

**ASAM**American Society of
Addiction Medicine

ASAM Practice Pearls Transcript

Methadone: The Right Dose, Every Day

Dr. Elizabeth Salisbury-Afshar: Welcome. This is ASAM Practice Pearls, a podcast series from the American Society of Addiction Medicine, where we turn clinical expertise into everyday addiction care, one conversation at a time. I'm today's host, Dr. Elizabeth Salisbury-Afshar. This episode is part of a special three-part series featuring highlights from ASAM's 57th Annual Conference.

We are joining you today from sunny San Diego at the meeting, and we will turn our attention to *The Right Dose Every Day*, a session that drew much interest at the conference. This session covered strategies for methadone dosing, including split dosing, increased take-home bottles, safe and accelerated induction titrations, and non-punitive misdosed approaches, as well as ways to transition patients from methadone to buprenorphine, ensuring patients take the right dose of methadone every day.

I'm excited to welcome our two experts from this popular session, Drs. Ruth Potee and Ari Kreigsman. Ruth, Ari, can you each please introduce yourselves, tell us a little bit about where you work, and what you do in your scope of practice?

Dr. Ruth Potee: So, I'm a family doctor and addiction doctor, and I work in rural western Massachusetts, but we've just expanded and now are all across the state of Massachusetts. We have nine methadone clinics.

Dr. Ari Kreigsman: And I'm Ari Kreigsman. I predominantly work in Springfield in western Massachusetts, and I oversee a large urban OTP as well as a 3.7-level facility.

Dr. Elizabeth Salisbury-Afshar: Amazing. So, for folks who have been to ASAM before, you have probably heard one of Dr. Potee's very famous methadone talks.

This year was yet another one. And when I talked to her in advance, she said, "Oh, and this year's going to be great because my colleague, Ari," – whom she had wonderful, wonderful things to say about – "is going to be joining me." And I could definitely see why when I heard your presentation this morning.

So I will just say, you know, as I sat in the session – I've never worked in an OTP, I'm an addiction doctor, but never worked in an OTP – the thing that really struck me was just how obvious the things you all were talking about should be, but because of federal regulation have really not been possible for a long time.

And it was both invigorating – one of my colleagues texted that she was almost going to cry just hearing how patient-centered the care was – but also how sad it is that it's

taken this much work and this much time. So, thank you both for an awesome session.

And to start off, I'm going to ask if you can briefly describe your overall approach to methadone treatment, dosing decisions, and the goals that guide your clinical decision-making.

Dr. Ari Kreigsmann: I like how you said how a lot of it seems common sense in a way, what we shared today, and I think I'll build on that a little bit.

When I think about patients when they come in, it can be such a big step for people to come into a methadone clinic. It's a really courageous and brave step for folks. And I think the reason that people are coming in, if I were to distill why people come to methadone, it's because they're choosing life. Like, choose methadone, choose life. I think sometimes people use those words, like, "I'm here because I want to live," or, "I want to get my life back together." And it's maybe simple, but it's also a great way to orient.

And so, when we think about getting people on the appropriate dose and getting them on it quickly, it's to help save their life. It's to help reduce their need to use illicit fentanyl from the streets. And so, getting them to meet their goals of staying alive. So, let's do it quickly, let's get you to appropriate dose where you feel well. That's sort of driving the overall piece of it.

And the other piece is, in addition to keeping people alive, which I think is the number one goal for all of us, it's to help people get their life back together. And so, the different decisions that we make in terms of take-home doses and take-home bottles for people, and what to do when people miss doses, and how do we help people get split doses if they need it, it's all in the interest of helping people get their lives back together and support them so they can do all the things that are important to them. They can get their families back. They can help work again. And so, it's all really in the support of life. And so, I like to use that as my orientation when people walk in, and I first get to meet them.

Dr. Ruth Potee: And it actually goes against, I think, the instinct of many people to walk into a methadone clinic because they're actually, in their minds at least, handing their lives over to a "punishing system" that actually causes a lot of people shame, and where it's really hard to have a job and take care of your kids.

And Ari and I have had the privilege of opening these nine methadone clinics since 2020, at a time where the rules had become more flexible. And so, we've been able to build from scratch, with zero patients, a system that takes care of almost 3,000 patients in Massachusetts. In fact, Ari oversees the largest methadone clinic in Massachusetts now, which six years ago didn't exist.

I often would say to a patient, "I need you to know that you came to the right place, and whatever happened to you in a previous methadone experience, it's not how it's going to go this time. And we want to talk you through the ways in which this could be different and better for you."

Dr. Ari Kreigsmann: When we were thinking about the mission of our talk, sort of telling the story to each other beforehand, and it was like, there's going to be people who come to us who are working in OTPs already, and we hope we give you information that you can sort of advocate within your system to make changes.

And we're also really happy to have the folks who don't work in an OTP but might work in addiction consult service or might work in the community in primary care, and sort of be like, this is what can be done in an OTP now, so that you can be empowered, you can have knowledge. So, when you go and speak to the OTPs in your community, you can be like, what about this? Or what about that?

That was really one of the sort of arcs that we were hoping that people took away from today.

Dr. Elizabeth Salisbury-Afshar: When I listened this morning, I really appreciated – I think for so long, at least again as an outsider, what we knew about methadone is that it's just so algorithmic. You start at this dose, and you go up at this many days, and that's just what you get.

And I appreciated that you both were talking about starting at higher doses, but it's always patient-centered. It's not just a singular algorithm. You're always looking at the person, which, again, seems like it should be obvious but is not the way that it's been able to function for many decades.

Dr. Ruth Potee: People afterwards came up and said, "Can you send me your protocol?" I said, "That's the trick. We don't really have protocols that are written down. We sit down with every patient and hear their story. And we create a plan together. So, I can't put that in writing and hand that off to your clinic." That's been the problem all along with methadone clinics. Is it has been so algorithmic.

Dr. Ari Kreigsmann: And I might build on one more thing there, which is one of the things that I've so appreciated about the final rule, is the emphasis on clinical decision-making.

As medical providers in clinics, now we get to use our clinical decision-making, which is a real gift. We've all trained this way. It's what we use in every other element of medicine that we practice. Now we actually get to make good clinical decisions for people.

Dr. Elizabeth Salisbury-Afshar: Which I think is so true and also kind of amazing, how many clinicians don't get much training in methadone across the board. We learn about it as a pharmacotherapy, but a lot of what you are describing, the nuance of it.

And so, I'm curious if you have thoughts or suggestions on what that training should look like as time goes forward, especially since folks working in OTPs have been historically so used to having an algorithm.

Dr. Ruth Potee: Right. I actually think there should be ASAM-sponsored training on how to do methadone and do it well with multiple, multiple cases that you would learn from. Because if you're providing truly individualized care, we can run 100 patient case stories and come up with a slightly different plan for each one.

I think more and more people, whether it's because they might work in an OTP someday, which is always my wish for many people. I mean, I came to methadone 20 years into my family medicine career. Interestingly, I used to counsel my patients against methadone because I was like, "It's going to ruin your life," not because the drug doesn't work, but because the clinic structure is so harmful to the rest of your life.

I'm embarrassed now that I did that, and yet the local methadone clinics at the time were bad. And then entering into that space for the first time as the medical director and realizing how impactful you can be to single individuals.

But also one of the things that Ari and I pride ourselves on is that when we move to town and our methadone clinics open and the rules have changed, then every other clinic that is anywhere near us has to change as well. Otherwise, we're just going to take all their patients. And so, my attitude is, we can raise all the boats. I don't need anybody to close, but you need to do a better job for your patients.

I think more people in addiction medicine do know about methadone because they are starting in the ER. They're starting on the inpatient service. And so, in the last five years even, there's much more knowledge about methadone in the addiction community. And someday it could be the case, an addiction doctor could start methadone and prescribe it to a pharmacy. That's our long-term goal. And then we really need to train the entire workforce to feel confident.

Dr. Elizabeth Salisbury-Afshar: As we're talking about these clinical decisions and how clinicians make the methadone dosing strategy recommendations, can you talk a little bit about how to think about caring for patients with unique clinical needs?

Dr. Ruth Potee: I think that the range of medicine for people varies, and you could have somebody who's elderly – these days, a lot of our patients who have opioid use disorder, they're aging. They're getting more comorbidities with chronic diseases that can cause respiratory depression or cardiac arrhythmias. And so, you really do need to know something about medicine, understand the higher-risk patients who might be

out there, and be able to tailor your protocol in your own head, with the patient, the right way.

So, although we've talked a lot about being a little bit more aggressive or a lot more aggressive on how to start people, it is still the case that everybody I see during the day, I really could start at 10 milligrams on day one, or I could start at 100, and I could choose any number on the in between.

There are people for whom we are much more careful, for any number of reasons, and the common ones are things like COPD or being aged or heart failure or, again, having an arrhythmia.

The other thing I'll say is that as our patients age and get hip replacements, knee replacements, get cancer, you also need to be really good at thinking, "Wow, this person is really suffering in an additional way, and we need to help with more pain management."

One of the things we'll do is reach out to the pain provider and say, "Look, they're on methadone. They're doing well from their opioid use. I want to let you know that I would recommend you use short-acting agonists on top of to help this person. We're willing to go up on the methadone, but really, they need some breakthrough medicine." We're not one of those clinics that's going to lose their minds because they have a short-acting agonist script when they need it as well.

And I have to say, one of the things that Ari and I love to do is break down the silos between us and the hospital, the ER, the primary care. We want them reaching out to us. It's really important.

Dr. Elizabeth Salisbury-Afshar: One of the things that I really enjoyed during the presentation was that you actually asked the audience to vote how they respond to missed doses and seeing that variability. Can you all share your approaches to missed doses?

Dr. Ari Kreigsmann: Yeah. Well, I'll give a little bit of background. There hasn't really been, I would say, a lot of research on this topic until recently. And so, for years, the guidance has been that if you miss three or more days, you would have a pretty substantial reduction in your methadone dose.

And I think, when Ruth started our clinics – I wish I could say I was there at the time – but it always felt overly punitive in terms of how much their doses were reduced at the time. So, I think the concern had always been that if people missed three or more days, they would lose tolerance. We put people at risk of overdosing by resuming their normal methadone dose.

Now, in most cases, when people miss three or four days, they're going to start feeling significant withdrawal. And the vast majority of people, unfortunately, will

resume using illicit opioids as a way to just not feel awful. And so, we think it's really important to consider when people miss doses, whether they've continued to use opioids or not. And in the cases where people have continued to use fentanyl, we know that there's a lot of cross-tolerance between fentanyl and methadone. And really, the vast, vast majority of cases, we don't actually need to reduce their doses.

That's our approach now, and I think we now have good research on this. There was a great article, which was published in JAMA in 2025 out of Denver Health, looking at coming up with a different approach and sort of a novel path for when people have continued to use opioids and missed doses. And really, what we found is that if people continue to use opioids, when they miss their methadone doses, and we can resume pretty much the same dose. That there are really no safety issues involved. And from a patient perspective, this is so helpful.

I think we really need to consider the harms that we've been doing for years in cutting people's doses significantly, which then forces them to go out to the streets and put themselves at risk of further overdose or further worsening of their substance use disorders.

And so, anyway, at BHN what we do is we have two pathways. And in most cases these days, if people continue to use opioids, we barely reduce their dose or don't reduce their dose at all.

Dr. Ruth Potee: And we learned about this at ASAM. ASAM 2024, we watched Paul Christine et al present this data, and we thought, "Holy smokes. We should be doing what they're doing." And we started it, sort of moderately, because it hadn't been published yet. It was all preliminary. And we were sort of waiting with bated breath, "Is this going to come out? What is it going to really say?"

And then in September of 2025, this really game-changing article was published, and we felt much more confident that we could go ahead. Really trying to protect the patient and not always have it be that the clinic is always protected and the patients are put in harm's way.

Dr. Ari Kreigsmann: Yeah. I think I might even borrow this idea from Paul as well, which is that traditionally what methadone clinics have done is if somebody's on 100 milligrams of methadone, they miss four days or continue to use fentanyl in the abstinence, clinics would cut their dose significantly, sometimes as much as half or a restart.

In those cases, if somebody continues to use fentanyl, the chance of somebody overdosing on methadone is pretty much zero. And yet clinics, I think, were so uncomfortable with whatever that infinitesimally small risk was and liability with that, that they would instead shift the risk to patients and say, "Okay, we're not going to take this risk, but instead you have to take it on and go into the community and continue to use fentanyl."

And I think that same piece of aversion to risk on the clinic's part isn't just with missed doses. But I think it was with starting doses, with take-home medications. Thankfully, we have more guidance now in the final rule telling us we should be making these patient-centered decisions, which is really great. But I think it's also time now that the field catches up to that and takes care of patients in the way that they deserve to be so.

Dr. Elizabeth Salisbury-Afshar: Yeah. I love what you said, Ruth, about how helpful it was hearing that someone else was doing it and then that they had data to share it.

And I think it's such a good example of the ways that coming together in these spaces and hearing what other people are doing can help us break down our own inertia of just like, "Oh, but we've always done it this way, and it must be the only safe way," and then you hear about people doing and trying new things and then go back and realize, "Oh gosh, yeah, we should be doing more of this."

Dr. Ruth Potee: The third person who was in our talk, Daniel Liauw. What was interesting to me and Ari is that most of the questions came to Daniel because what Daniel brought was how to move people from methadone to long-acting injectable buprenorphine. And people have tons of questions about that, and not many people are really doing it.

And so, you get to see in the room, people are thinking, "Oh, he's doing this thing that I've been trying to do, but I haven't quite figured it out." And so, they were peppering him with questions.

And Daniel was a fellow who trained with us at our methadone clinics.

Dr. Elizabeth Salisbury-Afshar: Oh, that's awesome. Also nice to have learners around to push us to say, "Wait, but that doesn't make sense. Why are you doing it like that?" And then you try to come up with a reason and realize, we actually don't know. We could try something else, you're right. So yeah, we're teaching them, but they're teaching us all the time.

So, I know, Ari, you mentioned take-home specifically. Can both of you walk us through some clinical scenarios where split dosing or increased take-home doses might be beneficial for a patient?

Dr. Ruth Potee: I'll take the split dosing. For some people, it really makes more sense to take their methadone multiple times a day. And guess what? Patients have been doing this all along. I'm old enough that I was the earliest year of bup prescribing. And it was a once-a-day medicine, and you should not vary from that.

And then as time went on, our patients would say, "Well, I take it two or three times a day, and it works much better." And eventually we all said, "Okay, let's start doing it

that way." And it wasn't because the FDA or the drug companies told us to do it. It's because the patients needed it that way.

And so, with split dosing, to be totally honest with you, my sense is that patients sometimes do sip their methadone bottles at home, right? They don't take the whole dose when they have a take-home bottle. They might divide it up of their own accord. They would never tell that to their methadone clinic because that is considered bottle mismanagement, and they would be punished for it. So, what really patients do with their methadone when they leave our building? We have no idea.

What we know is that there's categories of people, pregnant, without a doubt. I have literally one person in my career who was pregnant who did not need a split dose of methadone; otherwise, you should presume that they're going to need it. They may not need it when they're 8 weeks gestation, but they're going to need it by 15 weeks, and you need to plan for that with them.

But also, anybody who walks in the door who has chronic pain, they will need a divided dose. And why wait for that? Why don't you start it on day one? Because they're going to get better coverage.

I take care of a lot of people who are in the trades. They work night shifts. They're arborists. They're roofers. And what they'll tell me is that by the end of the day, "my normal pattern is I use substances after a terrible, hard day at work. My body hurts. I'm full of metal and plates and screws, and I always have to use. It's what helps me go to bed." And what I say to them is, "What would you think if we instead had you use some methadone before you went to bed? What do you think of that idea?" And they're like, "Yeah, that'd be way better than what I'm doing." And I say, "Well, let's add some at night for you that's separate from your morning dose so that you can actually go to bed without entering into the toxic drug supply."

So those are three examples I would use for split dosing. A final one would be somebody who's having a lot of side effects for any reason at their big dose of methadone. Divide it up so that they're not getting hit all at once with a big dose. We find side effects improve.

Dr. Ari Kreigsmann: That's great. So, I'll talk about take-home medications. I'll share our philosophy and maybe also what we can take from 42 CFR part of the final rule, where we're encouraged that it's an individual decision.

We should weigh the risks and benefits for everyone. Given the benefit of taking methadone every day for people and how many lives it saves and lives improves, we need to do everything we can to ensure people get their dose every day.

Now, if you live an hour away from clinic, or you have to take three buses to get to clinic, that's a real risk that you're actually not going to get your dose that day. But I think for everyone, we feel like there's nowhere else in medicine where you have to

travel every day to take a dose of your medicine, right? And so, we feel the same should really apply to methadone. That instead of something like you need to earn, it really should be a right that people have, unless they prove otherwise. That's our philosophy, broadly speaking.

But then I think, how do you actually do it? I think it's an individual risk assessment for everybody. And generally, what we do is we start people with bottles as soon as we can, and then we see how they do. And folks, longer in treatment, they show that they're not having any issues, we can expand and expand and expand.

And the ultimate goal is that people can get their lives back in the way that we sort of orient in the beginning. And one of the best ways to get your life back is not have to spend hours of your day, every day, traveling to get a dose. And, you know, it can be traumatizing to go back to clinic. You can see people you used to use drugs with or people who are dealing drugs still at times.

And so, there's so many benefits to take-home medications, and we now know through the large natural experiment that happened during the pandemic that for the vast majority of people, they're actually quite safe. And so, we don't think that just because you're using drugs, you can't have take-home bottles.

We feel that many people who continue to use drugs have shown us that they can safely manage their doses. And so, who should get take-home medications? I would say pretty much everyone, until you prove otherwise.

Dr. Ruth Potee: Exactly. In the final rule in 42 CFR 8.12, it does talk about the fact that you should not be giving bottles to people with active substance use disorder unless the benefits outweigh the risk. And in most cases, that's the thing, is the benefits do outweigh the risk.

We also spend a lot of time teaching each other and teaching our clinical staff about what truly an active substance use disorder is. You can use cocaine or fentanyl intermittently, and it doesn't ruin your life. Knowing the difference between what you might see on toxicology and what you might see by actually communicating and asking questions of a patient are two separate things.

There's so many great things about what happened in 2024, this final rule change, and I hope it is never revoked. But one of my favorite ones is that they removed toxicology as part of the evaluation for who got a take-home bottle. It was a game changer. It's not the way most clinics are working now, and yet most clinics should be working that way.

Dr. Elizabeth Salisbury-Afshar: I've shared this with both of you, but I live in Wisconsin, which is a state that still requires seven-day-a-week visits in the clinic for the first months of care. So we were not a state that adopted the regulation changes. And so, in case we have any audience members who have not adopted, can you just

talk a little bit about what that transition was like in your own clinics, especially if people had been working in OTPs for a long time, what that change looked and felt like, or if people have reservations? Perhaps they're in a setting that hasn't really embraced the opportunity for take-homes.

Dr. Ruth Potee: I think there's a lot of clinic culture, and clinic culture can be old and dated and not current with 2026. And I'm going to be honest, Ari and I were really lucky. We started brand new clinics with mostly brand new staff from scratch. And we got to do it at a time where we were working within COVID-19 emergency relaxation of things.

So we had some nurses who did come from other methadone clinics, right? Those were some of our first hires. And Ari and I spent a lot of time standing back in the nurses' stations, talking with the nurses, listening to how the nurses were talking to the patients, sometimes modeling how maybe to do it differently.

And what most of our nurses would say, who came from other clinics, is, "We're so much happier being here. The patients are less angry at us. We're not getting yelled at all the time. We feel like people are actually getting better." And they also sometimes think, particularly me, I'm too liberal. And they'll say that. They're like, "Dr. Potee will give anybody anything." And so, there is this balance for sure.

If you said to me, Elizabeth, "You need to hire this person. They've been running this other methadone clinic for years and years. They're very skilled and knowledgeable." My instinct would be like, "No, not a good idea." I would much rather take a brand new grad, who the two of us have trained over a period of time, and have their bright, wide-open eyes into that circumstance.

Dr. Ari Kreigsman: Yeah. I'd like to share what we learned from the pandemic and the science that we know now, like the large-scale epidemiology of it. Knowing that we went from people dosing every day to this large-scale experiment where some people were getting all of a sudden 13 or 27 bottles due to social distancing reasons.

And there wasn't an increase in rates of methadone overdose, which is, I think, what people worry about. People were more satisfied with their treatment. They had better adherence to treatment, which obviously tracks really well with mortality data. And so, I think partly it's sort of leaning into the science when people have concerns, and also sharing what we feel is the risk of when people have to dose every day.

You know, I think what I found, though, is to work with people, we have to first understand them. And so, I think it is when people have pushback or have concerns, really being able to listen to them, consider them, share our pieces. But ultimately, in our clinics, it's our medical director who's most responsible and who gets to make these decisions. And I think we're fortunate enough to be in lockstep there.

Dr. Elizabeth Salisbury-Afshar: So, as we're wrapping up, I want to ask each of you, what are the main practice pearls or action items you want our listeners to remember from this episode?

Dr. Ruth Potee: I think that most of the listeners don't work in an OTP, and some of them will never work in an OTP. And yet, I want you to feel empowered as somebody who knows about methadone. And for some of your patients, it's the right molecule for their bodies and their brains. I want you to feel empowered that you can impact and influence your local OTP. You should know where your local OTPs are. You should know who the medical directors are.

And if you're working in a hospital emergency room, a bridge clinic, you primarily do buprenorphine at an OBAT, you need to have this relationship so you can warm hand off patients to them. And you should develop a relationship enough that you could say, "Look, I work in a hospital setting. We have 24/7 eyes on patients. We have dosing trajectories that are going to be more aggressive than what you might do at a methadone clinic. Will you accept those patients on our doses? If we are admitting somebody on a split dose, I need to know that you're going to continue them on their split dose."

The world of methadone clinics are so locked away in a black box, and no one seems to know how to access them, and they seem scary. And we need to acknowledge they are part of medical care in this country, and they should never have been shifted away from mainstream medicine. And yet, 52 years ago, it happened.

Our job is to break down those silos and build the relationships, because you calling from the hospital saying, "This is my plan. We think this person's going to be better on a split dose," will influence what that OTP receives on the other end. So I do think that whether you're working from within or you're working from without, we could all work together to improve the quality of care for our patients at methadone clinics.

Dr. Elizabeth Salisbury-Afshar: I really appreciate that so much. In reflecting on my own practice on the inpatient side, I've only been there for about five and a half years. It took a little bit to build some of those relationships, but now I have all the OTP med directors' numbers in my phone. And of course, we always get a release, but to just be able to call and say, "Hey, we need to chat. I want to update you on what's going on," or "Hey, we have this new patient that lives close to your clinic. They gave us permission. Can I give you an update and see what we can do?" The power of relationships we can never underestimate.

Dr. Ruth Potee: Absolutely. And when people leave hospitals, they're sick, right? They can't make it to clinic. And so, it's an opportunity for the hospital to use the 72-hour rule to dispense methadone for three days to the patient, which is allowed. And then on day four, they can come to the methadone clinic. Or we could set up VNA to go to their house, or one of our nurses can deliver.

You have to create these workarounds, and consequently, the importance of these good collegial relationships.

Dr. Elizabeth Salisbury-Afshar: Thanks. Ari?

Dr. Ari Kreigsmann: I'll start with simple but deep idea that when people are coming to choose methadone, they're choosing their life. And they want to stay alive, and they want to get their life back. And let's orient that way, towards their life, towards positivity, and help supporting them get what they want and what they need.

What comes to mind first is really how can we help people get take-home doses and take-home medications. We could consider that more of a right that people have rather than something that has to be earned. Can we help them do that as soon as possible so they can start to get their lives back? And even think of that as a quality measure.

So, as clinics, we should look at ourselves and look at the proportion of people who have to come every day. And if we see that certain clinics, or our clinic, has a really high proportion of people who are still dosing daily, ask ourselves why and what we can do to help make that better.

Dr. Elizabeth Salisbury-Afshar: So I want to thank both of you, Ruth and Ari, and also the third speaker, Daniel Liauw. You guys were brilliant. And I know sometimes it's hard to know and to feel it when you're in the session, but I really believe that due to sessions like the one you gave today, due to sessions like the one you gave in the past, you are change agents in the ways that people go home and think about adapting care models in ways that are so much more patient-centered. And it's meaningful beyond just, you know, the CMEs people get, so thank you for that.

I want to remind our listeners that the full recording of their session, *The Right Dose Every Day*, will be available in ASAM's e-learning center. So if you missed it at the conference, be sure to check it out online.

Please remember to claim your CE credits for this episode. And also make sure to subscribe and share this episode with colleagues who may find it interesting and helpful.

Thanks so much for listening. We'll see you next time on ASAM Practice Pearls, where we turn clinical expertise into everyday addiction care one conversation at a time.