CRISM-ICRAS
Canadian Research Initiative in Substance Misuse
Initiative Canadienne de Recherche en Abus de Substance

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 (OUD). 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 associated with substance use cessation, such as withdrawal seizures. However, as a standalone intervention, withdrawal management does not constitute "addiction treatment," and can cause harm, especially in the context of OUD.

What the Research Says:

When offered as an isolated intervention for OUD, inpatient withdrawal management may leave patients particularly vulnerable to the following serious health harms:

1. **Nearly universal rates of relapse to opioid use** – Abrupt (e.g., < 1 week) taper off of opioids results in relapse to opioid use in the vast majority of individuals.[1]
2. **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]
3. **Elevated risk of infection** – 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]

Opioid Agonist Therapy: When risk of relapse presents upon discharge from a rapid (e.g., one week) inpatient withdrawal program, 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 is recommended. A slow taper would mitigate the challenges with continuity of 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 OUD who decline long-term OAT.

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 further reading, please refer to the *CRISM National Guideline for the Clinical Management of Opioid Use Disorder*.

1. Wright N, et al. 2011 *Br J Gen Pract* 61(593):e772-780.
2. Strang J, et al. 2003 *BMJ* 326(7396):959-960.
3. MacArthur G, et al. 2012 *BMJ* 345:e5945.
4. MacArthur G, et al. 2014 *Int J Drug Policy* 25(1):34-52.
5. Mattick R, et al. 2014 *Cochrane Database Syst Rev* 2:CD002207.
6. Esmaeili H, et al. 2014 *Drug Alcohol Rev* 33(2):186-193.
7. Nosyk B, et al. 2012 *Addiction* 107(9):1621-1629

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