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▶ Psychosocial combined with agonist maintenance treatments versus agonist maintenance treatments alone for treatment of opioid dependence.

Amato L., Minozzi S., Davoli M. et al.
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Update of Cochrane review of rigorous studies surprisingly finds that adding psychosocial therapy to opiate substitute prescribing makes no difference to retention or substance use – a testament to the power of the routine treatment and a blow (but not a fatal one) to hopes that extra therapy would aid recovery and treatment exit.

Summary Maintenance treatments with pharmacological agents which substitute for heroin can reduce the risks associated with use of street drugs for addicts unable to abstain from drug use. Methadone retains patients in treatment and reduces heroin use, but re-addiction remains as a substantial challenge. Opiate addicts often have psychiatric problems such as anxiety and depression and may not be able to cope with stress. Psychosocial interventions including psychiatric care, psychotherapy, counselling, and social work services are commonly offered as part of maintenance programmes. Psychological support varies from structured psychotherapies such as cognitive-behavioural therapy and supportive-expressive therapy to behavioural interventions and contingency management. This review addressed whether these specific psychosocial interventions create any additional benefit relative to usual pharmacological maintenance treatment, which itself routinely includes counselling.

The reviewers sought trials which randomly allocated patients to opiate substitute prescribing with and without extra therapy or used some other procedure to ensure comparability between the sets of patients. In the event all 35 studies (involving in total 4319 participants) randomly allocated patients either as individuals or groups. The USA accounted for 31 studies and one each was conducted in Germany, Malaysia, China, and Scotland. Most often they tested therapies from the behavioural family which generally assume drug dependence is a learnt behaviour which can be unlearnt, and focus on changing behaviours rather than for example developing insights in to why those behaviours might have come about.

Main findings

Without psychosocial therapy 68 of 100 patients were retained in treatment to the end of the study; with therapy this rose to 70, a difference which might have occurred by chance. Similarly the three studies which reported retention to the end of the follow-up period also together found no significant difference, though here the balance was actually in favour of standard treatment (71 versus 64 in every 100 retained).

Eight studies documented how many patients remained abstinent from non-prescribed opiate-type drugs as confirmed by consecutive urine tests over at least three weeks. Though in favour of therapy patients (on average 12% more abstinent) this difference was not statistically significant so might reflect chance variations. Results were similar across the three studies reporting abstinence at the end of the follow-up period.

Across the three studies to have reported on these variables, there were no statistically significant differences in treatment session attendance or in symptoms of psychological problems and specifically depression.

Neither were there any statistically significant improvements in these outcomes when the different types of psychosocial therapies were considered separately. Of these, the most often evaluated were therapies from the behavioural family, across which retention and abstinence were virtually identical regardless of whether therapy was offered. In relation to retention, the same was true of contingency management studies studies in particular.

The authors' conclusions

The previous version of this review found that therapy improved both retention and opiate abstinence; with more studies at its disposal, this update found neither to be the case. Though larger and further studies with longer follow-ups and rigorous, wide-ranging assessments may yet record benefits, as things stand the evidence does not indicate that adding psychosocial therapy improves the effectiveness opiate substitute prescribing programmes. This means that methadone maintenance treatment should be provided even if additional psychosocial therapies cannot be funded.

It should be however be remembered that that these therapies were compared not with substitute drugs only, but these plus routine counselling. The results reflect the added value of structured psychosocial interventions implementing specific therapies, not whether any kind of psychosocial intervention helps.

The results of this review contrast with those of a companion review of adding psychosocial therapy to 'detoxification' programmes which prescribe substitute drugs on a reducing schedule with a view to patients becoming entirely free of these and street drugs. Across these studies, adding therapy did improve retention as well as reducing opiate use during and after treatment. The difference between impacts in these two types of treatments may arise because maintenance treatments have robust effects in themselves and counselling is usually offered along with methadone. Possibly too, detoxification patients are less stable – usually a personal crisis precipitates detoxification – and have more issues to deal with. If psychosocial interventions help with these issues, it seems reasonable to expect improved outcomes.

FINDINGS The results of this review will be a blow to ambitions in British national drug policies (England; Scotland) to make methadone maintenance in Britain more recovery-

oriented. For an expert group convened for the UK government which addressed this issue, psychosocial therapies were one way to enhance the recovery potential of methadone treatment. The review suggests that across the entire caseload, these therapies do not help. That they do not extend retention may be dismissed in an era when the emphasis has shifted to treatment exit. However, this emphasis is softened by the expectation that exit will be of 'recovered' addicts no longer using street drugs; it seems in that respect too that structured psychosocial therapies have offered no added value across researched caseloads.

Methadone treatment: powerful in itself

Sometimes denigrated as 'merely' substituting one drug for another, the review's findings are a testament to the power of routine methadone maintenance. The impact of a legal supply of a more 'normalising', smoother and longer acting drug like oral methadone on patients, many of whom previously had to offend several times a day to sustain the roller-coaster of repeated daily heroin injections, is in itself typically rapid and powerful. Some examples below.

The impact was visible in a study in Baltimore where for the first four months crisis counselling only was provided to randomly selected patients. Over this period they did as well as patients offered standard weekly or more enhanced counselling and the improvements were substantial, heroin use falling from on average virtually daily to two to four days a month. That kind of finding has been replicated in other studies of 'interim' methadone arrangements which accelerate treatment entry by for a time doing without standard counselling. Particularly instructive was a different kind of trial in San Francisco which randomly allocated patients to methadone-based detoxification, or to six months of methadone maintenance with just 15 minutes of counselling a month or at least two sessions a month and more if needed. What made the difference to both heroin use and drinking was being on methadone. Additional counselling led to no further reductions or any other statistically significant differences in outcomes.

In Britain too questions have been raised about the benefits of and therefore the need for regular counselling. Finding itself overwhelmed with referrals, a prescribing service in Scotland introduced a 'low threshold' methadone programme which provided counselling and other forms of help only when the client actively sought them. The 'chaotic' caseload was typically unemployed and recently or currently homeless and injecting several times a day. The effect was to widen treatment access, the impact on retained patients was beneficial, and many went on to the full prescribing programme or to GPs. 69 of 101 patients were retained long enough to complete the eight-week follow-up. They reported dramatic reductions in injecting and sharing injecting equipment. The proportion involved in crime fell and depression receded. Discharged patients had typically stayed for 4.5 months, longer than envisaged, partly because many did not want to transfer to the more comprehensive programme with standard counselling.

Also a testament to the power of methadone maintenance, one conclusion reached by the review was that on average psychosocial therapies add little or nothing to this treatment but do bolster other treatments, specifically those which use the same drug but on a reducing detoxification schedule. It was also one finding of a US study of intensive case management support for welfare applicants with substance use problems. Providing this helped in terms of achieving abstinence, but only among applicants not already managed in substitute prescribing programmes. For those who were, case management made no significant difference. Again it is important to remember that in the US context the methadone patients would already have been being counselled regularly and seeing clinic staff virtually daily.

Not an argument against counselling

The review's findings do not however mean psychosocial support is useless. First, the therapies tested did not exhaust the possibilities. Second is the point made by the reviewers that counselling was provided to comparison patients. It can be added that since most studies were from the USA, they would also usually have been required to attend the clinic almost daily to take their methadone – more potentially therapeutic staff contact than many British patients experience – and that generally patients volunteered to be randomly allocated to therapy or not. If they did so because they did not care much either way, it comes perhaps as no surprise that on average they did as well with as without.

Evidence that counselling does help in some circumstances comes from for example a US study which for the first 24 weeks randomly assigned 100 patients starting methadone maintenance either to monthly counselling, three sessions a week, or seven sessions a week plus medical, psychiatric, employment and family therapy services. More support led to better drug problem, crime and health outcomes. Though it cost more, the three times a week option was actually more cost-effective than monthly counselling in terms of the cost of services actually delivered per patient abstinent from heroin and cocaine.

Psychotherapy benefits only patients who need it

For research purposes, commonly studies exclude psychologically unstable patients, the very ones who some US studies described below suggest might have benefited from psychotherapy.

These studies found extra benefits from psychotherapy for methadone patients with psychiatric problems but not for those without. Benefits were apparent in some ways (but not in substance use) among patients with moderately severe problems, but more clear cut for the high severity patients who consistently improved more after being randomly allocated to professional psychotherapy, including a greater reduction in days of opiate use. Without psychotherapy, among these patients opiate use remained virtually unchanged. Clinical records showed that the two groups of patients with appreciable (mid or high) psychiatric severity had more drug positive urines when offered drug counselling alone without psychotherapy and had required higher doses of methadone, typically a response to continuing problems.

Later the study was broadly replicated among patients selected for severe psychiatric symptoms attending three more typical methadone programmes. In all 123 were sufficiently severe to be randomly allocated to an extra therapy session a week for 24 weeks of either supportive expressive psychotherapy, or drug counselling of the kind they were already receiving. On nearly every measure, by the final follow-up psychotherapy patients were doing better than those given drug counselling, though usually the differences were modest. After the initial impacts of being on methadone had evened out, patients given psychotherapy evidenced somewhat better psychiatric adjustment and a move towards a more conventional and law-abiding lifestyle. However, in some respects the effects were not as substantial as in the previous study and were not seen at the initial follow-up, perhaps partly because both groups of patients were offered an extra therapy session a week. This was intended to eliminate concerns that the earlier findings might have reflected the amount of therapeutic contact rather than its type. Given the relative findings of the two studies, it seems these concerns were at least partly valid – that perhaps amount was an important active ingredient.

But is it the therapy or the quality of the interaction?

These studies cast some doubt over the implicit assumption tested by the review that it is the structured, theory-driven nature of psychosocial therapy which is important. An alternative is that it is instead the quality and quantity of therapeutic contact with staff whether or not this features 'brand name' therapies. If this is what counts most, it makes sense that offering a little extra therapy to what is already intensive staff contact would

make no difference. The answer is probably a mix of both but perhaps more weighted to the quality of the interaction whether or not it adopts a specific therapeutic programme or philosophy.

This seemed the message of a rare British study which found that offering cognitive-behavioural therapy to methadone patients in addition to routine keyworking led to reductions in the severity of addiction and heroin use, and improved compliance with prescribed methadone. But with a small sample, the differences were not statistically significant so may have occurred by chance. If they were real it was generally not because cognitive-behavioural therapy led to the intended psychological changes any more effectively than routine treatment. The findings suggest that extra therapeutic contact did help stabilise patients who were prepared to accept it, but whether this needed to be cognitive-behavioural or a recognised therapy of any kind seems questionable, particularly since in addiction treatment in general, cognitive-behavioural therapy is no more effective than other similarly extensive and coherent approaches, even when these amount simply to well-structured medical care.

As described in these Findings notes, the quality of counselling seemed decisive at a US methadone clinic where patients were allocated in a virtually random fashion to four drug counsellors. Two were moderately effective, the third very effective and the fourth not effective at all. The most effective counsellor was able to bring his clients to a point over a six-month period where their drug use and unemployment were significantly reduced when compared with the prior six months, while at the same time reducing their use of both methadone and ancillary psychoactive medications. By contrast, the clients of the least effective counsellor showed increased unemployment, drug use and criminal activity, and needed more methadone and ancillary medication. When the case notes were examined in detail, it became clear that the most effective counsellor was able to help clients anticipate their problems and assist them in developing ways of dealing with them before they arose. This was the quality which most clearly distinguished this counsellor from the moderately effective ones who were similarly qualified.

Other issues

In respect of contingency management, the review's findings differ from those of another synthesis of the research published in the year 2000. It found 30 relevant studies across which the systematic application of incentives led to more drug-free urine tests. Though effects were significantly smaller than in non-randomised trials, this was also the case among the 17 trials which randomly allocated patients, but effects were modest and even more so when urine tests were conducted less than three times a week.

According to the featured review, only 1 of 27 studies in itself found a statistically significant improvement in retention at the end of the study. In fact it was even worse – a remarkable clean sweep with no finding in favour. The one apparently positive finding seems to have been a mistake by the reviewers and that study too found no significant difference.

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