Published Online: 2026 February 12 **Letter**

# Rethinking Methadone Distribution in Iran: Towards Ethical and Effective Addiction Treatment

Mohsen Khosravi [1, *]

[1] Department of Psychiatry, School of Medicine, Zahedan University of Medical Sciences, Zahedan, Iran

[*] ***Corresponding Author:*** Department of Psychiatry, School of Medicine, Zahedan University of Medical Sciences, Zahedan, Iran. Email: dr_khosravi2016@yahoo.com

**Received:** 19 October, 2025; **Revised:** 6 December, 2025; **Accepted:** 7 February, 2026

*Keywords:* Drug Distribution, Ethics, Iran, Methadone, Opioid-Related Disorders, Substance-Related Disorders

*Dear Editor,*

Substance use is a major challenge for healthcare, judicial, and social systems in Iran, significantly contributing to the national burden of disease (1). Notably, Iran's disability adjusted life years (DALY) and years lived with disability (YLD) indices attributable to substance use are 698 per 100,000 and 11.1, respectively — well above global averages (200 and 4 per 100,000, respectively) (2). Over the past two decades, Iran has developed one of the world's largest networks for methadone maintenance therapy (MMT), currently encompassing approximately 7,000 clinics and serving around 700,000 patients nationwide (2).

Methadone provision in Iran follows a physician-led model, in which the same clinician is responsible for both prescribing and directly dispensing methadone within MMT centers. While this model is consistent with Iran's regulatory obligations under national and international law — including the United Nations Single Convention on Narcotic Drugs (1961) — and is intended to ensure strict medical supervision over a controlled substance, it also presents important ethical, clinical, and operational challenges (3, 4).

It is important to clarify that physician involvement in dispensing methadone is not inherently unethical; rather, it reflects the current regulatory framework for controlled substances in Iran and many other countries. Nevertheless, the dual role of prescribing and dispensing can blur boundaries between clinical care and drug distribution, potentially leading to operational inefficiencies and conflicts of interest (5). Recent Iranian studies have reported patient dissatisfaction with the lack of individualized psychotherapy and social support, as well as concerns about overreliance on medication, limited privacy, and stigmatization (4). Additionally, there is documented evidence of methadone diversion and non-medical use, which has been linked to regulatory gaps and insufficient oversight in the current system (6).

Internationally, best practices advocate separating the roles of assessment/prescribing (by physicians) and dispensing (by pharmacists in regulated community pharmacies), which can reduce conflict of interest, enhance accountability, and leverage the expertise of pharmacists in managing controlled substances. Countries such as Australia and the United Kingdom have achieved improvements in access, patient satisfaction, and diversion control by transitioning to pharmacy-based dispensing models, supported by clear protocols and multidisciplinary teams (7).

A central limitation of the Iranian system is the insufficient integration of psychosocial interventions (1). Addiction is a biopsychosocial disorder, and comprehensive care — including psychological counseling, vocational support, and social reintegration — is key to improving retention and outcomes (8). The heavy focus on pharmacotherapy alone contributes to high relapse rates and persistent stigma, as reported by Iranian patients and families (4).

Reforming the current model would require a phased transition to pharmacy-based dispensing, regulatory reforms to clarify professional roles, and substantial investment in pharmacist training, infrastructure, and digital health systems (7, 9). Stakeholder engagement — including patients, families, clinicians, and pharmacists — is essential for successful implementation and for ensuring that changes do not disrupt access to opioid agonist therapy (OAT). Pilot



**How to Cite:** Khosravi M. Rethinking Methadone Distribution in Iran: Towards Ethical and Effective Addiction Treatment. Iran J Psychiatry Behav Sci. 2026;20(1):e167369. doi: https://doi.org/10.5812/ijpbs-167369

programs, robust monitoring, and continuous evaluation are recommended to manage risks and guide scaling up (10).

Any reform must also prioritize the integration of robust psychosocial interventions through multidisciplinary teams — drawing on the demonstrated effectiveness of such approaches in both Iran and comparable settings (1, 8). Resource allocation and outcome measurement should be reoriented toward comprehensive, patient-centered care.

In summary, while Iran's physician-led model for methadone provision is rooted in regulatory necessity, evolving toward a pharmacy-based, multidisciplinary system — with separated roles, expanded psychosocial services, and enhanced oversight — can address current shortcomings and align with international best practices (Table 1). With phased implementation, stakeholder engagement, and ongoing evaluation, Iran has the opportunity to modernize its addiction treatment infrastructure, safeguard public health, and better support recovery for people with substance use disorders.

## Footnotes

**AI Use Disclosure:** The authors declare that no generative AI tools were used in the creation of this article.

**Authors' Contribution:** M. Kh. is the only author of the article and the study was solely carried out by the author.

**Conflict of Interests Statement:** The author declares no conflict of interest.

**Funding/Support:** The author declares no funding/support.

## References

1. Ekhtiari H, Noroozi A, Farhoudian A, Radfar SR, Hajebi A, Sefatian S, et al. The evolution of addiction treatment and harm reduction programs in Iran: a chaotic response or a synergistic diversity? *Addiction*. 2020;**115**(7):1395-403. [PubMed ID: 31737965]. https://doi.org/10.1111/add.14905.
2. Radfar N, Radfar SR, Mohammadi F, Azimi A, Amirkafi A, Tehrani-Banihashemi A. Retention rate in methadone maintenance treatment and factors associated among referred patients from the compulsory residential centers compared to voluntary patients. *Front Psychiatry*. 2023;**14**:1139307. [PubMed ID: 37304442]. [PubMed Central ID: PMC10248436]. https://doi.org/10.3389/fpsyt.2023.1139307.
3. Lande A. The Single Convention on Narcotic Drugs, 1961. *Int Organ*. 2009;**16**(4):776-97. https://doi.org/10.1017/s0020818300011620.
4. Khazaee-Pool M, Moeeni M, Ponnet K, Fallahi A, Jahangiri L, Pashaei T. Perceived barriers to methadone maintenance treatment among Iranian opioid users. *Int J Equity Health*. 2018;**17**(1):75. [PubMed ID: 29890990]. [PubMed Central ID: PMC5996552]. https://doi.org/10.1186/s12939-018-0787-z.
5. Ahmed R, Tanzimur Rahman T. Enhancing Medication Safety: The Role of Community and Hospital Pharmacists in Modern Healthcare Systems. *Radinka J Health Sci*. 2025;**2**(3):328-55. https://doi.org/10.56778/rjhs.v2i3.418.
6. Afshari R. Non-medical use of medications in middle and low income countries. *Asia Pacific J Med Toxicol*. 2014;**3**(2):49.
7. Vasilev G, Milcheva S, Vassileva J. Opioid Use in the Twenty First Century: Similarities and Differences Across National Borders. *Curr Treat Options Psychiatry*. 2016;**3**(3):293-305. [PubMed ID: 27493878]. [PubMed Central ID: PMC4968876]. https://doi.org/10.1007/s40501-016-0089-2.
8. Bohle K, Otterholt E, Bjorkly SK. A Prospective Biopsychosocial Repeated Measures Study of Stress and Dropout from Substance Addiction Treatment. *Subst Abuse Rehabil*. 2023;**14**:61-75. [PubMed ID: 37465017]. [PubMed Central ID: PMC10351681]. https://doi.org/10.2147/SAR.S376389.
9. Thornewill J, Antimisiaris D, Ezekekwu E, Esterhay R. Transformational strategies for optimizing use of medications and related therapies through us pharmacists and pharmacies: Findings from a national study. *J Am Pharm Assoc*. 2022;**62**(2):450-60. [PubMed ID: 34758925]. [PubMed Central ID: PMC8572696]. https://doi.org/10.1016/j.japh.2021.10.018.
10. Conway A, Marshall AD, Crawford S, Hayllar J, Grebely J, Treloar C. Deimplementation in the provision of opioid agonist treatment to achieve equity of care for people engaged in treatment: a qualitative study. *Implement Sci*. 2023;**18**(1):22. [PubMed ID: 37296448]. [PubMed Central ID: PMC10250852]. https://doi.org/10.1186/s13012-023-01281-4.

**Table 1.** Comparison of Current and Proposed Methadone Distribution Models in Iran

| Component | Current Iranian Model | International Best Practice/Proposed Model | Key Actions for Transition |
|---|---|---|---|
| **Methadone prescribing and dispensing** | Both prescribing and dispensing by physicians in MMT centers (combined role) | Prescribing by physicians; dispensing by regulated community pharmacies (separated roles) | Establish legal/regulatory framework separating roles; accredit pharmacies; Pilot programs |
| **Psychosocial services** | Limited; Focus on medication only | Multidisciplinary team approach (psychologists, social workers, peer support, vocational/family support) | Mandate integration of psychosocial interventions; Allocate resources; Outcome measurement |
| **Regulatory oversight** | Limited oversight; Risk of diversion | Strict protocols for pharmacies, ongoing monitoring | Develop inspection, reporting, and monitoring systems; Digital health platforms |
| **Provider training** | Minimal pharmacist involvement; Limited addiction training | Pharmacists trained in addiction medicine, counseling, harm reduction | Develop and mandate training/certification programs for pharmacists and all staff |
| **Stakeholder engagement** | Minimal involvement of patients, families, and pharmacists | Continuous engagement (patients, families, physicians, pharmacists) | Involve stakeholders in design/implementation; Conduct surveys; Qualitative research |
| **Implementation approach** | Centralized, static system | Phased, incremental reform: Pilot programs, scaling up, ongoing evaluation | Start pilots in urban centers; Monitor diversion and outcomes; Adapt as needed |
| **Resource allocation** | Primarily medication-focused | Balanced: Medication+psychosocial services Balanced: Medication+psychosocial services Balanced: Medication+psychosocial services | Redirect funding to comprehensive care; Invest in infrastructure and human resources |
| **Patient experience** | Limited autonomy, confidentiality, and respect | Improved transparency; Patient autonomy; Confidential, respectful environments | Set patient-centered guidelines; Regular feedback and satisfaction measurement |