. Treatment provider perceptions of take-home methadone regulation before and during COVID-19. Drug and Alcohol Dependence. 2021 Nov 1;228:109100.
18. McCarty D, Bougatsos C, Chan B, Hoffman KA, Priest KC, Grusing S, Chou R. Office-based methadone treatment for opioid use disorder and pharmacy dispensing: A scoping review. American Journal of Psychiatry. 2021 Sep 1;178(9):804-17.
19. McNeil R, Puri N, Boyd J, Mayer S, Hayashi K, Small W. Understanding concurrent stimulant use among people on methadone: A qualitative study. Drug and alcohol review. 2020 Mar;39(3):209-15.
20. Rhodes T, Azbel L, Lancaster K, Meyer J. The becoming-methadone-body: On the onto-politics of health intervention translations. Sociology of health & illness. 2019 Nov;41(8):1618-36.