



PCSS Guidance

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

Original Author: Andrew J. Saxon, M.D.

Last Updated: 11/29/2021 (A. Benjamin Srivastava, M.D.)

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://www.ncbi.nlm.nih.gov/books/NBK64245/pdf/TOC.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. The high rates of relapse seen in opioid dependence treatment, despite the pharmacological effectiveness of agonist treatment, suggest that many of the symptoms most distressing to opioid users during early abstinence are psychological rather than physical symptoms associated with the withdrawal syndrome (Amato et al., 2008). And for opioid-dependent patients maintained for five years or more on agonist treatment, psychological distress -- rather than drug-related variables -- has been found to have a significant negative impact on Quality of Life (De Maeyer et al., 2011). It makes sense that many 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. It is also important to note that all clinical trials of psychosocial treatments for opioid users have taken place in programs that also provide either opioid agonist maintenance (i.e. methadone or buprenorphine) or opioid antagonist treatment.

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 (McLellan et al., 1993; Calsyn et al., 1994; Avants et al., 1999). However, the lower cost-effectiveness of more intensive services may nullify any slight advantage they hold over moderate services (Avants et al., 1999; Kraft et al., 1997). One study that has 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 (Fiellin et al., 2006). In another study, 141 patients with OUD were randomized to receive either standard medical management or weekly cognitive behavioral therapy (CBT) in addition to buprenorphine. There were no differences between the two groups in terms of reductions in opioid use (though opioid use decreased significantly in both groups (Fiellin 2013)). In yet another study OUD patients were randomized to receive CBT, contingency management, CBT+ contingency management, or medication management in addition to buprenorphine. All groups showed improvement in opioid use behavior, with no significant difference between groups (Ling et al 2013). In a multi-site trial enrolling 653 participants with OUD randomized to weekly medical management or individual drug counseling during a four week buprenorphine taper and for those who relapsed, 12 weeks of

buprenorphine maintenance treatment. While very few (7%) patients achieved abstinence during the taper phase, 49% achieved abstinence during the stabilization phase. There was no significant difference in rates of abstinence between the two groups (medical management or drug counseling) in either phase (Weiss 2011).

While these studies suggest medical management alone may be appropriate, how this translates to community-based settings is unclear. Given attrition with buprenorphine, psychosocial interventions, particularly contingency management, may improve compliance and treatment retention. (Weiss and Carroll 2017). Other modalities have also demonstrated efficacy across substance use disorders (link with next paragraph).

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 (Horvath et al., 1993). More specifically, the therapeutic alliance has a strong effect on outcomes in psychosocial interventions for substance dependence (Meier et al., 2005). Nevertheless, a variety of specific modalities have been applied to patients with opioid dependence such as individual drug counseling, (Woody et al., 1995) cognitive-behavioral therapy, (Woody et al., 1984) supportive-expressive psychotherapy, (Woody et al., 1995) relapse preventions (McLellan et al., 1993) contingency management, and medical managements. Network therapy, involving the participation in treatment of drug-free significant others or family members, has also been found helpful in methadone-maintained patients. Most methadone patients have abstinent support people who are willing to participate in weekly treatment, and this participation is associated with high rates of attendance at scheduled sessions (Kidorf et al., 1997).

A 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 (Dutra et al., 2008). Psychotherapy performed better than drug counseling for patients with high psychiatric symptomatology (Woody et al., 1984). There is some evidence that targeting psychosocial services specifically to address patient problem areas is beneficial (McLellan et al., 1993). In particular, concurrent depression should be assessed during the outset of treatment for opioid dependence; if it does not improve, specific psychosocial interventions or antidepressant medications should be offered (Nunes et al., 2004). Further, combining opioid agonist maintenance with either psychological counseling or contingency management has been found to reduce rates of relapse to intravenous heroin use and related risk factors, thereby reducing the incidence of HIV and hepatitis C (Wang et al., 2014). A recent meta-analysis of randomized clinical trials for individuals with opioid dependence undergoing detoxification has confirmed that psychosocial therapies offered in addition to pharmacological treatment are more effective in terms of treatment completion, opioid use, and adherence (Amato et al., 2008). Moreover, treatment with buprenorphine and associated psychosocial counseling has been found to be safe and relatively easy to implement in a variety of treatment settings (Miotto et al., 2012).

Psychosocial treatment, its benefits notwithstanding, may be a barrier to care, particularly for individuals without resources (i.e., homeless populations). Recent evidence suggests that provision of buprenorphine without a structured psychosocial program may yet engage these populations in treatment and reduce opioid use (Carter 2019). In addition, self-help 12-step programs such as Narcotics Anonymous and Alcoholics Anonymous 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 (Ferri et al., 2006). Studies of substance abuse treatment counselor attitudes have found that a 12-step orientation predicted less favorable attitudes toward buprenorphine (Rieckman et al., 2011, Knudsen et al., 2005), and stigma towards MOUD is a well recognized phenomenon in 12-Step groups (Monico 2015). Nonetheless, these groups do offer readily available psychosocial treatment at no cost, and they are beneficial in providing peer support for relapse prevention and continued participation in treatment. In the past couple of years, there has been growing acceptance of buprenorphine among some prominent addiction treatment organizations. Clearly, more integrated treatment efforts are needed, combining the strengths of this traditional approach to addiction with newer pharmacotherapies that can prevent relapse and protect against overdose risk for recovering opioid users.

General Principles:

Patients with OUD treated with buprenorphine may benefit from concurrent psychosocial treatment in addition to pharmacotherapy, though more research is needed to better identify these patients (Carroll and Weiss 2017). Treatment providers should encourage engagement in psychosocial treatment when available; however psychosocial treatment should not be a barrier to provision of buprenorphine when it is not available or if the patient declines such interventions. The quality of the therapeutic alliance between psychosocial therapist and patient is probably more important than the type of therapy applied. A modest intensity and frequency of psychosocial treatment is probably sufficient for most patients, particularly those with social anxiety. Appropriate psychosocial treatments, offered in conjunction with pharmacotherapy for opioid dependence, can be valuable in supporting patients' recovery efforts. Providing such referrals can help to address the substantial public impact of opioid dependence. Current guidelines for the treatment of opioid dependence by PCSS-MAT are consistent with those developed by the American Society of Addiction Medicine (ASAM) (Crotty et al 2020).

Treatment with pharmacotherapies such as buprenorphine/naloxone, methadone, or naltrexone combined with psychosocial therapy.

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.

Recommendations:

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.
- 4) Given that depression and other types of psychological distress are associated with dropout from treatment and relapse to opioid addiction, psychosocial treatments addressing such symptoms can improve treatment retention and outcome.

Recommendation:

Level of evidence: **Low - expert opinion/clinical experience**

- 5) 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.

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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/>

The following links may be helpful in locating buprenorphine (Suboxone, Subutex) providers:

http://www.suboxone.com/hcp/certification/physician_locator.aspx

<http://www.naabt.org/tl/buprenorphine-suboxone-treatment.cfm>

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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