WHO Guidelines for psychosocially assisted pharmacological treatment of opioid dependence applying the GRADE methodology

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Intended readership of these guidelines

- These guidelines are intended to be read by those involved in providing psychosocially assisted pharmacological treatments at any level. The readership falls into three broad groups:
  - policy makers and administrators who make decisions on the availability of medicines and the structure and funding of services in countries or in subnational health administrative regions
  - managers and clinical leaders responsible for the organization of specific health-care services, and for the clinical care those services provide
  - health-care workers treating patients within the health-care system

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WHO guidelines for psychosocially assisted pharmacological treatment of opioid dependence

- The draft guidelines containe recommendations for three different levels:
  - System level, service level and individual level
- Quality of evidence and strength of recommendation were present only for individual level recommendations
- Overall, there were 15 clinical recommendations specifically related to treatment of opioid dependence

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- Should agonist maintenance therapy (i.e. methadone or buprenorphine maintenance) be used in preference to withdrawal and oral antagonist therapy (naltrexone) or withdrawal alone?"

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Opioid agonist maintenance treatment: QUESTIONS

- What are the indications for opioid agonist maintenance treatment?
- In patients to be treated with agonist maintenance treatment, should preference be given to methadone or buprenorphine?
- What initial dose of methadone should be used?
- What maintenance doses of methadone should be used?
- What maintenance doses of buprenorphine should be used?
- Should methadone and buprenorphine doses by fixed or individually tailored?
- Should agonist opioid maintenance treatment be supervised?
- What is the optimal duration of opioid agonist treatment?
- Should psychosocial interventions be used in addition to pharmacological maintenance treatments?

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Management of opioid dependence

The panel identified 20 different outcomes for this area, 8 of these were considered critical

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Outcome	
Retention in treatment	Critical
Side effects	Critical
Mortality	Critical
Level of social functioning	Critical
Quality of life	Critical
HIV seroconversion	Critical
Hepatitis seroconversion	Critical
patient satisfaction	Critical
use of primary substance	Important but not critical
patients who have relapsed at follow-up at 12 months	Important but not critical
patients who have relapsed at follow-up > 12 months	Important but not critical
frequency of high risk behaviours	Important but not critical
criminal and delinquent behaviour	Important but not critical
use of other drugs	Important but not critical
relapse rate in abstinence oriented treatment program	Not important
disability	Not important
psychiatric comorbidity	Not important
compliance with treatment	Not important
diversion of medication (not naltrexone)	Not important
cost of treatment	Not important

Management of opioid withdrawal: QUESTIONS

- What treatments should be used to assist withdrawal from opioids?
- Should antagonists with minimal sedation be used for opioid withdrawal?
- Should antagonists with heavy sedation or anaesthesia be used for opioid withdrawal?
- Should withdrawal from opioids be conducted in inpatient or outpatient settings?
- Is psychosocial assistance plus pharmacological assistance for opioid withdrawal more useful than pharmacological assistance alone?

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Management of opioid withdrawal

Outcome	
severity and duration of withdrawal symptoms	Critical
side effects	Critical
completion of treatment	Critical
mortality	Critical
patients who have relapsed at follow-up at 12 months	Critical
Cost of treatment	Critical
use of primary substance during treatment	Important but not critical
use of other drugs during treatment	Not important
patients who have relapsed at follow-up > 12 months	Not important

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System level recommendations

- **Recommendation (optimal)**
- A strategy document should be produced, outlining the government policy on the treatment of opioid dependence. The strategy should aim for adequate coverage, quality and safety of treatment.

- **Recommendation (minimal)**
- Psychosocially assisted pharmacological treatment should not be compulsory.

- **Recommendation (minimal)**
- Treatment should be accessible to disadvantaged populations.

- **Recommendation (minimal)**
- At the time of commencement of treatment services, there should be a realistic prospect of the service being financially viable.

- **Recommendation (optimal)**
- Pharmacological treatment of opioid dependence should be accessible to all those in need, including those in prison and other closed settings.

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Service level recommendations

- **Recommendation (minimal)**
- Treatment services should have a system of clinical governance, with a chain of clinical accountability within the health-care system, to ensure that the minimal standards for provision of opioid dependence treatment are being met.

- **Recommendation (optimal)**
- Treatment of opioid dependence should be provided within the health-care system.

- **Recommendation (minimal)**
- Patients must give informed consent for treatment.

- **Recommendation (minimal)**
- Treatment of opioid dependence should be carried out by trained health-care personnel. The level of training for specific tasks should be determined by the level of responsibility and national regulations.

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Table 2. Recommendations by strength and quality of evidence

	Strength of recommendation		total
Quality of evidence	strong	standard	
High/moderate	3	1	4
Low/very low	3	3	6
No evidence	3	2	5
Total	9	6	15

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Recommendation

- For the pharmacological treatment of opioid dependence, clinicians should offer opioid withdrawal, opioid agonist maintenance and opioid antagonist treatment, but most patients should be advised to use opioid agonist maintenance treatment.
- Strength of recommendation – Strong
- Quality of evidence – Low–moderate

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Recommendation

- For opioid agonist maintenance treatment, most patients should be advised to use methadone in adequate doses in preference to buprenorphine
- Strength of recommendation – Strong
- Quality of evidence – High

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Recommendation

- Clinicians should not use the combination of opioid antagonists with heavy sedation in the management of opioid withdrawal.
- Strength of recommendation – Strong
- Quality of evidence – Low

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