**Substitution Treatment for Opioid Dependence**

**Clinical Protocol**

Tallinn 2013

Foreword

“The Clinical Protocol of Substitution Treatment for Opioid Dependence” was compiled based on „Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence“ that were published by WHO in 2009. Additionally, this document is also based on a Lithuanian Clinical Protocol for psychiatrists titled „Pharmacotherapy for Opioid Dependence: treatment with methadone“, which was published in cooperation with the UNODC in 2009, and on „Opioid Treatment Program: Clinical Guidelines for methadone and buprenorphine treatment“, which was published in the State of New South Wales, Australia, in 2006.

“The Clinical Protocol of Substitution Treatment for Opioid Dependence” was developed in cooperation with the Estonian Psychiatric Association, Estonian Society for Infectious Diseases and the Estonian Respiratory Society. The following substitution treatment service providers were also involved in developing the protocol: Lääne-Tallinna Keskhaigla AS, Wismari Haigla AS, Tervisekeskus Elulootus OÜ, Tartu Ülikooli Kliinikum SA, Corrigo OÜ, Narva Sõltuvuste Ravikeskus OÜ and Aasa Kliinik OÜ.

“The Clinical Protocol of Substitution Treatment for Opioid Dependence” is meant primarily for treatment teams who provide substitution treatment to people with opioid dependence at health care institutions.

The most widely used drug in substitution treatment of opioid dependency in Estonia is methadone, which is why the main emphasis has been placed on methadone in these guidelines. However, as opioid dependence treatment also uses other opioid preparations in addition to methadone, some chapters of the protocol describe other commonly used medications, such as buprenorphine and naltrexone. This applies primarily to chapter 4, which describes setting the initial dose of the substitute medication, switching from medication to another, and completing treatment.

So far, the provision of opioid dependence treatment in Estonia has been conducted according to “Opioid Dependence Treatment Guidelines” compiled by the Estonian Psychiatric Association, and according to the “Service Description of Methadone Substitution Treatment” compiled by the National Institute for Health Development. This Clinical Protocol replaces the two aforementioned documents, as well as the Drug Dependence Treatment Guidelines published in 2001.

In Estonia, methadone was first used in opioid dependence withdrawal treatment at the AS Wismari Haigla (Wismari Hospital) in 1999. Methadone was used in withdrawal treatment until 2001, which was followed by provision of long-term methadone based substitution treatment. The expansion of methadone substitution treatment service was conducted in 2003, with financing from the Global Fund to Fight AIDS, Tuberculosis and Malaria. Methadone substitution treatment is currently provided by health care institutions that hold a psychiatric outpatient license in Tallinn, cities of the Ida-Viru County (Kohtla-Järve, Kiviõli, Jõhvi, Narva, Sillamäe) and Tartu. The service is financed by the National Institute for Health Development with the AIDS strategy means.

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# 1. Opioid dependence and treatment of opioid dependence

## 1.1. Definition of opioid dependence and ICD-10

1.1.1. Opioid dependence is characterized by a cluster of cognitive, behavioural and physiological features. Opioid dependence does not develop without a period of regular use, although regular use alone is not sufficient to induce dependence. Opioid dependence is diagnosed after determining the patient’s medical history, including determining the use of psychotropic substances and prior dependence treatment background, evaluation of living conditions, employment and legal situation.

1.1.2. According to the International Statistical Classification of Diseases and Related Health Problems (ICD-10), a person is diagnosed with opioid dependence syndrome if they have experienced at least three of the following criteria in the past twelve months:

─ a strong desire or sense of compulsion to take opioids;

─ difficulties in controlling opioid-use behaviours (in terms of the onset, termination or levels of use);

─ Physiological withdrawal symptoms, which are characteristic to withdrawal syndrome, occur when opioid use has ceased or been reduced (sneezing, yawning, lacrimation, dilated pupils, diarrhoea, various pains in the body, a compulsive need to use opioids, insomnia, depressed mood, anxiety, irritability);

─ evidence of higher tolerance, such that increased doses of opioids are required to achieve effects originally produced by lower doses (opioid tolerance can increase many times and exceed the dose that may cause respiratory failure and even death in a healthy person);

─ progressive neglect of alternative pleasures or interests because of opioid use;

─ increased amounts of time spent on obtaining opioids or recovering from their effects;

─ persisting with opioid use despite clear evidence of overtly harmful consequences, such as complications during injections.

1.1.3. Opioid dependence syndrome is a mental and behavioural disorder, which is caused by the use of opiates. A decisive factor in the etiology of the disease is the fact that constant use of opiates activates motivation systems in the midbrain, which under normal circumstances are activated by stimuli such as food, water, danger or a sexual partner. Altered brain activity will result in potentially significant changes in thinking and behaviour. In other words, opioid dependence is a chronic illness caused by changes in brain activity, which is also characteristic to other neurological and mental illnesses. The pathogenesis of the disease is affected by individual psychological, genetic, social and environmental factors, which play an important role in the initial stage of the pathogenesis.

1.1.4. A central characteristic of the dependence syndrome is the desire (often strong, sometimes overpowering) to take opioids, which is caused by malfunctioning dopamine metabolism, endorphins and other neurotransmitters.

1.1.5. Opioid dependence is characterised by relapses; therefore, relapse prevention and constant medical and psychosocial support are important part of opioid dependence treatment.

## 1.2. Treatment of opioid dependence

1.2.1. Treatment of opioid dependence is a set of pharmacological and psychosocial interventions aimed at eliminating or reducing illicit opioid use, reducing the harm and health risks associated with opioid use, improving quality of life and well-being of the opioid-dependent patient.

1.2.1.1 Opioid dependence treatment is carried out on a voluntary basis.

1.2.2. The treatment method for opioid dependence is selected by taking into account the thorough assessment of a patient’s general condition of health and needs, as well as the validity of treatment methods, which is based on evidence and whether a treatment is acceptable and accessible to the patient.

1.2.3. The following treatment, rehabilitation and support services are available for people with opioid dependence in Estonia:

- ambulatory substitution treatment with opioid agonists;

- short-term inpatient withdrawal treatment;

- long-term inpatient rehabilitation;

- outpatient consultation services;

- self-help and support groups.

1.2.4. Physicians are obliged to offer different treatment options to opioid-dependent people based on a patient’s assessment results; however, in the case of long-term dependence, it is advisable to use medications that are long-acting opioid agonists (methadone or buprenorphine).

1.2.5. Substitution treatment is the most common form of treatment used in opioid dependence treatment, which provides that an opioid-dependent person is transitioned from the use of illicit opioids to the use of a legal, long-acting substitute medication. There are two substitute medications, the effectiveness of which has been scientifically proven; these are methadone and buprenorphine. Two medications contain buprenorphine as an active ingredient: Subutex (buprenorphine) and Suboxone (buprenorphine+naloxone).

1.2.6. When compared to withdrawal treatment, placebo and purely psychosocial measures, methadone based substitution treatment decreases the use of opioids significantly and helps patients adhere to treatment.

1.2.7. When the administered doses of methadone and buprenorphine are correct, the number of patients who continue with methadone treatment is higher than the number of patients continuing their buprenorphine treatment. Both medications effectively suppress illicit opioid use.

1.2.8. Based on scientific data, which shows the efficacy of methadone and buprenorphine in substitution treatment for opioid dependence, both medications have been added to the 17th List of Essential Medicines of the World Health Organization.

1.2.9. Two general approaches can be distinguished in substitution treatment:

– Withdrawal treatment, which can be carried out in stages and which includes the daily tapering of substitute medication doses with the goal of opioid withdrawal.

– Maintenance treatment, the goal of which is to stabilize the patient, improve their health and psychosocial condition though long-term administration of a stable dose of substitute medication without a fixed treatment completion date.

1.2.9.1 It is advisable to conduct fast treatment with opioid medications only in inpatient care. In outpatient care, it is recommended to carry out slow rehabilitation treatment, which lasts at least 6 months and which is followed by long-term psychosocial support provided to the patient.

# 2. Pharmacological properties of substitute drugs

## 2.1. Opioids

2.1.1. Opioids (heroin, morphine, methadone, etc.) function through receptors (μ- OP3-, κ- OP2- and δ- OP1- and OP4-receptor) on a molecular (cellular) level of the nervous system. Opioids can be divided into full agonists (e.g. heroin, methadone), partial agonists (e.g. buprenorphine), agonist-antagonists (e.g. pentazocine) and antagonists (e.g. naloxone).

2.1.2. **Full agonists** are substances that have affinity towards receptors, bind to receptors and bring about changes in the cell, which in turn stimulate physical activity. The effect of an agonist is dependent on the dose, the substance's affinity to receptors and its internal activity on the receptor level, it also affected by pharmacokinetic factors (how much of the substance will reach the blood circulation and then to receptors). Morphine, methadone, heroin, cocaine, fentanyl, pethidine, hydrocodone and oxycodone are opioid agonists.

2.1.3. **Partial agonists** are medications that bind to receptors, but do not provide maximum stimulation. As it occupies the receptor, it prevents full agonist effect by the agonist that has lower affinity towards the receptor. Most likely, this effect will occur when the medication is administered to a patient who uses large quantities of a full agonist. Buprenorphine is a partial agonist. The effect of partial agonists has an upper limit, even in the case of continuously increasing doses.

2.1.4. **Mixed agonist-antagonist** provide an agonistic effect at one receptor and an antagonistic effect at another. Pentazocine, butorphanol and nalbuphine are agonist-antagonists.

2.1.5. **Antagonists** do not have a true pharmacological effect, but they can block the effect of an agonist. Naloxone and naltrexone are opioid receptor antagonists that reverse the effects of agonists, e.g. morphine and methadone. Opioid antagonists, which have high affinity towards opioid receptors, prevent receptors from being activated by agonists, thereby causing intense withdrawal symptoms. Opioid antagonists are often used as an antidote for opiate overdose.

2.1.6. Repeated use of opioids causes tolerance, which means that repeated use of a substance decreases its effect or that a larger dose is needed to achieve previous effect; it also causes physical dependence, which brings about unpleasant symptoms when opioids are no longer used. The development of tolerance and physical dependence is referred to as **neuroadaptation** to opioids.

2.1.7 The withdrawal symptoms of opioids include irritability, anxiety, restlessness, dysphoria, muscle and abdominal pain, chills, nausea, diarrhoea, yawning, lacrimation, piloerection (gooseflesh), sweating, snuff, sneezing, rhinorrhea (running nose), general weakness and insomnia. The onset of withdrawal symptoms usually occurs with 1–3 days after the last dose of methadone, 8–12 hours after the last dose of heroin and 0,5–10 hours after the last dose of fentanyl.

## 2.2 Methadone

2.2.1 Pharmacological properties of methadone:

- onset of effect in 30 minutes;

- peak effect in about 2–3 hours;

- half-life of 15–60 hours;

- plasma concentration increases during the first week of daily administration;

- stabilization of methadone level in the body is achieved in 5–10 days;

- withdrawal symptoms will appear in 36–48 hours and reach their peak 3–8 days after the last dose.

2.2.2 Pharmacodynamics and [[1]](#footnote-1)pharmacokinetics of methadone[[2]](#footnote-2)

2.2.2.1 Methadone is a synthetic opioid, the pharmacological effect of which is similar to that of morphine. Methadone is bioavailable by oral administration or injection. The main effect of methadone is expressed through μ-receptors and its effects are similar to those of endogenous opioids, e.g. enkephalins and endorphins. Methadone increases the release of some neurotransmitters: acetylcholine, norepinephrine and dopamine.

2.2.2.2 Methadone can increase the concentration of serotonin in the synapsis, which is why the use of other medications that increase serotonin levels in the synapsis (selective serotonin re-uptake inhibitors, new generation of anti-migraine medication) needs to be carefully adjusted.

2.2.2.3 When used orally, the bioavailability of methadone is high (85%) and varies among patients. Peak plasma concentration occurs about 1–7.5 hours after administration (after 3–4 hours on average). The impact of food on the bioavailability of methadone is not clearly known. Due to its pharmacological properties, methadone is a very beneficial substance in opioid substitution treatment.

2.2.2.4 Methadone is a fat-soluble (lipophilic) substance, and it accumulates in many tissues, including the lungs, kidneys, liver and spleen. The concentration of methadone in those tissues is significantly higher than in the blood. The movement of methadone between these tissues and the blood is relatively slow. Methadone is secreted in saliva, breast milk, and through placenta, thereby reaching the fetus.

2.2.2.5 Methadone is metabolized into inactive metabolites in the liver as a result of the N-demethylation process. Metabolism involves cytochrome P450 isoenzymes, mainly CYP3A4, CYP2B6, CYP2D6 and CYP2C19. CYP2C9 is not an equally active enzyme.

2.2.2.6 Methadone is eliminated from the body with urine and faeces. After repeated administration, the elimination half-life of methadone ranges from 8 to 59 hours (24 hours on average). Despite a low plasma concentration, the slow excretion of methadone from the liver and from other tissues may extend its effects.

2.2.3 The effects of methadone

2.2.3.1 The principal effect of methadone is pain relief, central nervous system and respiratory suppression, euphoria. Regular administration of methadone can lead to, as a result of neuroadaptation (tolerance towards opioids), to the disappearance or significant decrease of effects characteristic to opioids.

2.2.3.2 As methadone affects the peripheral nervous system, it lowers blood pressure, makes pupils smaller, slows down peristalsis and motility, and increases muscle tone in some gastrointestinal sphincters. Continuous administration of methadone can, as a result of neuroadaptation, lead to the disappearance or significant decrease of aforementioned effects.

2.2.3.3 Methadone can affect cognitive abilities and attention. Methadone treatment may cause constipation, sexual dysfunctions and (sometimes) excessive sweating. The appearance of side effects can decrease the patients’ compliance to treatment.

2.2.3.4 Methadone does not cause damage to any vital organs or organ systems. The main threat is the risk of overdosing, especially at the start of treatment and when methadone is combined with other sedative medications. Due to the slow onset of methadone’s effects and its long half-life, toxic effects can become life-threatening several hours after the administration of methadone. Clinical monitoring is vital during the first 14 days of treatment.

2.2.4 Drug interactions involving methadone

2.2.4.1 **Other sedative substances**: the combination of methadone and other sedative substances (opioids, alcohol, benzodiazepines, tricyclic antidepressants, most tranquilizers and sedating antihistamines) can be lethal.

2.2.4.2 **Opioid antagonists**: the effects of methadone can be inhibited or suppressed with opioid antagonists (naltrexone and naloxone).

2.2.4.3 **Buprenorphine**: people whose daily dose of methadone is 40 mg or higher, will likely experience withdrawal symptoms when administered buprenorphine. Patients who are taking methadone are not advised to transfer to buprenorphine before their daily dose of methadone has been reduced to 40 mg.

2.2.4.4 **Opioid agonists**: if other opioids are administered while taking methadone compounds, methadone can, due to its pharmacodynamic characteristics, lead to overdose and death.

2.2.4.5 **Inhibitors and inducers of liver enzymes:** Methadone is metabolized by cytochrome P450 3A4 enzyme. Medications that induce this system can speed up the metabolism of methadone and intensify withdrawal symptoms; cytochrome P450 inhibitors can slow down the metabolism of methadone and lead to an overdose. Specialist consultation and special precautions are vital, when it is planned to prescribe a medication that affects cytochrome P450 to a patient receiving methadone.

2.2.4.6 **Highly active antiretroviral therapy:** Medications used in HIV infection treatment affect the pharmacokinetics of methadone; therefore, it is vital to practice caution in the case of patients who receive highly active antiretroviral therapy.

## 2.3 Buprenorphine

2.3.1 Pharmacological properties of buprenorphine:

- onset of effect in 30–60 minutes;

- peak effect in about 1–4 hours;

- half-life 20–72 hours (36 hours on average);

- stabilization of buprenorphine level in the body is achieved in 7–10 days;

- withdrawal symptoms will appear in 3–5 days and are usually less severe than the withdrawal symptoms of other opioids.

2.3.2 Pharmacodynamics and pharmacokinetics of buprenorphine

2.3.2.1 Buprenorphine is a partial (μ-receptor) opioid agonist, which has been derived from a morphine alkaloid thebaine. Due to its pharmacological properties, buprenorphine is a great means for opioid substitution treatment and treatment of opioid withdrawal symptoms.

2.3.2.2 Buprenorphine has low oral bioavailability as its extensive initial metabolism occurs in the liver and small intestine. Its bioavailability is moderate (30–40%), when administered by placing it under the tongue, the tablet will dissolve in 2 to 7 minutes. The tablet might dissolve better if it is broken into smaller pieces (this may also decrease the variability of the dose). Crushing/pulverizing tablets should be avoided, as it facilitates swallowing.

2.3.2.3 As buprenorphine is a partial agonist, its physiological and toxic effects will plateau at 4–8 mg in the case of sublingual administration (some patients will experience higher toxicity with higher doses). This is why people who are used to high doses of heroin or methadone may find that buprenorphine is not a sufficient alternative. In the case of most patients, the maximum therapeutic effect of buprenorphine will occur in the dose range of 12–24 mg.

2.3.2.4 Buprenorphine has higher affinity towards opioid receptors when compared to fentanyl, heroin or methadone, and buprenorphine can prevent receptors from binding with the aforementioned substances, thereby accelerating opioid withdrawal in people who have recently used methadone, fentanyl or heroin. Buprenorphine is fat-soluble and the majority of buprenorphine binds with plasma cells.

2.3.2.5 Buprenorphine is metabolised in the liver by the enzyme system (CYP 3A4) of cytochrome P450 into norbuprenorphine and other metabolites, which are then excreted in faeces (70%) and urine (30%).

2.3.2.6 The half-life of buprenorphine is highly variable: 20–72 hours, 36 hours on average. In the case of a low dose (2 mg), the effect of buprenorphine last up to 12 hours, but higher doses (24–32 mg) can last up to 72 hours. In the case of stable administration, a steady concentration will be achieved in 7 days.

2.3.3 The effects of buprenorphine

2.3.3.1 Buprenorphine causes less euphoria and does not have as strong of a sedative effect than full opioid agonists (heroin, morphine and methadone). Nevertheless, is natural activity is usually sufficient for decreasing the urge for heroin or fentanyl, and for preventing or relieving opioid withdrawal symptoms in opioid dependent people. Buprenorphine has a strong affinity towards opioid receptors and decreases the effects of heroin, morphine and fentanyl, by preventing those substances from binding to receptors.

2.3.3.2 Side effects are usually cold or flu-like symptoms, headaches, sweating, sleep disturbances, nausea and mood swings. As a rule, side effects are more intense at the start of treatment and last for several weeks. Buprenorphine affects cognitive abilities and attention. Buprenorphine treatment may cause constipation, sexual dysfunctions and (sometimes) excessive sweating.

2.3.4 Drug interactions involving buprenorphine

2.3.4.1 **Other sedative substances**: the combination of buprenorphine and other sedative substances (opioids, alcohol, benzodiazepines, tricyclic antidepressants, most tranquilizers and sedating antihistamines) can be dangerous (deaths have occurred).

2.3.4.2 **Opioid antagonists**: buprenorphine has higher affinity towards opioid receptors when compared to naloxone and naltrexone. Very high doses of naloxone (10–35 mg) are necessary in the treatment of buprenorphine overdose.

2.3.4.3 **Opioid agonists**: buprenorphine can cause withdrawal syndrome if a person uses it while the effects of other opioids are still apparent. This is why patients receiving methadone cannot be easily transferred to buprenorphine before their daily dose is lower than 40 mg. Buprenorphine can hinder the effects of other opioids that are used for analgesia.

2.3.4.4 **Inhibitors and inducers of liver enzymes**: buprenorphine is metabolised by the cytochrome P450 3A4 enzyme system. In theory, the concentration of buprenorphine can be affected by substances that inhibit or stimulate the activity of that enzyme. A lot of medications, especially most of anticonvulsants, induce that enzyme. However, no clinical cases have been reported concerning significant interactions with buprenorphine.

# 3. Patient assessment

## 3.1 Assessment of potential patients

3.1.1 The goal of the initial assessment is to forge a trusting relationship with the patient; determine whether substitution treatment is suitable for the person; inform the patient of treatment options and explain the nature of substitution treatment to the patient, thereby allowing them to make an informed decision about starting substitution treatment; provide counselling about harm reduction, especially when the patient want to have some more time to think about starting treatment.

3.1.2 The patient should not feel as though the assessment carried out by the treatment team is an obstacle course that they have to pass in order to get treatment.

3.1.3 A patient who has come or linked to care from another health care institution, where they received opioid based substitution treatment, should be assessed again.

3.1.4 It is advisable to conduct the initial assessment within one day. The compilation of the initial assessment may take more than a day if additional specialists have to be involved in order to make an assessment. The initial assessment has to be concluded with the completion of an initial treatment plan, on the basis of which treatment can be started right away.

3.1.5 Assessment is a continuous process. A patient might not be willing to provide complete information about their psychosocial situation at the start of treatment. The reason for this might be poor health and physical condition, emotional crisis or difficulties with trusting others, including people on the treatment team. At first, the primary focus should be on stabilizing the patient’s situation and creating a trusting relationship between the treatment team and the patient.

## 3.2 Key questions for initial assessment

3.2.1 Opioid use

3.2.1.1 What kind of opioids does the person use, the quantity and frequency of use of the opioids, length of current episode of use, time of the last dose taken and the pattern of use (used narcotic, quantity, frequency) within the past three days.

3.2.1.2 An addictive disorder diagnosis according to ICD-10 classification.

3.2.1.3 Age at the onset of opioid use, during regular use and when a dependence developed.

3.2.1.4 Frequency and length of periods of abstinence.

3.2.1.5 Overdose episodes.

3.2.2 Use of other psychotropic and narcotic substances.

3.2.2.1 Use of alcohol, illegal drugs and prescription drugs, currently administered medication.

3.2.2.2 Overdoses caused by concurrent use of various drugs.

3.2.3 General condition of health.

3.2.3.1 Occurrence of infectious diseases (HIV, HCV, HCB, TB).

3.2.3.2 Other comorbid somatic diseases.

3.2.3.2 Occurrence of mental disorders.

3.2.3.4 Pregnancy.

3.2.4 Psychosocial situation.

3.2.4.1 Social position (job, education, professional skills, housing, financial situation, civil status).

3.2.4.2 Psychological status (mood, cognition, self-harming and suicide attempts).

3.2.4.3 Risky sexual behaviour, involvement in prostitution.

3.2.4.4 Violent behaviour towards others.

3.2.4.5 Occurrence of domestic violence.

3.2.4.6 Criminal behaviour (past and present criminal charges and convictions, previous imprisonments).

3.2.4.7 Dependent minors under the guardianship of the patient.

3.2.5 Previous treatment attempts (institution, type of treatment, period of abstinence, success of treatment and reasons for relapse).

3.2.6 Motivation (why the person wants to get help, motivation to take this step, reason behind the breakthrough, the patient’s goals and expectations to the treatment).

3.2.7 Objective observation

3.2.7.1 Signs of drug use (injection marks, skin infections, withdrawal symptoms).

3.2.7.2 Characteristics indicating the presence of other diseases (e.g. liver diseases, valvular heart diseases).

3.2.7.3 A urine test can be useful in confirming what the patient has claimed.

## 3.3 Diagnosing an opioid dependence

3.3.1 Determining an opioid dependence is preceded by a compilation of the patient’s thorough medical history concerning use of drugs and by conducting a physical examination. It might be beneficial to conduct a urine test and collect evidence from other medical institutions where the person has received prior treatment due to taking drugs.

3.3.2 In order to determine the patient’s history of drug use, thorough documentation is necessary regarding the start of drug use, its duration and extent, as well as changes in the patient’s life caused by drug use. The ICD-10 classification is used for diagnosing an opioid dependence.

3.3.2.1 Several criteria can be answered if you ask a patient to describe a typical day for them. When they wake up and how they feel upon waking up. If they do not feel well upon waking up, ask them to describe how they feel in more detail. If the patient does not feel unwell when waking up, ask them when withdrawal symptoms usually occur for them. When and where they take their first dose of the day. How their day begins, do they eat breakfast, who they meet during the day and where do they go, what kind of leisure activities do they engage in that are not linked to taking drugs, what kind of a social circle do they have, what do they do in the evenings, do they fall asleep easily, do they take additional medication to fall asleep at night.

3.3.3 A lot of opioid addicts, primarily those who inject, have seen overdosed themselves or seen someone else overdose. Unintentional overdoses usually occur due to fluctuating opioid tolerance, purity levels of the substance, general condition of health and concomitant use (opioids primarily with alcohol and benzodiazepines). Opioid dependent people who have recently been released from prison have an increased risk of overdosing, as their tolerance to opioids has decreased significantly during their time spent in prison. Intentional overdose cases are not rare, as a lot of opioid dependent people also have comorbid mental problems; therefore, it is important to find out whether the patient’s previous overdoses have been accidents, i.e. unintentional or intentional.

3.3.4 During the physical examination, in addition to signs of opioid use on the body, attention should also be paid to potential opioid withdrawal symptoms.

3.3.4.1 Opioid withdrawal symptoms include dilated pupils, anxiety, bone and muscle pain, muscle spasms, sleep disturbances, sweating, hot and cold flashes, yawning, piloerection (gooseflesh), lacrimation (teary eyes), runny nose, nausea, diarrhoea, heart palpitations, rapid pulse, elevated blood pressure.

3.3.4.2 Signs of opioid intoxication include constricted pupils, itching and scratching, sedation and drowsiness, low blood pressure, slow heart rate, respiratory depression.

3.3.4.3 Signs of opioid overdose include extremely small pupils, loss of consciousness, respiratory arrest, hypotension, bradycardia, fluid accumulation in the lungs.

3.3.5 Urine drug testing can be used to verify recent opioid use. A positive urine test does not automatically mean that a person is opioid dependent; however, it is a tool that help determine whether a patient uses opioids. Treatment should be conducted with caution and the patient’s level of opioid dependence reevaluated if, in addition to a negative drug test result, low tolerance to opioids is apparent at the start of the treatment.

## 3.4. Indications for provision of substitution treatment

3.4.1. Substitution treatment with methadone is meant for people from the ages 18 and up, who

have been diagnosed with opioid dependence (a behavioural or physiological disorder has been diagnosed as a result of opioid use, dependence syndrome (ICD-10, F11.2). In the case of minors from the age of 14, the preferred medication is buprenorphine.

3.4.2. Opioid dependence is usually accompanied by neuroadaptation (see clause 2.1.6) towards opioids, but this is not necessarily the case at all times. As a rule, people who have not developed neuroadaptation towards opioids are not suitable candidates for substitution treatment. Although, in some cases it might be reasonable to offer substitution treatment to people who do not have apparent tolerance and physical dependence to opioids.

3.4.2.1. Readmission might be best in the case of long-term opioid addicts, who have gone through opioid withdrawal and achieved abstinence, but who feel that they are very likely to relapse back to regular opioid use, and who wish to return to treatment.

3.4.2.2. It is also wise to admit opioid dependent people who have recently been released from prison, if they wish to receive treatment, even if they were not using drugs while in prison. The reason for this is that a lot of addicts go back to using drugs after being released from prison.

3.4.3. Special precautions have to be taken when starting treatment with people who do not display apparent signs of neuroadaptation. The daily dose of methadone during the first week cannot exceed 20 mg per day.

## 3.5. Contraindications for substitution treatment

3.5.1. Liver disorders (cirrhosis, jaundice). Severe, decompensated hepatitis.

3.5.2. Respiratory failure, acute asthma.

3.5.3. The patient is unable to provide informed consent for substitution treatment (e.g. due to a severe mental disorder).

## 3.6. Circumstances that demand that caution be used when starting treatment

3.6.1. The patient has used various psychotropic substances, especially sedatives and hypnotics;

3.6.2. Alcohol dependence; if a patients arrives to the administration of a substitute medication while intoxicated by alcohol, then they should be given half of the usual dose of substitution medication or be left completely without a dose that day. All service providers of substitution treatment of opioid dependency must be equipped with a breathalyzer.

3.6.2.1. Patients who are visibly under the influence of drugs must not be given methadone that day. However, it should be determined that the intoxication-like state has not been caused by some other medical condition.

3.6.3. Other comorbid mental and behavioural disorders (e.g. psychosis, severe personality disorder);

3.6.4. Low or unclear opioid tolerance level (e.g. after the patient has been released from a detention facility, polysubstance dependence);

3.6.5. Somatic diseases (head injuries or increased intracranial pressure, kidney failure, bronchial asthma and other respiratory disorders, hypothyroidism, Addison's disease, prostatic hypertrophy);

3.6.6. Risk of QT interval prolongation (QT interval is already prolonged due to a heart condition or if medications have been prescribed that may prolong QT interval). In that case, buprenorphine is the preferred substitute medication.

3.6.7. The patient is taking prescription drugs that suppress or activate P450 isoenzymes.

## 3.7. Compiling a treatment plan

3.7.1. The aim of the treatment plan is to plan activities necessary for the patient receiving treatment in relation to their addictive disorder and general condition of health, as well as to solve social coping problems caused by dependence and to prevent relapse. The treatment plan is compiled according to the treatment plan form (annex 1) based on the results of assessment conducted by the treatment team (annex 2). The initial treatment plan will be compiled on the basis of the initial assessment and, if necessary, it may be revised during the first weeks of treatment or when new circumstances occur. The treatment plan will be added to the patient’s medical records.

3.7.2. Principles of compiling a treatment plan

3.7.2.1. The patient has to be notified of the content and potential side-effects of the treatment. The patient should have realistic expectations towards the treatment, which is why it is important to find out the patient’s expectations towards the treatment prior to starting the treatment and to provide extensive information about the nature of substitution treatment to patients.

3.7.2.2. It is important to get the patient involved in compiling the treatment plan by taking their wishes into account and realistically evaluating their abilities to achieve the goals set in relation to the treatment. As a rule, patients are more successful with the treatment if they have been involved in determining the goals of treatment.

3.7.2.3. The treatment plan should be reviewed regularly, at least once in three months and at least once in 6 months after the first year of treatment, in order to go over the goals and activities planned and define new ones with the patient.

# 4. Provision of substitution treatment

## 4.1. Start of treatment

### *4.1.1. Setting the initial dose*

4.1.1.1. It is recommended that substitution treatment be started in an environment where the patient can be monitored. Special precautions have to be taken with patients who:

- have decreased or unknown tolerance towards opioids;

- use several drugs, especially substances that suppress the central nervous system;

- have comorbid alcohol dependence,

- have a comorbid mental illness and/or who are receiving concomitant psychotropic treatment;

- has other comorbid diseases.

4.1.1.2. The following circumstances increase safety:

- creating a treatment relationship that facilitates contact between the patient and the clinician;

- careful dosing at the start of treatment;

- continuous monitoring of the patient during the first two weeks of treatment;

- thorough explanation to the patient about toxic effects and withdrawal symptoms at the start of treatment and during the maintenance period.

4.1.1.3. Patients should be monitored for intoxication and withdrawal symptoms for 3–4 hours after administering the first dose (i.e. during the peak effect of methadone).

### *4.1.2. Setting the initial methadone dose*

4.1.2.1. The following has to be taken into account when setting the initial methadone dose:

- dependence level and tolerance level (history of drug use, evidence, observations made during examinations and monitoring, consultation with clinicians who have worked with the patient before);

- time passed since last opioid use;

- concurrent use of benzodiazepines or alcohol.

4.1.2.2. The goal of administering the initial methadone dose is to keep the patient in treatment, relieve their withdrawal symptoms and ensure the safety of the patient (avoid methadone overdose and death cases caused by respiratory depression).

4.1.2.3. Initial dose is based on the severity of dependence and level of tolerance. A dose of 20 mg and lower is considered safe for people who weigh about 70 kg, even if they are not opioid users. It is necessary to adopt precautionary measures and monitor the effects of methadone on the patient if the initial dose of methadone is 30 mg or higher. Should withdrawal symptoms appear, an additional dose (5–10 mg) can be administered after 3–4 hours have passed from the administration of the initial dose.

4.1.2.5. Extreme caution should be practiced when the necessary initial dose of methadone exceeds 40 mg. A thorough consultation with a psychiatrists or keeping the patient under observation is advisable to ensure that treatment is started under monitoring.

### *4.1.3. Setting the initial buprenorphine dose*

4.1.3.1 As buprenorphine prevents other opioids from activating opioid receptors and it has lower natural opioid activity, buprenorphine can accelerate the occurrence of withdrawal symptoms, if buprenorphine is administered while other opioids are used. The first dose of buprenorphine (usually 4 mg) should not be administered before at least 8–12 hours have passed from the patient’s last dose of a short-acting opioid and at least 24–36 hours from their last methadone treatment.

4.1.3.2. In the case of buprenorphine, a fast start with a higher dose (up to 16 mg by the 3rd day of treatment) is safe, effective and advisable for improving therapeutic effects and compliance to treatment. It should be followed by clinical monitoring and adjustment to dosage.

4.1.3.3. there are two buprenorphine based medications: buprenorphine (Subutex) and buprenorphine-naloxone (Subuxone).

4.1.3.4. It should be explained to the patient that using other opioids after starting treatment with buprenorphine will not alleviate withdrawal symptoms due to buprenorphine’s competing affinity towards opioid receptors.

## 4.2. Dose stabilization and administering of a maintenance dose

4.2.1. The goal for the first two weeks of treatment is to stabilize the patient’s condition, so that they would not fluctuate between intoxication and withdrawal symptoms. This does not necessarily mean that the patient will reach their optimal maintenance dose during this time. After the initial stabilization of the patient it might be necessary to further adjust their dosage.

### *4.2.2. Methadone dose stabilization and administering of a maintenance dose*

4.2.2.1. Methadone dose titration:

- Reduce the dose if intoxication symptoms, severe or intolerable side effects occur during the peak effect of methadone (3–4 hours after administration).

- Don not increase methadone during the first three days if there are no clear withdrawal signs during peak effect, as the patient will experience stronger effects from methadone with each day.

- Consider increasing the dose by 5–10 mg after every three days, taking the patient’s condition into account.

- The weekly total dose should not be increased more than 20 mg.

- The maximum dose at the end of the first week should not exceed 40 mg.

- Warn your patients not to drive or operate machinery during dosage adjustment.

- Can be accelerated if the patient is hospitalized and methadone treatment is conducted under specialist observation.

4.2.2.2. Deaths occurring during the first two weeks of treatment have been associated with a methadone dose range of 25–100 mg per day, most cases the dose range is 40–60 mg per day.

4.2.2.3. Patients should be inspected for withdrawal and intoxication symptoms every day for the first two weeks of treatment as the concentration of methadone increases in the blood plasma during the first week of administration. The physician should review the next dose before administration, if intoxication caused by the prescribed opioid or some other substance is suspected. It is vital that nurses who dispense methadone are able to recognize potential withdrawal or intoxication symptoms.

4.2.2.4. In most cases a patient’s condition can be stabilized by administering 30–50 mg methadone per day, which is usually sufficient for suppressing withdrawal symptoms. Although some patients may experience continuing withdrawal symptoms. The most effective dose for keeping a patient in treatment and suppressing their use of fentanyl or heroin is over 60 mg per day. Methadone blocks the effect of fentanyl and heroin by increasing tolerance to opioids and decreasing its extent, by binding the receptors of the central nervous system and preventing the binding of heroine metabolites. The effective daily dose of methadone is considered to be 60–100 mg (Faggiano F. et al., 2003).

4.2.2.5. Increasing the dose may be necessary after the stable dose has been reached. However, this will not be done more often than once a week. Indications for increasing the dose after reaching the maintenance dose:

- insufficient suppression of withdrawal symptoms during 24 hours;

- constant strong desire to take drugs;

- continuous use of illicit opioids.

4.2.2.6. When increasing methadone dosage, it is important to remember that it can take up to seven days for a new stable serum concentration to develop after each increase in dosage.

4.2.2.7. Methadone doses that exceed 100 mg should be administered to patients who can be characterized by fast metabolisation of methadone. Everyone’s tolerance to methadone is different, about 30% of patients treated digest methadone quickly and also experience withdrawal symptoms quicker, which can be relieved to some extent by increasing methadone dosage; in that case, it is recommended to administer the medication twice a day. There is no clear evidence that methadone doses exceeding 100 mg would be more effective for most patients (Henry-Edwards, 2003).

4.2.2.8. It is not necessary to alter methadone dosage if a single daily dose has been missed. If the patient has not received their dose for two days in a row, it is advised to administer their usual dose, if there are no intoxication symptoms. If the patient has not received their dose for three days in a row, it is advisable to reduce the methadone dose by 50%. If the patient has not received their dose for four days in a row, it is advisable to administer 40 mg of methadone or half of their set dose (whichever is smaller). If the medication has not been administered for 5 days or more, the treatment should be continued by administering 20–30 mg of methadone at first and then continue pharmacotherapy as if dealing with a new patient.

4.2.2.9. Should the medical personnel notice that a patient has vomited after the administration of a medication dose, another dose can be administered to the patient. It is advisable to administer another dose if the patient has vomited within 15 minutes after receiving methadone. It is advisable to administer 50% of the usual dose if the patient has vomited within 15–30 minutes after receiving methadone. It is not necessary to administer another dose of methadone if the patient has vomited more than 30 minutes after the administration of the initial dose.

### *4.2.3. Buprenorphine dose stabilization and administering of a maintenance dose*

4.2.3.1. Buprenorphine dose titration:

- During the first week of treatment, buprenorphine doses can be increased quickly and safely by 2–8 mg a day.

- The dose should not be increased if the patient experiences side effects (e.g. nausea, dizziness, agitation, sedation).

- Reduce the dose if intoxication symptoms, severe or intolerable side effects occur during the peak effect of methadone (1–4 hours after administration).

- Most patients can be stabilized with a daily dose of 12–24 mg.

- The maximum daily dose at the end of the first week should not exceed 32 mg. Cases where prescribing a buprenorphine dose exceeding 32 mg is justified are very rare.

- Patients should be warned not to drive or operate machinery during dosage adjustment.

4.2.3.2. Due to the long plasma half-life of buprenorphine, this medication can, in most cases, be successfully administered after every other day or three times a week, without the patient experiencing increased withdrawal symptoms or decreasing the therapeutic effect of buprenorphine. All patients who have received a stable daily dose for two weeks, can try out receiving the dose every other day or three times a week.

4.2.3.3. Buprenorphine doses can be increased even faster (up to 8 mg per day), however, maximum effectiveness will be achieved relatively quickly: there is very little evidence that a daily dose exceeding 32 mg would have any additional therapeutic effect. It has been noted that some patients experience decreased therapeutic effect in the case of large doses as those increase the antagonistic effects of buprenorphine.

## 4.3. Patient monitoring and alleviation of medication side effects

4.3.1 Methadone was first used in the substitution treatment of opioid dependence forty years ago and has been administered to millions of patients ever since. If correctly administered, it has been qualified as the safest medication. The side effects and toxicity of methadone and buprenorphine are similar to those of morphine and other opioids.

4.3.2 There is evidence of death cases among patients during the first and second week of treatment. These death cases are related to both excessively high methadone doses prescribed by doctors and the concurrent use of some other depressant (e.g. sedatives); other reasons include the effects of combining medications, individual sensitivity (e.g. liver malfunction). The risk of overdosing is lower in the case of buprenorphine.

4.3.3 Patients who have completed substitution treatment and started to use fentanyl or heroin again are in greater risk of death due to opioid overdose. Physicians should warn patients about this. The risk of death due to opioid overdose will decrease when opioid substitution treatment is continued.

4.3.4 Methadone and buprenorphine can cause sleep disturbances, nausea, vomiting (especially in the beginning of treatment), constipation, urinary retention, drowsiness and sweating; disorientation, respiratory tract suppression very infrequently. Patients may experience euphoria during the first few weeks of methadone based substitution treatment, decreased libido is another potential side effect. Rare side effects of buprenorphine treatment include hallucinations.

4.3.4.1 If the patient is constipated, they should be advised to eat more vegetables and fruits and to drink more water.

4.3.4.2 In the case of excessive sweating due to intolerance towards the medication, it is advisable to reduce the daily dose of medication. However, it should also be considered that the sweating might be a withdrawal symptom.

4.3.4.3 Decreased libido and sexual dysfunctions can be regulated with reducing the dose; however, the accompanying increased risk of relapse should also be kept in mind.

4.3.4.4 In the case of insomnia, it is advisable to teach the patient relaxation skills and give them information concerning sleep hygiene, to recommend that they stop or reduce consumption of alcohol, caffeine and nicotine. It is not advisable to use sedatives or hypnotics.

4.3.4.5 There is evidence that in some cases, when the daily dose of methadone exceeds 100 mg, it may cause QT interval prolongation on the electrocardiogram. This may cause increased risk of ventricular tachycardia (Torsades de Pointes). It is recommended to reduce the methadone dose in the case of prolonged QT intervals. The option of replacing methadone with buprenorphine should be discussed with the patient, while taking into account that switching medication can cause withdrawal symptoms and relapse. if the patient is using some other medication, which may cause prolonged QT intervals, the use of that medication should be reviewed as well.

4.3.4.6 Methadone, alike other opioids, reduces the secretion of saliva. Drug users are known to have dental problems due to malnutrition and frequent intoxication. The poor condition of teeth is often blamed on using methadone. Secretion of saliva can be stimulated by chewing gum. It is advisable to pay more attention to oral hygiene.

4.3.5. Urine tests for psychotropic substances are carried out at a need-based random frequency, taking into account the clinical and social situation of the patient. It is advisable to conduct urine tests for diagnostic purposes. When conducting urine testing, precautions should be taken to prevent cheating.

4.3.5.1. During the first two months, urine tests should be conducted at least three times a month. From the third month on, urine tests can be conducted once a month or whenever there is doubt about the patient’s intoxication status.

4.3.5.2. Urine tests can only determine recent use of substances. After determining the use of fentanyl or some other opiate, especially if the substances have been injected, it is advisable to have a discussion with the patient about the option of increasing the daily methadone, in order to achieve the blocking effect of methadone and identify the psychosocial factors that stimulate the use of psychoactive substances and decrease their effects.

4.3.6 Patients should be regularly inspected and evaluated; this applies to those patients who seem stable as well. The frequency of clinical examinations depends on the stability of the patient; however, all patients should be examined by a psychiatrist at least once in three months / 4 times a year. Unstable patients benefit from more frequent meetings with doctors. During an examination of a patient, the following things should be documented: the patient’s concerns and wishes regarding the medication, suitability of the substitute medication dosage, side effects and interactions of medications, use of other medications and substances (alcohol, tobacco), general condition of health (physical and psychological), social coping, risk behaviours, HIV, hepatitis B and C, hepatic status, future plans and steps in the patient’s treatment plan.

## 4.4 Dispensing take-away doses of substitute medication

4.4.1 Substitution treatment based on opioid antagonists is conducted according to the principles of directly observed treatment. Administering of methadone should take place under the daily supervision of medical personnel for at least the first 6 months of treatment, before the patient has the option of administering methadone at home.

4.4.2 The patient will be administered the substitution medication daily at a treatment facility, under the direct supervision of a nurse, who is responsible for making sure that the medication is given to the right person. In case of doubt, the identity of the patient can be verified by their personal identification document.

4.4.3 The patient can be given the opportunity to administer methadone at home, on 1–2 days a week, for a motivational purpose and as a reward for good results, if the patient’s situation has been stabilized (positive changes in their family and at work, discontinued use of psychoactive substances and injected drugs), and their risk of abusing methadone has been assessed to be low. Providing the opportunity to administer methadone at home is an important prerequisite for keeping patients in long-term treatment while allowing them to adapt socially.

4.4.4 Methadone can be dispensed to patients for more than 2 days per week in the following cases:

4.4.4.1 The patient has received substitution treatment for at least 3 years, but has become disabled and cannot move independently or has serious difficulties moving around. In this case, it can be considered whether it might be beneficial to dispense methadone doses for up to 6 days to close ones of the patient or their legal representative. This applies provided that the patient attends an appointment with a substitution treatment nurse or physician once a week. If necessary and possible, the substitution treatment nurse and physician will make house visits to see the patient. When the patient’s condition improves and their mobility is restored, dispensing take-away doses of methadone is again conducted according to clause 4.4.3.

4.4.4.2 Patients who have just given birth may be dispensed up to 3 days’ worth of take-away doses at a time, during a period of no longer than 3 months.

4.4.4.3 Patient works at another city or cannot come to the health-care provider during its opening hours due to their work schedule. Working in another city or having a work schedule that is not suitable with the opening hours of the service is not a sufficient reason by itself for dispensing take-away methadone for the patient to use at home. The opening hours of the substitution treatment service have to be adjusted to the patients’ needs as much as possible. If a patient’s work schedule still does not allow for them to come to the treatment facility every day, the following guidelines have to be adhered to:

- if the patient has received treatment for 6–12 months (and their urine tests have been negative for the past 6 months), they can be given take-away medication for up to 2 days a week;  
- if the patient has received treatment for 12–24 months (and their urine tests have been negative for the past 6 months), they can be given take-away medication for up to 3 days a week;

- if the patient has received treatment for at least 3 years (and their urine tests have been negative for the past 12 months), they can be given take-away medication for up to 4 days a week; 4.4.4.4 If a patient will be staying in another city for longer than they are allowed to receive take-away doses, it is necessary to organise temporary methadone dispensing for the patient in that other city. This option can be used only when the destination has a health care institution that provides substitution treatment.

4.4.4.5 The aforementioned only applies to those patients who have displayed long-term stability. Every health care institution has to evaluate the risk of abusing the medication and ask for evidence from the patient that would confirm their illness, loss of mobility, start of work, work schedule, or going abroad.

4.4.4.6 Exceptions can also be considered in crisis situation, such as pandemic outbreaks or extreme weather conditions, which make accessing the health care institution impossible or pose a risk for the patient’s life and/or safety.

4.4.5 If a patient is headed abroad, the same rules as listed in clause 4.4.3.3 apply to dispensing take-away doses of medication to them. If the patient does not fit the criteria listen here, they should, if possible, be organised substitution treatment at the destination country.

4.4.6 At home administration will be allowed for patients who have displayed long-term stability; therefore, involving third parties should not be necessary as the medication can be dispensed to the patient to take away. Should the treatment team, in cooperation with the patient, find that it would be safer to give the medication to the patient’s close ones, that can be done as well. Close ones are the patient’s relatives (both lineal and collateral). The person (the patient receiving treatment or their close one) to whom the take-away medication is given is responsible for the doses. Methadone doses cannot be given to the patient’s friends or acquaintances.

4.4.6.1 The patient should be warned that they should keep methadone from others and especially from the reach of children. Even the smallest amount of methadone can be potentially lethal to small children. When the patient lives with other people, especially with children, they should not store methadone next to their bed or in the fridge, neither should they take methadone when children can see. Methadone doses have to be stored in a bottle with a safety cap and kept high in a (preferably lockable) cupboard.

4.4.7 The patient will be required to give their signature every time a take-away dose of substitute medication is dispensed to them. Dispensing a take-away dose of medicine has to be documented on the day that the take-away dose was dispensed, by marking the size of dose administered on the spot and the dose(s) dispensed for take-away and for which dates those doses are meant.

4.4.8 Daily doses of methadone are given to the patient in separate flasks for each day. The name of the patient, name of the substance, dose, date for use, name and contact information of the health care institution that dispensed the medication, are marked on the flask.

4.4.9 If the take-away flask is destroyed or lost on more than two occasions, that patient will no longer be given take-away doses, as they or their close one are not able to take responsibility for take-away medication. The doses lost or destroyed by the patient will not be replaced.

4.4.10 If the patient has received take-away doses and their urine drug test turns out to be positive, dispensing take-away doses to them has to be stopped and the reasons for the positive test result should be identified. Dispensing take-away doses of methadone can be continued after 3 months of supervised substitute medication administration. A urine drug test is considered positive if the patient refuses to take part in the test.

4.4.11 All urine test results and decisions concerning the dispensing (and ceasing to dispense) take-away medication doses to the patient have to be documented. When making the decision on whether or not to dispense take-away doses to a patient, the opinions of all treatment team members, who have treated the patient during the past 6 months, will be taken into account.

## 4.5 Switching the substitute medication

### *4.5.1. Switching from methadone to buprenorphine*

4.5.1.1 Switching from methadone to buprenorphine may be necessary when:

- the side effects of methadone are intolerable;

- the methadone treatment of a pregnant patient has not been successful, or the pregnant patient prefers buprenorphine.

4.5.1.2 Patients receiving low methadone doses (30 mg a day or less) can usually switch medications with minimal discomfort. Patients receiving higher methadone doses may experience intense withdrawal symptoms.

4.5.1.3 Prior to switching to buprenorphine, the patient’s daily dose of methadone should be lower than 40 mg, preferably lower than 30 mg a day. Prior to starting buprenorphine treatment, patients should receive a stable dose of methadone for at least one week.

4.5.1.4 The first dose of buprenorphine should be administered when at least 24 hours have passed since the last methadone dose. The first dose is usually 4 mg. In general, lower buprenorphine doses are insufficient substitute for methadone and higher doses increase the likelihood of intensified withdrawal symptoms.

4.5.1.5 It is best to administer the first dose early in the morning, so that potential symptoms related to switching medications (e.g. intensified withdrawal symptoms) can be alleviated. A treatment plan will be compiled to alleviate severe withdrawal symptoms. Clonidine (100 μg after every 3–4 hours) can be a beneficial medication for alleviating symptoms.

4.5.1.6 If a patient switches medication after previously receiving 30 mg or less methadone per day

- Schedule the first dose of buprenorphine to the time during which the first withdrawal symptoms are going to appear. This usually takes place more than 24 hours after the last dose of methadone.

- Administer 4 mg of buprenorphine as the first dose. Inspect the patient 3–4 hours after administering the first dose.

If the patient does not experience intensified withdrawal symptoms and the withdrawal symptoms remain, administer an additional 2–4 mg of buprenorphine.

- Inspect the patient once more on the 2nd treatment day, usually the dose can be increased to 8 mg.

4.5.1.7 If a patient switches medication after previously receiving 30–60 mg methadone per day

- Schedule the first dose of buprenorphine to the time during which the first significant withdrawal symptoms are going to appear. This usually takes place 48–96 hours after the last dose of methadone.

- Administer 4 mg of buprenorphine as the first dose. Inspect the patient 3–4 hours after administering the first dose.

If the patient does not experience intensified withdrawal symptoms, administer an additional 2–4 mg of buprenorphine. If the withdrawal symptoms of the patient intensify, do not increase the dose on that day. It may be necessary to start symptomatic treatment (e.g. 100 μg of clonidine after every 3–4 hours).

- Inspect the patient once more on the 2nd treatment day, usually the dose can be increased by 8 mg.

- Future doses can be increased based on the patient’s needs.

4.5.1.8 Patients who receive higher doses of methadone and whose doses cannot be reduced under 60 mg per day, should not switch to buprenorphine. Switching medicine in that situation can only be carried out when the patient is hospitalised or with specialist support. A specialist should also be consulted when the patient is receiving more than 30 mg of methadone.

4.5.1.9 Withdrawal symptoms are usually light and short-term (4–8 hour after administering a dose of 4 mg). Treatment can include use of clonidine, intramuscularly injected nonsteroidal anti-inflammatory substances and antiemetics. When buprenorphine is taken directly after methadone treatment, then withdrawal symptoms may be very intense and might need to be alleviated with aggressive methods. In the case of initial alleviating of intense withdrawal symptoms, the patient should be monitored and hospitalised for a short period, if necessary. The patient has to wait for at least 24 hours before taking another dose of buprenorphine.

### *4.5.2. Switching from methadone to buprenorphine-naloxone*

4.5.2.1 People who have received a stable methadone dose for a long time may wish to switch to buprenorphine in order to eventually switch to buprenorphine-naloxone. This type of patients have to be explained that there is a small risk that switching from a successfully used medication to another medication can destabilize their condition. Patients should be warned about making non-informed decisions.

4.5.2.2 Patients who were previously receiving stable methadone treatment are first recommended to achieve at least a month-long stability in buprenorphine treatment prior to switching to buprenorphine-naloxone. Switching from methadone to buprenorphine will be conducted according to clause 4.5.1.

### *4.5.3. Switching from buprenorphine to methadone*

4.5.3.1 Switching from buprenorphine to methadone may be necessary when:

- the side effects of buprenorphine are intolerable;

- the response to treatment is insufficient.

4.5.3.2 Prior to switching to methadone, the patient has to be receiving a stable daily dose of buprenorphine. If possible, the daily dose of buprenorphine should be reduced to 8 mg or less, several days before the switch.

4.5.3.3 Methadone treatment can be started when at least 24 hours have passed since the last dose of buprenorphine. The initial dose of methadone cannot exceed 30 mg. The first dose of methadone to patients who are transferring from a buprenorphine dose of 4–8 mg is usually in the range of 20–30 mg. Patients who are transferring from a buprenorphine dose of 4 mg or less are usually given 20 mg of methadone as their first dose. Caution should be practiced when increasing dosage, just like with other patients who are starting methadone substitution treatment.

## 4.6 Completing substitution treatment

4.6.1. The duration of substitution treatment depends on duration of opioid use (e.g. fentanyl, heroin), psychological state and general condition of health, as well as social situation. Enforcing behavioural and psychological changes takes time. This is why it is recommended to continue with treatment for a minimum of 12 months, preferably 2–4 years, after reaching stable dosage levels. It is not unusual for some patients to decide to stay in methadone substitution treatment indefinitely. It is not advisable to rush completing treatment, as experience shows that those who complete their treatment very quickly, tend to relapse to drug use more frequently.

4.6.1.1 Patients of methadone substitution treatment should not be pressured into reducing their doses. It is not allowed to establish a mandatory duration of treatment or a maximum treatment duration.

4.6.2. The treatment contract with a patient can be terminated prematurely when the patient:

- threatens or is violent towards personnel or other patients;

- steals or intentionality destroys property of the treatment facility;

- traffics or sells drugs at a health care institution or in its close vicinity;

- sells their substitute treatment doses or exchanges them for some other goods;

- violates internal rules intentionally;

- does not comply with requirements set by the personnel;

- repeatedly uses illegal drugs in a way, which may pose a danger to the patient’s life when taken with the substitute medication.

4.6.3 If the patient wishes, they should be readmitted to substitution treatment when they have gone back to using illegal drugs after completing substitution treatment, voluntary discontinuation of treatment or during the treatment.

4.6.4 Principles of completing substitution treatment

- good cooperation and planning between the patient and the treatment team;

- flexible and slow reducing of doses;

- provision of psychological support (counselling, teaching skills, frequent monitoring and communicating with patients, involving the patient’s family);

- planning follow-up activities (counselling, linking to care in a rehabilitation programme, or finding some other solution suitable to the patient).

4.6.5 The risk of using other substances and abusing medication is heightened during the completion period of substitution treatment. Reduced doses may bring about increased psychological distress and one of the most common symptoms manifests in sleep disturbances; therefore, it is important to inform the patient of potential symptoms that may occur as a result of reduced doses and teach them means to cope with those symptoms. It is important to provide psychological support.

4.6.6 When withdrawal symptoms occur as a result of reducing the dose, it is advisable halt reductions to the dose and consider increasing it. Based on the nature of withdrawal symptoms, the necessity of using symptomatic treatment can be discussed.

4.6.7 The completion of substitution treatment should be suspended and the increasing of dose considered, if the patient fails to show up for regular administration of medication doses, does not arrive for a previously scheduled examination, experiences worsening of psychological or social situation, or uses additional drugs.

4.6.8. Reducing methadone doses

4.6.8.1. Doses that are 80 mg or higher are not recommended to be reduced by more than 10 mg per week.

4.6.8.2. Doses that are 40–80 mg are not recommended to be reduced by more than 5 mg per week.

4.6.8.3. Doses that are lower than 40 mg are not recommended to be reduced by more than 2.5 mg per week.

4.6.8.4. Patients will tolerate the reduction of doses relatively well up to a certain limit, after which the reduction of doses should be (temporarily) suspended or slowed down significantly.

4.6.7. Reducing buprenorphine doses

4.6.7.1. It is not recommended to reduce daily doses of 16 mg more than 4 mg per week or within two weeks.

4.6.7.2. It is not recommended to reduce daily doses of 8–16 mg more than 2–4 mg per week or within two weeks.

4.6.7.3. It is not recommended to reduce daily doses that are lower than 8 mg more than 2 mg per week or within two weeks.

4.6.7.4. Patients whose treatment regimen included administering buprenorphine less frequently than once a day should start receiving the medication once a day as soon as their dose has been reduced to 8 mg per day.

4.6.8. Patients who wish to switch from methadone to naltrexone should have completed full withdrawal from methadone and a 14-day drug free period prior to starting naltrexone treatment.

4.6.9 Patients who wish to switch from buprenorphine to naltrexone should have completed full withdrawal from buprenorphine prior to starting naltrexone treatment. Naltrexone treatment can be started 4–5 after the last dose of buprenorphine if that last dose of buprenorphine was 2 mg or less. It is necessary to wait 7 days with starting naltrexone treatment if the last dose of buprenorphine was higher than 2 mg.

# 5. Specifications for provision of substitution treatment

## 5.1. HIV-infected patients

5.1.1 A patient of substitution treatment of opioid dependence should be offered HIV testing, counselling before and after the analyses.

5.1.2 A health care institution that provides substitution treatment for opioid dependence has to ensure supervision by an infectious disease physician and timely assistance to HIV-infected patients. The key to successful treatment of HIV-infection is close cooperation between institutions that offer substitution treatment for opioid dependence and treatment to HIV-infected people, as well as providing extensive support to the target group.

5.1.3 Initial screening for HIV infection for people in or planning to start substitution treatment for opioid dependence does not differ from the screening conducted for people not in methadone substitution treatment. A physician should explain the importance of HIV diagnosis in order to ensure monitoring of the patient’s condition of health and the coordination of their treatment. If no HIV antibodies are found, the patient will be offered an opportunity to repeat the analysis regularly, at least once a year. The patient has the right to refuse an HIV analysis.

5.1.4 Antiretroviral treatment (ARV treatment) will be prescribed:

5.1.4.1 if the patient has an AIDS-defining illness;

5.1.4.2. if the total number of CD4 cells is repeatedly <350/mm3 or there is a decrease of >120 cells per year at any viral load;

5.1.4.3 treatment is also advisable when the patient has a high number of RNA copies (> 100 000 copy/mL);

5.1.4.4 to an HIV-infected woman during her pregnancy and labour, in order to prevent the infection being transferred from the mother to the child;

5.1.5 ARV treatment will be prescribed by an infectious disease physician if the patient is ready for it and motivated to start treatment. The patient will be informed of the necessity to adhere to the treatment, potential adverse reactions to the medication and what to do in case those occur, AVR medication interactions with other medications used (methadone, buprenorphine, etc.), duration of treatment, risks of drug resistance, etc.

5.1.6 ARV treatment should include informing the patient of the treatment process and relevant problems, and if necessary:

- alcohol and drug dependence treatment;

- stabilization of living conditions;

- treatment of psychiatric disorders;

- treatment of opportunistic infections and other concurrent diseases.

5.1.7 Drug classes – ARV drug components:

5.1.7.1 nucleoside reverse transcriptase inhibitors (NRTI);

5.1.7.2 non-nucleoside reverse transcriptase inhibitors (NNRTI);

5.1.7.3 protease inhibitors (PI);

5.1.7.4 fusion inhibitors (FI);

5.1.7.5 integrase inhibitors (II);

5.1.7.6 co-receptor antagonists (CA).

5.1.8. Recommended initial ARV treatment combination for HIV infection treatment:

- 2 NRTI and 1 NNRTI;

- 2 NRTI and 2 PI (one of which is an ritonavir administered as an additional dose);

An infectious disease physician will compile a treatment combination, taking into account the stage symptoms of the HIV infection, presence of opportunistic infections, other illnesses and conditions; number and percentage of CD4 cells; administering frequency of the used medication, number of pills per day; possible reactions to medications; concurrent infections and illness of hepatitis B and C, drug dependence; woman’s reproductive state[[3]](#footnote-3).

5.1.9 Methadone effects on bowel movement and methadone’s participation in the metabolism of cytochrome P450 isoenzymes 3A4 and 2D6; adverse drug reactions occur frequently. This has an impact on the efficacy of methadone and/or antiretroviral medications.

5.1.9.1. NNRTI-s do not have a significant clinical impact on methadone metabolism. Methadone has recorded interactions only with Zidovudine (ZDV) and no other NRTI.

- Methadone increases the blood concentration of zidovudine by 40% and this may intensify the toxic effects of ZDV;

5.1.9.2. Clinically significant pharmacokinetic interactions may occur when methadone is administered concurrently with NNRTI-s: both efavirenz and nevirapine are strong P450 inducers that significantly reduce the blood concentration of methadone (efavirenz reduces up to 60%, nevirapine’s effect is smaller). In both cases, the patient should be monitored more frequently and it might be necessary to increase their methadone dose (the latter option is generally more acceptable than modifying ARV treatment).

5.1.9.3. As a rule, methadone does not have any clinically significant effect on the pharmacokinetics of PI, and in most cases frequent monitoring of the patient is sufficient. In some cases PI-s might have a two-way effect (e.g. darunavir, ritonavir, that can both increase and reduce the concentration of methadone). This means that PI-s might increase the level and effects of methadone through CYP 3A4 metabolism (especially fosamprenavir), as well as reduce it by accelerating metabolism. Therefore, it is necessary to ensure more frequent monitoring of the patient and be very cautious about modifying methadone doses (both increasing and reducing dosage). When it comes to ARV, the use of PI-s does not lead to changes in treatment.

5.1.10. The clinical effect resulting from reduced blood concentration of methadone will manifest as a withdrawal symptom, which starts around 4–10 days after administering. The dose of methadone should be increased gradually, usually 5–10 mg per day and not more than 20 mg per week, until the patient’s condition has improved.

5.1.11. Medical personnel should ensure the patient’s motivation to use ARV medications regularly. Life-long regular use of ARV treatment is necessary in order to achieve a sustained virologic response.

5.1.12. Due to high risk of HIV infection transmission though infectious injecting equipment, opioid dependent patients with HIV should receive substitution treatment in priority order.

## 5.2. Hepatitis C virus (HCV)

5.2.1. Taking into account the high level of hepatitis C among former and current drug users, they should be offered second and third generation enzyme-linked immunosorbent assay for detection of hepatitis C (anti-HCV). The diagnosis can be confirmed by determining RNA (ribonucleic acid) of hepatitis C virus in serum by using polymerase chain reaction (PCR). When anti-HCV is not found, the analysis will be repeated once a year (if some factors in the patient’s behaviour still imply risk of being infected).

5.2.2. Patients with HCV infection are strongly advised to refrain from consuming alcohol – they should be informed of alcohol’s extremely dangerous effect on the liver. Alcohol dependent patients are recommended to undergo alcoholism treatment.

5.2.3. Potential medications for the treatment of HCV infection are PEG-interferon-alpha (PEG-IFN alpha) and ribavirin (RBV).

5.2.3.1 Hepatitis C treatment is recommended to HIV and HCV coinfected patients, if the patient fits the treatment criteria of chronic hepatitis C, has ceased to inject drugs, is not alcohol dependent and has a total CD4 lymphocyte count of >350 cells/mm3. The treatment will start with antiretroviral treatment, if the number of CD4 lymphocytes is <200.

5.2.3.2 peg-INF α can increase methadone concentration and bring about toxic effects of methadone (methadone has not been recorded to have interactions with ribavirin). In these cases, the infectious disease physician should carefully monitor the patient and, if necessary, inform the psychiatrist of the need to reduce the patient’s methadone dose.

5.2.3.3 Depression is one of the side effects of inteferon. As soon as relevant signs appear, a psychiatrist will provide consultation to the patient and prescribe treatment, if necessary. It would also be advisable to provide consultation to this patient prior to starting treatment for chronic hepatitis C, as in a lot of cases, depression has already been a problem before.

## 5.3. Hepatitis B virus (HBV)

5.3.1. Hepatitis B is determined by examining the serological markers of hepatitis B (HBsAg and anti-HBc). In the case of a positive result, the patient will undergo further diagnostic tests following general recommendations for diagnosing and treating hepatitis B.

5.3.2. Potential medications for the treatment of HBV infection are nucleoside analogues and interferon. Treatment does not have to be excluded for patients receiving methadone treatment. These kinds of patients have to be ensured psychological and social support by the team.

5.3.3. Patients with HBV infection are strongly advised to refrain from consuming alcohol – they should be informed of alcohol’s extremely dangerous effect on the liver. Alcohol dependent patients are recommended to undergo alcoholism treatment.

5.3.4. It is recommended to vaccinate the patient against hepatitis B, if no hepatitis B antibodies are found during the first diagnostic test.

## 5.4 Tuberculosis (TB)

5.4.1. Prior to starting methadone treatment and later, taking into account their specific clinical and social situation, the patient should be directed to TB check-up once a year. All HIV-infected patients should be tested for TB.

5.4.2. Patients who have been diagnosed with tuberculosis, have to be treated until they are no longer infectious (the patient’s bacterioscopic sputum analysis is negative); outpatient treatment is conducted after that. Treatment facilities of tuberculosis should be ready to start methadone substitution treatment for patients in inpatient treatment. Outpatient tuberculosis treatment is conducted only in the form of directly observed treatment (TB medications are administered under direct monitoring by medical personnel).

5.4.3. If possible, outpatient treatment will be organised in a way that the patient would be able to receive TB treatment and methadone substitution treatment at the same treatment facility.

5.4.3. If an HIV-infected patient is diagnosed with tuberculosis, they should first undergo TB treatment. If the patient has already started ARV treatment, it shall be continued, while making adjustments to their treatment plan, if necessary.

5.4.3.1 People with a number of CD4 – cells below 100/mm3 should start ARV treatment from the 2nd week after starting TB treatment; in the case of CD4 100-200 cells/mm3, 2-8 weeks after the start of TB treatment; and in the case of CD4 >200-350, 8 weeks after the start of TB treatment or once the TB treatment round has been completed.

5.4.4. Patients, especially those with HIV, should be reminded that going to crowded places or other locations where there is high risk of contracting tuberculosis (detention facilities, shelters, etc.) increases their likelihood of contracting tuberculosis.

5.4.5. It is advisable to implement measure that prevent the spread of TB infection at waiting rooms, where patients receive medications and counselling, by using rooms that can be ventilated easily, dividing patients on a priority basis, etc.

5.4.6. Administering rifampicin during TB treatment can decrease methadone blood level significantly (by 33–68%) and induce methadone withdrawal symptoms. Therefore, it may be necessary to increase methadone dosage.

## 5.5. Treatment of comorbid psychiatric disorders

5.5.1. When compared to the general population, opioid dependent people have other mental disorders more frequently, which is why assessment of various mental disorders should be an integrated part of assessing an opioid dependent patient. Concurrent mental and addictive disorders should be treated at the same time.

5.5.2. Patients in substitution treatment should undergo assessment for mental disorders both at the start of treatment and periodically during treatment, once the patient has been prescribed a stable dose of methadone. The two most commonly diagnosed mental disorders among opioid users are depression and anxiety. At the start of treatment, the anxiety might be related to opioid withdrawal symptoms and it might pass only after a few weeks. Opioid dependent patients are also considered to be a high suicide risk group; substitution treatment patients might also experience mood disorders. Undiagnosed depression hinders psychosocial rehabilitation and increases the risk of relapse.

5.5.3. Antidepressants are recommended when depressions has been diagnosed (incl. mood disorders, sleep disorders, weight loss). Tricyclic antidepressants (amitriptyline) have suppressive effects towards the central nervous system, which is why they have to be administered very carefully. Treatment with SSRI-s, especially with sertaline, reduces methadone metabolism, which may lead to a need to reduce methadone dosage.

5.5.4. When patients in treatment have fully developed manic episodes, it is important to differentiate whether an episode is linked to previous manic episodes, hypomania and depression or with the use of some other psychotropic substance. Stimulating substances can cause manic symptoms on their own.

5.5.5. All psychoses registered in a patient’s medical history should be assessed again, in order to differentiate those from episodes caused by psychotropic substances (e.g. amphetamine). As amphetamine induces psychosis lasts a short time, it is usually not necessary to administer antipsychotic medications.

## 5.6. Polysubstance dependence

5.6.1. In relation to death cases of opioid dependent people, it has often been determined that opioids (methadone, fentanyl, heroin) were used in combination with other substances (sedatives, hypnotics). Special precautions should be taken when administering methadone to patients who use sedatives, hypnotics or alcohol, as the inhibitory effect of those substances is increased by methadone.

5.6.2. When a patient comes to their methadone administering appointment while intoxicated, under the influence of sedatives or hypnotics, they will not be administered their daily methadone dose, or their daily methadone dose will be decreased (for example, they might be given half of their daily methadone dose). It is recommended to determine the level of alcohol intoxication by using a breathalyser. Intoxicated people may be given a chance to return in a few hours and then decide whether they will be administered methadone.

5.6.3. Alcohol dependent patients are recommended to go through sensitizing treatment with disulfiram in parallel to methadone treatment; psychosocial interventions are also necessary.

5.6.4. When a patient continues to use other substances in addition to the prescribed pharmacotherapy, they should be offered assistance and support with solving problems in other fields of life, determine their well-being (e.g. do they live with other addicts), assess potential occurrence of other mental problems (e.g. anxiety, depression, paranoia), and if necessary, provide suitable treatment, implement motivating interviewing, if the patient is not sure whether they want to stop polysubstance use.

5.6.5. It is also advisable to write down steps for selective withdrawal with the patient; these should include various strategies for coping with withdrawal symptoms, training for preventing relapse, teaching skills (such as relaxation techniques), teaching social skills, goals and dates for reviewing these goals. It is advisable to give a copy of what was written down to the patient as well.

5.6.6. Sedatives (benzodiazepines)

5.6.6.1. Benzodiazepines are not safe drugs when used with opioids, especially methadone. Opioid induced lethal overdoses are often tied to the use of benzodiazepines.

5.6.6.2. It is safer to avoid prescribing benzodiazepines to patients in methadone substitution treatment in the first place. If a physician is certain that in order to cope with benzodiazepine dependence, it is necessary to prescribe decreasing doses of benzodiazepine to a patient, concrete steps have to be established and documented:

- Compile thorough medical history about the use of benzodiazepines, taking into account that it is common to overestimate amounts used. When assessing tolerance, a lot of users will describe their level of use in relation to intoxication and falling asleep. This far exceeds the level needed for preventing withdrawal symptoms.

- Try to find evidence on previous withdrawal symptoms (e.g. hospitalization due to seizures).

- Collect a urine sample to prove the use of benzodiazepines.

- If you decide to prescribe a sedative, it should only be done if the patient cannot get that prescription from elsewhere, and this should be checked regularly.

- Define the aims of treatment – i.e. to conduct safe withdrawal from benzodiazepine. The issue at hand is *safety*, not the patient’s convenience. Diazepam should be the only prescribed benzodiazepine, all doses should be administered once a day under surveillance, and patients should not receive take-away doses of methadone during the period of using benzodiazepines. Never start benzodiazepine treatment at the same time with administering methadone, as the risk of overdose is highest at that time.

- If patients are stabilized with a diazepam dose of 40–80 mg/day, their dose should be reduced by at least 5 mg per week until the dose is 40mg, after which the dose should be reduced by 2.5 mg per week. As this speed, withdrawal from 80 mg of diazepam will take almost six months. Maximum dosage reducing speed until a 40 mg dose is 10 mg per week and 5 mg per week after that. Withdrawal would then take 12 weeks.

5.6.6.3 During withdrawal, the patient should be clinically monitored and their use of their medications ought to be checked. Experience in most clinics shows that very few patients are satisfied with what they get during the treatment and most of them continue to acquire and use additional benzodiazepines. In that case, it is not reasonable to continue withdrawal treatment, as treatment has just become a way to acquire benzodiazepines.

## 5.7. Pain management during substitution treatment

5.7.1. Patients in methadone substitution treatment have been recorded to have increased tolerance to opioids. This is why there are certain peculiarities when it comes to relieving their pain.

5.7.2. Non-opioid analgesics (paracetamol, ibuprofen, etc.) are recommended for relieving nociceptive pain. Patients receiving methadone who experience severe pain, should be administered opioid analgesics to relieve pain, and the doses of analgesics ought to be higher due to increased tolerance to opioids.

5.7.2.1. Tolerance to opioids increases during methadone substitution treatment and the effects of additionally administered opioids are therefore reduced, which is why it is not suitable to prescribe opioid analgesics in case of chronic pain.

5.7.2.2. Concurrent use of analgesics and buprenorphine should be avoided, as those are partial antagonists of opioid receptors and induce withdrawal symptoms.

5.7.3. Due to cross-tolerance between opioids and analgesic medications, it might be necessary to administer larger doses of analgesics during dental surgery or other surgical treatments.

## 5.8. Pregnancy and breastfeeding

5.8.1 As most female candidates of substitution treatment are of fertile age, the initial assessment should determine the following:

- Could the patient be pregnant?

- Is the patient breastfeeding?

- If she is pregnant, what are her plans in relation to the pregnancy?

- If she is not pregnant, is she planning on getting pregnant?

- What kind of birth control is the patient using if she does not want to get pregnant?

5.8.2. Although some pregnant women may wish to stop using fentanyl or heroin, withdrawal symptoms include high risk of miscarriage during the first trimester and premature birth during the third trimester. However, the use of fentanyl or heroin, or relapse to using those substances, may cause several birth defects. The fetus can be damaged by injecting, use of alcohol, drug overdoses, malnutrition and other medical complications caused by addiction. Compared to the damages caused by fentanyl or heroin use relapse, opioid based pharmacotherapy poses minimal risk to the development of the child.

5.8.3. Although methadone substitution treatment is not the only treatment method available for pregnant women, it is often the most acceptable treatment option for the patient and in most cases, allows for a safer and more stable pregnancy. If a pregnant woman uses opioids less than three times a week and has been using opioids for less than three months, or has been using in very small amounts, other treatment methods should be considered.

5.8.4. If a pregnancy has been confirmed, the woman’s condition and indications for substitution treatment should be taken into account when prescribing substitution treatment. In the case of an unconfirmed pregnancy, the opioid dependent person who is requesting substitution treatment should be send to an appointment with a gynecologist. In order to stabilize the patient and minimize the risk resulting from injecting drugs, it is recommended to start substitution treatment as soon as possible.

5.8.5. It is advisable for the physician to take into account that pregnant women who use fentanyl/heroin, may be more sensitive to emotional stress, guilt, fear, inability to organise their life, intensified attention from healthcare workers and family members. Unfavourable emotional condition can lead to use of drugs or some other psychoactive substances. The physician should assess the patient’s use of alcohol and nicotine and inform the patient about their harmful effects to the fetus.

5.8.6. Substitution treatment with methadone is preferred as its effects to pregnant women have been researched more thoroughly than those of buprenorphine. However, from the overviews of all previous studies concerning opioid medication use in pregnant women, no significant differences between methadone and buprenorphine have been recorded (Minozzi S., Amato L., Vecchi S., Davoli M., 2008). If a patient has been successfully treated with buprenorphine, the characteristics of methadone should be taken into account prior to transferring from buprenorphine to methadone. If treatment with buprenorphine has been successful, it might be reasonable to not switch from buprenorphine to methadone.

5.8.7. Due to naloxone’s adverse effect on a fetus, pregnant women should not be administered a combination of buprenorphine and naloxone (Suboxone).

5.8.8. The decision to start methadone treatment includes careful assessment of risks of continuing drug use; should there be any uncertainty about the level of opioid dependence, the risks accompanying the use of opioid medications that cause dependence should also be assessed.

5.8.9. A pregnant should be administered methadone at a dose that would ensure stability, prevent intensified or continued use of opioids.

5.8.10. Women who are already in methadone substitution treatment, can continue with the treatment when they get pregnant. The bioavailability of methadone decreases at the end of pregnancy due to the increased amount of plasma, increased concentration of plasma proteins that bind methadone, and methadone metabolism in placenta. If may be necessary to divide the daily dose of methadone into smaller doses, or to increase methadone dosage at the end of the second trimester and during the third trimester, in order to avoid withdrawal symptoms and minimize use of additional drugs.

5.8.11. Even though methadone and buprenorphine can enter breast milk, their concentration is low and not harmful to infants. Breastfeeding is beneficial in several aspects as it strengthens the bond between mother and child, improves nutrition and helps prevent childhood illnesses. Breastfeeding is not allowed, when the patient has HIV, as HIV can be transmitted through breast milk. Neither is breastfeeding an option if the mother uses additional drugs or other psychotropic substances, including alcohol. If the patient has contract hepatitis C, it is necessary to consult an infectious illnesses physician, in order to avoid transmitting hepatitis C from mother to child during breastfeeding.

5.8.12. The correlation between occurrence of neonatal abstinence syndrome and mother’s methadone dosage during pregnancy has not been sufficiently proven and the occurrence of the syndrome cannot be predicted. Some newborns, whose mothers have received methadone or buprenorphine treatment, can experience opioid withdrawal symptoms. Untreated neonatal opioid withdrawal syndrome can cause distress and, in some cases, even seizures in newborns. Reviews of scientific studies show that opioids and barbiturates are more effective in the treatment of neonatal abstinence syndrome than placebo or benzodiazepines, and opiates are more effective than barbiturates (Osborn D. A., Jeffery H. E., Cole M. J., 2005a, 2005b).

5.8.13. Frequent symptoms of neonatal abstinence syndrome include irritability and sleep disorders, sneezing, thumb sucking, shrill crying, watery stools, general hyperactivity, ineffective sucking, poor weight gain, dislike of bright lights, tremors, rapid breathing. Less frequent symptoms are yawning, vomiting, increased mucus secretion, increased sensitivity to sound, seizures (rare).

5.8.14. Withdrawal symptoms often appear during 48 hours after birth, but they can also appear within 14 days in rare cases. Experiences recoded in the United States show that one reason behind delayed appearance of withdrawal symptoms can be the concurrent use of methadone and benzodiazepines, as the infant will then experience withdrawal from benzodiazepines.

## 5.9. Detention facilities

5.9.1. The option of opioid dependence treatment, including methadone substitution treatment, must be available to opioid dependent people in detention facilities. Patients receiving methadone substitution treatment are recommended to continue treatment while in prison or in a detention cell.

5.9.2 Patients who wish to start substitution treatment for opioid dependence during incarceration should be given that opportunity. Indications for methadone substitution treatment are the same as for patients who are not incarcerated.

5.9.3. It is important to ensure that methadone substitution treatment is continued once the patient has been released from prison or a detention cell.

5.9.4. Opioid dependent people who have not received substitution treatment while incarcerated are in greater risk of drug overdose after being released from detention facilities.

## 5.10. Driving and operating machinery

5.10.1. Coordination difficulties may occur at the start of methadone substitution treatment. Therefore, patients should be warned about methadone’s impact on their ability to drive. They should be advised to avoid driving and operating machinery for the first 7–10 days of treatment and during 3–4 days after increasing or reducing their medication dose. Driving is contraindicated if the patient is taking benzodiazepines or other central nervous system depressants in addition to the substitute medication.

## 5.11. First aid in the case of acute intoxication (overdose)

5.11.1. Acute opioid intoxication (caused by the use of fentanyl, heroin or methadone) is diagnosed on the basis of several symptoms. An overdose is characterised by sudden CNS depression, which causes coma, bradypnoea (slow deep breathing, 2-4 times per minute), cyanosis, pulmonary edema, hypoxia, bradycardia, hypothermia, nausea, vomiting, myosis (narrowed pupils). Acute opioid intoxication has to be treated if the respiration rate of the person is lower than 10 times per minute.

5.11.2. In general, overdose cases occur more frequently at the start of methadone substitution treatment, less so in the case of buprenorphine treatment. Patients should be warned about this at the start of methadone substitution treatment.

5.11.3. Naloxone is an effective antidote in the dose of 0.4 mg/ml; it is a competing antagonist to opioid receptors. The main treatment plan includes a single 0.4–2mg injection into a vein or muscle as soon as possible. This may be repeated until the patients regains consciousness or starts breathing. When injected intravenously, the medication will take effect after 1–2 minutes and the effect will last for 5–10 minutes. When injected intramuscularly, the medication will take effect after 5–10 minutes.

5.11.3.1 Further monitoring of the patient is recommended as the effects of naloxone are shorter than those on fentanyl, heroin or methadone.

5.11.4. All service providers of substitution treatment of opioid dependency must have naloxone on site.

5.11.5. Overdose deaths often happen while people are asleep at home. The risk of death caused by overdose is decreased when substitute medication is administered in the morning, so that there are more people close by who can call help should anything happen during the day. The patient’s family should be warned that very deep snoring sounds at the start of substitution treatment can indicate dangerous respiratory arrest and that their doctor ought to be notified of this the next day.

5.11.6. The naloxone dose administered for methadone overdose is not sufficient in the case of buprenorphine overdose. Buprenorphine overdose should be treated with a naloxone dose of 10–30 mg/70kg.

# 6. Social and psychological assistance

6.1 Psychosocial assistance should be ensured for all patients who receive substitution treatment based on methadone or some other substitute medication. If a patient refuses psychosocial assistance, substitution treatment should be continued, as well as work on creating and maintaining a trusting relationship with the patient.

6.2 Studies have shown that psychosocial help significantly increases the percentage of patients who refrain from relapsing back into using psychoactive substances. However, there is no evidence that methadone substitution treatment, with or without psychosocial assistance, influences whether or not patients remain in treatment (Amato L., 2008).

6.3. Psychosocial assistance includes various psychological and social interventions. Social interventions may include counselling concerning such vital issues as food and clothing, accommodation and employment, opportunities for working and studying, as well as basic health-care, managing a social network, and friendships. Psychological interventions range from unstructured supportive counselling and implementation of motivational counselling techniques, to using highly structured psychotherapeutic techniques. Psychological interventions should be implemented in a way that an individual approach is adopted for each patient based on their preferences, readiness and responsiveness to treatment.

6.4. The most common psychological methods used in dependence treatment are cognitive behavioural therapy, motivational interviewing and contingency management.

6.4.1. Cognitive behavioural therapy focuses on creating a shared understanding of the patient’s problems and determining how those problems affect the patient’s thoughts, behaviour, feelings and daily coping. The therapist and patient will then agree upon the aims of the therapy. The goal here is to help the patient find new solutions that would help them solve problems more effectively than their previous coping mechanisms. In cognitive behavioural therapy, the time between therapy sessions is often meant for the patient to test out new solution methods in real situations.

Additionally, cognitive behavioural therapy is the most common form of psychotherapy used for preventing relapses. Patients are taught to recognize situations with high risk of substance use. It is necessary to learn about both external (people, places, things) and internal (thoughts and imagination) risk situations. After this, skills are developed for predicting risk situations and dealing with them. To achieve a thorough lifestyle change, it is usually necessary to help the patient redesign their entire relationship system, increase the amount of drug-free leisure activities that they engage in and learn general problem solving skills. Sometimes, giving up drugs will bring about a deeper change of identity for the person.

6.4.2. Motivation interviewing is a client-centered directive counselling style, which is used to induce an inner desire to change in the patient by helping them analyse and overcome conflicting emotions, feelings and wished related to the use of drugs.

Motivational counselling is more than a method of individual psychological counselling; it should be the general approach in communication between medical specialists and patients. Therefore, all specialists working in opioid dependence substitution treatment teams ought to have mastered the methods of motivational counselling.

6.4.3. Contingency management includes rewarding or punishing certain behaviours in patients on the basis of clearly established rules. Most dependence treatment programmes focus on rewarding desired behaviour, which might be in the form of verbal acknowledgement, vouchers, allowing a take-away medication dose for the patient administer at home, or other motivational means.

6.5 Health care institutions that provide substitution treatment substitution treatment for opioid dependence do not have to be able to provide all the following services and activities; however, they should cooperate with local governments and other establishments to find solutions that match the patients’ needs:

- Finding accommodation and a place of residence

- Debt counselling and learning financial skills

- Teaching social skills

- Organizing leisure activities

- Acquiring professional skills

- Finding a job

- Finding a suitable self-help or support group for the patient

Social workers in the opioid dependence substitution treatment team must be knowledgeable about different options and be able to direct and help patients according to that knowledge.

6.6. Service providers of substitution treatment for opioid dependence should also pay attention to the patients’ underage children and their situation. When possible, children should be offered support services through various activities, while also including specialists in different fields (e.g. psychologists, social educators, social workers) and employees of local governments.

6.7. Addiction is often accompanied by various social and health related problems; in order to help a patient find their way among a wide variety of health care institutions and other establishments, as well as ensure assistance that fits their needs, it is important to base the work with patients on the principles of case-based work. It is recommended to appoint one person on the treatment team as a contact person for each patient, so that they have someone to turn to with questions and someone who can direct them to suitable specialists. A contact person is responsible for ensuring that the patient takes part of psychosocial activities established in their treatment plan and for contacting the patient should they go missing (fail to show up).

6.8. The planning of a patient’s psychological and social assessment and interventions can be conducted by a specialist with relevant training (see requirements for the treatment team in chapter 7).

6.9. Opioid dependent people have a high risk of relapsing to opioid use even after successfully completing substitution treatment; therefore, it is of critical importance to provide follow-up counselling and support services after substitution treatment has been completed. Follow-up activities should be agreed upon with the patient and confirmed in writing prior to the completion of substitution treatment; additions can be made during substitution treatment according to the patient’s needs.

# 7. Legal framework and requirements for service providers of substitution treatment for opioid dependence

## 7.1 Legal framework for providing substitution treatment for opioid dependence

7.1.1. The provision of substitution treatment service for opioid dependence should be documented according to § 42 of the “Health Services Organisation Act” and the Regulation of the Minister of Social Affairs “Conditions and procedure for the documentation of provision of health care services and for storing these documents” (Regulation no. 56 of the Ministry of Social Affairs, 18.09.2008).

7.1.2. The patient’s medical records should include all decisions that have been made in relation to their treatment, including decisions about reducing or increasing medication doses, dispensing take-away doses or halting the dispensing of take-away doses. All meetings between the patient and health care employees of the treatment facility and other specialists should be documented. A file has to be kept about every patient; this file shall include the treatment contract under the law of obligations entered into with the patient (the treatment contract form can be found in Annex 4), their medical records and treatment plan.

7.1.3. A service provider of substitution treatment for opioid dependence is responsible for improving the quality of the health care service, including the development and increased competencies of their employees, in accordance with the Regulation of the Minister of Social Affairs “Requirements for ensuring quality of health care services” (15.12.2004 no. 128).

7.1.4 The handling of medicinal products (incl. storage and safe destruction) and record keeping should be conducted according to the following legislation:

“Conditions and procedure for storage and transportation of medicinal products” (Regulation no. 19 of the Ministry of Social Affairs, 17.02.05) provides general requirements for storing medicinal products.

“The handling of narcotic and psychotropic substances for medicinal and scientific purposes and relevant record keeping and reporting conditions and procedure and lists of narcotic and psychotropic substances” (Regulation no. 73 of the Ministry of Social Affairs, 18.05.2005) contains requirements for the storage, record keeping and reporting related to narcotic and psychotropic substances.

“Rules for keeping record of medicinal products dispensed in the course of provision of health care or veterinary services, and by social welfare institutions” (Regulation no. 20 of the Ministry of Social Affairs, 17.02.2005) contains requirements for keeping record of medicinal products by health care service providers.

“Conditions and procedure for prescribing medicinal products and dispensing medicinal products at pharmacies and prescription form” (Regulation no. 30 of the Ministry of Social Affairs, 18.02.2005) contains requirements of compiling health care service provider order forms for acquiring medicinal products.

§ 35 and § 36 of the “Medicinal Products Act” (+ Guidelines of the State Agency of Medicines <http://www.ravimiamet.ee/ravimite-havitamine>) contain requirements set for the handling and destruction of unusable medicinal products.

## 7.2 Requirements for service providers of substitution treatment for opioid dependence

7.2.1. A service provider of substitution treatment for opioid dependence must have an activity licence for providing health-care services issued by the Health Board.

7.2.2. Health care workers employed at the service provider of substitution treatment for opioid dependence must be registered at the national registry of health care workers. The provider of a health care service is obligated to notify of changes in health care workers staff in accordance to clause 1 of section 1 of § 47 of the “Health Services Organisation Act”. Psychologists and social workers have to be registered in the register of professionals (as of 2014).

7.2.3. The treatment team of substitution treatment for opioid dependence includes the following specialists:

- a nurse;

- a psychologist who has a officially accredited university degree in psychology (as of 2014, psychologists are required to comply with the professional standard of clinical psychology);

- a sociologist who has a officially accredited university degree in social work;

- a psychiatrist;

- it is recommended to also include a general practitioner or a family physician on the team.

7.2.3.1 Based on patients’ needs and the service provider’s means, additional specialists can be included when providing the service.

7.2.3.2 At least 2 nurses have to be present if the service provider 80 or more patients.

7.2.3.4 The treatment team has to have at least one full-time psychologist per 100 patients.

7.2.3.5 The treatment team has to have at least one full-time social worker per 100 patients.

7.2.3.6 The treatment team has to have a psychiatrist (at least 0.3 FTE) per 100 patients.

7.2.3.7 The treatment team is recommended to have a general practitioner or a family physician (at least 0.5 FTE) per 100 patients. The general practitioner[[4]](#footnote-4) or a family physician may replace the psychiatrist, if they have completed dependence treatment related training on the basis of a programme approved by the Health Board, and have certificate confirming that.

7.2.3.8. All specialists working in opioid dependence substitution treatment teams ought to have gone through training for motivational counselling.

7.2.4. At least 2 employees have to be present at all times during opening hours of the service.

7.2.5. The service must be open seven days a week. An exception is allowed if the service provider has less than 30 patients. In that case, the service should be open from Monday to Friday.

7.2.6. In order to receive substitution treatment, patients have to visit the facility every day, which is why it is important that the substitution treatment service is also open during those hours that are suitable for patients who have a job.

7.2.6.1 The substitution treatment service should be accessible to patients from 08:00 in the morning at the latest.

7.2.7. The facilities of a service provider of substitution treatment for opioid dependence should comply with the Regulation of the Minister of Social Affairs “Requirements for the facilities, installations and equipment necessary for the provision of non-hospital specialized health care” (State Gazette Annex 2002, 25, 353).

Specialist health care workers who work with the patient individually (psychologist, social worker) should have separate work rooms.

7.2.8. A service provider of substitution treatment for opioid dependence should compile internal rules for the handling, storage and record keeping of medicinal products (including narcotic substances); appoint a person responsible (and the person(s) responsible during their absence) for storing and keeping record of medicinal products; appoint people who have access to narcotic and psychotropic substances and the right to receive and prescribe those medicinal products. The rules should be introduced to employees for their signature and also document the date of introducing the rules to employees.

7.2.9. A service provider of substitution treatment for opioid dependence should organise regular team meetings, for discussing topics concerning team work, as well as topics related to improving health care provided to patients.

7.2.10. In order to prevent burnouts among employees and to help employees cope with situations and emotions that occur in their daily work, service providers should offer regular team and/or individual supervision to their employees.

Members of a treatment team of substitution treatment for opioid dependence are recommended to take part in inter-team intervision meetings, which are attended by members from different treatment teams of substitution treatment for opioid dependence. Intervision can be considered a method for learning among colleagues; learning takes place in a group, the members of which have equal positions, and which has a leader. Intervision can be described as an exchange of knowledge and consulting among colleagues. The usual discussions during intervision include general issues/topics related to the treatment of patients, as well as specific (treatment) cases, about which people would like hear their colleagues’ opinion as to how the problem or situation could have been solved. Additionally, intervisions are suitable for discussing questions related to improving coping in work situations (e.g. aggressive patients, heavy workload and stress, emotionally taxing situations).

# Annexes:

Annex 1 Individual treatment plan form of substitution treatment of opioid dependence (Excel form)  
Annex 1a Guidelines for compiling an individual treatment plan

Annex 2 Assessment interview for involving in substitution treatment for opioid dependence

Annex 3 Treatment contract for signing up for the substitution treatment for opioid dependence

**Annex 1a**

**GUIDELINES FOR COMPILING AN INDIVIDUAL TREATMENT PLAN**

1. Counselling and providing information

Patients who have been assigned treatment or who have sought out treatment themselves will be given an overview of substitution treatment options, principles of treatment and rehabilitation, regime, expected results, etc. Attempts are made to increase the patient’s motivation to start treatment. The counselling and informing will be done by a nurse or social worker, plus another member of the treatment team (should that be necessary).

1. Assessment of the suitability of service

In order to assess the patient’s suitability concerning a specific treatment service, the patient’s medical and general history will be compiled, their social situation and psychological factors related to their illness will be assessed. Treatment interventions and stages of rehabilitation that are necessary for dependence treatment are planned and scheduled, while specifying:

* the need for pharmacological treatment (substitution treatment with opioid agonists or other treatment)
* in the case of substitution treatment, its type (withdrawal or maintenance treatment)
* necessary psychological interventions and their aims (psychological counselling, individual psychotherapy, group psychotherapy)
* necessary social interventions and their goals (supporting coping, work with a network).

The assessment of a service’s suitability will be conducted by a treatment team compiled for the service (psychiatrist, psychologist, nurse, social worker)

1. Formalizing a written treatment plan

The patient’s treatment plan will be formalized in written form, specifying:

* the goal of treatment and rehabilitation:
  + withdrawal from the use of an illegal drug;
  + stabilizing a person’s conditions so that they can be resocialized;
* pharmacological treatment:
  + substitution treatment with opioid agonists;
  + other treatment.
* in the case of substitution treatment, it’s type:
  + withdrawal;
  + maintenance treatment,
* initial dose of medication
* planned psychological interventions:
  + psychological counselling;
  + individual psychotherapy;
  + group psychotherapy;
  + frequency and duration and goals of intervention
* planned social interventions:
  + supporting coping,
  + work with a network, etc.

The compilation of a treatment plan involves team work with a psychologist, social worker and nurse, under the guidance of a psychiatrist. The treatment plan will be approved by the leader of the organizing team.

Once a treatment plan has been confirmed, a relevant entry will be added to the Drug Treatment Registry.

**Annex 2**

#### ASSESSMENT INTERVIEW FOR INVOLVING IN SUBSTITUTION TREATMENT FOR OPIOID DEPENDENCE

1.Conducted by………………………………, interviewee ………………………………

Interview date…“…….“………….201….., duration……..hours……..min.

**2. CURRENT COPING IN SOCIETY**

1. Last permanent residence …………………………………(where)…………..........(when)

2. Last job…………………………………(position)……………………(duration)

3. Work situation

|  |
| --- |
| works all the time (regularly) |
| works periodically |
| unemployed |
| has never worked |
| has not worked regularly as of |

**3. PHYSCIAL CONDITION**

1. Physical health problems (including chronic issues) within the past 30 days…………

………………………………………………………………………………………………….

|  |  |
| --- | --- |
| 2. Is aware of having the following infectious diseases: | 3. Build and nutrition: |
| HIV | overweight |
| HBV | average |
| HCV | satisfactory |
| tuberculosis | exhausted |
| other | other |

4. Pregnancy No Yes 5. Injection marks No Yes

6. Tattoos No Yes 7. Scars , rashes No Yes

**4. HISTORY OF DRUG USE**

Tried drugs for the first time at the age of ……….. Consumed………………………(what substance)

|  |  |
| --- | --- |
| First experience with drugs involved use: | First experience with drugs took place: |
| orally | alone |
| nasally | with friends |
| by smoking | other |
| via extravenous injection |  |
| via intravenous injection |  |

What kind of drugs have they used within the past 48 hours? ………… …………………

…………………………………………………………………………………………..

Method of administration:

|  |
| --- |
| orally |
| nasally |
| by smoking |
| via extravenous injection |
| via intravenous injection |

How old were they at the time of first injection? ……………………………………………………………..

What kind of substances do they inject regularly?………………………………………………………….

Examples about highest doses used…………………………………………………

How much money in a day do they spend on narcotics?………………………………..

How long was the last period of voluntary refusal to use the main substance (abstinence), when did that period end?..................................................................................................................................

How many times have they experienced intoxication/overdose?……………………..

Have they received treatment in relation to dependence problems? No Yes

In which establishment……………………………………………how many times…………………...

in relation to the use of which drug……………………………………………………….....

Comments:………………………………………………………………………………......................................................................................................................................................

**5. FAMILY RELATIONSHIPS**

1. Does the applicant claim to have supportive parents and close ones? No Yes

Comments:……………………………………………………………………………

2. Does the applicant have children? No Yes

3. How many children, how old are they? …………………………………………………………

4. Do the applicant’s children live with them or separately? Together Separately

5. Does the applicant have other dependants? No Yes

Comments:……………………………………………………………………………..

**6. MENTAL CONDITION AND MOTIVATION**

1. Verbal contact Achieved Missing

2. Behaviour

|  |
| --- |
| appropriate |
| short-tempered |
| obsequious |
| arrogant |
| other |

3. Mental or personality disorders concurrent with dependence Does not have Has

If they do have any such disorders, what kind? …………………………………………(ICD-10: ………)

4. Concurrent somatic illnesses that reduce work capacity Does not have Has

5. Severity of psychosocial stressors……………………………………………………

6. Desire to systematically participate in work that would earn them living  
 Has Does not have Ambivalent

7. What kind of social problems have been caused by the use of drugs? …………………………………………………………………………………………….

8. How long has been the longest period during which they have been sober/”clean” and what caused it? .............................................................................................................

..............................................................................................................................................................................................................................................................................................

|  |  |
| --- | --- |
| 9. How high is the applicant’s estimation for their readiness to give up opioid drugs completely? | 10. How high is the interviewer’s estimation for the applicant’s readiness to give up opioid drugs completely? |
| very high (5) | very high (5) |
| high (4) | high (4) |
| average (3) | average (3) |
| meagre (2) | meagre (2) |
| poor (1) | poor (1) |

11. What does the applicant expect from the substitution treatment service for opioid dependence?

|  |  |
| --- | --- |
|  | Comments |
| to stop using drugs completely |  |
| to decrease their daily dose of drugs |  |
| to escape their daily worries |  |
| long-term methadone based substitution treatment |  |
| other |  |

**7. ESTIMATED PARTICIPATION ABILITY DURING THE PROVISION OF THE SERVICE**

1. Based on the assessment interview, I estimate that the applicant’s use of drugs

during the next 24 months will:

|  |
| --- |
| decrease |
| change chaotically, potentially includes the concurrent use of substitute medication and opioids |
| increases regularly |

2. Assessment of the applicant based on the interview:

|  |
| --- |
| regarding their mental and physical health, the applicant is capable of comprehending the meaning of their actions and controlling their own actions |
|  |
| the applicant is capable of doing up to moderate levels of work |
| the applicant is capable of taking part in group work |

INTERVIEWER:……………………………(signature)…………..(date)

**SUMMARY OF PSYCHOLOGICAL EVALUATION**

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**SUMMARY OF AN INTERVIEW WITH A SOCIAL WORKER**

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**SUMMARY OF AN INTERVIEW WITH A PSYCHIATRIST**

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**ASSESSMENT BY THE PSYCHIATRIC TREATMENT TEAM**

1. The goal of treatment and rehabilitation (withdrawal from the use of an illegal drug, stabilizing the person’s conditions so that they can be resocialized) with justification

........................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................

1. The need for pharmacological treatment (substitution treatment with opioid agonists or other treatment)

.....................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................

1. The necessity and type of [withdrawal or maintenance treatment] with justification

....................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................

1. Necessary psychological interventions, their aims (psychological counselling, individual psychotherapy, group psychotherapy) and frequency

...................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................

1. Necessary social interventions (supporting coping, work with a network)

................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................

Decision of the treatment team:

1. Will sign up for the substitution treatment for opioid dependence ...................................................... (service provider) as of ........................................... date
2. Included on the treatment queue at ................................................................... health care facility
3. There is no indication to provide substitution treatment for opioid dependence (provide justification)

............................................................................................................................................................................................................................................................................................................................................................................................................

1. Refuses to participate in treatment
2. Necessity for interval assessment of condition .................. (indicate the period)

MEMBERS OF THE TREATMENT TEAM:

(signatures)

(date)

**Annex 3**

**TREATMENT CONTRACT FOR SIGNING UP FOR THE SUBSTITUTION TREATMENT FOR OPIOID DEPENDENCE**

…..................………………. (date)

In order to ensure the effectiveness of drug dependence treatment …………………………… represented by …….……………… (authorization ……….………) (hereinafter: the **SERVICE PROVIDER**) and ………………………….... (hereinafter: the **PATIENT**), enter into this contract under the following conditions:

**DUTIES OF PARTIES TO THE CONTRACT:**

1. The **PATIENT** is responsible for their compliance to treatment and thereby undertakes to:
   1. Following the internal rules of the treatment facility and its schedule.
   2. Refraining from using illegal narcotic or psychotropic substances, or those that are not included in the treatment plan, during treatment and rehabilitation.
   3. Participating in drug use check-ups conducted by the treatment team.
   4. Complying with orders, which aim to improve the health condition of the patient and comply with the goals of treatment, given by the treatment team immediately.
   5. Immediately notifying the treatment team of all circumstance that threaten material or organizational values.
   6. Reimbursing intentionally caused losses on the basis of this contract and in accordance with the law. The Patient does not have material responsibility if it is proven that the losses were not caused by through the fault of the Patient.
   7. Remaining prudent with equipment trusted in their use.
   8. Refraining from threatening employees or using violence towards other patients or the personnel.
   9. Participating in psychological and social counselling and taking part in group therapy according to their individual treatment plan.
2. The **SERVICE PROVIDER** undertakes to:
   1. Creating conditions necessary for the Patient’s treatment and rehabilitation according to the treatment service.
   2. Basing their actions on altruistic goals and taking into account requirements necessary for the treatment and rehabilitation of the Patient.
   3. Introducing internal rules, daily schedule and treatment principles to the Patient.
   4. Administering substitute medication to the Patient daily, in accordance with their treatment plan.
   5. Notifying the Patient of changes to their treatment plan and confirming these changes with the Patient beforehand.

**RIGHTS OF PARTIES TO THE CONTRACT:**

1. The **PATIENT** has the right to:
   1. Use treatment options offered by the treatment facility.
   2. Participate in compiling their treatment plan.
   3. Participating in making decisions that concern their treatment.
   4. Get information about their personal data that has been shared with other institutions.
2. The **SERVICE PROVIDER** has the right to:
   1. Inquire information concerning the Patient from other health care institutions, law enforcement bodies and other institutions.
   2. Disclose information to other treatment facilities within the limits of the laws in Estonia and in relation to issues concerning treatment.
   3. In the case of suspicion, conduct tests/analyses on drug use.
   4. Terminate the treatment relationship under the circumstances marked in the contract and the treatment protocol.

**TERMINATION OF THE CONTRACT**

The contract will be terminated with the treatment team’s decision as a result of any of the following occurrences:

* The Patient threatens or is violent towards personnel or other patients;
* The Patient steals or intentionality destroys property of the treatment facility;
* The Patient traffics or sells drugs at the treatment facility or in its close vicinity;
* The Patient sells their substitute medication or exchanges it for some other goods;
* The Patient violates internal rules intentionally;
* The Patient does not comply with requirements set by the personnel;
* The Patient uses illegal drugs repeatedly.

When a contract has been terminated, the Patient cannot apply to participate in another treatment programme now sooner than 3 months have passed since the termination of the previous contract.

This contract has been compiled in two counterparts, one is given to the Service Provider, the other to the Patient.

…………………./SERVICE PROVIDER …...………………../PATIENT

1. describes processes related to the effects of the medication, i.e. what the medication does to the organism. [↑](#footnote-ref-1)
2. describes processes related to the absorption, distribution, metabolism and excretion, i.e. what the organism does with the medication [↑](#footnote-ref-2)
3. The WHO Clinical Protocol for WHO regions (WHO, 2006) primarily promotes ARR: 2NRTI+NNRTI in most cases. Other options are recommended only in the case of contraindication to NNRTI (Patient evaluation and antiretroviral treatment for adults and adolescents (1), Clinical Protocol for the WHO European Region, paragraph 4.2.3, WHO, 2006). [↑](#footnote-ref-3)
4. Will take effect when the “Mental Health Act” amendment is implemented. [↑](#footnote-ref-4)