Opioid detoxification

This article should be read in conjunction with the separate overview article Drug Misuse and Dependence: UK Guidelines.

Other topics related to this article are discussed in separate articles Opioid Analgesics, Opioid Misuse and Dependence, Assessment of Drug Dependence, Substitute Prescribing for Opioid Dependence, and Opiate Poisoning.

What is opioid detoxification?[1]

Detoxification is a clearly defined process to support safe and effective discontinuation of opioids while minimising withdrawal symptoms.

Detoxification normally follows induction and stabilisation on opioid substitution therapy, it is not a stand alone treatment. Detoxification alone has been associated with increased rates of relapse, morbidity, and mortality. If a person wishes to start detoxification without stabilisation on opioid substitution therapy, seek specialist advice.

Detoxification or discontinuation of opioid substitution therapy that is not agreed and part of a recovery care plan carries substantial risk and should be avoided apart from in the most exceptional circumstances.

Introduction[2]

- Opioid detoxification should be offered in an appropriate setting to informed opioid-dependent patients ready for, and committed to, abstinence.[2]
- Suitability for detoxification should be determined during the assessment process.
- The aim is for safe and effective discontinuation of opiates and minimal withdrawal symptoms.

- Detoxification usually takes about 28 days as an inpatient and up to 12 weeks in the community.
- NICE recommends that a community-based programme should be routinely offered. However, it does suggest that exceptions to this may include:
    - Those who have had previous unsuccessful community detoxification.
    - Those who need medical and nursing care due to significant mental or physical health problems.
    - Those who require complex polydrug detoxification.
    - Those who have significant social problems that may limit the success of community-based detoxification.
- Methadone, and buprenorphine are equally effective in detoxification regimens. The place of lofexidine in detoxification programmes requires further research.[3]
- Opioid detoxification should be offered as part of a package including preparation and post-detoxification support to prevent relapse.
- Psychosocial interventions (eg talking therapies, cognitive behavioural therapy, family therapy) and keyworking should be delivered alongside pharmacological interventions.[2]
- If detoxification is unsuccessful, patients should have access back into maintenance and other treatment.

Suitability for opioid detoxification

- Is the patient committed and fully informed about the detoxification process?[2]
    - Does the patient understand the physical and psychological aspects of opioid withdrawal and how they can be managed?
    - Does the patient understand how non-pharmacological approaches can help with withdrawal symptoms?
    - Does the patient understand the increased risk of overdose and death after detoxification if illicit drug use resumes (due to the loss of opioid tolerance; increased risk if alcohol and benzodiazepines are also used)?
- Has the high risk of relapse been explained to the patient?
- Are adequate social support networks available following detoxification?
- Is there availability of continuing professional support and treatment to maintain abstinence?

Drugs used in opioid detoxification[1]

Use the drug on which the patient has been stabilised. NICE states that there is no evidence that methadone or buprenorphine differs in its effectiveness during detoxification and recommends that they can both be used as first-line.[4]

Offer methadone or buprenorphine as first-line treatment in opioid detoxification, taking into account:

- The type of opioid that the person is currently taking for maintenance therapy (detoxification would normally be started with the same opioid).
- The person's preference.

Consider lofexidine for people:[2]

- Who have made an informed and clinically appropriate decision not to use methadone or buprenorphine for detoxification.
- Who have made an informed and clinically appropriate decision to detoxify within a short time period.
- With mild or uncertain dependence (including young people).

If lofexidine is used arrange for the person to be reviewed daily for blood pressure monitoring in the early stages of treatment as hypotension and bradycardia can be clinically significant.

Do not routinely offer ultra rapid or rapid detoxification using precipitated withdrawal. This should only be considered for people who specifically request it, clearly understand the associated risks and are able to manage the adjunctive medication.

Naltrexone is an opioid antagonist. It can block a former opiate user from experiencing the effects of opiates when taken regularly. Therefore, it can be helpful in maintaining abstinence following detoxification. Naltrexone is not licensed for detoxification, but is licensed as an adjunct to prevent relapse in detoxified formerly opioid-dependent people. Refer to a specialist if this is being considered. NICE guidance advises:[2]

- Naltrexone can be considered as a treatment option in people who have previously been opioid-dependent and are highly motivated to remain abstinent after detoxification.
- It should be given as part of a programme of supportive care.
- Patients should be fully informed of its potential adverse effects.
- Its effectiveness should be regularly reviewed and it should be discontinued if there is evidence of opioid misuse.

Drugs which should not be used routinely in detoxification include:

- Dihydrocodeine is not licensed for the treatment of drug dependence, and is not recommended for use in primary care. Dihydrocodeine may occasionally be prescribed for people unable or unwilling to consider or tolerate methadone or buprenorphine. However, it should only be prescribed by clinicians with appropriate specialist competencies.

- Clonidine.

GPs prescribing methadone or buprenorphine should do so in instalments using FP10 (MDA) in England and Wales or GP10 (3) in Scotland, initially daily. For more information on writing prescriptions for controlled drugs in general practice see separate Controlled Drugs article.

Review people at intervals determined by the speed of withdrawal and the supportive care available from the shared-care team. Following successful opioid detoxification continue to monitor for at least 6 months.

Other drugs for withdrawal symptoms

Evidence that any of these drugs improve outcome is lacking: [1]

- **Diarrhoea**: loperamide 4 mg immediately followed by 2 mg after each loose stool for up to five days; usual dose 6-8 mg daily, maximum 16 mg daily.
- **Nausea, vomiting and stomach cramps**: metoclopramide 10 mg every eight hours or prochlorperazine 5 mg tds or 12.5 mg IM 12-hourly.
- **Stomach cramps**: mebeverine 135 mg tds.
- **Agitation, anxiety and** insomnia: diazepam up to 5-10 mg tds prn or zopiclone 7.5 mg nocte if previously benzodiazepine-dependent.
- **Muscular pains and headaches**: paracetamol and non-steroidal anti-inflammatory drugs or topical rubefacients.

Further reading

- Supporting opioid detoxification; GOV.UK, July 2021.

Authored by:	Peer Reviewed by: Dr Hayley Willacy, FRCGP	
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