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▶ Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence.

World Health Organization.
World Health Organization, 2009.

Unequivocal backing from UN agencies for methadone and other forms of long term maintenance treatments as the prime modality for the treatment of dependence on heroin and allied drugs. In contrast say the experts, detoxification results in poor long term outcomes.

Summary These guidelines were developed in response to a resolution from the United Nations Economic and Social Council (ECOSOC), which invited the World Health Organization (WHO) in collaboration with the United Nations Office on Drugs and Crime (UNODC) "to develop and publish minimum requirements and international guidelines on psychosocially assisted pharmacological treatment of persons dependent on opioids". The recommendations were based on systematic reviews of the literature and consultation with experts from different regions of the world.

Treatment of opioid dependence is a set of pharmacological and psychosocial interventions aimed at reducing or ceasing opioid use, preventing related harms, and improving the quality of life and well-being of the patient. In most cases, treatment will be required in the long term or even throughout life. The aim in such instances is not only to reduce or stop opioid use, but also to improve health and social functioning, and to help patients avoid some of the more serious consequences of drug use. Such long-term treatment should not be seen as a failure, but rather as a cost-effective way of prolonging and improving the quality of life, supporting the natural and long-term process of change and recovery.

Psychosocially assisted pharmacological treatment refers to the combination of specific pharmacological and psychosocial measures used to reduce illicit opioid use and related harms and improve quality of life.

Opioid agonist maintenance treatment

Opioid agonist maintenance treatment is the administration of thoroughly evaluated opioid agonists (ie, drugs with opiate-type effects) to opioid dependent patients by accredited professionals in the framework of recognised medical practice to achieve defined treatment aims. Of the treatment options examined in these guidelines, such treatment, combined with psychosocial assistance, was found to be the most effective. Clinicians should offer other modalities including opioid withdrawal and opioid antagonist (naltrexone) treatment, but most patients should be advised to use opioid agonist maintenance treatment.

Oral methadone liquid and sublingual buprenorphine tablets are the medications most widely used for opioid agonist maintenance treatment. Both are sufficiently long acting to be taken once daily. They have a strong evidence base and have been placed on the WHO model list of essential medicines. Prescribed in the context of high quality, supervised and well-organised treatment services, they do not produce the cycles of intoxication and withdrawal seen with shorter acting opioids such as heroin and greatly reduce heroin and other illicit opioid use, crime, and risk of death through overdose. Both can also be used in reducing doses to assist in withdrawal or 'detoxification' from opioids.

More specifically, the evidence is that compared to detoxification or no treatment, methadone maintenance (using mostly supervised administration of liquid methadone) significantly reduces opioid and other drug use, criminal activity, HIV risk behaviours and transmission, opioid overdose and all-cause mortality; it also helps retain people in treatment. Compared to detoxification or no treatment, buprenorphine also significantly reduces drug use and extends treatment retention.

Comparing the two medications, both generally provide good outcomes. Methadone is preferred because it is more effective and costs less, but buprenorphine has a slightly different pharmacological action. Making both available may attract greater numbers of people to treatment and improve the matching of patients to appropriate treatments.

In new patients, methadone doses should gradually be increased to the point where illicit opioid use ceases; this is likely to be in the range of 60–120 mg per day. Methadone consumption should initially be supervised as suited to the individual patient, balancing the benefits of reduced attendance requirements in stable patients with the risks of injection and diversion of methadone to the illicit drug market. Psychosocial assistance should be offered to all patients.

Buprenorphine doses should be rapidly increased (ie, over days) to a dose that produces stable effects for 24 hours, generally 8–24 mg per day. If opioid use continues, usually the dose should be increased. Dosing supervision and other aspects of treatment should be determined on an individual basis, using the same criteria as for methadone maintenance treatment.

Treatment for withdrawal and prevention of relapse

An alternative to maintenance is to help patients completely withdraw from opioids, a process also referred to as opioid detoxification. Methadone and buprenorphine can be used in reducing doses; alpha-2 adrenergic agonists such as clonidine can also be used to ameliorate withdrawal symptoms. Following detoxification, the long-acting opioid antagonist naltrexone can be used to help prevent relapse. Naltrexone produces no opioid effects itself, and blocks the effects of opioids for 24–48 hours.

Compared to maintenance treatment, opioid withdrawal results in poor outcomes in the long term; however, patients should be helped to withdraw from opioids if it is their informed choice to do so. Methadone and buprenorphine are the preferred treatments because they are effective and can be used in a supervised fashion in both inpatient and outpatient settings. Inpatient treatment is more effective, but also more expensive, and is recommended only for a minority of patients, such as those with polysubstance dependence or medical or psychiatric comorbidity.

Accelerated withdrawal using opioid antagonists with heavy sedation or anaesthesia offer little benefit over buprenorphine-assisted withdrawal or opioid antagonists with minimal sedation, yet result in significantly higher complication rates. These procedures should not be used. Opioid antagonists with *minimal* sedation do offer some benefits including shortening withdrawal and increasing the chances that it will be completed, but also some risks such as a more severe peak intensity of withdrawal symptoms. These procedures should not be a routinely used detoxification method. If they are used, careful and continuous monitoring is necessary for at least eight hours following administration of opioid antagonists, due to the possibility of delirium, vomiting and diarrhoea, and systems should be available for identifying and managing people who become dehydrated or delirious.

Naltrexone can be useful in preventing relapse in those who have withdrawn from opioids, particularly in those motivated to abstain from opioid use. Following opioid withdrawal, such patients should be advised to consider naltrexone to prevent relapse.

Psychosocial treatment

Psychosocial interventions – including cognitive and behavioural approaches and contingency management techniques – can add to the effectiveness of treatment if combined with agonist maintenance treatment or medications for assisting opioid withdrawal. Psychosocial services should be made available to all patients, although those who do not take up the offer should not be denied effective pharmacological treatments.

Treatment systems

In planning treatment systems, resources should be distributed in a way that delivers effective treatment to as many people as possible. Opioid agonist maintenance treatment appears to be the most cost-effective treatment, and should therefore form the backbone of the treatment system for opioid dependence. Countries with established opioid agonist maintenance programmes usually attract 40–50% of dependent opioid users into such programmes, with higher rates in some urban environments. Because of their cost, inpatient facilities should be reserved for those with specific needs, and most patients wanting to withdraw from opioids should be encouraged to attempt opioid withdrawal as outpatients.

Ethical principles of care

Ethical principles should be considered together with evidence from clinical trials; the human rights of opioid-dependent individuals should always be respected. Treatment decisions should be based on standard principles of medical-care ethics: providing equitable access to treatment and psychosocial support that best meets the needs of the

individual. Treatment should respect and validate the autonomy of the individual, with patients being fully informed about the risks and benefits of treatment choices. Furthermore, programmes should create supportive environments and relationships to facilitate treatment, provide coordinated treatment of comorbid mental and physical disorders, and address relevant psychosocial factors.

FINDINGS These guidelines (to which Findings contributed) constitute an important and authoritative statement from international experts issued with the backing of the relevant United Nations agencies. Their target is largely nations which are ambivalent about, unduly restrict, or oppose drug-based treatments of heroin addiction and other forms of opioid dependence, particularly treatments which involve the prescribing of opiate-type drugs like methadone. To these treatments − which should form the "backbone" of national treatment systems − the guidelines lend their unequivocal backing. They are also clear that long-term prescribing is no failure and that interventions aimed at healing psychological wounds and social reintegration should be provided when possible, though their rejection by the patient should not be grounds for denying them the benefits of the drug element of the treatment.

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