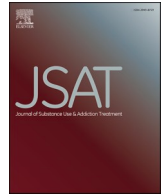




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Changes to methadone maintenance therapy in the United States, Canada, and Australia during the COVID-19 pandemic: A narrative review

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ARTICLE INFO

Keywords:

Opioid agonist therapy
COVID
Methadone
Take-home
MOUD
Take away

ABSTRACT

Introduction: In response to the COVID-19 pandemic, countries across the world made adaptations to policies regulating the provision of methadone maintenance therapy (MMT) to facilitate social distancing for health care providers and people in treatment. Many countries issued guidance about increasing take-home methadone doses after the onset of the pandemic.

Methods: In this review, we compare the regulation of MMT prior to the pandemic in the United States, Canada, and Australia, analyze changes to treatment policy in the context of COVID-19, and review emerging data on treatment outcomes.

Results: The United States only permits the prescription and disbursement of methadone for MMT treatment at federally designated opioid treatment programs (OTPs). Conversely, Australia and Canada operate on a community pharmacy-based distribution model, where patients can access methadone doses either in participating pharmacies or in some methadone clinics.

Conclusion: Given reports of similar treatment outcomes and increased patient satisfaction since the pandemic-related policy changes, some changes including increased receipt of take-home doses should be considered for incorporation into post-pandemic treatment policies and regulations.

1. Introduction/background

Methadone is a long-acting opioid receptor agonist and an evidence-based treatment for opioid use disorder (OUD). Patients with OUD treated with methadone have better clinical outcomes, improved quality of life, and decreased risk of mortality compared to patients not in treatment (National Academies of Sciences, 2019). Despite this, methadone as a treatment for OUD is difficult to access and highly regulated in many countries, resulting in a significant number of those who might benefit from methadone treatment never receiving the medication (Klimas et al., 2021). With the introduction of buprenorphine as a second form of opioid agonist therapy, many countries placed less restrictive regulations on its dispensation due to evidence of a superior safety profile as a partial opioid agonist compared to full agonist opioids such

as methadone (Whelan & Remski, 2012). Unfortunately, some evidence has shown that methadone may be superior to buprenorphine at retaining patients in treatment (Mattick et al., 2014). Thus, methadone has remained a mainstay of treatment for OUD.

Internationally, increasing prevalence of synthetic opioids such as fentanyl in the illicit drug supply of many countries has driven an overdose epidemic, particularly in North America (Krausz et al., 2021). While surveillance data out of Australia has yet to provide evidence of significant synthetic opioid contamination of the illicit drug market, research has reported increase in harms associated with pharmaceutical opioids and heroin (Brown & Morgan, 2019; Nielsen & Dietze, 2019). Given these data, an urgent need exists to expand access to medications for opioid use disorder (MOUD) to address the ongoing opioid overdose crisis. In addition, some evidence exists in support of the need to adapt

Abbreviations: MOUD, Medications for Opioid Use Disorder.

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<https://doi.org/10.1016/j.josat.2023.209086>

Received 31 October 2022; Received in revised form 8 January 2023; Accepted 23 May 2023

Available online 1 June 2023

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methadone induction schedules to account for the increased potency of fentanyl compared to heroin (Buresh et al., 2022).

The COVID-19 pandemic disrupted methadone access and regulatory agencies attempted to facilitate social distancing by relaxing regulatory requirements and expanding delivery options (Joudrey, Adams, et al., 2021). Comparing treatment outcomes following changes to methadone regulation by nation to identify differences and similarities in response to COVID-19 may inform efforts to reform methadone policy and expand access to all patient who may benefit. Therefore, we conducted a narrative review to identify changes to MMT policy after the onset of the COVID-19 pandemic in the United States, Canada, and Australia, and examined emerging treatment outcomes to comment on their impact.

2. United States

2.1. Methadone treatment prior to COVID-19

In the United States, methadone is considered a schedule II substance, along with drugs such as hydromorphone, oxycodone, and fentanyl (*Lists of: Scheduling actions controlled substances regulated chemicals*, 2021). The US Drug Enforcement Administration “schedules” drugs based upon their evaluation of the drug’s acceptable medical use as well as its potential for unhealthy use or dependence. Both methadone scheduling and the regulations surrounding its delivery were heavily influenced by fears about diversion and coincided with the start of the “war on drugs” (“4 Methadone diversion control”, 1995). Thus, methadone can only be provided for OUD via dedicated opioid treatment programs (OTPs) certified by the Substance Abuse and Mental Health Service Administration (SAMHSA). As a part of the previous regulations, federal law dictated that patients on methadone maintenance therapy must present 6 days per week in person at their OTP for daily witnessed dispensing of methadone, until they meet stringent criteria that would allow them to “earn” additional take-home doses (Joudrey, Bart, et al., 2021). According to these regulations, a patient must be in treatment for 90 days before earning a second take-home dose per week (*Federal guidelines for opioid treatment programs*, 2015; Joudrey, Bart, et al., 2021). During this time, they must adhere to strict requirements including: regular clinic attendance, absence of serious behavioral problems at the clinic, absence of recent drug or alcohol use, no known recent criminal activity, and stability of home environment and social relationships. They also must undergo random urine drug screening at least 8 times per year while in treatment (*Federal guidelines for opioid treatment programs*, 2015). Despite the absence of an evidence base to support these practices, such criteria are intended to limit potential diversion of methadone doses. OTPs are also further regulated at the state and local levels with OTP regulations present in 47 of 50 states (Jackson et al., 2020). These overlapping regulations are associated with racial and geographic disparities in access to medication for opioid use disorder (MOUD) across the United States. A recent research report on MOUD in the United States found state-level differences in the proportion of OTPs that accept Medicaid for MOUD—meaning that in some states, Medicaid patients would have to pay out-of-pocket, presenting another barrier to care (Doyle & Baaklini, 2022). Research has found state Medicaid coverage and expansion to be correlated with increased provision of MMT, and national-level data highlights the unmet need for MOUD across the United States (Mojtabai et al., 2019). As methadone is only permitted to be dispensed at OTPs, rural patients face barriers such as long daily drive times to access treatment (Amiri, Hirchak, et al., 2021; Joudrey et al., 2020; Joudrey et al., 2019). As of 2020, the state of Wyoming did not have a single OTP (Doyle & Baaklini, 2022). Racial differences in access to MMT have been well documented in the United States, due in part to practices such as medical redlining against methadone clinics, where services are disproportionately placed in communities with high overdose rates, minority neighborhoods, and areas with a low average household income (Adams, 2021; Amiri, McDonnell, et al., 2021; Bratberg & Walsh, 2021; Dorfman, 2020; Hill & Asberry-

Chresfield, 2021; Webster, 2012). Thus, some studies have shown that Black and Hispanic communities have increased access to methadone treatment while buprenorphine is more accessible to White and high income populations (Andraka-Christou, 2021; Goedel et al., 2020; Hansen et al., 2013; Hawryluk, 2022; Lagisetty et al., 2019; Nguyen et al., 2022). As a result, racial and ethnic minorities have lower MMT initiation and retention rates (Andraka-Christou, 2021).

2.2. Change in methadone treatment due to enacting COVID-19 related policy changes

In response to the COVID-19 pandemic, administration and dispensing regulations for methadone were amended to facilitate social distancing. On March 16, 2020, SAMSHA released guidance permitting states to request an exemption to allow all stable patients to receive up to 28 days of take-home medication, and less stable to receive up to 14 days of take-home medication. Defining stable and less stable patients was per provider or program discretion (Administration, 2020b). In addition, SAMHSA also relaxed previous rules on methadone treatment via telehealth for existing patients only, although patients on buprenorphine were permitted to initiate and continue treatment via telehealth (Administration, 2020a). On November 18, 2021, SAMHSA extended these take-home flexibilities for one year, “effective upon the eventual expiration of the COVID-19 Public Health Emergency” (*Methadone take-home flexibilities extension guidance*, 2022; SAMHSA, 2021). On December 13, 2022, SAMHSA proposed an update to federal regulations, which would make COVID-era MOUD flexibilities permanent (*SAMHSA proposes update to federal rules to expand access to opioid use disorder treatment and help close gap in care*, 2022). The revised criteria would allow “up to 7 days of take home doses during the first 14 days of treatment, up to 14 take home doses from 15 days of treatment and up to 28 take home doses from 31 days in treatment”. In addition, the criteria allow for both initiation and continued buprenorphine treatment to be conducted via telehealth. Finally, the criteria specify that no fewer than 8 random drug tests must be conducted per year per patient (“*Medications for the treatment of opioid use disorder*”, 2022). As of April 2020, 24 US states did not implement any COVID-19 expansion of MOUD policy for buprenorphine or methadone (Nesoff et al., 2021). Of these states, 7 did not permit OTPs to follow SAMHSA’s new flexibilities (Joseph, 2022). A survey of 142 OTPs found that 127 OTPs increased take-home doses, although not always to the maximum extent permitted by the SAMHSA guidelines (*Opioid treatment programs reported challenges encountered during the COVID-19 pandemic and actions taken to address them*, 2020). In addition, a survey of the members of the American Association for the Treatment of Opioid Dependence found that not all OTP leaders adopted the methadone take-home treatment exemption (Levander et al., 2022).

2.3. Outcomes post-COVID-19 related policy changes

Since this exemption has been in effect, the number of patients receiving increases in take-home methadone doses has varied between OTPs, however multiple analyses show that a large proportion of patients received an increase in take-home doses after the onset of the pandemic (Amram, Amiri, Thorn, et al., 2021; Figgatt et al., 2021; Hoffman et al., 2022; Hunter et al., 2021; Joseph et al., 2021). Evidence from numerous studies has shown that increases in take-home methadone doses following the SAMHSA exemption have not been associated with higher overdose rates, worse treatment outcomes, increased health care utilization, lower adherence to treatment, increased use of illicit opioids or significant diversion of doses among patients on methadone maintenance therapy (Amram et al., 2021a; Brothers et al., 2021; Figgatt et al., 2021; Jones et al., 2022; Joseph et al., 2021; Knopf, 2020; Suen et al., 2021). One mixed-methods analysis of patients on MMT in five rural Oregon counties found that each percentage point increase in take-home dosing due to COVID-19 era policy changes was negatively

associated with the percent of UDTs positive for opioids other than methadone, as well as the probability of treatment discontinuation (Hoffman et al., 2022). The qualitative results from this study illustrated that patients had predominantly positive views of policy changes resulting in increased take-home doses, and identified themes of reduced travel time permitting increased recreation and employment, reduced exposures to triggers or individuals less stable in recovery, and feeling trusted with increased responsibility (Hoffman et al., 2022). Another study conducted in Spokane, Washington, assessed methadone-positive UDT results, ED visits, and overdose rates in a cohort of patients on stable methadone dosing for 9 months before and after COVID-19. This study found that mean take-home doses increased by almost 200 % during the post-COVID time period, while ED visits dropped significantly. The study observed no change in overdose rates or methadone adherence post-COVID-19 (Amram, Amiri, Panwala, et al., 2021a, 2021b). A secondary analysis of the same dataset found no significant relationship between change in opioid-positive urine drug screens and increased take-home doses (Panwala et al., 2023). A state-wide survey of all OTPs in Connecticut between July 8 and August 18, 2020, found that no increase in fatal opioid overdoses following relaxation of take-home dosing restrictions. Methadone treatment flexibilities varied substantially by program, but OTP providers surveyed were predominantly in favor of relaxing take-home dosing and telehealth restrictions (Brothers et al., 2021). Another survey conducted in North Carolina in June and July 2020 found that the proportion of patients receiving take-home doses increased, and very few patients reported diverting their take-home doses (Figgatt et al., 2021). A national analysis of CDC methadone-involved and non-methadone-involved overdose data found that in March 2020, overdose deaths both with and without methadone increased, but that after March 2020, overdose deaths increased but methadone-involved overdose deaths remained stable. These data suggest that OTP take-home policy changes did not result in a significant increase in overdose deaths among MMT patients (Jones et al., 2022). Immediately following the issuance of the COVID-19-era treatment exemptions, a clinic with more than 3600 patients on MOUD in the Bronx, NY, drastically increased take-home dosing, and halted urine drug screening. In the first three months, only 6 nonfatal overdoses and zero fatal overdoses occurred (Joseph et al., 2021). Another cohort of 440 patients on MOUD in Rhode Island who received significant increases in take-home dosing following the COVID-19 treatment exemption reported no overdoses and no diversion of take-home doses (Knopf, 2020). Although not explicitly mentioned in the SAMHSA exemption, some clinics also decreased requirements for surveillance activities such as urine drug testing (Joseph et al., 2021). This decrease in urinalysis testing has strengthened previous calls for a reassessment the utility of regular, required drug testing among patients, given the lack of evidence supporting this practice (Hunter et al., 2021; Khatri & Aronowitz, 2021; Niles et al., 2021; Pytell & Rastegar, 2021). Even prior to COVID-19, some experts have questioned the utility of regular urinalysis and the lack of take-home dosing, and have posited that financial incentives rather than clinical utility are responsible for driving some of these practices (Frank et al., 2021). Some emerging evidence suggests both clinicians and patients have positive views on these policy changes (Goldsamt et al., 2021; Harris et al., 2021; Hunter et al., 2021; Madden et al., 2021; Suen et al., 2021; Treitler et al., 2021). A qualitative study of 25 OTP program directors found that most had a generally positive view of the regulatory changes necessitated by the COVID-19 pandemic (Goldsamt et al., 2021). Semi-structured interviews conducted with 20 New Jersey MOUD providers found that all providers expressed support for making temporary COVID-era regulatory flexibilities permanent (Treitler et al., 2021). Two other qualitative studies of OTP clinicians reported mixed findings, and found that while some expressed support for the increased treatment flexibilities, others reported concern about the increased risk of medication diversion and overdose (Hunter et al., 2021; Madden et al., 2021). Similarly, qualitative interviews conducted with 20 MOUD patients in Boston identified that one group of patients

reported increased flexibility, freedom, and safety from COVID-19 post-treatment exemption, while another group felt destabilized by changes in addiction treatment, or found that it exacerbated existing inequities in housing and access to social supports (Harris et al., 2021). Finally, a qualitative study of both MOUD patients and providers found that both groups perceived benefits to expanding access to take-homes post-COVID-19 and experienced few adverse outcomes (Suen et al., 2021).

3. Canada

3.1. Methadone treatment prior to COVID-19

In Canada, the regulatory environment for methadone is more flexible than in the United States. Methadone is considered a controlled substance that is regulated under the Controlled Drugs and Substances Act (CDSA) and the Narcotic Control Regulations (NCR), but as of 2018 practitioners are no longer required to obtain an exemption from Health Canada to prescribe (Methadone program, 2017). Practice standards for MOUD prescribing in Canada are established individually by provincial bodies and, while still highly prescriptive, are less stringent than in the United States (CAMH, 2021b; *A guideline for the clinical management of opioid use disorder*, 2017). Neither the provincial nor federal governments are involved in overseeing prescribing practices, and associations such as the provincial medical regulatory bodies are the ones tasked with ensuring that appropriate standards are observed (Priest et al., 2019). Methadone can be prescribed by clinicians and can be dispensed directly within some clinics, though generally it is provided via witnessed dosing in any participating community pharmacy (Calcaterra et al., 2019; Priest et al., 2019). Prior to the COVID-19 pandemic, clinicians in Canada had more discretion with regard to the provision of take-home methadone doses than in the United States, though significant restrictions were still in place. In British Columbia, for instance, the take-home MOUD guidance for methadone states that all patients should demonstrate a persistent and high degree of stability (minimum 12 weeks) and a stable methadone dose (minimum 4 weeks) before take-home doses are considered, and that take-home doses should start with one per week. Additional take-home doses were then provided sequentially based on ongoing stability and provider judgement, supported by ongoing random urine drug tests and medication counts (*A guideline for the clinical management of opioid use disorder*, 2017). In addition, rather than issuing strict guidance for administration of urine drug screens, clinical practice guidelines in Canada emphasize its utility as part of a comprehensive risk assessment for patients on methadone, and caution against the potential to exacerbate stigma and increase costs due to its overuse ((BCCSU), 2021; CAMH, 2021b).

3.2. Change in methadone treatment due to enacting COVID-19 related policy changes

During the COVID-19 pandemic, provinces and territories across Canada released guidance similar to that issued in the United States intended to temporarily increase access to take-home doses of methadone to facilitate social distancing (*COVID-19 opioid agonist treatment guidance*, 2021; Gomes et al., 2022). Such guidance came alongside a federal exemption issued to the Controlled Drugs and Substances Act. Specifically, this exemption relates to controlled substances and permits pharmacists to extend prescriptions under their license and to transfer such prescriptions to other pharmacies. It also allows practitioners to verbally provide prescriptions, and pharmacy employees to deliver prescriptions of controlled substances such as methadone to a patient's home or other locations where they may be witnessed (*Subsection 56(1) class exemption for patients, practitioners and pharmacists prescribing and providing controlled substances in Canada*, 2021). Use of telehealth to provide MMT increased after the COVID-19 pandemic as well, with examples such as the expansion of a virtual opioid dependency treatment program in Alberta and new clinical guidance on the use of

telemedicine in MOUD issued in BC (Weng, 2020). With the elimination of many COVID-19 restrictions, some provinces, such as Ontario, have since lifted their COVID-era MOUD prescribing guidelines, stating that physicians should now “resume more traditional approaches to carries [i.e., take-home doses] and office visits”. However, they do acknowledge recent data on the benefits of the early COVID-era prescribing regulations, and state that “For patients who have achieved or are maintaining stability on extended or ‘exceptional’ carries, prescribers should consider maintaining this approach. It may also be appropriate to continue this practice for patients who have remained stable without regularly providing urine samples” (COVID-19 opioid agonist treatment guidance, 2021). In reality, a return to previous prescribing patterns and urine drug screening frequency has been noted even prior to the official lifting of COVID-era prescribing guidelines, though the aforementioned federal exemption remains in place until 2026 (CAMH, 2021a).

3.3. Outcomes post-COVID-19 related policy changes

While comparative data from prior to the pandemic are not available, a study conducted in the context of the COVID-19 pandemic found Canadian methadone clinics provided timelier access to methadone treatment than US OTPs, with a mean difference in wait time of approximately two fewer days. However, clinics in both nations reported barriers to accessing timely care due to COVID-19 (Joudrey, Adams, et al., 2021). Similar to the United States, emerging analyses of people on MOUD in Canada show that patients received less urine drug screens and received more take-home doses post-COVID-19, and that these changes were not associated with a corresponding increase in overdose rates or other adverse health outcomes among patients (Bouck et al., 2022; Corace et al., 2022; Kitchen et al., 2022). Indeed, an analysis of patients on methadone in Ontario showed that patients who received an increase in take-home doses after the onset of the COVID-19 pandemic actually had a decreased risk of opioid overdose, treatment disruption, or discontinuation (Gomes et al., 2022). Another analysis of both prescribers and patients in Ontario reported positive experiences with pandemic-associated changes in MMT delivery (Corace et al., 2022). A separate analysis found that patients on MOUD in Ontario had no significant increase in weekly treatment discontinuation rates during the first 8 months of the COVID-19 pandemic, despite the flexibilities provided by the pandemic-specific MOUD guidance (Garg et al., 2022).

4. Australia

4.1. Methadone treatment prior to COVID-19

In Australia, methadone is considered a schedule 8 medicine under the Standard for the Uniform Scheduling of Medicines and Poisons along with morphine, oxycodone, and codeine (The Poisons Standard (the SUSMP), 2022). Schedule 8 medicines, including methadone, are regulated at a state or territory level and are classified as such due to their risk of unhealthy use or dependence. Methadone program service delivery is supported in each jurisdiction by local policies that generally align with national guidelines (Gowing et al., 2014). The majority of Australians on MOUD receive methadone for pharmacotherapy treatment, making up 58 % of those on MOUD in 2021 (National Opioid Pharmacotherapy Statistics Annual Data collection, 2022). Methadone treatment may be prescribed at both public (government-funded) and private medical clinics and hospitals. Similar to Canada, methadone dosing may occur in clinic as well, but can also occur in community pharmacies (Gowing et al., 2014). Pre-pandemic quantities of take-home methadone doses were determined based on risk stratification of potential harm from overdose or diversion. While daily methadone supervised dosing was required for newly initiated or “higher risk” patients, “lower risk” patients could typically receive up to 6 takeaway doses per week based on criteria such as regular clinic attendance, no missed doses, lack of use of other drugs, and access to housing to support

safe storage (Policy for maintenance pharmacotherapy for opioid dependence, 2016). Thus, prior to the COVID-19 pandemic, take-home doses of methadone were given to individuals based on clinician judgement, although take-home dosing policy guidance was provided to clinicians to support their decision-making (Gowing et al., 2014). In addition, similar to Canadian policy on urine drug screening requirements, the frequency of urine drug screening is primarily based on the judgement of the prescribing physician (Gowing et al., 2014).

4.2. Change in methadone treatment due to enacting COVID-19 related policy changes

Similar to the policy changes enacted in Canada and the United States during the COVID-19 pandemic, increased methadone take-home dosing, decreased urine drug test monitoring, reduction in face-to-face prescriber assessment and increased utilization of telehealth were encouraged in Australia based on clinical judgement (Lintzeris et al., 2020). Rather than one federal source of guidance, individual states and territories released their own recommendations (Lintzeris et al., 2020). Despite separate guidance in each jurisdiction, patients considered at lower risk of potential harm may have been granted up to 13 take away doses per fortnight (Checklist for assessing appropriateness of take-away doses to support continuity of pharmacotherapy during the COVID-19 pandemic, 2021).

4.3. Outcomes post-COVID-19 related policy changes

Patients responded positively to COVID-19-related changes in practice such as increased prescription of take-home doses, and data on adverse incidents such as ambulance utilization among patients receiving additional take-home doses showed no increase in adverse outcomes including methadone-involved overdose deaths (Efunnuga et al., 2022; TurningPoint, 2020; Victorian overdose deaths, 2011–2020, 2021). A pre- and post-COVID-19-related policy change analysis conducted in Sydney, Australia, showed that MOUD patients had high rates of treatment retention, and that increases in the number of take-home doses disbursed were not associated with increased substance use (Lintzeris et al., 2022). While this sample does not only reflect methadone patients, the majority of patients (57 %) were on methadone pre-COVID, while the remaining patients were on sublingual or depot buprenorphine (31 % and 12 % respectively) (Lintzeris et al., 2022). The same study noted an increase in patients dosed at community pharmacies rather than in clinics (Lintzeris et al., 2022). The study saw an overall increase in patients accessing any take-home doses from 23 % pre-COVID related policy change to 67 % post-COVID related policy change, and patients receiving 6 or more take-home doses per week increased from 7 % to 30 %, excluding patients on depot buprenorphine, who do not present daily for treatment (Lintzeris et al., 2022).

5. Conclusion

Across all three countries, regulators of methadone treatment programs responded with increasing access to take-home doses, loosening restrictions on MMT via telehealth, and decreasing requirements for urine drug screening. However, they differed in regard to the length of time that these COVID-era exemptions were in effect, as some settings in Canada have already rolled back take-home dosing flexibilities, while the US federal government has sought to extend them.

Issues of access to methadone are widespread in each country and present a major barrier to both treatment initiation and retention. Specifically, patients report requirements for daily in-person dosing and surveillance to be particularly difficult to maintain, particularly for high-risk populations, such as individuals recently released from incarceration (Frank et al., 2021; Russell et al., 2022). Thus, the increase in take-home dosing flexibilities after the onset of the COVID-19 pandemic was beneficial for many patients, especially those in rural and remote

communities, many of whom have to travel far to access daily treatment (Amiri, Hirschak, et al., 2021; Patil Vishwanath et al., 2019).

Whether these regulatory changes to MOUD will be maintained after the pandemic remains to be seen. In the United States, organizations of health care professionals such as the American Medical Association (AMA) have come out in support of extending COVID-era take-home methadone guidelines (*Bridging health equity gaps for people with disabilities and chronic conditions*, 2022). SAMHSA, the department responsible for methadone treatment regulation in the United States, is attempting to make the increase in take-home methadone dosing more permanent due to the positive outcomes associated with its provision (*Methadone take-home flexibilities extension guidance*, 2022). In addition, two US senators (Ed Markey and Rand Paul) have introduced a bipartisan bill intended to codify the COVID-era treatment exemptions at a legislative level (Hawryluk, 2022). Despite the possibility that some of these changes may become permanent, emerging data also suggest the provider adoption of take-home regulatory changes may be a limiting factor in its impact (Figgatt et al., 2021; Hunter et al., 2021; Levander et al., 2022).

Prior to the pandemic, both the Canadian and Australian model of pharmacy-based methadone distribution allowed for greater flexibility for many patients, and the stress placed on the US system by the COVID-19 pandemic has renewed calls for a transition to community pharmacy-based MOUD (Bach & Hartung, 2019; Cochran et al., 2020; Hawryluk, 2022; Joudrey et al., 2020). At an international level, the widespread findings of improved clinical outcomes support re-evaluation of the utility of regulation and restrictive prescribing practices. Further research should evaluate the evidence base behind restrictive and punitive practices such as urine drug screens and mandatory in-person visits and dosing. Given the increasing opioid overdose rates in each country discussed in this review, and particularly the synthetic opioid-related overdose crisis currently devastating Canada and the United States, now is not the time re-instate restrictive policies that would decrease access to MOUD. Hopefully, the lessons learned from providing addiction treatment during this global public health emergency will lead to a shift toward patient-centered practice guidelines moving forward.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

CRedit authorship contribution statement

The authors have participated sufficiently in the conception and design of this work, as well as the writing of the manuscript, to take public responsibility for it. The authors believe this review manuscript represents valid work.

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