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Do manualized psychosocial interventions help reduce relapse among alcohol-dependent adults treated with naltrexone or placebo? A meta-analysis.

Agosti V., Nunes E.V., O'Shea D. et al.

American Journal on Addictions: 2012, 21(6), p. 501–507.

Unable to obtain a copy by clicking title? Try asking the author for a reprint by adapting this prepared e-mail or by writing to Dr Agosti at agostiv@pi.cpmc.columbia.edu.

Supplementing the medication naltrexone with psychosocial relapse-prevention therapies has not helped prevent relapse among alcohol-dependent patients. However, these therapies have elevated outcomes among placebo patients to the level of those prescribed naltrexone.

SUMMARY Medications such as naltrexone and acamprosate are used in the treatment of alcohol dependence to combat frequent relapse to heavy drinking, but their impact has overall been modest, and many patients leave treatment early or do not take medication as intended. Researchers have tried to address these shortcomings by supplementing medication with psychosocial interventions. The featured review assessed whether these attempts have been successful by conducting a meta-analytic synthesis of results from studies which used psychosocial relapse-prevention interventions (typically cognitive-behavioural in approach) to support adult, alcohol-dependent patients who had achieved abstinence, and then randomly been allocated either to naltrexone or a placebo. Relapse was defined as a return to drinking at least 70g alcohol a day for men or 56g for women.

Four of the 18 studies which met these criteria had also randomly allocated patients to cognitive-behavioural therapies versus a different approach – specifically either medical management or supportive psychotherapy. These direct tests of the impact of a cognitive-behavioural approach were analysed separately from the remaining 20 studies, in which all the patients were offered the same psychosocial therapies, either cognitive-behavioural or one typical of that type of service.

All 18 studies had recruited nearly 2,600 patients on average about 42 years old. Where this was known, three-quarters were men, 71% were employed, and about half were married.

Key points

The review synthesised results from relevant studies to test whether supplementing the medication naltrexone with psychosocial relapse-prevention therapies helps prevent relapse among adult, alcohol-dependent patients.

It concluded this was not the case, though one finding suggested that psychosocial therapies can elevate outcomes for patients prescribed a placebo to the level of those prescribed naltrexone.

The implications of this and of other studies are that naltrexone can be a valuable supplement to medical counselling of dependent drinkers, especially when specialist therapies such as cognitive-behavioural therapy are refused or unavailable.

In some situations these therapies also work better when naltrexone is added. But if the core treatment is naltrexone, good quality medical care or counselling will on average be as effective as specialist structured psychosocial therapies.

Main findings

Within each of the four studies which had randomly allocated patients to these therapies, generally the proportions who relapsed when supported by cognitive-behavioural therapies were about the same as those who relapsed when supported in other ways. This was the case both among patients given naltrexone and those allocated to a placebo. When results from these studies were pooled, relapse rates among patients allocated to naltrexone or placebo were virtually the same regardless of the type of psychosocial support.

Among the remaining studies which each allocated all their patients to the same form of psychosocial support, results were available from seven in which this was a structured, manualised programme, usually cognitive-behavioural in nature. Across these studies, virtually the same proportion of patients (about half) relapsed whether prescribed naltrexone or placebo. In contrast, when support took a typical, less structured form such as counselling, fewer naltrexone patients relapsed (33%) than did patients prescribed a placebo (43%). This contrast was statistically significant, and was largely due to results from older studies published between 1992 and 1997. Another unexpected finding was that whether prescribed naltrexone or a placebo, fewer patients relapsed when the treatment was a typical approach than when it was a structured psychosocial therapy.

The authors' conclusions

Results show that relative to other approaches, cognitive-behavioural therapy did not significantly decrease the likelihood of relapse to heavy drinking among patients prescribed naltrexone or among those prescribed a placebo, and did not augment the impacts of naltrexone relative to an inactive placebo. In the four studies which made direct comparisons, supportive psychotherapy and medical management interventions worked as well. Among the remaining studies, overall those which used a manualised programme such as cognitive-behavioural therapy actually recorded higher rates of relapse than studies which used a more typical, less structured approach.

These results should be viewed in the light of several major limitations. No adjustments could be made for important factors related to the chance of successful treatment such as severity of dependence, and relapse to heavy drinking was

the only drinking outcome sufficiently commonly reported to be amalgamated across the studies. Also, the results derived from studies that required initial abstinence and excluded patients with major comorbid disorders, diminishing their applicability to routine practice.

COMMENTARY The weight of the evidence in respect of treating alcohol or drug dependence is that despite the prominence of cognitive-behavioural therapies, their theoretical pedigree, and an extensive research effort which has distilled them in to expert manuals (for example, 1 2), overall the advantage they confer over alternatives is minor, and especially so when added to a drug-based treatment. In respect of alcohol problems, an analysis has concluded that any variation in outcomes across different psychosocial therapies is likely to have been due to chance or to the allegiance of the researchers.

However, the large US COMBINE trial did find that supplementing inactive placebo pills with psychological therapy incorporating cognitive-behavioural elements raised outcomes to the level of patients prescribed naltrexone. A similar message emerged from another US study which found that as long as naltrexone was prescribed, primary care-style consultations were as effective as specialist cognitive-behavioural therapy in initiating and sustaining recovery from alcohol dependence. Without the medication, cognitive-behavioural therapy was the more effective option. A similar result emerged from the featured review's analysis of studies which offered the same psychosocial support to all patients; when this was a structured therapy (generally cognitive-behavioural), it helped raise outcomes for placebo patients to the level of those prescribed naltrexone.

All these results suggest that structured therapies can elevate the outcomes of patients not prescribed an active medication to the level of those prescribed naltrexone – that either medication *or* structured therapy help relative no medication plus typical care. Combining the two does not augment the drug's impacts – a surprise, since relapse-prevention therapies would be expected to have their own impacts and to give medication greater leverage by persuading more patients to complete treatment and take the pills as intended.

Even if adding structured cognitive-behavioural therapy to naltrexone does not help, the reverse may still be the case – that supplementing cognitive-behavioural therapy with naltrexone makes a more effective package. In several studies (described in these notes) this has indeed been the case. The findings are in line with guidance from the UK's National Institute for Health and Clinical Excellence (NICE) that in addition to evidence-based psychological interventions, patients whose alcohol dependence is moderate or severe should also be able to access relapse prevention medication, including naltrexone.

Practice implications seem to be that naltrexone can be a valuable supplement to the medical counselling (by GPs or nurses) of dependent drinkers of the kind who might be treated in primary care, especially when specialist therapies such as cognitive-behavioural therapy are refused or unavailable. In some situations these therapies also work better when naltrexone is added. But if the core treatment is naltrexone, a good quality medical care approach or counselling will on average be as effective as specialist structured psychosocial therapies.

Last revised 17 April 2015. First uploaded 10 April 2015

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