

Opioid agonist maintenance treatment as an essential health service:

implementation guidance on mitigating disruption of services for treatment of opioid dependence



**World Health
Organization**

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Suggested citation. Opioid agonist maintenance treatment as an essential health service: implementation guidance on mitigating disruption of services for treatment of opioid dependence. Geneva: World Health Organization; 2025. <https://doi.org/10.2471/B09543>. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at <https://iris.who.int/>.

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Acknowledgements

This document is the result of collaboration between the World Health Organization (WHO) Department of Global HIV, Hepatitis and Sexually Transmitted Infections Programmes and Department of Mental Health, Brain Health and Substance Use. The work was coordinated by (in alphabetical order) Anja Busse, Dzmitry Krupchanka, Niklas Luhmann and Annette Verster, with supervision by Dévora Kestel (Department of Mental Health, Brain Health and Substance Use) and Meg Doherty (Department of Global HIV, Hepatitis and Sexually Transmitted Infections Programmes), under the overall leadership of Jérôme Salomon (Assistant Director-General, Universal Health Coverage/Communicable Diseases, Noncommunicable Diseases and Mental Health). Ernst Wisse (consultant, WHO) was the main technical writer, supported by the above WHO technical staff and with contributions from Agnes Chetty (WHO Regional Office for Africa), Antons Mozalevskis (Department of Global HIV, Hepatitis and Sexually Transmitted Infections Programmes) and Dilkushi Poovendran (Access to Medicines and Health Products, Department of Health Product Policy and Standards).

WHO extends its gratitude to the United Nations Office on Drugs and Crime (UNODC) and to the external experts and organizations that participated in public consultations for finalization of the document. WHO acknowledges the external contributors for additional input who supported the development of this document: Monica Ciupagea (UNODC), Andrew Scheibe (TB HIV Care, South Africa), Marie-Ève Goyer (University of Montréal, Canada) and Alireza Noroosi (WHO Country Office in Afghanistan). WHO also acknowledges the contributors to the external peer review process: Muhammed Shahid Jamil (WHO Eastern Mediterranean Region), Stela Bivol (WHO European Region), Raúl Martín del Campo Sánchez (WHO Americas Region), Idrissa Ba (CEPIAD, Senegal), Marcelo Naveira (WHO European Region), Dasha Ocheret (The Joint United Nations Programme on HIV/AIDS (UNAIDS)).



Key messages

1. WHO recommends opioid agonist maintenance treatment (OAMT) as the intervention to be offered to most patients with opioid dependence, in view of its proven safety and effectiveness in addressing broad range of health and social issues.
2. OAMT must be maintained without interruption, even during periods of instability. It is an essential health service that should be prioritized in the same way as other life-saving health services to protect those who rely on it.
3. OAMT should be an integral, embedded part of national health systems, ideally included within national strategies and not reliant on fluctuating funding or considered as an optional intervention.
4. When unplanned interruptions of OAMT are expected, contingency measures must be implemented early to minimize harm. These include community consultations on mitigation measures, scaling up community management of opioid overdose with naloxone, reinforcing take-home opioid agonist schemes in case of workforce shortages, increasing psychosocial support and ensuring multi-stakeholder coordination.
5. Unplanned reductions in OAMT dosage can be life-threatening. If opioid withdrawal is unavoidable, people must receive adequate medical support in following established protocols for pharmacologically assisted withdrawal management.

Introduction

In times of instability, disease outbreaks, financial crises and other emergencies, health systems can be under significant pressure. Sometimes, the widespread effects of such challenges include impairment or interruption of the delivery of critical clinical and public health services, often compounded by increased health needs during emergencies (1).

In these contexts, health systems may have to prioritize the services to be maintained, often perpetuating barriers to care for already marginalized communities, such as people who use drugs and those with drug use disorders. This underlines the urgency of consolidating and increasing system resilience and safeguarding equitable access to life-saving interventions such as opioid agonist maintenance treatment (OAMT), including by proactive planning for mitigation and by embedding such services more firmly in the core functions of national health systems (2).

This guidance is based on existing WHO recommendations for opioid dependence treatment and lessons learnt from past disruptions and reduced service availability, such as during the COVID-19 pandemic (see details on the process of development in [Annex I](#)).



Doctor examining a patient receiving treatment with methadone at the outpatient clinic.

© WHO / Ahmad Yusni



Global opioid use

In 2022, an estimated 60 million people worldwide engaged in non-medical opioid use, including substances such as heroin, morphine, codeine, fentanyl, methadone and tramadol (3). According to the latest WHO estimates, opioids are responsible for a significant proportion of drug-related mortality, accounting for approximately 450 000 of the 600 000 deaths attributed to drug use globally (4). Infectious diseases, including HIV and viral hepatitis, and opioid overdose are among the leading causes of death associated with opioid use (5, 6).

It is crucial that people with opioid dependence and those at risk of opioid overdose have access to treatment and care that is of good quality, affordable, ethical and evidence based. While some 64 million people globally are estimated to live with drug use disorders, access to treatment remains very limited, with fewer than 10% having access.


Opioid agonist maintenance treatment

WHO recommends a range of treatment options for opioid dependence. These include OAMT with medicines such as methadone and buprenorphine, pharmacological treatment with opioid antagonists such as naltrexone (after completion of opioid withdrawal) and non-pharmacological approaches such as psychosocial support (7). The short-acting opioid antagonist naloxone should also be available for emergency management of opioid overdose (8).

WHO recommends that OAMT be used for most patients with opioid dependence, as it is the intervention for which there is the strongest evidence of effectiveness for a broad range of health and social outcomes (7, 9). OAMT comprises the use of long-acting opioid agonists such as methadone and buprenorphine to reduce craving and prevent withdrawal symptoms, thereby reducing the need for non-medical opioid use. A range of other services are often provided in addition to OAMT, depending upon the setting, and may include other medical care, overdose prevention, mental health services, social support, vocational trainings and other assistance. This approach not only reduces non-medical opioid use, mortality and morbidity – including risks associated with opioid overdose, HIV and viral hepatitis – but also contributes to lowering the rates of crime and incarceration, improving adherence to treatment and enhancing the quality of life and overall well-being (10, 11).

Buprenorphine and methadone are lifesaving medications and evidence-based treatment for people with opioid dependence. They are on the WHO Model Lists of Essential Medicines (12). OAMT and emergency management of opioid overdose with naloxone are considered essential health services that must be maintained even in extraordinary situations and even with increased pressure on health systems, such as during the coronavirus disease 2019 COVID-19 pandemic (2). Furthermore, OAMT is listed in the WHO Universal Health Coverage (UHC) Compendium (13), a repository of interventions for UHC, indicating its critical role in public health. It is also included in WHO guidelines for mental, neurological and substance use disorders in non-specialized health settings, stressing the importance and feasibility of using OAMT in non-specialized settings, also as a treatment for dependence on prescription opioids (14).

OAMT should be widely accessible, provided free of charge or covered by public health-care insurance, with an appropriate system of governance. A national strategy on the treatment of opioid dependence should include a clear outline of government policy to ensure adequate coverage, quality and safety of treatment. Health systems should have stable procurement and supply chain mechanisms, ideally with multiple products and suppliers to avoid disruptions linked to single-source dependency. Treatment should be made widely accessible to all who need it (15), with specific attention to populations who require tailored approaches, such as women and people in prisons and other closed settings.



Opioid agonist maintenance therapy (OAMT) is a cost-effective intervention that reduces mortality, morbidity, opioid use, and HIV and hepatitis C virus (HCV) transmission. It lowers risky behaviours, crime, and social costs, while improving treatment retention and overall wellbeing. Its economic value grows further when broader health and social outcomes are factored in, especially with optimized service costs. OAMT also fosters access to other treatments, harm reduction, and support services.

More details can be found in relevant WHO guidelines (*WHO Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence* and *WHO Guidelines on Community Management of Opioid Overdose*) and UNODC/WHO operational tool on Establishing and delivering evidence-based, high-quality opioid agonist therapy services.

Ideally, opioid dependence treatment should be fully integrated into health-care systems, within a framework of clinical governance and clear lines of clinical accountability to ensure that minimum standards are consistently met. Context-specific measures, such as including OAMT medicines on national lists of essential medicines and in clinical guidelines and national strategies and plans, can be important in embedding opioid dependence treatment within national health systems, ensuring stable financial coverage and strengthening long-term access and continuity of care. The sustainability of OAMT in public health structures is critical to protecting lives and preventing death from overdose.

Long-term perspective for opioid dependence treatment

Reducing non-medical opioid use by providing medically supervised, regulated OAMT is a stable, safe option for individuals with opioid dependence, in a long-term perspective tailored to individual needs. WHO guidelines state that: “Treatment plans should take a long-term perspective” and “[...]opioid agonist treatment should be seen as open ended and should be continued as long as clinically indicated.” (7).

To maximize the safety and effectiveness of OAMT, policies and regulations should encourage flexible dosing structures, with low starting doses and high maintenance doses, and without placing restrictions on dose levels and the duration of treatment (7). Dosages can be adjusted throughout treatment; some people opt for a gradual reduction towards complete cessation of opioid use. This is not, however, a requirement, as the primary strength of OAMT lies in its long-term therapeutic approach. Any dose reduction should be person-initiated, well informed and guided by clinical best practices to ensure safe, sustained treatment benefits.



Person from HIV and HCV prevention and treatment programme in Thailand.

Uninterrupted OAMT is critical

Given the biopsychosocial nature of opioid dependence, that often take the course of a chronic health condition, in most cases, OAMT will be required in the long term or even throughout life. Involuntary or unplanned interruption of OAMT may have life-threatening consequences and must be avoided. Without pharmacotherapy, many patients are highly likely to reinstate non-medical substance use and thus be exposed to a high risk of morbidities and premature mortality (16).

Interruptions in OAMT can lead to withdrawal symptoms, often driving individuals to seek alternative opioids or other substances, increasing their risk of escalating non-medical drug use and, often, polysubstance use. Such disruptions can lead to lower adherence to HIV, viral hepatitis, or tuberculosis treatment, increased risk of HIV and viral hepatitis transmission, undermine trust with healthcare service providers, and have negative impact on employment, education, family dynamics and other social aspects of wellbeing. An abrupt return to non-medical opioid use carries an especially heightened risk of overdose. These situations are life-threatening, and their consequences must not be underestimated.

OAMT services must be resilient to ensure continuity of care and to prevent life-threatening disruptions. This requires effective stock management by OAMT programmes, mitigating the risk of supply shortages and ensuring uninterrupted treatment access. It is equally essential to ensure the stability of services, such as an adequately prepared and well-trained workforce, well-functioning health facilities, outreach programmes and psychosocial support, with stable service procurement and referral pathways.

Buprenorphine and methadone can be used for both maintenance treatment and assisted withdrawal. Withdrawal management is, however, a distinct strategy and should not be confused with maintenance treatment. Most importantly, it should not be a stand-alone intervention. The WHO guidelines state, “Opioid withdrawal services should be structured such that withdrawal is not a stand-alone service but is integrated with ongoing treatment options”.



A health care provider in a mobile unit providing a patient with a methadone dose.



Mitigation measures in case of unplanned interruptions

All necessary measures must be in place to ensure uninterrupted provision of OAMT during times of instability and service disruptions. Provision of essential medicines should not be disrupted during emergencies. Flexibilities in the import and export of controlled medicines should be used during these times (17).

When unplanned interruptions in OAMT are expected, contingency measures should be implemented as early as possible to minimize potential negative consequences. Preparedness is crucial. There is no established evidence base to guide safe, effective management of sudden, unplanned interruptions in OAMT.

Ensuring the continuity and integration of OAMT in times of crisis

OAMT is not an optional service that can be suspended during times of crisis. It must be recognized as a core, non-negotiable component of the health system. Enjoyment of the highest attainable standard of health is a fundamental human right of every individual, without distinction of race, religion, political beliefs, economic or social condition. It is applicable to all people, including those who use drugs and live with opioid dependence, both in community- and in prisons or other closed settings. OAMT should therefore be of the same priority as other life-saving, essential health services to protect the health and lives of those who depend on it.

Health systems are inherently dynamic, comprising multiple interdependent components. Disruptions due to funding cuts, policy shifts, emergency situations or logistical failures can have cascading effects throughout the system, often disproportionately affecting vulnerable populations. The multifaceted nature of health systems can, however, also ensure resilience, whereby alternative structures and resources can be repurposed to maintain service continuity.

In times of crisis, strategic shifts are required to ensure that increasingly limited resources provide maximum benefit for a population (2). For instance, while charities and nongovernmental organizations often play a leading role in OAMT provision in some contexts, their services can be vulnerable to unexpected funding cuts. Redistribution of resources and task-sharing among stakeholders can mitigate service gaps.

If OAMT programmes must close due to shortages of resources and workforce, other providers, including local public health facilities, primary healthcare doctors, pharmacies or private health facilities, should be considered for delivery of OAMT services to ensure the safety, accessibility and affordability of services for long-term treatment without discrimination. Public health services can support OAMT provision if the services of non-governmental organizations are disrupted and vice versa. Redirection of budget allocations could be used to secure essential methadone or buprenorphine supplies, preventing stock shortages. Crisis-initiated budget reallocations can catalyse endorsement of OAMT in national budget allocations, minimizing the reliance of essential health services on fluctuating external funding sources.

The COVID-19 pandemic demonstrated the tremendous resilience of OAMT providers and the role of task-shifting and increased take-home dosage schemes, in sustaining services despite strained health systems. Peer workers facilitated OAMT distribution, and extension of the roles of nurses helped to maintain treatment continuity. These lessons highlight the importance of flexible, adaptive strategies to safeguard OAMT access in times of crisis and beyond (18).

Community-led resilience and multi-stakeholder coordination in OAMT disruptions

The community of people who use drugs has shown remarkable resilience, particularly in times of severe disruptions, such as during armed conflicts and the COVID-19 pandemic. In anticipating potential supply ruptures or shifts in OAMT distribution, it is essential to involve and consult affected individuals in finding mitigation measures. The provision of clear, timely information when OAMT are under pressure is crucial, as unnecessary distress can cause harm and further destabilize patients.

To support individuals during uncertain periods, peer workers could be deployed at OAMT sites to address patient concerns, fears and frustrations. Strengthening communication channels with community workers, peers and volunteers will help to ensure rapid response mechanisms, so that people can seek support or intervention when needed, especially when they are at risk of overdose.

Training could be organized to equip people with skills for managing withdrawal and people should receive harm reduction counselling on avoiding high-risk injection behaviour, such as using alone and titrating dosages to mitigate the risk of overdose and other health complications.

Beyond the community itself, if OAMT interruptions are expected, a coordinated, multi-stakeholder approach is essential. Law enforcement, health facilities, and other key actors must be informed and engaged to prepare for and respond effectively to a crisis in which large groups may experience withdrawal symptoms. Cross-sectoral coordination will help mitigate risks and maintain stability during service disruptions.



Staff from the Bangkhen community health centre go out into the community to demonstrate how they do home visits. © WHO / Conor Ashleigh

Consideration of take-home doses

If funding cuts primarily affect the workforce but treatment availability remains stable, less labour-intensive distribution schemes can provide relief. Well-structured take-home doses for stable patients are recommended by WHO in any setting (7). “Take-home doses can be recommended when the dose and social situation are stable and when there is a low risk of diversion for illegitimate purposes.”

Distribution of take-home doses can be a rapid response measure when distribution systems are under pressure. Take-home doses can be distributed safely with appropriate safeguards, significantly reducing the strain on distribution sites and staff requirements. The number of people receiving take-home doses can be expanded and existing take-home schemes can be extended when the dose and social situation are stable and when there is a low risk of diversion for non-medical purposes. This approach was successfully used in several countries during emergency situations, including the COVID-19 pandemic, to mitigate limited access to services due to restriction of social contacts.



Two health care workers talking in the drug addiction treatment center in Kandahar, Afghanistan. © WHO / Zakarya Safari

Overdose management

The risks of overdose should not be underestimated, as most patients will likely resume non-medical opioid use when their treatment is interrupted and will be exposed to higher risks of opioid overdose, with possible lethal consequences.

Extending access to naloxone and training in its use are the most effective interventions for acute management of opioid overdose. WHO recommends community-based naloxone distribution and training for peers, family members and community workers to ensure timely interventions (8):

People likely to witness an opioid overdose should have access to naloxone and be instructed in its administration to enable them to use it for the emergency management of suspected opioid overdose.

Naloxone is effective when delivered by intravenous, intramuscular, subcutaneous and intranasal routes of administration.

The people who use it should select a route of administration according to the formulations available, their skills in administration, the setting and the local context. Injectable naloxone is often significantly cheaper than other formulations, such as intranasal, and is frequently the only option. Its use may, however, require training and alignment with the national legal framework to permit administration by non-medical personnel in life-threatening situations. Several legislative approaches have been used to address these situations, including application of “Good Samaritan” laws, which recognize that the risk of withholding naloxone outweighs potential concern about allowing lay people to administer injections in emergency situations. In light of the urgent and life-saving nature of overdose response—particularly in times of crisis—there may be both legal and policy barriers to the access and use of naloxone by lay first responders, which may need to be reviewed in order to implement this recommendation.


A sudden surge in purchases of illicit substances could change the dynamics of the drug supply, potentially leading to greater variation in the potency and purity of drugs and possibly resulting in a ripple effect of heightened risks beyond OAMT patients. Ensuring the widespread availability of naloxone and overdose response capacity as well as access to health and social services are critical to mitigating these risks.

Assisted withdrawal management

Most people should be advised to continue OAMT, as it has significantly higher success rates in reducing harm, preventing re-initiation of non-medical opioid use and improving long-term health and social outcomes than opioid withdrawal.

Forced and abrupt opioid withdrawal can trigger severe physical and psychological symptoms—such as agitation, anxiety, insomnia, intense abdominal cramps, muscle and joint pain, nausea and diarrhoea—and significantly increases the risk of mental health complications, including self-harm, suicide, and violence. It may also result in serious medical consequences for pregnant women and their foetuses, as well as for individuals with coexisting medical conditions.

In practice, most patients resume opioid use within 6 months of commencing withdrawal. Given the high rate of relapse, assisted opioid withdrawal is not considered to be effective treatment of opioid dependence on its own. If opioid withdrawal is unavoidable, however, people must receive adequate pharmacological services and psychosocial support and follow well-established protocols for pharmacological management of opioid withdrawal.



The severity of withdrawal symptoms depends on the dose and pharmacological properties of the opioids used and on the extent of neuroadaptive changes in the person. Psychoactive substances with short half-lives will give rise to withdrawal symptoms at an earlier phase than those with long half-lives; the symptoms will also peak and resolve earlier.

Opioid withdrawal can be managed by controlling the rate of cessation of opioids and by providing medication to relieve symptoms or by a combination of the two: (a) gradual cessation (tapering) of an opioid agonist (i.e. methadone); (b) short-term use of a partial agonist (i.e. buprenorphine); and (c) use of alpha-2 adrenergic agonists in cases of sudden opioid cessation to relieve withdrawal symptoms (clonidine, lofexidine).

In assisted withdrawal, some of the following factors should be considered.

- Prioritize high-risk clients to be maintained on OAMT as long as possible. These include pregnant women, seriously immunocompromised patients, those who started antiretroviral therapy or treatment for hepatitis C or tuberculosis in the previous month, people with diabetes and those with certain mental health conditions, etc.
- For people undergoing withdrawal from opioids, combined psychosocial and pharmacological assistance increases the chances of success. Therefore, psychosocial support should be offered routinely in combination with pharmacological treatment in management approaches. Sudden withdrawal may cause greater destabilization and increase the likelihood of risky behaviour.
- WHO does not recommend antagonist-induced withdrawal techniques (or accelerated or rapid withdrawal management) nor heavy sedation, as they increase the severity of opioid withdrawal initially and may increase the adverse effects of withdrawal. Furthermore, there is not enough evidence of benefit to recommend routine use of these techniques.
- To maximize the safety and effectiveness of agonist maintenance treatment programmes, policies and regulations should include flexible dosing structures. It is important to provide high maintenance doses based on individual assessments without placing restrictions on dose levels or duration of treatment, as higher doses are likely to result in better retention.
- In extreme cases of medication shortages, some programmes may choose to use a proportional tapering protocol, whereby each day's dose is calculated as a percentage of the previous day's dose. This approach enables a gradual, structured reduction, which is often better tolerated by individuals on higher doses and avoids abrupt changes for those on lower doses. Maintaining people on low but stable doses may offer limited withdrawal relief while helping to preserve therapeutic relationships. Proportional tapering allows faster reductions of higher doses, which helps to extend the medication stock while naturally slowing the pace of reduction as the dose decreases, thus minimizing the risk of destabilization. This approach requires careful clinical monitoring by experienced teams to ensure the safety of patients.
- In terms of the setting for withdrawal management, in-patients appear to have higher rates of completion of detoxification than outpatients, but there is no demonstrable difference in relapse rates. Inpatient withdrawal management can be used for people who previously failed to complete outpatient detoxification, had complications during opioid withdrawal and have insufficient social support or comorbid medical or psychiatric conditions.
- In cases of successful completion of withdrawal, it is essential to provide access to further support and, at a minimum, support strategies for prevention and management of opioid overdose.
- It is important to keep in contact with patients and to commence or reinstate pharmacotherapy of opioid dependence as soon as it is again available, in consultation with and according to the preferences of the person

The duration of dose tapering should be at least 3 days. Five days of buprenorphine and 10 days of methadone result in acceptable withdrawal symptoms during treatment and minimal rebound withdrawal symptoms on cessation of the opioid agonist. Lofexidine should be used in preference to clonidine, particularly in outpatient settings, because it has fewer adverse effects.

Relapse prevention with other forms of evidence-based pharmacotherapy

While OAMT should be used as first-line treatment for opioid dependence, opioid antagonist pharmacotherapy (with naltrexone) can be considered for some patients after completion of opioid withdrawal. The rate of adherence to treatment is generally lower than with OAMT; nevertheless, in those patients who have withdrawn from opioids and are motivated to cease opioid use completely, relapse prevention with naltrexone is likely to be superior to those with no pharmacotherapy.

Psychosocial support

WHO recommends (7) that best-practice OAMT include the following:

“A variety of structured psychosocial interventions should be available, according to the needs of the patients. Such interventions may include – but are not limited to – different forms of counselling and psychotherapy and assistance with social needs such as housing, employment, education, welfare and legal problems.”

Services should be available to meet the psychosocial needs of patients (19) during periods of extraordinary stress and detrimental impact due to interruption of OAMT.

In pharmacologically assisted withdrawal protocols, psychosocial assistance results in higher rates of completion of treatment (7), suggesting that it could be helpful in unintended interruption of OAMT.

Provision of structured psychosocial interventions, including counselling, peer support and crisis management, could help to mitigate the emotional and social consequences of treatment disruption. Ensuring access to such support services might improve patient resilience and engagement, even in challenging circumstances.



A staff member from HIV and STI prevention and treatment center in South Africa talking to a client.

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References

1. Planning for health system recovery: guidance for application in countries. Geneva: World Health Organization; 2024. <https://iris.who.int/handle/10665/378458>. License: CC BY-NC-SA 3.0 IGO.
2. Maintaining essential health services: operational guidance for the COVID-19 context: interim guidance, 1 June 2020. Geneva: World Health Organization; 2020. <https://iris.who.int/handle/10665/332240>. License: CC BY-NC-SA 3.0 IGO.
3. World Drug Report 2024. Vienna: United Nations Office on Drugs and Crime; 2024 (<https://www.unodc.org/unodc/en/data-and-analysis/world-drug-report-2024.html>).
4. Consultation on WHO Opioid Treatment Guidelines. Geneva: World Health Organization; 2024 (<https://www.who.int/news-room/events/detail/2024/12/11/default-calendar/consultation-on-who-opioid-treatment-guidelines>).
5. Opioid crisis: addiction, overprescription, and insufficient primary prevention. *Lancet Reg Health Am*. 2023;23:100557. <https://doi.org/10.1016/j.lana.2023.100557>.
6. Degenhardt L, Webb P, Colledge-Frisby S, Ireland J, Wheeler A, Ottaviano S et al. Epidemiology of injecting drug use, prevalence of injecting-related harm, and exposure to behavioural and environmental risks among people who inject drugs: a systematic review. *Lancet Glob Health*. 2023;11(5):e659–72. [https://doi.org/10.1016/S2214-109X\(23\)00057-8](https://doi.org/10.1016/S2214-109X(23)00057-8).
7. Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence. Geneva: World Health Organization; 2009. <https://iris.who.int/handle/10665/43948>.
8. Community management of opioid overdose. Geneva: World Health Organization; 2014. <https://iris.who.int/handle/10665/137462>.
9. WHO updates guidelines on opioid dependence treatment and overdose prevention. Geneva: World Health Organization; 2025 (<https://www.who.int/news/item/09-02-2025-who-updates-guidelines-on-opioid-dependence-treatment-and-overdose-prevention>).
10. Platt L, Minozzi S, Reed J, Vickerman P, Hagan H, French C et al. Needle syringe programmes and opioid substitution therapy for preventing hepatitis C transmission in people who inject drugs. *Cochrane Database Syst Rev*. 2017;9(9):CD012021. <https://doi.org/10.1002/14651858.CD012021.pub2>.
11. Palmateer N, Hamill V, Bergenstrom A, Bloomfield H, Gordon L, Stone J et al. Interventions to prevent HIV and hepatitis C among people who inject drugs: latest evidence of effectiveness from a systematic review (2011 to 2020). *Int J Drug Policy*. 2022;109:103872. <https://doi.org/10.1016/j.drugpo.2022.103872>.
12. The selection and use of essential medicines: report of the WHO Expert Committee on Selection and Use of Essential Medicines, 2023 (including the 23rd WHO model list of essential medicines and the 9th WHO model list of essential medicines for children). Geneva: World Health Organization; 2024. <https://iris.who.int/handle/10665/376570>. License: CC BY-NC-SA 3.0 IGO.
13. UHC Compendium. Health interventions for Universal Health Coverage. Version 1.3 (online). Geneva: World Health Organization (<https://www.who.int/universal-health-coverage/compendium>).
14. mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: mental health Gap Action Programme (mhGAP), version 2.0. Geneva: World Health Organization; 2016. <https://iris.who.int/handle/10665/250239>.
15. Establishing and delivering evidence-based, high-quality opioid agonist therapy services. Vienna: UNODC; 2022. https://www.unodc.org/documents/drug-prevention-and-treatment/22-10821_eBook_OAT_implementing_tool.pdf
16. Kornør H, Waal H. From opioid maintenance to abstinence: a literature review. *Drug Alcohol Rev*. 2005;24(3):267–74. <https://doi.org/10.1080/09595230500170241>.
17. INCB, UNODC and WHO Joint Statement on Access to Controlled Medicines in Emergencies. Geneva: World Health Organization; 2021 (<https://www.who.int/news/item/08-09-2021-incb-unodc-and-who-joint-statement-on-access-to-controlled-medicines-in-emergencies>).



18. Wisse E, Burke-Shyne N, Chang J, Southwell M. COVID-19 and people who use drugs; seizing opportunity in times of chaos. *Int J Drug Policy*. 2021;90:103097. <https://doi.org/10.1016/j.drugpo.2020.103097>.
19. Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations. Geneva: World Health Organization; 2022. (<https://www.who.int/publications/i/item/9789240052390>) Licence: CC BY-NC-SA 3.0 IGO



Annex. Development process of the implementation guidance

This implementation guidance was developed during the first half of 2025, in line with WHO procedures for the preparation and development of normative and operational documents. The process was jointly led by the WHO Departments of Global HIV, Hepatitis and Sexually Transmitted Infections Programmes and Mental Health, Brain Health and Substance Use.

Initially a desk review was conducted by WHO technical teams to identify relevant existing WHO guidance, including normative content and implementation considerations. This guidance draws on existing WHO publications related to the treatment of opioid dependence, overdose prevention and guidance on maintaining essential health services during crisis situations.

An initial outline and concept were presented to a group of external contributors for their feedback on general framing, length and priority messages. An initial advanced draft was then presented during an online public consultation, followed by a structured survey to collect feedback from a broad range of stakeholders.

The input from this public consultation was reviewed and incorporated into the draft which was shared again with the group of external contributors for additional input and review.

A near-final version was subsequently reviewed by peer reviewers with expertise in implementation and service delivery. This thorough process ensured that the final publication was comprehensive and embodies a broad spectrum of expert perspectives.

As with all WHO documents, all external peer reviewers and contributors participating in the development of this document submitted declarations of interest and confidentiality statements to the WHO technical team. The WHO technical team reviewed all declarations and found no conflicts of interest sufficient to preclude anyone from participating in the development of the document.

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