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▶ Psychosocial and pharmacological treatments versus pharmacological treatments for opioid detoxification.

Amato L., Minozzi S., Davoli M. et al.
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Review of controlled studies finds that offering therapy and incentives alongside drugs which ameliorate withdrawal symptoms increases the numbers who complete detoxification from heroin and allied drugs and who stay opiate free, but still most do not do either.

Summary People who abuse opioid drugs and become dependent on them experience social issues and health risks. Medications such as methadone and buprenorphine are substituted to help dependent drug users detoxify and return to living drug free, by reducing physiological withdrawal symptoms (pharmacological detoxification). Yet psychological symptoms can occur during detoxification and may be distressing. Often a personal crisis led to a drug user deciding to detoxify. Furthermore the psychological reasons why a person became addicted are important. They may not be able to cope with stress and have come to expect that using mood-modifying illicit substances helps. Even after successful return to a drug-free state, many people return to heroin use and re-addiction is a substantial problem. The physiological, behavioural and social conditions in an individual's life that made them an opiate addict may still be present when physical dependence on the drug has been eliminated. These considerations suggest that psychosocial therapy should be an important component of detoxification programmes. These interventions include behavioural treatments, counselling and family therapy.

To test this propositions, the review authors searched the medical literature and found eleven studies involving 1592 adults which randomly allocated opioid-dependent patients to pharmacological detoxification with versus without psychosocial interventions. All but one study was from the USA. Psychosocial interventions tested in these studies were: contingency management; community reinforcement structured counselling of various kinds; or family therapy

Main findings

Meta-analytic synthesis of the findings showed that adding psychosocial interventions to withdrawal-ameliorating substitute drugs significantly improved the number of patients who completed treatment (from about 64 in every 100 dropping out the number was reduced to 45), reduced the proportion who continued to use opiate-type drugs during (from about 79 in every 100 down to 65) and after (from about 80 in every 100 down to 53) treatment, and halved the number of times patients failed to turn up at treatment sessions.

For the different types of psychosocial intervention, it was possible to pool data only for contingency management and psychotherapeutic counselling. Combining contingency management with pharmacological treatments significantly reduced drop-out rates, opiate use during treatment, and missed appointments. Only the latter could be assessed for psychotherapeutic counselling, and was also significantly reduced. Three other outcomes were reported only in one study (engagement in further treatment; use of other drugs; and mortality), so it was not possible to pool the data.

The authors' conclusions

The results of this review show that psychosocial adjuncts to pharmacological detoxification treatments improve completion rates and reduce opiate use during and after treatment. Their effects seems stronger than when such interventions are added to maintenance treatments which prescribe substitute opiate-type medications on a long-term and non-reducing basis. This may be 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.

The main limitation is that nearly all the studies were from the USA, a particular social and cultural context. Context can affect treatment outcomes, so it impossible to sure the same results would be found in other countries.

Outpatient opiate detoxification is a quick, inexpensive and common procedure that helps by ameliorating withdrawal symptoms and temporarily reducing health risk associated with illegal drug use. It also constitutes the first point of contact of many addicts with the various treatment services available, and may facilitate transition to long-term care. Given that methadone-based detoxification is so widely used, it is reasonable to attempt to try to develop more effective techniques, of which adding psychosocial interventions seems an example. Particularly interesting are the findings of improved attendance, providing extra opportunities to counsel patients in psychiatric, employment and other drug and non-drug related areas.

It is important however to remember that there is no evidence that detoxification can substitute for long-term treatment in the management of opiate addiction. Relapse to opiate use is not entirely due to avoidance of or escape from withdrawal symptoms, so a treatment which only addresses these symptoms can be at best partially effective. Many if not most of the physiological, behavioural and social conditions prevailing during an individual's life as an opiate addict will still be present when physical dependence has been eliminated. Furthermore, once methadone prescribed during detoxification (the

typical medication used) is no longer active, opiates will regain the reinforcing properties which previously sustained self-administration. Under these conditions, relapse is probable.

FINDINGS In Britain successful completion and exit from the treatment system of patients no longer dependent on drugs or using heroin or crack is now an important criterion of success on which some funding also hinges. This review suggests that for opiate users, the bulk of the treatment caseload, the opiate-free state and treatment completion essential to meeting this criterion is more likely to be achieved if drugs to ameliorate withdrawal symptoms are accompanied by systematically applied incentives geared to these objectives and/or counselling and therapy to help patients build a new and stable life without resort to opiate-type drugs. Conducted under stringent Cochrane collaboration procedures, the review focused on studies which should have virtually eliminated bias due to different types of patients opting for or being given different treatments by randomly allocating patients to the different programmes. It means the resulting estimates can be relied on as indications of the impact of the extra support in these studies, but also that very few studies made it in to the analysis, reducing the extent to which their results can be taken as indicative of what would happen in routine practice with different caseloads and in different countries.

Of those studies which did get through, just one was not from the USA. It was a British study published in 2002 which supplemented gradual methadone detoxification with family therapy for patients willing to have their partners or families involved and to join the study. On a variety of measures, family therapy patients were doing better six and 12 months later, when 22% and 15% were not using street opiates or being prescribed methadone, compared to at both times 8% of patients also withdrawn from methadone on a fixed schedule but with minimal psychosocial support, and just 5% and 0% of a 'standard' treatment group offered normal counselling and reduced at the discretion of the service, typically over 12 months compared to the six to 12 months on the fixed schedule. The patients who qualified for and joined the study were however just 119 of the 423 who sought treatment at the clinic, and family therapy was most clearly beneficial for those in a couple relationship. One year after starting treatment two of the 41 patients allocated to family therapy had died but none from the other treatments. With such small numbers this might be pure chance, but it might also reflect the greater risk faced by patients who relapse after having completed detoxification and become for a time opiate-free, during which time their tolerance to opiate-type drugs will have waned to the point when previously taken doses could be fatal. This will remain an important consideration as long as the relapse rate – in this study even with family therapy support – remains so high that return to opiate use is the norm after detoxification. As the featured review confirms, the extra support it evaluated is often the icing on what remains a very unsatisfactory cake, usually offering a short-lived respite which most patients do not complete.

British guidance for clinicians treating drug misuse and dependence on how to detoxify opiate-dependent patients draws on an appraisal of evidence and expert opinion published in 2007 by Britain's National Institute for Health and Clinical Excellence. In respect of psychosocial adjuncts, it was faced with a narrow set of research studies heavily weighted to the contingency management regimens favoured in recent US studies. Unable on the basis of the generally lacking scientific evidence to pronounce on

other interventions, its recommendations on specific types of programmes were limited to contingency management, which it saw as a cost effective option when wider economic, social and public health consequences of drug misuse are considered. The result was a recommendation for phased and evaluated introduction of these regimens to see if they work as intended in Britain. However, this aspect of NICE's recommendations was downplayed by the clinical guidance which instead called for a "full programme of psychosocial support" during detoxification and "access to a range of drug-free support services" afterwards.

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