



MEDICAID EVIDENCE-BASED DECISIONS PROJECT

Efficacy for Use of Detoxification Alone as a Treatment for Opioid Use Disorder

OVERVIEW

Opioid use disorder (OUD) is a major public health concern. According to the Centers for Disease Control and Prevention, over 65,000 Americans lost their lives to a drug overdose in the 12 months leading up to March 2017 (Centers for Disease Control and Prevention, 2017). The human and economic costs of the opioid crisis affect all aspects of our society.

State policymakers are interested in learning about the most effective treatments to address OUD and avoid unintended consequences such as overdose events, mortality from overdose, and use of illicit and unregulated drugs. Some policymakers have advocated for the use of residential detoxification programs to manage drug withdrawal as an option for patients with OUD. Some see residential programs as an avenue to medication assisted therapy and others see it as the first step in abstinence-based recovery. State officials requested this rapid response briefing on the role of inpatient or residential detoxification for the treatment of OUD.

ROLE OF DETOXIFICATION/ WITHDRAWAL MANAGEMENT IN TREATMENT OF OUD

According to the National Institute on Drug Abuse, detoxification can be defined as the management of withdrawal symptoms as opioids are discontinued. Addiction treatment experts consider detoxification to be one step in a comprehensive addiction treatment plan, but not definitive treatment in and of itself (National Institute on Drug Abuse, 2016b). Detoxification manages physical withdrawal symptoms as the drugs are discontinued, but the effects of OUD include changes to brain chemistry as well as social and functional behaviors that contribute to the addiction. After acute opioid withdrawal is over, the vast majority of patients must address continued opioid cravings, their addiction behaviors, and the psychosocial factors associated with their addiction. As the National Institute on Drug Abuse states in its fact sheet on treatment approaches for drug addiction,

“Detoxification is not in itself ‘treatment’ but only the first step in the process” of successful treatment (National Institute on Drug Abuse, 2016a, p. 3). Successful treatment for OUD includes the following:

- Detoxification
- Behavioral counseling
- Medications such as buprenorphine, methadone, or naltrexone which treat withdrawal symptoms and help patients stay in treatment to prevent relapse
- Evaluation and treatment for co-occurring mental health issues such as depression and anxiety
- Long-term follow-up care to prevent relapse (National Institute on Drug Abuse, 2014, 2016a)

Addiction relapse is common among individuals with OUD, although there are few published studies that track relapse rates. A commonly cited 2010 study published in the *Irish Medical Journal* found that of 109 patients followed after completing residential detoxification and abstinence-oriented treatment, 91% experienced a relapse; 59% relapsed within a week of discharge, and 80% relapsed within a month after being discharged from a residential detoxification program (Smyth, Barry, Keenan, & Ducray, 2010). Ensuring that patients have access to the full continuum of care for OUD treatment is essential in preventing patient relapse to OUD (Hser, Evans, Grella, Ling, & Anglin, 2015). Longer-term retention in treatment is associated with lower rates of illicit drug use, criminal behavior, and death (Hser et al., 2015).

AMERICAN SOCIETY OF ADDICTION MEDICINE GUIDANCE ON WITHDRAWAL MANAGEMENT

The American Society of Addiction Medicine (ASAM) publishes the most widely used criteria for the assessment of patients for substance use disorders and the creation of an appropriate treatment plan and level of care. The ASAM criteria uses the term “withdrawal management” rather than detoxification

and includes three levels of residential withdrawal management:

- **Level 4 Medically Managed Intensive Inpatient Withdrawal Management** in a hospital inpatient unit overseen by medical staff, which is intended for patients with such severe withdrawal symptoms that they require acute medical care services
- **Level 3.7 Medically Monitored Inpatient Withdrawal Management** at a freestanding withdrawal management center overseen by medical staff providing 24-hour inpatient care
- **Level 3.2 Clinically Managed Residential Withdrawal Management** in a freestanding withdrawal management facility with care overseen by specially trained clinicians but not medical or nursing staff (Mee-Lee, Shulman, Fishman, Gastrfriend, & Miller, 2013)

Level 3.2 withdrawal management is sometimes referred to as “social setting detoxification” or “social detox” (Mee-Lee et al., 2013).

While acknowledging that some patients may require residential detoxification because of the severity of their symptoms, the ASAM criteria specifically states that “current medication protocols now allow all but the most severe withdrawal syndromes to be managed effectively on an ambulatory basis” (Mee-Lee et al., 2013, pp. 128-129). Furthermore, the ASAM criteria states that “because withdrawal management protocols can relieve withdrawal symptoms so quickly and effectively, counseling and therapy focused on resumption of recovery *can be instituted at the same time as withdrawal management*, rather than being delayed (Mee-Lee et al., 2013, p. 128).

The ASAM criteria emphasizes the importance of each patient having a thorough assessment to determine the appropriate level of care and reduce inappropriate service utilization or readmission to intensive levels of service including repeated detoxification admissions. As the ASAM criteria states, “a ‘successful detox’ encounter involves more than acute management of withdrawal. It involves engagement in services to address the accompanying addiction process and thus reduce the likelihood of ‘readmission for detox’” (Mee-Lee et al., 2013, p. 129).

There is currently insufficient evidence to determine which therapy is best for a particular patient (Connery, 2015). The best evidence suggests that medication-

assisted treatment using methadone or buprenorphine is most likely to achieve long-term outcomes and provide patient safety (Connery, 2015). However, other treatments could be appropriate for some patients.

CONSIDERATIONS FOR POLICYMAKERS

Because detoxification in and of itself is not a treatment for OUD, policymakers should ensure that inpatient or residential detoxification providers conduct thorough patient assessments leading to an individualized plan of treatment with follow-up services. Most crucially, detoxification providers should ensure that patients have access to continuing treatment immediately upon discharge from detoxification, including access to opioid agonist therapy (i.e., buprenorphine and methadone), and opioid antagonists (i.e., injectable naltrexone), which can be started while the patient is in the detoxification program. In addition, policymakers could consider requiring detoxification providers to track patient outcomes and report on their findings.

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