



PCSS Guidance

Topic: Psychosocial Aspects of Treatment in Patients Receiving Buprenorphine/Naloxone

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Guideline Coverage: This topic is also partially addressed in Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction (TIP 40), pages 63-64. <http://buprenorphine.samhsa.gov/Bup%20Guidelines.pdf>

Clinical Questions:

1. Do my patients who are receiving buprenorphine/naloxone (bup/nx) for the treatment of opioid dependence need additional psychosocial treatment?
2. What type of psychosocial treatment should they get?
3. How much psychosocial treatment should they get?

Background:

Many patients with opioid dependence do not fully respond to buprenorphine treatment alone. They may continue some degree of illicit opioid use, they may continue problematic use of other substances, or they may continue to struggle with core life issues such as relationships and employment. It makes sense that some patients would benefit from psychosocial interventions directed at the areas in which difficulties persist, although some uncertainty remains as to the optimal intensity or modality of psychosocial treatments for these patients.

Studies of various intensities of psychosocial services in licensed methadone programs do offer some illumination on this point: patients who receive minimal psychosocial services do not fare as well as those who receive moderate or high levels of services.¹⁻³ However, the lower cost-effectiveness of more intensive services may nullify any slight advantage they hold over moderate services.^{3,4} A study evaluating different doses of buprenorphine for combined opioid and cocaine dependence did find that more frequent attendance at weekly individual psychotherapy appointments was associated with better outcomes.⁵ The one study that has so far rigorously addressed the question of intensity among buprenorphine treated patients supports the idea of providing a moderate intensity of psychosocial services. The study examined the efficacy of weekly extended medical management counseling (45 minute sessions) compared to weekly standard medical management counseling (20 minute sessions) and demonstrated no advantage of the extended counseling.⁶

In regard to modalities of psychosocial treatments, the accumulated general knowledge on modalities of psychotherapy indicates that individual therapist skill at creating a therapeutic alliance has more effect on outcomes than the particular type of therapy practiced.⁷ More specifically, the therapeutic alliance has a strong effect on outcomes in

psychosocial interventions for substance dependence.⁸ Nevertheless, a variety of specific modalities have been applied to patients with opioid dependence such as individual drug counseling,⁹ cognitive-behavioral therapy,¹⁰ supportive-expressive psychotherapy,⁹ relapse prevention,¹¹ contingency management,¹² and medical management.⁶ A recent meta-analysis of psychosocial interventions for substance use disorders that included interventions for opioid dependence found that both cognitive-behavior therapy and contingency management had positive moderate effects with a slight advantage for contingency management.¹³ Psychotherapy performed better than drug counseling for patients with high psychiatric symptomatology.¹⁰ There is some evidence that targeting psychosocial services specifically to address patient problem areas is beneficial.¹

A third point pertains to the use of self-help groups such as 12 step programs. Such groups are widely attended and generally encouraged or even required by many addiction treatment programs. A large body of literature has addressed the benefit of self help groups for alcohol dependence with methodological limitations precluding firm scientific validation of their value.¹⁴ There has been very little study of use of such groups for opioid dependence. In the past and probably currently many of these groups tend to stigmatize patients on agonist therapy. Nonetheless, these groups do offer readily available psychosocial treatment at no cost.

General Principles: The majority of opioid dependent patients treated with buprenorphine will benefit from some amount of psychosocial treatment in addition to pharmacotherapy. Treatment providers should encourage engagement in psychosocial treatment. The quality of the therapeutic alliance between psychosocial therapist and patient is probably more important than the type of therapy applied. A modest “dose” of psychosocial treatment is probably sufficient for most patients.

Recommendations: Level of evidence: **High – randomized trials**

- 1) Refer patients receiving buprenorphine/naloxone for some type of psychosocial intervention (or provide these services onsite)
- 2) For most patients weekly or monthly psychosocial intervention is an adequate frequency.

Recommendation: Level of evidence: **Moderate – observational studies**

- 3) Since therapeutic alliance is a good predictor of benefit from psychosocial treatment, seek referral sources with whom patients report substantial positive rapport early in the course of psychosocial treatment.

Recommendation: Level of evidence: **Low – expert opinion/clinical experience**

- 4) Do not require patients to attend self-help groups but encourage those with an interest to try such groups and to find a particular group where they feel accepted.

References

1. McLellan AT, Arndt IO, Metzger DS, Woody GE, O'Brien CP. The effects of psychosocial services in substance abuse treatment [see comments]. *JAMA* 1993;269:1953-9.
2. Calsyn DA, Wells EA, Saxon AJ et al. Contingency management of urinalysis results and intensity of counseling services have an interactive impact on methadone maintenance treatment outcome. *Journal of Addictive Diseases* 1994;13:47-63.
3. Avants SK, Margolin A, Sindelar JL et al. Day treatment versus enhanced standard methadone services for opioid-dependent patients: a comparison of clinical efficacy and cost. *American Journal of Psychiatry* 1999;156:27-33.
4. Kraft MK, Rothbard AB, Hadley TR, McLellan AT, Asch DA. Are supplementary services provided during methadone maintenance really cost-effective? [see comments]. *American Journal of Psychiatry* 1997;154:1214-9.
5. Montoya ID, Schroeder JR, Preston KL et al. Influence of psychotherapy attendance on buprenorphine treatment outcome. *J Subst Abuse Treat* 2005;28:247-54.
6. Fiellin DA, Pantalon MV, Chawarski MC et al. Counseling plus buprenorphine-naloxone maintenance therapy for opioid dependence. *N Engl J Med* 2006;355:365-74.
7. Horvath AO, Luborsky L. The role of the therapeutic alliance in psychotherapy. *Journal of Consulting & Clinical Psychology* 1993;61:561-73.
8. Meier PS, Barrowclough C, Donmall MC. The role of the therapeutic alliance in the treatment of substance misuse: a critical review of the literature.[see comment]. *Addiction* 2005;100:304-16.
9. Woody GE, McLellan AT, Luborsky L, O'Brien CP. Psychotherapy in community methadone programs: a validation study. *Am J Psychiatry* 1995;152:1302-8.
10. Woody GE, McLellan AT, Luborsky L et al. Severity of psychiatric symptoms as a predictor of benefits from psychotherapy: the Veterans Administration-Penn study. *Am J Psychiatry* 1984;141:1172-7.
11. Weddington WW. Towards a rehabilitation of methadone maintenance: integration of relapse prevention and aftercare. *Int J Addict* 1990;25:1201-24.
12. Stitzer M, Petry N. Contingency management for treatment of substance abuse. *Annu Rev Clin Psychol* 2006;2:411-34.
13. Dutra L, Stathopoulou G, Basden SL, Leyro TM, Powers MB, Otto MW. A meta-analytic review of psychosocial interventions for substance use disorders. *Am J Psychiatry* 2008;165:179-87.
14. Ferri M, Amato L, Davoli M. Alcoholics Anonymous and other 12-step programmes for alcohol dependence. *Cochrane Database Syst Rev* 2006;3:CD005032.

The following links may be helpful in locating professional counseling services or locations of self-help meetings:

<http://findtreatment.samhsa.gov/>

http://www.alcoholics-anonymous.org/en_find_meeting.cfm

<http://portaltools.na.org/portaltools/MeetingLoc/>

PCSS Guidances use the following levels of evidence*:

High = Further research is very unlikely to change our confidence in the estimate of effect.

Moderate = Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.

Low = Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.

Very low = Any estimate of effect is very uncertain.

Type of evidence:

Randomized trial = **high**

Observational study = **low**

Any other evidence = **very low**

* Grading quality of evidence and strength of recommendations

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