

7.1 Rapid opiate detoxification guarantees completion; abstinence depends on what follows

Findings A study funded by the Israeli Ministry of Health compared outcomes from the world's largest private provider of 'ultra-rapid' opiate detoxification with those from a public service, conventional 30-day inpatient regime. Main findings were that more patients completed the rapid procedure but fewer remained abstinent.

At the private clinic withdrawal is precipitated by opiate antagonists (drugs which blocks the effects of opiates) while the patient is deeply sedated. Normally just one night's stay is required. Before discharge the patient starts daily naltrexone intended to continue for a year to prevent relapse. 60% of 139 'rapid' patients who had been treated 12 to 18 months earlier and 92% of 87 'conventional' patients were interviewed by phone. All the rapid patients had completed detoxification compared to 81% in the conventional programme, but nearly twice as many of the latter had remained abstinent from heroin – 42% versus 22%. The gap remained significant when differences between the patient groups were taken into account. None of the measured variables (including number of prior detoxification attempts) indicated that certain patients were suited to one of the programmes rather than the other. Even if the rapid programme had been implemented as a public service it would have cost nearly twice as much as the conventional programme per abstinent client.

In context Though details are scant, the study seems to be an example of how the benefits of rapid detoxification under sedation or anaesthesia (virtually guaranteed completion) can be undermined without adequate continuing support – the key factor in good long-term outcomes regardless of the detoxification method. In the shorter term, how rapid detoxification compares with conventional programmes will depend on the relative quality of the treatments. In the featured study, the completion rate in the conventional programme suggests that (on this indicator) quality was far higher than is typical in Britain. In contrast, the rapid detoxification clinic de-emphasised aftercare and its outcomes, though not atypical, have been bettered.

Deep sedation or anaesthesia entail a small risk of serious complications, including death. Assuming that alternatives are available and of acceptable quality, relatively few people will need (as opposed to choose) to undergo procedures requiring intensive care. Equally rapid procedures using lighter sedation (but sufficient to induce sleep) are likely to be safer and may have wider application. Regimes during which withdrawal is precipitated by antagonists but patients remain fully conscious, take a day or two longer, do not guarantee completion, and involve greater discomfort, but can produce good completion rates for inpatients and good long-term outcomes.

Rapid detoxification under deep sedation or anaesthesia costs about the same as conventional inpatient detoxification. Since completion rates are higher, the cost per completed detoxification is lower. However, there is some evidence that, given identical aftercare support, long-term success rates are similar, implying that the cost per long-term success too will be comparable. Lighter sedation eliminates the need for intensive care, potentially making it more cost-effective.

As with any antagonist-based treatment, loss of tolerance creates a serious risk of fatal overdose if patients discharged on naltrexone stop taking their medication and return to heroin use.

LINKS Nuggets 5.5 1.6

Practice implications Detoxification under anaesthesia or deep sedation may have a role for the minority of patients who are good candidates for continuing relapse prevention therapy, and among these, only patients who have not completed or will not countenance withdrawal using less radical procedures. In this sense, the method's main health benefit could be that it extends the opportunity to become opiate-free to a wider range of people.

How wide this range might be depends on the quality and attractiveness of the alternatives. Poor retention at British inpatient detoxification units creates scope for a technique where retention is not an issue. Similarly, lack of these units in some areas and waiting lists in others create a gap which could be filled by a high throughput method such as rapid detoxification, especially if costs and risks are reduced by lighter sedation. But unless accompanied by effective post-detoxification relapse prevention, high throughput could simply mean more frequently repeated detoxifications and overdose risk.

Fears that rapid and relatively painless detoxification would reduce engagement with longer term therapy, or hopes that it might provide a more auspicious start to an opiate-free life, do not seem to have been realised. Long-term recovery depends less on the detoxification technology than on what follows, particularly whether a supervisor is on hand (such as a family member or spouse) to help ensure naltrexone is taken and on the quality and intensity of monitoring and therapeutic support. It is too early to judge whether long-acting naltrexone implants will safely and effectively reduce the need such supervision and support.

Patients should be warned that though sedation or anaesthesia will shield them from the worst of the withdrawal process, they may well still feel unwell for days or weeks after discharge – the process is not an entirely painless exit from dependence.

Featured studies Lawental E. "Ultra rapid opiate detoxification as compared to 30-day inpatient detoxification program – a retrospective follow-up study." *Journal of Substance Abuse*: 2000, 11(2), p. 173–181. Copies: apply DrugScope.

Additional reading O'Connor P.G., et al. "Rapid and ultra-rapid opioid detoxification techniques." *Journal of the American Medical Association*: 1998, 279(3), p. 229–234. Copies: apply DrugScope.

Contacts Eli Lawental, Haifa Drug Abuse Treatment Centre, Rambam Medical Center, 26 Hagefen Street, Haifa, Israel, e-mail lawental@netvision.net.il.

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