BRITISH COLUMBIA CENTRE ON SUBSTANCE USE
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# Safety Bulletin

## Avoid the use of withdrawal management as a standalone treatment for opioid use disorder

### *Recommendation*

Withdrawal management alone is not an effective treatment for opioid use disorder, and offering this as a standalone option to patients is neither sufficient nor appropriate. Care providers should clearly communicate to patients the risks of withdrawal management as a standalone strategy and encourage a period of opioid agonist therapy or a slower outpatient taper (e.g., > 3 months) with methadone or buprenorphine/naloxone.

In the event that patients choose to proceed with withdrawal management without follow-up treatment, providers may consider using an informed consent form or waiver to document that this decision has been made against medical advice. A sample waiver is appended to this document.

### *Risks of Detox*

Acute withdrawal management (also known as "detox") is an intervention aimed at reducing health harms, such as withdrawal seizures, associated with substance use cessation. However, as a standalone intervention, withdrawal management does not constitute "addiction treatment," and can be associated with harm, especially in the context of opioid use disorder.

### *What the Research Says*

Research has shown that, when offered as an isolated intervention for opioid use disorder, inpatient withdrawal management may leave patients particularly vulnerable to the following serious health harms:

- Nearly universal rates of relapse to opioid use – Abrupt (e.g., < 1 week) taper off of opioids results in the vast majority of individuals returning to opioid use.[1]
- Elevated risk of overdose – Individuals who relapse following withdrawal management are at increased risk of overdose as a result of the rapid loss of tolerance to opioids.[2]
- Elevated risk of infection – Studies have shown that, in comparison to offering nothing, persons who inject drugs who undergo withdrawal management are more likely to contract HIV and Hepatitis C, likely as a result of high risk behaviours upon relapse.[3,4]

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**Opioid Agonist Therapy:** In British Columbia, inpatient opioid withdrawal programs are generally rapid (e.g., 1 week). When risk of relapse presents upon discharge, continuity of care can be particularly challenging as waitlists and other programmatic barriers often prevent immediate readmission to inpatient withdrawal or other safe environments. Instead of rapid inpatient opioid tapers, studies suggest that opioid agonist therapy (OAT) using buprenorphine/naloxone or methadone is more effective in terms of patient retention and satisfaction, sustained abstinence from opioid use, and decreased risk of morbidity and mortality related to overdose, HIV and HCV transmission.[3-6]

**Outpatient Withdrawal Management:** For patients who wish to discontinue opioid use without long-term OAT, a slow (e.g., > 3 month) outpatient taper with buprenorphine/naloxone or methadone should be an available option to address continuity of care issues associated with discharge from inpatient care, and ensure ongoing close follow up with an outpatient care provider should longer term OAT be necessary. Slower (e.g., up to one year) tapers have been associated with improved rates of abstinence and successful discontinuation of OAT.[7] Additionally, referral to an evidence-based residential treatment or an intensive outpatient addiction program should be considered for all individuals with opioid use disorder who decline long-term OAT.

**Specific Populations:** Although inpatient, rather than outpatient, withdrawal management has traditionally been recommended for specific patient populations, such as individuals with concurrent mental health conditions, these patients may be particularly vulnerable to harm from short term (e.g. one week) inpatient opioid withdrawal management. For these patients, as with patients without serious comorbidities, outpatient community care involving OAT or slow tapers off of opioids through community-based withdrawal management involving ongoing addiction treatment should be prioritized.

**Using Inpatient Withdrawal Management Effectively:** Inpatient withdrawal management can be an important first point of contact and act as a bridge to ongoing addiction treatment. Additionally, inpatient facilities can provide more intensive monitoring, support and symptom management, and may be appropriate care settings for challenging OAT inductions or transitions between treatments
(e.g., methadone to buprenorphine/naloxone).

For additional support, physicians should consider contacting the Rapid Access to Consultative Expertise (RACE) telemedicine addiction support at 604-696-2131 (raceconnect.ca).

For further reading, please refer to the BCCSU/Ministry of Health Guideline for the Clinical Management of Opioid Use Disorder at www.bccsu.ca.

References
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2. Strang J, McCambridge J, Best D, et al. Loss of tolerance and overdose mortality after inpatient opiate detoxification: follow up study. BMJ. 2003;326(7396):959-960.
3. MacArthur GJ, Minozzi S, Martin N, et al. Opiate substitution treatment and HIV transmission in people who inject drugs: systematic review and meta-analysis. BMJ. 2012;345:e5945.
4. MacArthur GJ, van Velzen E, Palmateer N, et al. Interventions to prevent HIV and Hepatitis C in people who inject drugs: A review of reviews to assess evidence of effectiveness. International Journal of Drug Policy. 2014;25(1):34-52.
5. Mattick RP, Breen C, Kimber J, Davoli M. Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. Cochrane Database Syst Rev. 2014;2:CD002207.
6. Esmaeili HR, Ziaddinni H, Nikravesh MR, Baneshi MR, Nakhaee N. Outcome evaluation of the opioid agonist maintenance treatment in Iran. Drug Alcohol Rev. 2014;33(2):186-193.
7. Nosyk B, Sun H, Evans E, et al. Defining dosing pattern characteristics of successful tapers following methadone maintenance treatment: results from a population-based retrospective cohort study. Addiction (Abingdon, England). 2012;107(9):1621-1629.

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# CONSENT AND RELEASE FORM FOR WITHDRAWAL MANAGEMENT SERVICES

Patient Label:

*affix here*

**By checking the boxes below and signing this consent form, I confirm that I understand and/or agree with the following statements:**

- ☐ I understand that I have been diagnosed with an **Opioid Use Disorder**.
- ☐ I understand that, according to current medical evidence, **the safest and greatest chance of recovery from opioid use disorder** can be achieved by starting **opioid agonist treatment** with buprenorphine/naloxone or methadone (first-line agents). The recommended duration of **opioid agonist treatment** varies depending on individual needs and circumstances.
- ☐ I understand that if I choose to proceed with **withdrawal management** (also known as **'detox'**) without follow-up care, I have a **high risk of relapse**, and a **high risk of overdose** due to decreased tolerance to opioids. Overdose can cause severe harms including brain damage, coma, and death.
- ☐ I understand that **withdrawal management alone is against medical advice**.
- ☐ I have been given sufficient time and opportunity to ask questions about the information above, and have received satisfactory clarification and advice.
- ☐ I fully release and discharge the physician and staff from any responsibility or liability for any losses, damages, or injuries I may suffer as a result of my decision not to go on opioid agonist treatment.
- ☐ **I consent to undergo withdrawal management services to be provided by the physician and care team, and have opted not to pursue follow-up care at this time.**

Client Signature Date

Physician, Nurse, or Staff Name and Signature Date